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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the St. Cloud VA Health Care System in Minnesota

Healthcare Facility Inspection	25-00252-204	August 7, 2026

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the St. Cloud VA Health Care System (the facility) from June 24 through 26, 2025. The OIG team also followed up with facility staff in April 2026. The facility is rated as *low complexity* and in fiscal year 2025, provided direct care to 35,328 unique patients through June 2025.[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. While conditions in the inspected areas were generally satisfactory, the team observed containers being used for hazardous pharmaceutical waste and sharp items that did not meet standards, unsecured medications that were accessible to unlicensed personnel, and an emergency exit door that did not open. They followed up with facility staff on April 22, 2026, and confirmed staff implemented corrective actions, so the OIG made no recommendations for further addressing these findings. An external auditor (previously contracted) also had not conducted an environmental compliance audit since October 15, 2020, despite VHA Directive 7707, *VHA Green Environmental Management System and Governing Environmental Policy*, requiring an outside audit every three to five years.[3] According to the memorandum, *For Action: Completion of External Environmental Compliance Audits*, VHA now allows (as of May 29, 2026) Veterans Integrated Service Networks to include additional reviews to maintain compliance with VHA

[1] VHA classifies facilities based on their complexity level. Low-complexity facilities have "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack-Operational Statistics Table FY2025 Through June," VHA Support Service Center (VSSC), last updated March 17, 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 7707, *VHA Green Environmental Management System and Governing Environmental Policy*, April 1, 2021.

Directive 7707, since the national contract that supported the external reviews is no longer available.[4] Based on this change the OIG did not make a recommendation.

- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG made no recommendations.
- **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

The OIG made no recommendations.

VA Comments and OIG Response

The Interim Veterans Integrated Service Network Director and facility Director reviewed the report (see appendixes C and D). No further action is required.

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[4] Veterans Integrated Service Networks (VISNs) are "regional care systems working together to better meet local healthcare needs and provide greater access to care." "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/visns. In December 2025, VA announced plans to reorganize and consolidate its VISNs from 18 networks to 5. All VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. For more information on this initiative, visit https://digital.va.gov/rise. Chief Operating Officer/Executive Director, Medical Operations Center (10C), "For Action: Completion of External Environmental Compliance Audits (VIEWS 14796613)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), May 29, 2026.

[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

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

Contents

Introduction

The Office of Inspector General (OIG) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[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]

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

[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 St. Cloud VA Health Care System (the facility) opened in September 1924 and has clinics in Alexandria, Brainerd, and Montevideo, Minnesota. The facility's budget was approximately $413 million in fiscal year (FY) 2025. At the time of the site visit from June 24 through 26, 2025, the facility had 15 inpatient mental health, 205 community living center, and 122 domiciliary beds.[11]

Figure 1. *Facility photo.*
Source: "VA St. Cloud Health Care," VA, accessed May 14, 2025, https://www.va.gov/st-cloud.

The executive leaders referred to throughout this report include the Director, Associate Director, Associate Director of Patient Care Services/Nurse Executive (ADPCS), and Acting Chief of Staff.[12] Executive leaders reported the ADPCS (assigned in April 2020) had the longest tenure, and the Acting Chief of Staff (who started in March 2025) was the newest, with a permanent Chief of Staff that was scheduled to start in July 2025. The Director had been in the position for just over one year but described having valuable institutional knowledge from nearly 25 years in various roles at the facility.

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.[13] 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

[11] A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/CLC. A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, last updated June 23, 2026, https://department.va.gov/dchv. "MCAS 2025- Medical Center Allocation System Reports and Documentation," VA, accessed April 16, 2026, https://vaww.arc.med.va.gov/reports/FY25_MCAS. (This web page is not publicly accessible.)

[12] The Acting Chief of Staff was out of office from June 24 through 26, 2025, so the OIG interviewed the chief of health informatics, who was the acting Chief of Staff at the time.

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

assess their level of trust in VA).[14] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[15]

System Shocks

During an OIG interview, executive leaders reported several system shocks: return to in-person work requirements, employee departures under the deferred resignation program, and potential reductions in the workforce.[16] The leaders stated the changes and uncertainty caused employees to feel anxious and disengaged from work because they were worried about job security.

To address employees' concerns, executive leaders, chaplains, equal employment opportunity managers, and the union president held weekly gatherings at the main entrances and the cafeteria to answer questions and share information. The Director also described increasing town halls from monthly to every other week. The ADPCS added that executive leaders also went to areas where employees returned to in-person work to welcome them back. The Associate Director shared that they converted spaces, such as a classroom, into cubicles to accommodate returning employees. Despite challenges, the Associate Director said they had created space for approximately 250 employees from February 2025 through the inspection in June 2025. According to the Director, employees told leaders these efforts decreased their anxiety.

Employee Experiences

The Director reported that executive leaders implemented a new communication process to enhance transparency and employee engagement in January 2025. They posted announcements on the facility's website for employees to reference and allowed them to send questions directly. The Director responded to the questions in a weekly all-employee email that also included updates on organizational matters, such as planning for potential reductions in workforce. Executive leaders communicated with employees through daily huddles and rounds (visits to employees in their work areas). As a result of these efforts, the Director said employees reported they felt more comfortable communicating and sharing concerns with leaders.

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

[15] 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.

[16] Office of Personnel Management, "Agency Return to Office Implementation Plans," memorandum to Heads of Executive Departments and Agencies, January 27, 2025; Office of Personnel Management, "Guidance Regarding Deferred Resignation Program," memorandum to Heads and Acting Heads of Departments and Agencies, January 28, 2025; A reduction in workforce includes "reduction in the number of full-time equivalent (FTE) positions by eliminating positions that are not required." Office of Management and Budget and Office of Personnel Management, "Guidance on Agency RIF [reduction in force] and Reorganization Plans Requested by *Implementing the President's* "*Department of Government Efficiency*" *Workforce Optimization Initiative*," memorandum to Heads of Executive Departments and Agencies, February 26, 2025.

The Director believed employees felt psychologically safe.[17] Most employees who responded to the OIG's pre-inspection questionnaire indicated they felt comfortable reporting patient safety or other concerns. The Director noted that employees report many patient safety events, and leaders celebrate them with awards and recognition during safety meetings.

Veteran Experiences

Patient advocates' answers to an OIG questionnaire indicated that facility staff and leaders were responsive to veterans' concerns. The advocates also highlighted, however, veterans' complaints that focused on disrespect from some employees and concerns with care coordination between community and facility providers.[18] The Director said the facility had a training event in 2025 that focused on having employees create a culture of caring and connecting with veterans during visits. The Director also reported implementing a service-level patient advocate program so employees can address veterans' concerns more quickly at the point of care.

The Acting Chief of Staff stated that veterans may have concerns about community care because they experienced coordination delays when employees did not receive healthcare records from community providers in a timely manner. Executive leaders addressed community care concerns with veterans individually and at town halls. Additionally, leaders communicated with veterans through a biweekly newsletter. Community care coordination is discussed further in the Patient Safety and Integrated Veteran Care sections of this report.

Attention to environmental design improves veterans' and staff's safety and experience.[19] 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.

[17] "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.

[18] 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.

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

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.[20]

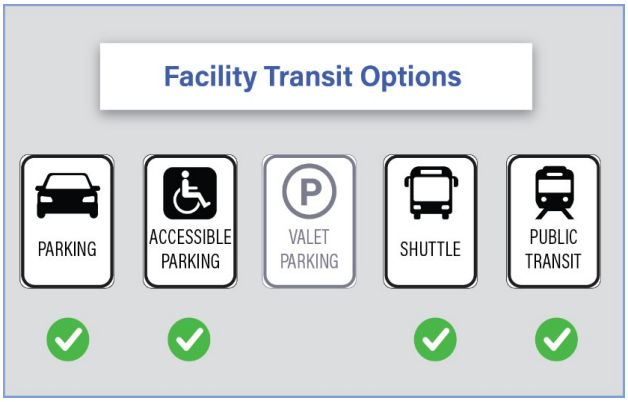

Figure 2. *Transit options for arriving at the facility. Source: OIG observations, parking lot map, public bus transit planner, and staff responses to document requests.*

General Inspection

The facility has a two-story parking structure near the main entrance. The main entrance was welcoming and clean and had volunteers at the information desk to assist veterans.

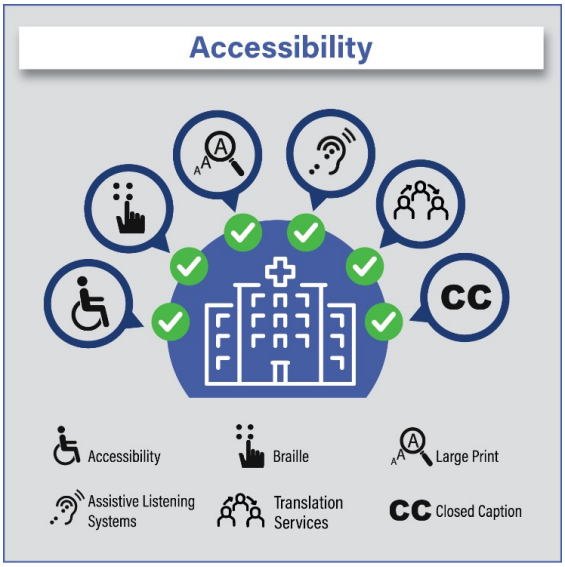

Figure 3. *Accessibility tools available to veterans with impairments.*
Source: Team observations, facility maps, facility liaison, OIG questionnaire responses, and a facility policy and procedure.

The inspection team noted signs, maps, and directories posted on walls. There were also various accessibility tools, including use of braille, closed captioning on televisions, and parking spaces accessible to those with disabilities.

However, OIG inspectors identified various safety hazards. Specifically, pharmaceutical hazardous waste disposal containers in multiple medication rooms did not meet the safe waste disposal standards stated in the Food and Drug Administration *Sharps Disposal Containers in Health Care Facilities* guidelines and the Code of Federal Regulations, title 29, section 1910.1030 on bloodborne pathogens.[21] The facility's containers had push-button tops and wide-rim openings like containers used for food storage. The containers also had labels directing staff to dispose of unused

[20] 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.

[21] "Pharmaceutical waste is any leftover, unused, or expired medication that is no longer needed or can no longer be used. It can be classified as either hazardous or non-hazardous depending on its chemical properties and its risk to humans and the environment." VHA Directive 1850.06(1), *Waste Management Program*, July 22, 2022, amended June 5, 2024. "Sharps Disposal Containers in Health Care Facilities," Food & Drug Administration, accessed June 26, 2025, https://www.fda.gov/medical-devices/sharps-disposal; 29 C.F.R. § 1910.1030 (2026).

medications and contaminated sharps, such as syringes, in them (see appendix B, figures B.1 and B.2).[22]

The containers were lined with a thin plastic bag, and the OIG team was concerned the bag was not puncture-resistant. The safety and occupational health manager explained that facility staff emptied the containers by lifting out the plastic bag and replacing it with a new bag. The Code of Federal Regulations requires sharps disposal containers to be "puncture-resistant;" it further states that containers "shall not be opened, emptied or cleaned manually or in any other manner" that could expose staff to risk of injury.[23] Further, the *Sharps Disposal Containers in Health Care Facilities* guidelines state that containers must have "an opening to accommodate depositing a sharp but not large enough for a hand to enter."[24] The OIG team was concerned that staff could reach inside and remove discarded medications or sharps, which could result in potential injury or misuse of medications, and so informed facility leaders of the problem.

The OIG team conducted a video follow-up call with facility staff on April 22, 2026. The staff provided evidence on the video call of replacements for these containers, and the inspection team was shown a black container in the urgent care medication room that met the standard for safe disposal. Based on these updates, the OIG did not make a recommendation.

The team also found that an external environmental auditor under contract conducted the last environmental audit virtually on October 14 and 15, 2020 (during pandemic precautions). VHA Directive 7707, *VHA Green Environmental Management System and Governing Environmental Policy* requires a third-party external environmental audit to be conducted every three to five years.[25] These audits ensure an external third party oversees the facility's management of hazardous materials or waste, as well as compliance with federal, state, and local environmental regulations. Although the facility was within the five-year audit window, the OIG learned that it would not undergo a third-party environmental audit. According to the Veterans Integrated Service Network (VISN) industrial hygienist, green environmental management system program manager, and national green environmental management system program manager for operations, this was due to funding issues that led to its cancellation.[26] Also during the follow-up

[22] "Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface." 29 C.F.R. § 1910.1030.

[23] 29 C.F.R. § 1910.1030.

[24] "Sharps Disposal Containers in Health Care Facilities," Food & Drug Administration.

[25] VHA Directive 7707, *VHA Green Environmental Management System and Governing Environmental Policy*, April 1, 2021.

[26] Veterans Integrated Service Networks (VISNs) are "regional care systems working together to better meet local healthcare needs and provide greater access to care." "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/visns. In December 2025, VA announced plans to reorganize and consolidate its VISNs from 18 networks to 5. All VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. For more information on this initiative, visit https://digital.va.gov/rise/.

video call on April 22, 2026, facility staff confirmed that the external audit has still not occurred—prompting the OIG to make a recommendation. In June 2026, the facility provided a May 29, 2026, VHA memorandum, *For Action: Completion of External Environmental Compliance Audits*, allowing VISNs to include additional reviews to maintain compliance with VHA Directive 7707 as the national contract that supported the external reviews is no longer available; therefore, the OIG did not make a recommendation.[27]

In the Urgent Care Clinic medication room, the OIG found medications stored on top of a counter, which made them available to any staff with access to the room. A unit nurse informed the OIG that certified nursing assistants (unlicensed personnel) had access to the locked medication room to retrieve patient care equipment stored there. VHA Directive 1108.07(2), *General Pharmacy Service Requirements* requires medications to be stored in a secure manner with access limited to authorized staff (those who are licensed, trained, or designated by facility policy to dispense, handle, or dispose of medications).[28] Inappropriate medication storage can increase the risk of drug diversion, tampering, contamination, and delays in patient care.

When interviewed, the chief of pharmacy reported being unaware that unauthorized staff had access to the medication room. While on-site, the OIG team returned to the Urgent Care Clinic the next day and found unauthorized staff could still enter the room. Facility staff confirmed and provided evidence during the follow-up on April 22, 2026, that access to the medications has been limited in accordance with the VHA directive. Based on the corrective action already taken, the OIG did not make a recommendation.

During the June 2025 inspection, the OIG team was unable to open an emergency exit door near a primary care clinic. The door had a sign that stated, "In emergency, push to open," but it did not open when an inspector applied force. Per the Code of Federal Regulations, title 29, section 1910.36(d)(1), "employees must be able to open an exit route door from the inside at all times without keys, tools, or special knowledge."[29] Additionally, the National Fire Protection Association's *NFPA 101: Life Safety Code* requires facilities to ensure exits are free of obstructions "in the case of fire or other emergency."[30] Facility staff repaired the door during the inspection, and a team member was able to open it later in the week, although the bottom of the door dragged against the ground when opened. The chief of facilities management stated in an interview that staff will continue to test the door to ensure it remains operational.

[27] Chief Operating Officer/Executive Director, Medical Operations Center (10C), "For Action: Completion of External Environmental Compliance Audits (VIEWS 14796613)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), May 29, 2026.

[28] VHA Directive 1108.07(2), *General Pharmacy Service Requirements*, November 28, 2022, amended December 6, 2024.

[29] 29 C.F.R. § 1910.36(d)(1) (amended April 22, 2026).

[30] The National Fire Protection Association, *NFPA 101: Life Safety Code*, 7.1.10.1, September 2023.

During the video call with facility staff on April 22, 2026, inspectors observed staff open the emergency exit door freely and it no longer dragged against the ground. Therefore, the OIG did not make a recommendation.

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 a policy and service-level workflows for staff to communicate test results, including urgent but noncritical test results, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[31] The facility also had standard operating procedures to address specific types of tests, such as critical results from imaging studies and critical and abnormal laboratory results.

The chief of quality and patient safety said the external peer review program coordinator presented external peer review data quarterly at Quality and Patient Safety Committee meetings.[32] The OIG reviewed the data and found communication of VA-specified test result metrics for quarter one of FY 2025 were above 90 percent.

Community care program leaders within the facility reported that local providers did not always respond to requests for test results in a timely manner, which could delay patient care. These leaders explained that when staff did not obtain community records after three unsuccessful attempts as the VHA Office of Integrated Veteran Care's *Community Care Field Guidebook* requires, they entered a patient safety event report and notified the VA-contracted third-party administrator responsible for overseeing community providers in their network.[33] Community care leaders in the facility met with the third-party administrator's representatives monthly to review concerns and trends, and to provide feedback. The OIG reviewed meeting minutes that showed leaders also reported issues regarding test result communications to the Community Care

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

[32] The external peer review program provides "an independent review of medical records to assess the quality of both inpatient and outpatient care provided across" VHA. "Clinical Performance Measurement Program," VHA Office of Quality and Patient Safety, last updated March 7, 2022, https://vaww.qps.med.va.gov/CPMP. (This website is not publicly accessible.)

[33] VHA Office of Community Care, *Veterans' Health Administration Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*, February 2022; VHA Office of Integrated Veteran Care, chap. 4 in *Community Care Field Guidebook*, November 14, 2025.

Oversight/Clinic Practice Management Committee, which included executive leaders. Based on these efforts, the OIG did not make a recommendation.

Action Plans and Process Improvements

The facility had completed all identified actions to address the OIG recommendations from the last comprehensive healthcare inspection conducted in 2022.[34] The chief of quality and patient safety said that patient safety staff routinely review OIG reports that focus on other facilities across the country to ensure they do not have the same identified problems to make certain they comply with VHA requirements.

Documents showed facility leaders and staff also incorporated OIG recommendations issued to other facilities into their risk assessments and quality improvement plans. The coordinator reported the facility had 15 process improvement projects underway and described a March 2025 collaborative high reliability organization and patient safety project to reduce falls, called the St. Cloud VA Falls Escape Room.[35] The patient safety manager said the project was successful, so patient safety staff also planned a suicide prevention escape room activity.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities. 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

The primary care administrative officer reported the facility offers primary care services through 33 teams across four locations. In June 2025, primary care team vacancies included provider, registered nurse, and licensed practical nurse positions. The OIG reviewed documents that showed two-thirds of all primary care panels (the number of patients assigned to a care team) were above the baseline of 1,200 patients, as recommended in VHA Directive 1406(3), *Patient*

[34] VA OIG, *Comprehensive Healthcare Inspection of the St. Cloud VA Health Care System in Minnesota*, Report No. 22-02666-214, September 19, 2023.

[35] An escape room is a space "where teams collaborate to uncover clues, solve puzzles, and complete tasks." Carla Sílvia Fernandes et al., "Escape Rooms in Nursing: A Systematic Review and Meta-Analysis," *The Journal of Continuing Education in Nursing* (May 2025): 175-182, https://doi/10.3928/00220124-20250416-05. The objectives of the project included the ability to demonstrate use of a fall risk assessment tool, implement fall interventions, assess environmental fall risk factors, and identify assistive device needs.

Centered Management Module (PCMM) for Primary Care.[36] A primary care provider explained that when vacancies occur, primary care leaders reassign patients across all other panels.

The inspection team found that established patients' wait times decreased from 5 to 3 days and new patients' wait times from 16 to 11 days from the second quarter of FY 2024 to the second quarter of FY 2025. The Acting Chief of Staff reported that efforts to streamline view alerts, including minimizing nonmandatory alerts and training new providers, were associated with improved primary care access at the facility.

Community Care Staffing and Access to Care

The OIG reviewed facility documents showing two community care administrative staffing vacancies; however, during an interview, the supervisory program specialist reported two additional vacancies. Executive leaders said they were delayed in filling the four positions because of broad, system-wide disruptions affecting hiring across the facility (as noted in the Culture section of this report).

The community care supervisory program specialist also said the facility averaged 1,981 community care consults (referrals) per month. The OIG inspection team reviewed the facility's referrals for the first two quarters of FY 2025 and found that on average, community care staff scheduled patients' appointments in 12 days; however, VHA's *Consult Timeliness Standard Operating Procedure* requires staff to schedule appointments within 7 days of referral.[37]

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

[36] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. As of April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website). VHA Directive 1406(3) *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

[37] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 2025.

life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[38]

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of homeless veterans who received an HCHV program intake assessment.[39] However, this fiscal year (FY 2026), VHA no longer uses intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[40] Finally, HCHV2 measured the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[41]

Performance and Improvement Highlights

- The facility program provided services to Native American veterans on the Leech Lake Band of Ojibwe tribal lands.
- The program met the intake assessment (HCHV5) target for FY 2024 and the first two quarters of FY 2025. Although the program met the target, the manager reported veteran outreach was a challenge because of the facility's large geographic service area and its rurality, particularly in the northern part of the state. The program also met the target for exits to permanent housing (HCHV1) for FY 2024 and the first quarter of FY 2025, but not the second quarter. The facility program

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

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

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

[41] 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*.

manager explained that they did not meet the target in the second quarter because a discharged veteran most likely did not enter permanent housing.

- Program staff did not keep negative exits (HCHV2) below the ceiling target for FY 2024 or the first two quarters of FY 2025. They reported the main barrier as the small number of veterans enrolled in their contracted emergency residential services program, so each negative exit had a large impact on the performance metric.

Housing and Urban Development–Veterans Affairs Supportive Housing

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

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

Performance and Improvement Highlights

- The facility program manager said the facility met the voucher use (HMLS3) target for FY 2024 and the first two quarters of FY 2025. Facility program staff achieved this through weekly meetings with community partners and landlords, as well as weekly staff meetings to conduct housing and rental searches.
- Program staff reported they worked closely with employees from two leased apartment complexes on facility property to prioritize admission for veterans and maintained relationships with public housing agencies in their service area.
- The program successfully met the employment (VASH3) target for FY 2024 and the first two quarters of FY 2025. Facility staff mentioned they meet monthly with their own employment specialist to discuss veterans' work situations and audit

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

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

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

records to ensure staff correctly entered participating veterans' employment status in VA's national database.

Veterans Justice Program

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

Performance and Improvement Highlights

- The program met the enrollment (VJP1) target for FY 2024 but not the first two quarters of FY 2025. The veterans justice outreach specialist reported conducting monthly activities at the prison and participating in its resource fairs.
- The specialist stated the veterans treatment court was unique because it is composed solely of volunteers, including the judge, prosecutors, defense attorneys, and county veteran service officers. The specialist also described the use of diversion interventions, a process in which facility program staff engage with veterans before they enter the criminal justice system or incur serious criminal charges to avoid them.[47] For example, a veteran with substance use issues frequently called emergency services while under the influence and faced criminal charges. The specialist worked with court officers to help the veteran enter a residential substance treatment program, which they completed to avoid criminal prosecution.

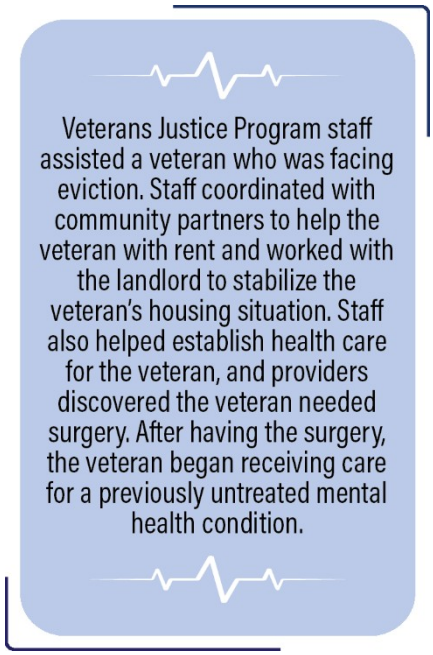

Figure 4. *Success story.*
Source: OIG questionnaire response.

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

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

[47] Diversion "allows a defendant to pursue treatment in lieu of traditional criminal processing." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Conclusion

To assist leaders in evaluating the quality of care at the St. Cloud facility, the OIG conducted an inspection across five domains. The OIG did not make recommendations following this inspection. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

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

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[48] 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 team inspected the facility from June 24 through 26, 2025. 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.[49] 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.*[50]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[51] 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.

[48] The accreditation reports covered the time frame of July 20, 2019, through September 30, 2024—the most recent available at the time of the inspection.

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

[50] 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.

[51] 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. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

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.[52] 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.

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

Appendix B: Additional Photographs

Figure B.1. *Pharmaceutical hazardous waste containers.*
Source: Photo taken by OIG inspector during site visit from June 24 through 26, 2025.

Figure B.2. *Pharmaceutical hazardous waste containers with the tops removed.*
Source: Photo taken by OIG inspector during site visit from June 24 through 26, 2025.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 15, 2026

From: Interim Network Director, VA Midwest Healthcare Network (10N23)

Subj: Healthcare Facility Inspection of the St. Cloud VA Health Care System in Minnesota

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

Chief Integrity and Compliance Officer (10OIC)

Thank you for the opportunity to review and comment on the Office of Inspector General Healthcare Facility Inspection draft report of the St. Cloud VA Health Care System in Minnesota.

I appreciate OIG's partnership in our continuous improvement efforts.

(Original signed by:)

Judith Johnson-Mekota
Interim Executive Director
VA Midwest Health Care Network (VISN 23)

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 9, 2026

From: Executive Director, St. Cloud VA Health Care System (656)

Subj: Healthcare Facility Inspection of the St. Cloud VA Health Care System in Minnesota

To: Director, VA Midwest Healthcare Network (10N23)

Thank you for the opportunity to review and comment on the Office of Inspector General Healthcare Facility Inspection draft report of the St. Cloud VA Health Care System in Minnesota that was conducted June 24 to June 26, 2025.

I appreciate the OIGs partnership in our continuous improvement efforts.

(Original signed by:)

Cheryl Thieschafer

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