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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Nebraska-Western Iowa Health Care System in Omaha

Healthcare Facility
Inspection

25-00239-196

October 9, 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 VA Nebraska-Western Iowa Health Care System (the facility) from September 23 through 25, 2025. The facility is rated as *high complexity* and in fiscal year 2025, provided direct care to about 62,370 patients.¹ The inspection team examined aspects of care delivery and patient safety within the facility using five domains.² In June 2026, the OIG received updates from facility leaders related to staffing challenges reported during the inspection.

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. During the inspection, the team identified cleanliness issues with storage shelves, refrigerator seals, and light fixtures. Additionally, staff stored housekeeping and biohazard materials together and did not decontaminate pneumatic tube system carriers, which transport medications, biohazardous materials, and lab specimens. These findings do not align with VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Controls Programs*; therefore, the OIG made one recommendation for corrective action.³

Additionally, the inspection team found that the facility's annual assessment for *Legionella* (a bacteria that causes pneumonia) did not include the Papillion community living center, as required by VHA Directive 1061(4), *Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems*, although a patient

¹ VHA classifies facilities based on their complexity level. High-complexity facilities have "medium-high-volume, high-risk patients, many complex clinical programs, and medium-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 March," VHA Support Service Center, last updated April 28, 2026, <https://reports.vssc.med.va.gov/ReportServer/Pages/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 Controls Programs*, November 27, 2023.

there tested positive for the bacteria the previous year.⁴ The team also found the facility's practice for hazardous pharmaceutical waste storage and disposal at both the Omaha and Grand Island VA Medical Centers did not align with its *Regulated Waste Materials Management* policy and *Pharmaceutical Return, Waste, and Disposal Standard Operating Procedure*. The OIG made two associated recommendations.

- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The team noted the facility did not have service-level workflows to define staff roles for communicating test results, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*. The OIG made one recommendation.⁵
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.⁶ 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 have recently been incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Director takes appropriate steps to maintain clean patient care areas and properly manage biohazards, in accordance with Veterans Health Administration Directive 1131, *Management of Infectious Diseases and Infection Prevention and Controls Programs*.
2. The Director takes appropriate steps so the facility's annual assessment for *Legionella* disease prevention includes the Papillion community living center, as required by Veterans Health Administration Directive 1061(4), *Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems*.
3. The Chief of Staff takes the appropriate steps for leaders to assess the facility's pharmaceutical waste disposal processes and reeducate staff on safe handling and

⁴ VHA Directive 1061(4), *Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems*, February 16, 2021, amended October 21, 2024. 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/VA_CLC.

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

⁶ 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.

disposal practices, in accordance with the facility's *Regulated Waste Materials Management* policy and *Pharmaceutical Return, Waste, and Disposal Standard Operating Procedure*.

4. The Chief of Staff and Associate Director for Patient Care/Nurse Executive take the appropriate steps so leaders create service-level workflows that outline staff roles for communicating test results to patients and providers, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

VA Comments and OIG Response

The 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 for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.



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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

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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.⁷ 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.⁸



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.⁹



Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.¹⁰



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.¹¹

⁷ "About Us," VA, last updated June 2, 2026, <https://department.va.gov/vha/about-us>.

⁸ 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>.

⁹ VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

¹⁰ VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

¹¹ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The VA Nebraska-Western Iowa Health Care System (the facility) includes two main locations: the Omaha VA Medical Center and the Grand Island VA Medical Center, both located in Nebraska. It has community living centers in the Grand Island VA Medical Center and in leased space at the CHI-Midlands hospital in Papillion, Nebraska.¹² The facility's fiscal year (FY) 2025 budget was over \$2.2 billion. It has 55 internal medicine, 18 mental health, 19 surgery, 9 compensated work therapy, 37 domiciliary, and 76 community living center operating beds.¹³



Figure 1. Facility photo.

Source: "VA Nebraska-Western Iowa Health Care," VA, accessed November 24, 2025, <https://www.va.gov/nebraska-western-iowa-health-care>.

The OIG team inspected the facility from September 23 through 25, 2025. The executive leaders referred to throughout this report include the Director, Chief of Staff, Associate Director, and Associate Director for Patient Care/Nurse Executive. According to facility staff, all members of the leadership team were assigned to their positions in 2021, except for the Chief of Staff, who began in 2016.



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.¹⁴ The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which

¹² As noted in the summary, 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/VA_CLC. "Locations," VA, accessed August 14, 2025, <https://www.va.gov/nebraska-western-iowa-health-care/locations>; "About Us," VA, last updated July 1, 2025, <https://www.va.gov/nebraska-western-iowa-health-care/about-us>; "Operating Beds, Average Daily Census, and Occupancy Rate Using Actual Beds," VHA Support Service Center, accessed August 14, 2025, <https://reports.vssc.med.va.gov/ReportViewerBedRpt>. (This web page is not publicly accessible.) "CHI" refers to Catholic Health Initiatives. "About Us," CHI Health, accessed June 24, 2026, <https://www.chihealth.com/about-us>.

¹³ Compensated work therapy "provides evidence based and evidence informed vocational rehabilitation services" for veterans as well as other supports and partnerships for employment. "Compensated Work Therapy," VA, last updated June 15, 2026, <https://department.va.gov/vha/cwt>. A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, <https://department.va.gov/homeless/dchv>.

¹⁴ Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, <https://doi.org/10.1136/bmjqs-2017-007573>.

summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).¹⁵ The team also interviewed executive and facility leaders and employees and considered data from patient advocates.¹⁶

System Shocks

Executive leaders interviewed in September 2025 said the facility’s aging infrastructure has disrupted facility operations within the past year. In the summer of 2025, for example, a leaking sink caused flooding in both inpatient and outpatient areas. Leaders reported that they arrived on-site, activated the incident command center (which coordinates information and resources to support response activities), and mobilized employees to take action.¹⁷ Employees relocated veterans, equipment, and furniture; completed most of the cleanup by late morning; and reported no adverse patient events.

Leaders also described operational disruptions due to the hiring freeze (in effect from January 20, 2025, to October 15, 2025) and return to in-person work initiatives.¹⁸ They reported that these actions resulted in staffing vacancies (particularly in administrative roles, such as fiscal, interior design, and support services), delayed hiring, and increased pressure on administrative and clinical employees. There were also human resources vacancies that delayed bringing new employees on board. For example, a pulmonologist’s (a physician who specializes in lung disease) onboarding was delayed, and employees had to reschedule procedures for after the physician’s planned start date.¹⁹

Leaders also said they redistributed responsibilities among existing employees who took on additional duties or served in acting roles for extended periods. Further, leaders submitted formal

¹⁵ “Veteran Trust in VA,” VA, last updated June 4, 2026, <https://www.va.gov/initiatives/veteran-trust-in-va>.

¹⁶ 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.

¹⁷ VHA Directive 0320.12(1), *National Incident Management System Compliance*, December 8, 2020, amended January 25, 2021.

¹⁸ 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; Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

¹⁹ Merriam-Webster, “Pulmonologist,” accessed September 29, 2025, <https://www.merriam-webster.com/pulmonologist>.

requests to VHA to reduce bed capacity in the acute mental health and the medical-surgical units due to low patient volume.

However, leaders acknowledged employees who served in acting roles or performed additional duties experienced frustration and burnout. To help retain staff, the Director said the Associate Director for Patient Care/Nurse Executive offered alternative work schedules when appropriate. Leaders emphasized that these temporary strategies helped sustain operations but expressed concern about their ability to operate long-term under constrained hiring conditions. In June 2026, facility staff reported that hiring capabilities for administrative roles have improved and the facility is now authorized to recruit for all positions listed on the organizational chart; however, hiring challenges remain. Facility staff noted that recruitment for certain positions (program support assistant, engineering, and environmental management positions) continue to be delayed by Office of Personnel Management's position description reviews, and vacancies remain in human resources staffing.

Employee Experiences

Approximately 42 percent of respondents to an OIG questionnaire indicated the culture of the facility was moving in a positive direction (about 32 percent disagreed). Additionally, most respondents reported feeling comfortable suggesting ways to improve their work environment and reporting a patient or staff concern.

Leaders described several efforts to support employees. They hired a wellness coordinator to lead initiatives focused on employee well-being. For example, both the Omaha and Grand Island VA Medical Centers offer on-site gyms and stress management resources, including chair yoga and tai chi classes. Leaders said that chaplains also offer brief reflections or stories to help employees recharge during the workday.

To address burnout and emotional fatigue, leaders implemented Team Lavender, a peer support initiative. The team includes chaplains and other wellness employees who respond to individual and unit-level support requests, particularly following emotionally challenging events such as patient deaths, medical emergencies, or administrative changes. Team members meet with employees to reflect on the event, provide emotional support, and refer them for additional resources as needed. Leaders stated at the time of the inspection in September 2025 that Team Lavender received frequent requests, at times as often as once per week.

To support patient safety, the Chief of Staff reported personally meeting with all new employees to encourage them to raise safety concerns. Leaders also present *Good Catch* awards (which recognize employees who identify patient safety issues and take action) and acknowledge employees who report concerns during daily huddles (meetings with different staffing levels) to reinforce a nonpunitive approach to safety reporting. They explained that these efforts, combined with consistent communication and responsiveness, have contributed to improved employee trust and engagement.

Veteran Experiences

The facility's outpatient VSignals trust scores exceeded the VHA average of 93 percent for FY 2024 and met or exceeded the VHA average in the first three quarters of FY 2025. Executive leaders attributed these results to their ongoing engagement and responsiveness to veterans' concerns. For example, leaders reported they meet monthly with a group of volunteers who receive care at the facility to gather feedback. In addition, volunteers manage a comment card system and share results with leaders. During visits to patient care areas, leaders solicit additional feedback directly from veterans.

However, executive leaders and facility staff acknowledged that veterans' common complaints were related to community care, such as issues with billing, scheduling wait times, and eligibility.²⁰ Leaders noted that community care billing issues, such as local providers charging private insurance instead of VA, were difficult to resolve because VA's national office manages these functions, not local facilities. Although local facilities have limited ability to resolve these issues directly, VA OIG special agents routinely review and investigate such matters to identify potential fraud, ensure accountability, and safeguard VA resources.

A facility staff member said patient advocates are located at the Omaha and Grand Island VA Medical Centers and the Lincoln community-based outpatient clinic. Three of five patient advocates responded to the OIG questionnaire and agreed there are established mechanisms for veterans to provide direct feedback to leaders, and leaders are responsive to concerns.



ENVIRONMENT OF CARE

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.

²⁰ 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.

²¹ "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.²²

General Inspection

The OIG team physically inspected the Omaha and Grand Island VA Medical Centers, and the Grand Island and Papillion community living centers. Based on documents and observations, the team found adequate parking, including accessible spots for those with disabilities, and shuttle service at the medical centers.

Inspectors also noted the facility completed an upgrade to exterior wayfinding signs in June 2025. At each location, the OIG observed clear and easy-to-read exterior signs that directed veterans to parking areas, building entrances, and specific services. Inside the buildings, directional signs were thorough and placed in reception areas, at hallway intersections, and near elevators.

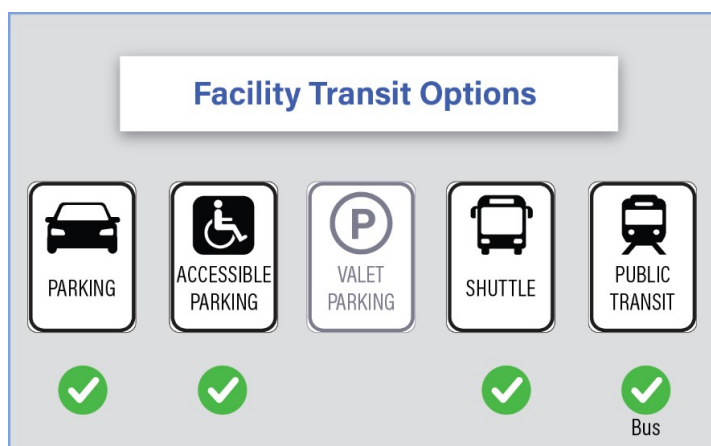


Figure 2. Transit options for arriving at the facility.

Source: Analysis of an OIG questionnaire response by a leader, team observations, and maps.

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.

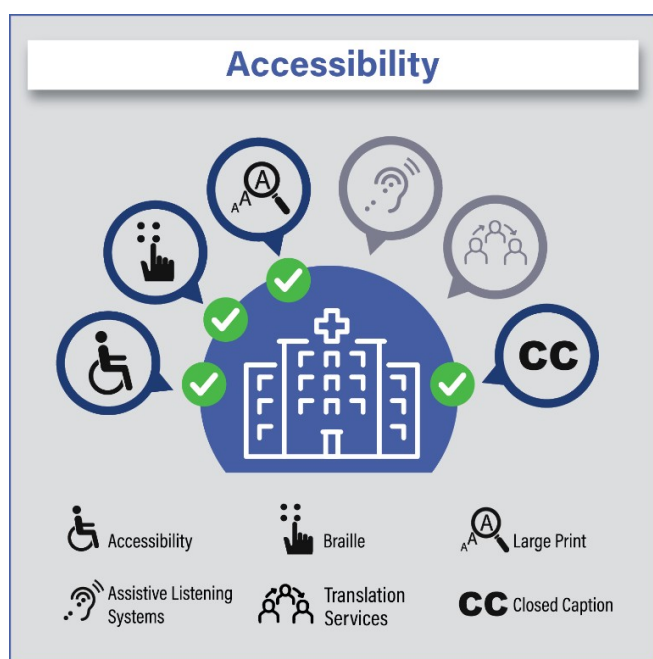


Figure 3. Accessibility tools available to veterans with impairments.

Source: Discussions with volunteers and leaders and team observations.

The team also evaluated whether facility navigational cues were effective for veterans with visual and hearing impairments and found several accessibility features (see figure 3). However, a veteran told the OIG team the monitor in the pharmacy waiting area, which notifies veterans when prescriptions are ready, uses small text and is difficult to see. This could cause them to miss notifications, delay medication pickup, and increase wait times. The veteran, who has hearing loss, appreciated closed captioning on televisions in waiting rooms, but the team found staff used it inconsistently across facility locations, which may negatively affect some veterans' experiences. Because VHA does not have specific accessibility requirements for monitors and televisions, the OIG did not make a formal recommendation to take

corrective action. The information was, however, shared with facility staff.

During the September 2025 inspection, the OIG team did not observe repeat environment of care issues previously identified in the March 2025 Veterans Integrated Service Network (VISN) Annual Workplace Evaluation or June 2025 Joint Commission survey.²³ The team inspected the Grand Island VA Medical Center's ambulatory care unit; the Omaha VA Medical Center's intensive care unit, emergency department, ambulatory care unit, and a medical and surgical unit; and the community living centers.

²³ VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). "Veterans Integrated Service Networks," VA, last updated July 24, 2026, <https://department.va.gov/visns>. In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit <https://digital.va.gov/rise>. *Annual Facility Evaluation for VA Nebraska-Western Iowa HCS*, March 17 through 20, 2025; *The Joint Commission, Final Accreditation Report VA Nebraska-Western Iowa Health Care System Hospital, Behavioral Health Care and Human Services, Home Care*, June 30, 2025.

Inspectors observed multiple cleanliness concerns at the Omaha VA Medical Center and the Papillion community living center. The Omaha VA Medical Center had dusty bottom shelves in clean storage rooms, visible debris on refrigerator seals, and dead insects inside light fixtures near the emergency department entrance. At the Papillion community living center, the team identified dirty sinks and microwaves.

The OIG discussed these concerns with leaders from environmental management, engineering, and infection control departments, who agreed staff needed to address these issues.

Environmental management leaders acknowledged they overlooked cleaning refrigerator seals and bottom shelves in clean storage rooms.

The OIG team also identified an infection control issue with the Omaha VA Medical Center's pneumatic tube system, which transports medications, biohazardous materials, and lab specimens to and from various medical center locations. Staff stated they use the same pneumatic tube system carriers to transport both clean and biohazardous items and do not have a process to ensure staff clean the carriers after they transport biohazardous substances. Proper cleaning and disinfection of pneumatic tube carriers is essential to prevent contamination of clean items and reduce the risk of infection to patients and staff. Staff said they used red-colored carriers for biohazard materials, and that some carriers had biohazard stickers, but they no longer consistently use them. At the time of the September 2025 inspection, the OIG could not locate any carriers specifically designated to transport biohazardous substances.

Additionally, the OIG team found staff used the same space for housekeeping items, like brooms and trash bags; linens; and biohazard storage in the medical and surgical inpatient unit. VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Controls Programs* requires facilities to ensure the provision of infection prevention and control guidance on the separation of soiled and contaminated versus clean or sterile.²⁴ In October 2023, facility staff had identified this issue in multiple patient care areas and developed a plan with VISN leaders that required staff to relocate linens and housekeeping supplies to a different storage closet. Staff reported the action plan was completed later that year. However, the OIG determined the plan was inadequate because at the time of the inspection in September 2025, staff had not removed all housekeeping supplies from the closet storing biohazard materials.

VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires facilities to maintain a clean environment to reduce risks of infection for patients and staff. The OIG team determined the issues discussed above suggest lapses in cleaning processes and environment of care oversight.

²⁴ VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Controls Programs*, November 27, 2023.

Recommendation 1

The Director takes appropriate steps to maintain clean patient care areas and properly manage biohazards, in accordance with Veterans Health Administration Directive 1131, *Management of Infectious Diseases and Infection Prevention and Controls Programs*.

 X Concur

 Nonconcur

Target date for completion: March 1, 2027

Director Comments

The VA Nebraska-Western Iowa Health Care System implemented corrective actions to address the identified environmental cleanliness, infection prevention, storage, and safety concerns. Actions include routine supervisory inspections of clean supply storage areas; enhanced cleaning of Nutrition and Food Service refrigerator seals; cleaning and planned replacement of affected Emergency Department entrance light fixtures; strengthened cleaning processes for sinks and microwaves at the Papillion Community Living Center (CLC); implementation of color-specific pneumatic tube carriers, associated staff education, signage, policy updates, and cleaning controls; and appropriate separation of housekeeping, linen, and biohazard-related items on the medical/surgical inpatient unit.

To ensure sustained compliance, responsible services will monitor corrective actions through supervisory checklists, environmental rounds, sanitation inspections, quality assurance reviews, and standardized audits, as applicable. The established goal is at least 90 percent compliance sustained for six consecutive months, with identified deficiencies corrected promptly and recurring trends addressed through additional corrective action or staff education. Results will be reported through the applicable oversight committees and leadership structures. Monitoring will continue through March 1, 2027, to demonstrate sustained compliance.

Facility staff also described challenges managing *Legionella* (a bacteria that can cause pneumonia) at the Papillion community living center.²⁵ Because the community living center is leased, facility staff have limited control over water management and *Legionella* testing. Facility leaders informed the OIG that in March 2025, one community living center patient tested positive for *Legionella* pneumonia. Staff treated and discharged the patient. VHA

²⁵ *Legionella* bacteria “are naturally found in water and have been associated with building water distribution systems and cooling towers.” VHA Directive 1061(4), *Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems*, February 16, 2021, amended October 21, 2024.

Directive 1061(4), *Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems*, requires facilities to complete an annual assessment to determine which buildings must be included in their *Legionella* disease prevention plan to ensure water safety. The OIG team reviewed the facility's annual assessment and found it did not include the community living center. The OIG reviewed facility data and found no additional reports of *Legionella* since the site visit in September 2025.

Recommendation 2

The Director takes appropriate steps so the facility's annual assessment for *Legionella* disease prevention includes the Papillion community living center, as required by Veterans Health Administration Directive 1061(4), *Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems*.

 X Concur

 Nonconcur

Target date for completion: January 30, 2027

Director Comments

The VA Nebraska-Western Iowa Health Care System updated the Healthcare-Associated (HCA) *Legionella* Disease Prevention Plan on August 28, 2026, to include the leased inpatient Papillion Community Living Center (PCLC), in accordance with VHA Directive 1061.

To ensure sustained compliance, the Facility Water Safety Committee (FWSC) will review the HCA *Legionella* Disease Prevention Plan at least annually and update the plan as necessary to ensure applicable facilities remain appropriately included. The FWSC meets at least quarterly and reports through the Environment of Care Committee, providing ongoing leadership oversight and accountability. As the PCLC has been incorporated into the plan and an established process is in place for continued review, the Health Care System considers the corrective action complete and respectfully recommends closure of this finding.

OIG Comments

The OIG considers this recommendation open to allow time for leaders to submit documents to support closure.

At both the Omaha and Grand Island VA Medical Centers, the inspection team found improper practices for storing and discarding hazardous pharmaceutical waste. The facility's *Regulated Waste Materials Management* policy mandates that hazardous waste containers be removed from

units daily and placed in a waste holding room.²⁶ In the Grand Island community living center, the OIG team observed bins containing chemotherapy waste in rooms that staff had cleaned and prepared for new patients. Additionally, the facility's *Pharmaceutical Return, Waste, and Disposal Standard Operating Procedure* requires hazardous drug waste to be disposed of in yellow containers.²⁷ However, staff used different color containers for pharmaceutical waste in the Omaha VA Medical Center's intensive care unit and Papillion community living center. If staff do not comply with proper disposal procedures, both patients and staff may be exposed to harmful hazardous substances.

Recommendation 3

The Chief of Staff takes the appropriate steps for leaders to assess the facility's pharmaceutical waste disposal processes and reeducate staff on safe handling and disposal practices, in accordance with the facility's *Regulated Waste Materials Management* policy and *Pharmaceutical Return, Waste, and Disposal Standard Operating Procedure*.

☒ Concur

☐ Nonconcur

Target date for completion: March 1, 2027

Director Comments

The VA Nebraska-Western Iowa Health Care System implemented corrective actions in response to the OIG findings related to pharmaceutical and chemotherapy waste disposal. At the Grand Island Community Living Center (CLC), all identified waste containers were immediately removed from patient care areas, EVS [Environmental Services] staff were re-educated on daily removal requirements, and verification that regulated medical and chemotherapy waste containers have been appropriately removed was added to the standardized preoccupancy inspection checklist. At the Omaha VA Medical Center and Papillion CLC, pharmaceutical waste signage was updated to clearly identify the appropriate containers for non-hazardous pharmaceutical waste, and the revised signage was deployed to the identified medication rooms and pharmacy locations.

To ensure sustained compliance, EVS supervisors conduct daily rounds and preoccupancy inspections at the Grand Island CLC, with identified deficiencies corrected immediately and compliance results reviewed monthly by EVS leadership and reported through the

²⁶ VA Nebraska-Western Iowa Health Care System Policy ASD-EMS-002, "Regulated Waste Materials Management," November 23, 2021.

²⁷ VA Nebraska-Western Iowa Health Care System, Pharmacy Service, "Pharmaceutical Return, Waste, and Disposal Standard Operating Procedure," April 21, 2023.

Environment of Care Committee. The established goal is at least 90 percent compliance sustained for six consecutive months. GEMS [Green Environmental Management Systems] and Pharmacy will continue monitoring pharmaceutical waste signage and compliance at the Omaha VA Medical Center and Papillion CLC, with a goal of 100 percent compliance and results reported through the GEMS Committee. Monitoring will continue through March 1, 2027 to demonstrate six consecutive months of sustained compliance.



PATIENT SAFETY

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 OIG team found the facility's policy for sharing test results with patients and the providers who order them includes clear steps for reporting, in alignment with VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*. However, the facility had one workflow that detailed team members' roles in the communication process, rather than a workflow for each service, as required by the directive.²⁸

Without clear workflows, staff might not communicate test results properly or timely, which could delay care and negatively affect patient safety and outcomes. In an interview, the Chief of Staff acknowledged not meeting the requirement. Leaders reported that they hired a compliance officer, who is responsible for forwarding new and revised directives to staff to ensure facility practices adhere to all VHA policies.

Recommendation 4

The Chief of Staff and Associate Director for Patient Care/Nurse Executive take the appropriate steps so leaders create service-level workflows that outline staff roles for communicating test results to patients and providers, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

☒ Concur

☐ Nonconcur

²⁸ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

Target date for completion: November 2, 2026

Director Comments

The Chief of Staff and Associate Director for Patient Care Services/Nurse Executive ensured leaders developed service-level workflows for all applicable services in which diagnostic tests are ordered, consistent with VHA Directive 1088(1) and facility policy COS-045.

The workflows identify staff roles and responsibilities for receiving, reviewing, communicating, documenting, and following up on test results, including delegation, surrogate coverage, and contingency processes when the ordering provider is unavailable.

As service-level workflows for all applicable services have been completed and establish the required processes for communicating and managing test results, the Health Care System considers the corrective action complete and respectfully recommends closure of this finding.

OIG Comments

The OIG considers this recommendation open to allow time for leaders to submit documents to support closure.

During an interview, quality management staff indicated they monitor data on test result communications through the External Peer Review Program, which oversees facilities' results on performance measures. The OIG reviewed the data and found that staff communicated test results that required action within seven days, as required by VHA Directive 1088(1), and outperformed other facilities in the VISN and VHA national averages for this metric.

Action Plans and Process Improvements

The inspection team noted that leaders had completed all corrective actions for recommendations from the OIG's most recent comprehensive healthcare inspection report, published April 24, 2024.²⁹ Quality management staff said the facility's Continuous Readiness Committee oversees all action plans from the time an oversight body issues a recommendation until they close it. The committee meets monthly to evaluate the ongoing plan for effectiveness and provides quarterly updates to the Quality, Patient Safety, and Value Council to ensure leaders remain informed and engaged. The patient safety manager shared that the facility received the Patient Safety Program of Excellence designation on April 7, 2025, from VHA's National Center for Patient Safety.³⁰

²⁹ VA OIG, [Comprehensive Healthcare Inspection of the VA Nebraska-Western Iowa Health Care System in Omaha](#), 23-00098-151, April 24, 2024.

³⁰ "VHA National Center for Patient Safety," VA, last updated September 29, 2025, <https://www.patientsafety.va.gov>.



INTEGRATED VETERAN CARE

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.³¹ 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

Based on facility documents and an interview with primary care leaders, the OIG identified vacancies for 7 providers, 5 registered nurses, 7 licensed practical nurses, 1 clinical pharmacist, and 15 medical support assistants across 51 primary care teams as of September 2025. In the interview, primary care leaders said they received approval from executive leaders to fill the vacant positions. Facility staff stated several providers and nurse candidates had accepted employment offers and were awaiting start dates. However, leaders described long-standing provider recruitment challenges at some sites due to rural locations. Leaders also reported a limited pool of licensed practical nurse applicants, which they attributed to a statewide shortage. They also discussed recruitment issues for medical support assistants due to noncompetitive pay compared to community hospitals. In a June 2026 update, facility leaders reported that challenges related to hiring licensed practical nurses and medical support assistants have improved since the OIG team was on-site. However, hiring and staffing challenges for providers have stayed the same and recruiting in rural areas remains difficult.

To address these challenges, primary care leaders said they used dedicated recruiters and student loan repayment as an incentive. Leaders also used temporary providers and staff to cover vacancies; some supported primary care teams at more than one location.

The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the facility's appointment wait time is greater than 20 days.³² The OIG reviewed data that showed average new patient wait times increased to 23 days starting at the end of FY 2024. Primary care leaders attributed the increase, in part, to staffing vacancies. For example, the North Platte community-based outpatient clinic reported the highest wait times for new patients, 55 days in September 2025, after losing a provider in May. The remaining nonphysician provider at the location managed a panel of 1,700 patients, nearly double the expected panel size of 900 patients, according to VHA Directive 1406(3), *Patient Centered*

³¹ "Community Care," VA, accessed June 29, 2026, <https://department.va.gov/vha/community-care>.

³² 38 C.F.R. § 17.4040 (2025).

*Management Module (PCMM) For Primary Care.*³³ Primary care teams face challenges in providing optimal care for patients when they have provider vacancies and remaining providers' panel sizes exceed VHA guidance. Lengthy appointment wait times may also negatively affect patient outcomes.

To address the increased wait times at the North Platte clinic, primary care leaders said they provided telehealth appointments for patients twice a week and assigned additional support staff to help manage the workload. For example, nurses reviewed upcoming appointments to identify patients with needs that clinical pharmacists or other staff can manage, such as medication refills, which freed up provider appointments for more complex cases.

The OIG team also reviewed facility documents that indicated leaders reviewed both overall and clinic-specific wait times monthly. Primary care leaders said they provide executive leaders with the data every month and communicate it to primary care teams regularly. The average new patient wait time decreased to 22 days for FY 2026 (through June) and wait times at the North Platte clinic were 31 days. The OIG acknowledges leaders' efforts to address new patients' wait times and made no recommendations for additional corrective action.

Community Care Staffing and Access to Care

As of September 2025, facility community care leaders reported 17 administrative and 2 clinical vacancies. The leaders said they were hiring four medical support assistants and planned to request approval to fill the clinical positions; however, they were not approved to fill some administrative positions due to the federal hiring freeze still in effect at that time.³⁴ In June 2026, facility leaders reported that the vacancy rate in community care slightly worsened from approximately 19 percent to 21 percent, with 72 of 91 positions filled, and they are implementing initiatives to address the issue, such as actively collaborating with human resources on recruitment incentives and realigning staff workload.

Community care staff stated the vacancies led to increased workload, scheduling delays, and decreased morale. Community care leaders acknowledged the workload concerns and said they were exploring ways to improve efficiency, which included an automated call service that contacts veterans and places them in a queue to speak with a staff member to schedule appointments. The leaders also authorized overtime to help manage workload, though they recognized that was not sustainable. Further, leaders hosted staff recognition and appreciation events to improve morale.

Data showed it took facility staff an average of 14 days to schedule patient appointments with community providers, but VHA's *Consult Timeliness Standard Operating Procedure* directs

³³ VHA Directive 1406(3), *Patient Centered Management Module (PCMM) For Primary Care*, June 20, 2017, amended April 16, 2026.

³⁴ Hiring Freeze, 90 Fed. Reg. 8247.

program staff to schedule appointments within 7 days after a provider enters the referral.³⁵ Community care staff attributed delays to coordination and communication issues with community providers, such as when some providers require the patient's records before they schedule the appointment.

Respondents to the OIG questionnaire also cited insufficient availability of community providers and increased workload as factors that contributed to appointment delays. Community care leaders added that it was also sometimes difficult for staff to contact patients. The OIG did not make a recommendation here because the facility was still advancing efforts resulting from a related 2023 OIG recommendation, and leaders were taking the actions above.³⁶



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 homeless veterans who received an HCHV program intake assessment.³⁸ However, 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

³⁵ VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 2025.

³⁶ VA OIG, [Care in the Community Summary Report for Fiscal Year 2022](#), Report No. 22-03772-28, November 29, 2023.

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.

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

Performance and Improvement Program Highlights

- The facility program met the intake assessment (HCHV5) target for the first three quarters of FY 2025. Facility program staff attributed the success to sustained collaboration with community partners.
- The program did not meet the targets for discharges to permanent housing (HCHV1) or negative exits (HCHV2) for the first three quarters of FY 2025. Facility program staff attributed not being able to meet the HCHV1 target to landlords who preferred not to rent to veterans with poor rental histories, as well as those with substance use issues. Additionally, some veterans chose to leave the program to live with relatives and friends or stay in other temporary housing, such as hotels, which counted as a negative exit.
- Facility program staff said their mobile medical unit provides basic medical services to veterans at resource fairs, stand down events (one- to three-day events where veterans can get food, housing assistance, and VA and community assistance), and homeless shelters.⁴¹

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

³⁹ VHA sets targets for HCHV1 at the national level each year. 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 and 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 2025 Homeless Performance Measures*.

⁴¹ VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

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 Program Highlights

- The facility program did not meet the voucher use (HMLS3) target for the first three quarters of FY 2025; program staff cited barriers such as landlords’ reluctance to rent to veterans with poor rental and credit histories, as mentioned in the HCHV section. However, staff said they came within 1 percent of meeting the target by the end of the fiscal year due to additional staffing and reduced caseloads.
- Facility program staff attributed meeting the employment (VASH3) target for the first three quarters of FY 2025 to efforts by their employment coordinators.
- Staff also described a pilot project for enhanced veteran geriatric services in which they combine Medicaid and disability benefits with program vouchers to secure assisted-living placements and case management for veterans who are unable to live independently.

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, 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).⁴⁶

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 2025 Homeless Performance Measures*.

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 2025 Homeless Performance Measures*.

Performance and Improvement Program Highlights

- The facility did not appear to meet the enrollment (VJP1) target for the first three quarters of FY 2025. A facility program staff member attributed missing the target during that fiscal year to staff underreporting enrollments in VHA's national database. The staff member reported they will begin properly entering all enrolled veterans into the database.
- Facility program staff trained local law enforcement and justice partners to effectively interact with veterans, understand military culture, and help veterans in crisis to prevent their arrest when possible.
- Staff further reported that one Nebraska prison established a 30-bed geriatric unit for veterans. Additionally, the state's veteran service officer, hired in 2024, helps veterans apply for benefits.

Conclusion

To assist leaders in evaluating the quality of care at the VA Nebraska-Western Iowa Health Care System, the OIG conducted an inspection across five domains. The OIG made four recommendations related to cleanliness and management of biohazards, water safety, pharmaceutical waste disposal, and service-level workflows for test result communications to patients and providers. 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.

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.⁴⁷ 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 physically inspected various areas of the medical facility from September 23 through 25, 2025, and interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. 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.

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.⁴⁸ 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*.⁴⁹

Possible limitations on the information collection methods include questionnaire and interview participants’ self-selection bias and response bias.⁵⁰ 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.

⁴⁷ Accreditation reports covered the time frame of October 1, 2021, through September 30, 2024—the most recent available at the time of the inspection.

⁴⁸ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

⁴⁹ 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.

⁵⁰ 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>.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.⁵¹ 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.

⁵¹ 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: August 21, 2026

From: Network Director, VA Heart of America Health Network (10N4)

Subj: Healthcare Facility Inspection of the VA Nebraska-Western Iowa Health Care System in Omaha

To: Director, Office of Healthcare Inspections (54HF01)
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 VA Nebraska-Western Iowa Health Care System in Omaha. I concur with the findings, recommendations, and submitted action plans.

(Original signed by:)

Fernando O. Rivera, FACHE
Network Director
VA Heart of America Health Network (VISN 4), VHA

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 8, 2026

From: Director, VA Nebraska-Western Iowa Health Care System (636)

Subj: Healthcare Facility Inspection of the VA Nebraska-Western Iowa Health Care System in Omaha

To: Network Director, VA Heart of America Health Network (10N4)

Thank you for the opportunity to review and respond to the Office of Inspector General (OIG) draft report of the Healthcare Facility Inspection of the VA Nebraska-Western Iowa Health Care System. I appreciate the collaboration, professionalism, and insights provided by the OIG and Healthcare Facility Inspection team throughout the inspection process. I have reviewed the draft report and concur with the OIG's recommendations. The VA Nebraska-Western Iowa Health Care System has developed corrective action plans to address the recommendations and remains committed to continuous improvement and our ongoing journey toward high reliability. We value the OIG's partnership in identifying opportunities to strengthen our processes as we strive to consistently deliver safe, high-quality care to our Nation's Veterans. Questions or comments regarding this response may be directed to the Chief of Quality and Patient Safety for the VA Nebraska-Western Iowa Health Care System.

(Original signed by:)

Eileen Kingston

Executive Director, Nebraska-Western Iowa Health Care System

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