THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

November 14, 2025

Mr. Charles N. Baldis
Senior Counsel and Designee of
Acting Special Counsel Jamieson Greer
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: OSC File No. DI-25-001246

Dear Mr. Baldis:

Thank you for your May 7, 2025, letter to the Department of Veterans Affairs (VA) regarding a whistleblower allegation that the Harry S. Truman Memorial Veterans' Hospital (hereinafter Columbia), located in Columbia, Missouri, may have engaged in conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; gross waste of funds; an abuse of authority; or a substantial or specific danger to public safety.

The Acting Under Secretary for Health directed the Office of the Medical Inspector to assemble and lead a VA team to investigate. The team conducted an onsite investigation June 24, 2025, through June 26, 2025.

The investigation does not substantiate the whistleblower's allegation. We make three recommendations to Columbia. The signed report will be sent to the respective offices with a request for an action plan.

Thank you for the opportunity to respond.

Sincerely,

Douglas A. Collins

Enclosure

DEPARTMENT OF VETERANS AFFAIRS

Washington, DC

Report to the
Office of Special Counsel
OSC DI-25-001246

Harry S. Truman Memorial Veterans' Hospital
Columbia, Missouri

Report Date: October 6, 2025

Content Manager 2025-C-16

Executive Summary

The Office of the Secretary of the Department of Veterans Affairs (VA) received an email from the Office of Special Counsel on May 7, 2025, requesting formal resolution. Subsequently, the Acting Under Secretary for Health, Veterans Health Administration (VHA), directed that the Office of the Medical Inspector (OMI) assemble and lead a VA team to investigate allegations concerning the Harry S. Truman Memorial Veterans' Hospital (hereinafter Columbia) located in Columbia, Missouri. The whistleblower, who consented to the release of their name, alleged that Columbia engaged in conduct that may constitute a violation of a law, rule, or regulation; gross mismanagement; or a substantial and specific danger to public health or safety. OMI conducted an onsite investigation on June 24, 2025, through June 26, 2025, to investigate these allegations.

Specific Allegation of the Whistleblower

Current admission practices for Unit 2B contravene the safety measures established under VHA Directive 1160.06 and the APCU Standard Operating Procedure (SOP) BH-6.

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place and **do not substantiate** allegations when the facts and findings showed the allegations are unfounded. We are **unable to substantiate** allegations when the available evidence was insufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of the findings, we make the following conclusions and recommendations:

Conclusions for Allegation

- We **do not substantiate** current admission practices for Unit 2B contravene the safety measures in VHA Directive 1160.06(1), Inpatient Mental Health Services, dated September 27, 2023.

- Columbia SOP BH-6's restrictive admission criteria are not in compliance with VHA Directive 1160.06(1). As a result, the whistleblower's assertion that Unit 2B admissions contradict Columbia SOP BH-6 could not be considered.

- The account of the August 16, 2023, event involving a 79-year-old patient and a 62 -year -old patient referenced in the Office of Special Counsel referral, which the whistleblower provided as an example of an inappropriate admission that resulted in an unsafe environment, was inconsistent with the associated documents and the patients' electronic health records.

- The current Registered Nurse (RN) review process of Unit 2B admissions presents the risk of an obstructed admission process and delayed or decreased access for Veterans requiring acute inpatient mental health care.

- A lack of training for Unit 2B staff regarding special care populations, such as those with dementia, may be contributing to the RNs' resistance to accepting patients with complex clinical needs.

Recommendations to Columbia

1. Complete the revision of Columbia SOP BH-6 as soon as possible and ensure compliance with VHA Directive 1160.06(1). Consult with the National Director, Inpatient Mental Health Services, VHA Office of Mental Health as needed for assistance with the revision.

2. Following revision of Columbia SOP BH-6, provide training on the SOP to all pertinent staff and specific training regarding the nurses' (who work or float to Unit 2B) role in the admission process. Include in the training how the SOP aligns with VHA Directive 1160.01(1).

3. Provide clinical -skill focused training to all Unit 2B staff regarding special care populations, including dementia.

Summary Statement

We have developed this report in consultation with other VHA and VA offices to address the Office of Special Counsel's concerns that Columbia engaged in alleged conduct that may constitute a violation of a law, rule, or regulation and a substantial and specific danger to public health or safety. We reviewed the allegation and determined its merit. We determined that current admission practices for Unit 2B do not contravene the safety measures in VHA Directive 1160.06(1) but were unable to use Columbia SOP BH-6 as a standard to assess admission compliance as it does not align with VHA Directive 1160.06(1). We found that nursing input into the decision to admit to Unit 2B has been misconstrued by nursing staff as having the ability to block an admission. The current RN review process of Unit 2B admissions presents the risk of an obstructed admission process and delayed or decreased access for Veterans requiring acute inpatient mental health care. We identified the need for clinical-skill focused training for all Unit 2B staff regarding special care populations. Our review of specific patient cases and aggregated patient safety and other data points did not find evidence that inappropriate admissions to Unit 2B had occurred, that any patient harm had occurred, or that an unsafe environment for the provision of inpatient mental health care exists at Columbia.

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I. Introduction

The Office of the Secretary of the Department of Veterans Affairs (VA) received an email from the Office of Special Counsel on May 7, 2025, requesting formal resolution. Subsequently, the Acting Under Secretary for Health, Veterans Health Administration (VHA), directed that the Office of the Medical Inspector (OMI) assemble and lead a VA team to investigate allegations concerning the Harry S. Truman Memorial Veterans' Hospital (hereinafter Columbia) located in Columbia, Missouri. The whistleblower, who consented to the release of their name, alleged that Columbia engaged in conduct that may constitute a violation of a law, rule, or regulation; gross mismanagement; or a substantial and specific danger to public health or safety. OMI conducted an onsite investigation on June 24, 2025, through June 26, 2025, to investigate these allegations.

II. Facility Profile

Columbia, which is part of Veterans Integrated Service Network (VISN) 15, is a complexity level 1c facility.[1] Columbia offers comprehensive services that include primary care, medical and surgical specialties, behavioral health care, rehabilitation medicine, and long-term care. Columbia operates nine community-based outpatient clinics located in Camdenton, Columbia, Jefferson City, Kirksville, Marshfield, St. James, Sedalia, and Waynesville, Missouri.[2] Columbia served 43,322 unique Veterans in fiscal year (FY) 2024.[3] Inpatient behavioral health (BH) care is provided at Columbia on the Acute Psychiatric Care Unit (hereinafter Unit 2B) with an average daily census of 5.84 patients as of 2nd quarter (Q2) FY 2025.[4]

III. Specific Allegation of the Whistleblower

Current admission practices for Unit 2B contravene the safety measures established under VHA Directive 1160.06 and the APCU Standard Operating Procedure (SOP) BH-6.

IV. Conduct of Investigation

The VA team conducting the investigation consisted of a Senior Medical Investigator and a Clinical Program Manager, both from OMI; a Human Resources Consultant, VHA Workforce Management and Consulting, Human Resources Center of Expertise; the

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1 Complexity 1c facilities have medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs. VHA Office of Productivity, Efficiency & Staffing, VHA Facility Complexity Model Fact Sheet, no date. Available at: http://raft.vssc.med.va.gov/SelfPacedDocuments/FY23, last accessed August 19, 2025. ***Note**: This is an internal VA website that is not available to the public.*
2 Columbia Trip Pack. Available at: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx, last accessed August 19, 2025. ***Note:** This is an internal VA website that is not available to the public.*
3 VHA Support Service Center (VSSC), Trip Pack-Operational Statistics Table, Columbia, FY 2024. Available at: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fMgmtReports%2fPocketCard%2fTripPack_OperationalStatisticsTable&rs:Command=Render, last accessed August 19, 2025. ***Note**: This is an internal VA website that is not available to the public.*
4 VSSC Report, Operating Beds, Average Daily Census, and Occupancy Rate Using Actual Beds, Columbia, Unit 2B, Q2 FY 2025. Available at: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx, last accessed August 19, 2025. **Note:** This is an internal VA website that is not available to the public.

National Director, Inpatient Mental Health Services, VHA Office of Mental Health; and a Clinical Consultant, VHA Office of Geriatrics and Extended Care, Facility Based Care and Community Living Center (CLC) and Geriatric Medicine Physician, VA Eastern Kansas Healthcare System. We reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A.

We interviewed the whistleblower on May 27, 2025, and again during the investigation.

We conducted an entrance briefing on June 24, 2025, with the following VISN 15 and Columbia leadership:

- Chief Medical Officer, VISN 15
- Quality Management Officer, VISN 15
- Medical Center Director (interim)
- Associate Director
- Chief of Staff (CoS)
- Assistant Director
- Nurse Executive
- Executive, High Reliability Organization

We interviewed the following staff:

- Network Director, VISN 15
- CoS
- Nurse Executive
- Chief, Behavioral Health
- Section Chief, Psychiatry
- Associate Chief Nurse, Behavioral Health and CLC Programs
- Nurse Manager, Unit 2B
- Nurse Manager, Outpatient Behavioral Health
- Risk Manager
- Patient Safety Manager

- Provider Utilization Management Advisor, Unit 2B
- Case Management and Utilization Management Nurse
- Staff Psychiatrist (3)
- Registered Nurse (RN), Unit 2B (4)
- RN, Unit 2C
- Licensed Clinical Social Worker (LCSW), Unit 2B (2)
- LCSW, Behavioral Health Triage
- Nursing Assistant, Unit 2B
- Nurse Practitioner, Employee Health
- Safety and Occupational Health Specialist
- Medical Director, CLC
- RN Admissions Coordinator

We conducted an exit briefing on June 26, 2025, with the following VISN 15 and Columbia leadership:

- Chief Medical Officer, VISN 15
- Quality Management Officer, VISN 15
- Medical Center Director (interim)
- Associate Director
- CoS
- Deputy CoS (acting)
- Nurse Executive
- Assistant Director
- Executive, High Reliability Organization

V. Background, Findings, Conclusions, and Recommendations

Allegation

Current admission practices for Unit 2B contravene the safety measures established under VHA Directive 1160.06 and the APCU Standard Operating Procedure (SOP) BH-6.

Background

VHA Directive 1160.06(1), Inpatient Mental Health Services, dated September 27, 2023, states *"it is VHA policy that acute inpatient mental health services are provided without delay to all eligible Veterans requiring this level of care."* The primary goal of inpatient mental health services is to provide a safe and secure therapeutic environment to stabilize Veterans experiencing acute distress and improve their functional status, so they no longer require acute hospitalization. Acute mental health care refers to high-intensity mental health services for Veterans with acute and severe emotional or behavioral symptoms causing a safety risk to self or others or resulting in a severely compromised functional status. This level of care is provided in a locked inpatient setting to ensure safety and provide the type and intensity of clinical observation and intervention necessary to treat the Veteran.[5]

VHA Directive 1160.06(1), Appendix A, Principles of Treatment and Program Requirements for Inpatient Mental Health, states that *"admission to inpatient mental health units must be available to all eligible Veterans who require hospital level care for a mental health condition. Services must be available in the VA medical facility where the Veteran is being treated, a nearby VA medical facility, or community care."*[6] VHA Directive 1160.06(1) Appendix A describes mental health services for Veterans with functional and cognitive impairments on inpatient mental health units, stating:

> *"Some Veterans have medical, sensory, functional or cognitive impairments that require special care to ensure their safety (for example, older Veterans with frailty or neurocognitive disorders). Unit design should take into account specialized care needs common among older Veterans. To prevent injury, these Veterans are to be kept safe from other Veterans demonstrating agitated behavior. Larger VA medical facilities may consider establishing a separate wing or unit for these Veterans within treatment programs designed to meet their needs."*[7]

VHA Directive 1117, Utilization Management Program, dated October 8, 2020, describes the role of the utilization management (UM) program, noting that it is a key component of VHA's quality management system and provides vital tools for managing quality and resource utilization. *"It strives to ensure the right care, in the right setting, at the right time, for the right reasons, utilizing evidence-based practices along with continuous measurement and improvement."* UM strategies provide guidance, but do

5 VHA Directive 1160.06(1), Inpatient Mental Health Services, dated September 27, 2023.
6 Ibid.
7 Ibid.

not supersede decisions made by VA providers. UM identifies the recommended level of care and services and provides information that assists with decision-making related to patient care management, avoidable bed days of care, and discharge coordination processes. *"The UM program addresses patient admission and continued-stay review of all acute inpatient care as well as any VISN or VA medical facility specific priorities."*[8]

VHA Directive 1117 describes a UM admission review noting that using the provider order and level of care provided, the review is a screening to determine the appropriateness of admission to a specific level of care. Ideally, this review is performed at the time the decision to admit is made and no later than the first business day following the admission. Nationally approved, standardized, objective, evidence-based criteria must be used to determine the appropriateness of admission to specific levels of care. The clinical appropriateness criteria used for the UM admission review is the Change Healthcare InterQual criteria. The facility UM reviewer is trained to perform UM reviews utilizing InterQual criteria. The Provider Utilization Management Advisor (PUMA) is responsible for providing recommendations for patients not clinically indicated for acute care per InterQual criteria as well as any case that has quality of care issues or serious systematic issues needing immediate attention.[9]

The Columbia Medical Staff Bylaws and Medical Staff Rules and Regulations, dated April 2025, states:

> *"individuals with admitting privileges are physician members of the Medical Staff and their House Staff members...Medical staff means the formal organization of all medical physicians and osteopathic physicians holding unlimited licenses, and duly licensed dentists, podiatrists, optometrists, doctoral psychologists, doctoral audiologists, doctoral speech pathologists, and doctoral nurses who possess qualifications identified by VA as necessary to attend to patients, provide consultation and teach in the hospital. The Hospital shall admit for care and treatment legally eligible patients suffering from any type of disease which, in the opinion of the admitting member of the Medical Staff, can be adequately cared for at this Hospital."*[10]

The Bylaws note that Medical Staff physicians and their House Officers (resident physicians) *"shall admit for care and treatment any person for humanitarian purposes until such time as that person may be safely transferred to another hospital or other suitable facility."*[11]

VHA Directive 1160.06(1) describes the required training for staff working on inpatient mental health units. *"Clinical and non-clinical inpatient mental health staff are required to complete mandatory PMDB [prevention and management of disruptive behavior] training as specified in VHA Directive 1160.08(1), VHA Workplace Violence Prevention*

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8 VHA Directive 1117, Utilization Management Program, dated October 8, 2020.
9 Ibid.
10 Columbia Medical Staff Bylaws and Medical Staff Rules and Regulations, dated April 2025. ***Note:*** *This is an internal VA document that is not available to the public.*
11 Ibid.

Program, dated August 23, 2021, and as specified in VHA Directive 1167, Mental Health Environment of Care Checklist for Units Treating Suicidal Patients, dated November 4, 2024."[12]

VHA Directive 1160.08(1) requires that each VA medical facility has a comprehensive workplace violence prevention program to address patient-generated and employee-generated disruptive behavior. VHA Directive 1160.08(1), Appendix B, Prevention and Management of Disruptive Behavior (PMDB) Program, states that PMDB *"is the only curriculum approved for mandatory training of all VHA personnel in concepts of workplace violence prevention."*[13] Additionally, VHA Directive 1160.08(1), Appendix B states that PMDB training is assigned to VHA personnel based upon the risk of violence in their physical workplace location as determined by the workplace behavioral risk assessment. Subparagraph c(1) through c(4) defines the alignment of risk to training as:

> *"(1) All employees must receive basic education in the universal precautions for violence through the completion of online training in awareness, preparedness, response, and reporting. This is the only training required of employees in minimal risk workplaces.*
>
> *(2) Employees in low-risk workplaces must also be assigned and complete training in customer service and verbal de-escalation skills.*
>
> *(3) Employees in moderate risk workplaces must also be assigned and complete training in customer service skills, verbal de-escalation skills, limit-setting skills, and physical safety skills.*
>
> *(4) Employees in high-risk workplaces must also be assigned and complete training in customer service skills, verbal de-escalation skills, limit-setting skills, physical safety skills, and safe patient containment techniques."*[14]

VHA Directive 1160.08(1), Appendix C, Data Collection and Event Reporting in the Disruptive Behavior Reporting System and the Annual Workplace Behavioral Risk Assessment, states that *"the Disruptive Behavior Reporting System (DBRS) is an approved disruptive event reporting mechanism that must be readily accessible to all VA medical center employees, and to others who have authorized access to VA computer systems…all personnel with access are encouraged to use DBRS to alert the Disruptive Behavior Committee or Employee Threat Assessment Team of disruptive or violent events."*[15]

Findings

To demonstrate concerns associated with the allegation, the whistleblower described a February 1, 2013, fatal patient-on-patient attack that occurred on Unit 2B. The incident

12 VHA Directive 1160.06(1), Inpatient Mental Health Services, dated September 27, 2023.
13 VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021.
14 Ibid.
15 VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021.

involved a younger patient who attacked an elderly patient. The incident resulted in Unit 2B admission process and policy changes intended to prevent a recurrence of the event, such as evaluating an incoming patient's condition relative to the milieu of the unit to determine the environmental safety for all unit patients. The whistleblower voiced concerns that patients with dementia are currently being admitted to Unit 2B at the same time as patients with behavioral issues and this may potentially result in a similar incident as the 2013 fatal attack.

In March 2013 the facility conducted an Administrative Investigation Board (AIB) of the fatal event and took actions to address the investigation's findings. The AIB actions included psychiatrists conducting additional rounds, requiring staff to ask specific patient history questions prior to admission, revisions of the resident physician orientation, and documentation of hand-off communication at shift change. In addition, Columbia conducted training and education for Unit 2B staff regarding how to elevate concerns, when to consider the use of seclusion and restraints, and how to address inpatient violent and disruptive behavior. The Office of Inspector General performed an onsite review in February 2014 to review the investigation and resulting actions taken by the facility. The Office of Inspector General concluded the facility had initiated appropriate actions prior to their review and closed the case with no recommendations.

Per multiple Unit 2B staff and Behavioral Health and facility leadership, after the 2013 fatality Unit 2B nurses wanted more input into unit admissions, and nursing became more prominently involved in admission decisions, both in practice and policy. This involvement included the assessment of the unit's milieu prior to admitting a patient to determine if safety could be ensured. The addition of nursing input into the admission process resulted in some nursing staff disagreeing with the admitting provider about the appropriateness of an admission. Examples of this included patients with co-morbidities such as cognitive impairment, frailty, and common medical conditions such as diabetes and high blood pressure. Examples also included patients who nursing deemed at risk for aggressive behaviors.

In addition, following the 2013 fatal event Columbia SOP BH-6, Acute Psychiatric Care Unit (APCU), was modified to include the following verbiage, *"All prospective admissions [or] transfers will be reviewed with the 2B charge nurse (or) 2B Nurse Manager for bed availability, unit acuity, and the ability to safely manage the Veteran and the unit. Nursing input includes information on the current 2B milieu and acuity ([that is]: physically aggressive and/or frail/vulnerable patients) and/or medical concerns. If the best course of action is unclear or uncertain, the charge nurse/Nurse Manager will call the attending psychiatrist and discuss."*[16] This verbiage remains in the current version of Columbia SOP BH-6, dated March 1, 2020.

Our review of Columbia SOP BH-6 noted that the SOP sets forth mandatory procedures and processes for Unit 2B. Columbia SOP BH-6 explains that the unit is designed as a mixed gender inpatient unit to meet the needs of a broad range of Veterans with acute

16 Columbia SOP BH-6, Acute Psychiatric Care Unit (APCU), dated March 1, 2020. ***Note:*** *This is an internal VA document that is not available to the public.*

psychiatric issues. Columbia SOP BH-6 notes that patients are admitted when they meet InterQual criteria or when the admitting psychiatrist believes there are other compelling reasons for inpatient care. We noted that some elements of the SOP were not aligned with VHA Directive 1160.06(1) and thus determined that we could not use the SOP as a standard to assess compliance about the admission process, as referenced in the allegation.

Specifically, Columbia SOP BH-6 describes exclusionary criteria stating that the unit *"is not designed to be a long-term psychiatric care facility, geropsychiatric, or forensic treatment facility. Consequently, unit acuity is carefully monitored and is considered when making admission decisions, particularly when there are concerns about how an admission may impact the safety of patients and staff on the unit. Additionally, the acute care focus of the unit contraindicates admissions for patients with chronic mental health concerns or who have corresponding impairment that necessitates more intense forms of supervision and structure, such [as] dementia."*[17] The contraindication of admitting patients with chronic mental health concerns or dementia described in the SOP conflicts with VHA Directive 1160.06(1) access to care guidelines, which note that admission to inpatient mental health units must be available to all eligible Veterans who require hospital level care for a mental health condition. Patients with chronic mental health concerns or dementia can have acute behavioral concerns that would warrant admission to an inpatient mental health unit.

Additionally, Columbia SOP BH-6 notes that all patients admitted to Unit 2B must be medically cleared in the Emergency Department (ED). If a patient is medically cleared at another facility, appropriate paperwork confirming the medical clearance will be requested and reviewed by the medical officer of the day for approval, prior to being brought to Unit 2B. Veterans admitted to the unit must be medically stable and not require intravenous therapy or other medical interventions. The SOP notes that all Veterans are to have an assault risk assessment completed upon admission and in the daily care plan. RNs may elevate the level of assault precaution by completing the assessment tool. A physician order and collaboration are required to decrease the level of assault precaution. Veterans who are deemed to require a higher level of assault precaution will be monitored via line of sight, will not have visitors, will be provided finger foods only to maximize safety, will not attend group activities to minimize interactions with others that might escalate to violent behaviors, and will not be allowed to use the sensory room. The Veteran's clinical condition and need for continued assault precautions are reviewed by a physician and the team daily and documented in the Veteran's electronic health record.[18]

We completed a tour of Unit 2B during the investigation. Unit 2B is an 11-bed unit with one restraint room that can also be used for seclusion. The patient rooms do not have bathrooms. There are three bathrooms located on the unit that are shared by the patients. There are two hallways on the unit, with the nurses' station located in the middle of the unit where the two hallways converge. The Unit 2B nurse manager

17 Ibid.
18 Ibid.

explained during the tour that when frail or cognitively impaired patients are admitted to the unit, they will be housed close to the nurses' station, they may have a one-to-one observer assigned, and fall precautions will be taken to ensure safety. The nurses' station is shared with the staff of Unit 2C, which houses the Mental Health Residential Treatment Program, located next door to Unit 2B. There are various common areas located on Unit 2B including two dayrooms, a computer room, a sensory therapy room, and a phone room. We reviewed the average daily census on Unit 2B and determined that the average number of admitted patients ranged from 5 to 7 from FY 2017 through Q2 FY 2025.[19]

We reviewed the Unit 2B nursing staff's (RNs, licensed practical nurses, and nursing assistants) training and orientation records. We confirmed that all nursing staff completed and were current in all elements of PMDB training required for an inpatient mental health unit. Regarding dementia training, the Unit 2B nurse manager explained that they coordinated with the nurse educator to provide a dementia simulation training exercise but noted that not all Unit 2B nurses have completed it. We reviewed the dementia simulation training content and found it to be lacking in specific skills for communication and de-escalation of patients with dementia. Our review of the Unit 2B nursing staff's training and orientation records did not find additional training associated with the elderly population or dementia-like cognitive issues.

Per the whistleblower, the changes made to the Columbia SOP BH-6 regarding inclusion of nursing in the admission process were positive and resulted in a safer milieu for patients and staff on Unit 2B. However, the whistleblower explained that starting in approximately 2021, facility leadership began allowing the admission of patients who did not meet the admission criteria described in the SOP. The whistleblower noted that the nurses' concerns, such as not *"mixing elderly dementia with young psychotic patients,"* were not being consistently considered in the admission process. The whistleblower described meetings held in approximately 2023 with members of the patient safety team and executive leadership team (ELT) regarding the nurses' concerns and how their input would be considered in the admission process but perceived the meetings as not productive. The whistleblower stated that concerning admissions have continued and describes the unit as *"unsafe and leaders did not want to follow policy."*

Per the Nurse Executive, who has been in the role since 2019, the ELT became aware of nursing resistance to some admissions to Unit 2B in calendar year 2023 when the then acting Chief of Behavioral Health brought the concerns to their attention. The Nurse Executive explained that due to the strength of the nursing pushback it seemed that the previous Chief of Behavioral Health and the staff psychiatrists had *"given up due to the intense resistance…and the psychiatrists were afraid of the nurses in a way."* The Nurse Executive acknowledged that the fear about the 2013 fatality drove nursing

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19 Power BI Report, Acute Inpatient Mental Health Services Dashboard, Columbia inpatient data, FY 2017 through Q2 FY 2025. Available at: https://app.powerbigov.us/groups/me/apps/c52b8d0c-53ba-499b-9c3a-aa0fae505e35/reports/6d905729-b4ab-4bc9-b529-9094c27b08f6/ReportSection1d23060a037cb0417e49?ctid=e95f1b23-abaf-45ee-821d-b7ab251ab3bf, last accessed July 31, 2025. ***Note**: This is an internal VA website that is not available to the public.*

to want control over admissions to ensure a safe milieu but noted that the *"pendulum had swung too far."* The Nurse Executive noted that the layer of nursing review added after the 2013 fatality, intended to improve safety, has contributed to a negative environment on the unit between nurses, between some nurses and nursing management, and between some nurses and psychiatrists.

Per the Nurse Executive, after the ELT became aware of the issue, they met multiple times with Unit 2B staff to advise them that resistance to admissions must cease. The Nurse Executive explained to staff that VA care is best for Veterans and that the staff at VA are the best prepared caregivers for them. The Nurse Executive noted that this communication from the ELT was a shock to staff. Some nurses stated *"we get the say"* in admission decisions but the Nurse Executive countered, *"you misconstrued, it was you have a voice"* in the process. Nursing staff shared concerns about patients being admitted to Unit 2B with medical issues not conducive to the unit and the Nurse Executive responded to them that *"if the admitting provider wants them admitted they will address and place orders or consult internal medicine"* for medical needs.

The Nurse Executive explained that the former Unit 2B nurse manager was encouraged and supported to enact the changes the ELT directed about the admission process and was also provided leadership training; however, the Unit 2B staff *"were just too strong"* and resistance continued. In addition, staff from Unit 2C, many of whom previously worked on Unit 2B and continue to float as needed to Unit 2B, continued pushing the narrative about nursing controlling admissions. Ultimately, as a result of being unable to enact the changes that the ELT directed, along with multiple other performance issues, the former Unit 2B nurse manager was removed from the role in approximately July 2024. An acting nurse manager who followed the removed nurse manager was also unsuccessful in managing the nurse resistance to admissions issue. In February 2025, the Unit 2B assistant nurse manager was appointed as nurse manager and per the Nurse Executive, is encouraged and supported by leadership to continue the efforts to evolve the unit and improve staff morale while maintaining appropriate admissions to the unit.

In addition to the 2013 fatality, the Office of Special Counsel referral included an August 2024 incident as an example of unsafe admission processes. Per the whistleblower a patient was allegedly admitted to Unit 2B with known violent tendencies despite the whistleblower warning against the admission because there was a geriatric patient with dementia already admitted to the unit. An altercation occurred between the two patients and resulted in injury of several staff, including the whistleblower. Through our interviews with the whistleblower, we learned this event actually took place in August 2023.

Our review of the admissions described in the Office of Special Counsel referral noted that on August 4, 2023, a 79-year-old patient (hereinafter Patient 1) was admitted due to suicidal ideation. Patient 1 has a history of dementia and atrial fibrillation. On August 16, 2023, a 62-year-old patient (hereinafter Patient 2) was admitted to Unit 2B for monitoring and detoxification (from methamphetamines) prior to a planned hip replacement surgery. Patient 2 has a history of schizophrenia, post-traumatic stress

disorder, and major depressive disorder. On August 16, 2023, Patient 1 was using one of the unit's bathrooms to shave when Patient 2 wanted to use the same bathroom. When the staff asked Patient 1 to come out of the bathroom, he became irate and went into another patient's room and slammed the door. When staff requested that Patient 1 come out of the other patient's room he yelled at the staff, went into his assigned room, and slammed the door.

Staff were concerned due to Patient 1 holding a razor in his hand and attempting to strike out at staff. At that time, staff put Patient 1 into a hold to prevent further physical aggression, and the patient was escorted to the restraint room with the intent to provide medication until calm. Patient 1 continued to fight and struggle with staff during this process, which resulted in Patient 1 being placed into four-point restraints under staff supervision. Ultimately, Patient 1 calmed down and was able to be removed from restraints. During this episode, Patient 1 suffered a skin tear and complained of pain in his right hand and arm. The skin tear was treated and x-rays taken were negative for injury such as a fracture. Patient 2 was not injured during this event and was minimally involved except for requesting that Patient 1 leave the bathroom. Our review concluded that the admission of Patient 1 and Patient 2 were both appropriate admissions per criteria set forth in VHA Directive 1160.06(1).

The whistleblower entered a DBRS report regarding the August 16, 2023, event. The section of the DBRS regarding if the reporter experienced any injury stated *"unknown."* The severity score of the event entered by the whistleblower on the DBRS was noted to be a "1," or the lowest level, for those present during the event (experiencer) and the severity score to Patient 1 (aggressor) was deemed a "2" (due to the skin tear and hand and arm pain). Under the DBRS section for the experiencer, the whistleblower reported, *"no physical contact"* and *"no time lost from work or care environment."*[20] We requested occupational safety reports of injury for this timeframe entered regarding the whistleblower or other Unit 2B staff and were advised by the safety and occupational health specialist that none had been entered. Thus, we found no evidence that any staff were injured during the August 16, 2023, event.

We reviewed a Joint Patient Safety Reporting (JPSR) system report entered for the August 16, 2023, event regarding Patient 1 and noted the report review indicated a Safety Assessment Code (SAC) actual score of "1" (lowest risk) and potential SAC score of "2" (intermediate risk). A SAC is a score assigned to a patient safety event utilizing a matrix that considers both the severity and probability of harm.[21] The JPSR system report noted that the restraint for aggressive behavior event was reviewed, all appropriate clinical actions were taken, and the patient injury of the skin tear was appropriately managed medically. There was no indication that staff were injured or that any other patients were injured or assaulted.

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20 Columbia DBRS #589A4.232482, dated August 16, 2023. ***Note:*** *This is an internal VA document that is not available to the public.*

21 VHA | National Center for Patient Safety JPRS Guidebook, dated December 2023. Available at: https://dvagov.sharepoint.com/sites/vhancps/Shared%20Documents/Forms/Internal.aspx, last accessed August 19 2025. ***Note:*** *This is an internal VA SharePoint website that is not available to the public.*

We reviewed the occupational safety reports of injuries for staff on Unit 2B for FY 2023 through May 2025, 13 total. Our review noted that in FY 2023, there was one report of a VA Police Officer injury that occurred in September 2023 when responding to a code (emergency) event on the unit. This was reportedly a minor injury to the Police Officer's lower left arm and wrist. In FY 2024, there were 7 reports of injuries to staff on Unit 2B, and all involved the same July 1, 2024, incident. All injuries were minor in nature. The reports included 5 RNs, 1 VA Police Officer, and 1 licensed practical nurse. In FY 2025 through May 2025, there have been 5 reports of injuries to staff on Unit 2B which all occurred on different days in May 2025 and involved 1 nursing assistant, 3 VA Police Officers, and 1 RN. All injuries were minor in nature.

We reviewed the Unit 2B DBRS reports entered in FY 2024, 25 total. Our review noted that none of the reports resulted in a critical or catastrophic severity rating. Of the 25 reports, the severity of outcome was scored as follows:

- 1 event scored "0" (no severity).
- 23 events scored "1" (negligible severity).
- 1 event scored "2" (marginal severity).
- No events scored a "3" (critical severity).
- No events scored a "4" (catastrophic severity).

We reviewed the Unit 2B DBRS reports in FY 2025 (through May 2025), 29 total. Our review noted that none of the reports resulted in a critical or catastrophic severity rating. Of the 29 reports, the severity of outcome was scored as follows:

- 4 events scored "0" (no severity).
- 22 events scored "1" (negligible severity).
- 3 events scored "2" (marginal severity).
- No events scored a "3" (critical severity).
- No events scored a "4" (catastrophic severity).

We reviewed all JPSR system reports entered for Unit 2B from FY 2021 through May 2025,138 total. We identified 9 JPSR system reports that appeared to be related to admission appropriateness, one of which was the event associated with Patient 1 previously discussed in this report. The other 8 JPSR system reports scored an actual SAC score of "1" and potential scores of "1" (2 events) and "2" (6 events). Our review noted the following regarding the 8 JPSR system reports:

- 4 reports were falls with no major injuries.

- 1 report was a restraint event following a patient's physical struggle with staff.
- 1 report was a staff concern that the unit was not appropriate for a patient detoxing, but the review found that the patient met admission requirements and was appropriate for the unit.
- 2 reports were related to medical concerns that required transfer from Unit 2B to a medical unit. The reviews of the events found no delays in transfer.

The Case Management UM Nurse explained that all Unit 2B admissions and continued stays are reviewed using InterQual criteria. The Case Management UM Nurse noted that generally Unit 2B consistently meets admission criteria. When the Case Management UM Nurse determines a patient may have not met admission criteria, the UM nurse will share the case with the PUMA who completes a secondary review. We reviewed UM data and determined that in Q2 FY 2025, 100% of Unit 2B admissions met InterQual criteria, and 98.02% met criteria for continued stay on the unit. In FY 2024, 100% of admissions met criteria and 79% met criteria for continued stay.

Based on our review of UM, DBRS, and JPRS system data, we found no evidence of inappropriate admissions, patient harm, or an unsafe environment for the provision of inpatient mental health care on Unit 2B.

A staff psychiatrist, who has worked on Unit 2B for 16 years, explained that nurses cannot *"block"* an admission, but that *"they can make it difficult"* to admit. The psychiatrist recalled the 2013 fatality and noted that it was traumatic for all staff. Afterwards, as part of the AIB recommendations, it was determined to bring the nurses into the *"conversation"* about admissions. The psychiatrist explained that this occurred very gradually at first, but over time nurses became more involved in the decision to admit. The psychiatrist noted that at one point, under the direction of a former Unit 2B nurse manager, nursing staff would not have to follow physician orders if they did not agree with them, resulting in nurses pushing back on different types of orders. These issues led to conflict amongst the unit staff and at times impacted admission decisions. The psychiatrist noted that if the nurse resistance to admit was strong, some patients would be sent to a medical unit bed if possible or transferred to the VA St. Louis Health Care System or to a non-VA facility.

The psychiatrist noted that in the last six months the nurse resistance to admissions on Unit 2B has improved but there are still issues that arise from time to time. The psychiatrist attributed this improvement to the support of nursing leadership, especially the Unit 2B nurse manager. The psychiatrist explained that the decision to admit to Unit 2B is on a case-by-case basis as well as needing to evaluate the unit milieu to determine if adding the patient would negatively impact the unit or make the environment unsafe. When encountering nurse resistance to an admission from the ED the psychiatrist has encouraged the nurse to go to the ED and assess the patient in person themselves and many times after seeing the patient in person, the nurse is less resistant to the admission.

A Unit 2B RN, who has been on the unit for two months and recently completed orientation, explained that during her orientation her preceptor told her that the unit was not meant to take dementia patients and that *"they are not a good mix with the other mental health patients and should not be on the unit."* The RN noted she had reviewed Columbia SOP BH-6 as part of her orientation and stated that wording used in the exclusionary criteria section regarding patients with dementia is suggestive and not implicit about whether that type of patient was an acceptable admission. The RN stated she has not received training specific to the care of a patient with dementia. The RN explained she accompanied her preceptor to the ED on one occasion to evaluate a patient (hereinafter Patient 3) for possible admission to Unit 2B. The preceptor explained to the RN that they were going to assess Patient 3 in the ED to determine his orientation, cognitive status, and if he could move independently. During the assessment of Patient 3, he exhibited semi-confusion and agitation and as a result he could not answer all questions asked. The preceptor did not think that Patient 3 was an appropriate admission to Unit 2B due to the cognition issues and noted that Patient 3 had been previously admitted to the unit and had other medical issues not appropriate for the unit. The preceptor then advised the psychiatry resident that, *"per policy,"* Patient 3 was *"not appropriate for admission"* to Unit 2B; however, Patient 3 was ultimately admitted to the unit.

We reviewed Patient 3's electronic health record and noted that Patient 3, a 73-year-old male patient, presented to the ED on June 5, 2025, after being directed there by his psychiatrist for evaluation. Patient 3's psychiatrist spoke with him on the phone on June 5, 2023, to discuss concerns about Patient 3's short term memory loss. Per Patient 3, his home health nurse noticed that he was not taking his medication correctly, appearing to be taking it only intermittently. Patient 3's medical history includes high blood pressure, diabetes, bipolar disorder, and major depression. Patient 3's medications include lithium (a mood stabilizer), an antipsychotic medication and two antidepressant medications. His ED evaluation found that Patient 3 was not taking his lithium, confirmed by laboratory testing, with disorganized thoughts as a result and would be admitted to Unit 2B for stabilization, safety monitoring, and medication management.

The ED physician noted that there were *"concerns over the patient's ability to take care of himself…the patient did get up from the bed on his own power and walk around…without difficulty."* After Patient 3's arrival to Unit 2B, the admitting RN noted that the physician on duty was contacted due to *"concern for this patient not being appropriate for 2B"* but was advised that the patient would remain on Unit 2B. During Patient 3's admission his medications were adjusted, his mood and behavior stabilized, and he was discharged home on June 13, 2025. Our review determined that Patient 3's admission to Unit 2B was appropriate per criteria set forth in VHA Directive 1160.06(1) and that this case illustrated current, ongoing nursing pushback regarding admissions of patients to Unit 2B who exhibit cognitive issues.

Per the Unit 2B nurse manager, he and the Section Chief of Psychiatry began reviewing and, when indicated, updating Unit 2B's policies and SOPs in Spring 2025. The revision

of Columbia SOP BH-6 is currently underway and per the Section Chief of Psychiatry, Unit 2B admission and exclusionary criteria within the SOP will be updated.

Conclusions for Allegation

- We **do not substantiate** current admission practices for Unit 2B contravene the safety measures in VHA Directive 1160.06(1).
- Columbia SOP BH-6's restrictive admission criteria are not in compliance with VHA Directive 1160.06(1). As a result, the whistleblower's assertion that Unit 2B admissions contradict Columbia SOP BH-6 could not be considered.
- The account of the August 16, 2023, event involving Patient 1 and Patient 2 referenced in the Office of Special Counsel referral, which the whistleblower provided as an example of an inappropriate admission that resulted in an unsafe environment, was inconsistent with the associated documents and the patients' electronic health records.
- The current RN review process of Unit 2B admissions presents the risk of an obstructed admission process and delayed or decreased access for Veterans requiring acute inpatient mental health care.
- A lack of training for Unit 2B staff regarding special care populations, such as those with dementia, may be contributing to the RNs' resistance to accepting patients with complex clinical needs.

Recommendations to Columbia

1. Complete the revision of Columbia SOP BH-6 as soon as possible and ensure compliance with VHA Directive 1160.06(1). Consult with the National Director, Inpatient Mental Health Services, VHA Office of Mental Health as needed for assistance with the revision.
2. Following revision of Columbia SOP BH-6, provide training on the SOP to all pertinent staff and specific training regarding the nurses' (who work or float to Unit 2B) role in the admission process. Include in the training how the SOP aligns with VHA Directive 1160.01(1).
3. Provide clinical-skill focused training to all Unit 2B staff regarding special care populations, including dementia.

VI. Summary Statement

We have developed this report in consultation with other VHA and VA offices to address the Office of Special Counsel's concerns that Columbia engaged in alleged conduct that may constitute a violation of a law, rule, or regulation and a substantial and specific danger to public health or safety. We reviewed the allegation and determined its merit. We determined that current admission practices for Unit 2B do not contravene the

safety measures in VHA Directive 1160.06(1) but were unable to use Columbia SOP BH-6 as a standard to assess admission compliance as it does not align with VHA Directive 1160.06(1). We found that nursing input into the decision to admit to Unit 2B has been misconstrued by nursing staff as having the ability to block an admission. The current RN review process of Unit 2B admissions presents the risk of an obstructed admission process and delayed or decreased access for Veterans requiring acute inpatient mental health care. We identified the need for clinical-skill focused training for all Unit 2B staff regarding special care populations. Our review of specific patient cases and aggregated patient safety and other data points did not find evidence that inappropriate admissions to Unit 2B had occurred, that any patient harm had occurred, or that an unsafe environment for the provision of inpatient mental health care exists at Columbia.

Attachment A
References

Columbia DBRS #589A4.232482, dated August 16, 2023. ***Note:*** *This is an internal VA document that is not available to the public.*

Columbia Medical Staff Bylaws and Medical Staff Rules and Regulations, dated April 2025. ***Note:*** *This is an internal VA document that is not available to the public.*

Columbia SOP BH-6, Acute Psychiatric Care Unit (APCU), dated March 1, 2020. ***Note:*** *This is an internal VA document that is not available to the public.*

Columbia Trip Pack. Available at: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx, last accessed August 19, 2025. ***Note:*** *This is an internal VA website that is not available to the public.*

Power BI Report, Acute Inpatient Mental Health Services Dashboard, Columbia inpatient data, FY 2017 through quarter 2, FY 2025. Available at: https://app.powerbigov.us/groups/me/apps/c52b8d0c-53ba-499b-9c3a-aa0fae505e35/reports/6d905729-b4ab-4bc9-b529-9094c27b08f6/ReportSection1d23060a037cb0417e49?ctid=e95f1b23-abaf-45ee-821d-b7ab251ab3bf, last accessed July 31, 2025. ***Note:*** *This is an internal VA website that is not available to the public.*

VHA Directive 1117, Utilization Management Program, dated October 8, 2020.

VHA Directive 1160.06(1), Inpatient Mental Health Services, dated September 27, 2023.

VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021.

VHA | National Center for Patient Safety JPRS Guidebook, dated December 2023. Available at: https://dvagov.sharepoint.com/sites/vhancps/Shared%20Documents/Forms/Internal.aspx, last accessed August 19, 2025. ***Note:*** *This is an internal VA SharePoint website that is not available to the public.*

VHA Office of Productivity, Efficiency & Staffing, VHA Facility Complexity Model Fact Sheet, no date. Available at: http://raft.vssc.med.va.gov/SelfPacedDocuments/FY23, last accessed August 19, 2025. ***Note:*** *This is an internal VA website that is not available to the public.*

VSSC, Trip Pack-Operational Statistics Table, Columbia, FY 2024. Available at: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx?%2fMgmtReports%2fPocketCard%2fTripPack_OperationalStatisticsTable&rs:Command=Render, last accessed August 19, 2025. ***Note:*** *This is an internal VA website that is not available to the public.*

VSSC Report, Operating Beds, Average Daily Census, and Occupancy Rate Using Actual Beds, Columbia, Unit 2B, Q2, FY 2025. Available at: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx, last accessed August 19, 2025. ***Note:*** *This is an internal VA website that is not available to the public.*

Other documents reviewed as part of this report.

Note: *The reports and website listed below are internal VA documents that are not available to the public.*

Columbia DBRS reports, Unit 2B, FY 2024.

Columbia DBRS reports, Unit 2B, FY 2025 through May 2025.

Columbia Employees' Compensation Operations and Management Portal (ECOMP) reports, FY 2023 through May 2025.

Columbia JPSR system report 2158851, dated August 16, 2023.

VHA Utilization Management Key Metrics Power BI report, Columbia, FY 2024 and FY 2025, quarter 2. Available at: https://app.powerbigov.us/groups/me/apps/f2c6eb4e-d013-4f5b-b864-762639ca69e8/reports/2af48328-71fc-4a7b-9faf-04cd31f9c43f/ReportSection?ctid=e95f1b23-abaf-45ee-821d-b7ab251ab3bf, last accessed August 19, 2025.

Attachment B
List of Acronyms

APCU[1]	Acute Psychiatric Care Unit
CLC	Community Living Center
CoS	Chief of Staff
DBRS	Disruptive Behavior Reporting System
ED	emergency department
ELT	executive leadership team
FY	fiscal year
JPSR	Joint Patient Safety Reporting
LCSW	Licensed Clinical Social Worker
PMDB	prevention and management of disruptive behavior
PUMA	Provider Utilization Management Advisor
RN	Registered Nurse
SAC	Safety Assessment Code
SOP[1]	standard operating procedure
UM	Utilization Management
VA	Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

[1]Note: Acronym first defined in allegation contained in this report.

Table B-1 List of Acronyms

Index of Names

Key to Investigative Team Members

- [redacted] M.D., Senior Medical Investigator, OMI
- [redacted] MSN, MEd, RN, CPHQ, Clinical Program Manager, OMI
- [redacted] PhD, National Director, Inpatient Mental Health Services, VHA Office of Mental Health
- [redacted] M.D., CMD, Clinical Consultant, VHA Office of Geriatrics and Extended Care, Facility Based Care and CLC and Geriatric Medicine Physician, VA Eastern Kansas Health Care System
- [redacted] Human Resources Consultant, VHA Workforce Management and Consulting, Human Resources Center of Expertise

Key to Interviewees

- [redacted] PhD, Network Director, VISN 15
- [redacted] M.D., CoS
- [redacted] RN, Nurse Executive
- [redacted] PhD, Chief, Behavioral Health
- [redacted] M.D., Section Chief, Psychiatry
- [redacted] RN, Associate Chief Nurse
- [redacted] RN, Nurse Manager, Unit 2B
- [redacted] RN, Nurse Manager, Outpatient Behavioral Health
- [redacted] RN, Risk Manager
- [redacted] RN, Patient Safety Manager
- [redacted] M.D., Provider Utilization Management Advisor (PUMA), Unit 2B
- [redacted] RN, Case Management and Utilization Management (UM) Nurse
- [redacted] D.O., Staff Psychiatrist
- [redacted] M.D., Staff Psychiatrist

- [redacted] M.D., Staff Psychiatrist
- [redacted] RN, Unit 2B
- [redacted] RN, Unit 2B
- [redacted] RN, Unit 2B
- [redacted] RN, Unit 2B
- [redacted] RN, Unit 2C
- [redacted] LCSW, Unit 2B
- [redacted] LCSW, Unit 2B
- [redacted] LCSW, Behavioral Health Triage
- [redacted] Nursing Assistant, Unit 2B
- [redacted] Nurse Practitioner, Employee Health
- [redacted] Safety and Occupational Health Specialist
- [redacted] M.D., Medical Director, CLC
- [redacted] RN, RN Admissions Coordinator