DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Issues Related to an Administrative Investigation Board at the VA Black Hills Health Care System in Fort Meade and Hot Springs, South Dakota

HEALTHCARE INSPECTION | REPORT #22-00540-107 | MAY 2, 2023

MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

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

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Black Hills Health Care System (facility) in Fort Meade and Hot Springs, South Dakota, to evaluate how facility leaders addressed an administrative investigation board's (AIB) findings and recommendations.[1]

In January 2021, the OIG received complaints alleging failures in leadership and management, and misconduct and inappropriate relationships between leaders and staff and between clinical staff and patients within the facility's Mental Health Service. The OIG requested additional information from the facility. In February 2021, the facility responded to the OIG and noted that an AIB was planned to investigate the allegations noted above. The OIG received a copy of the AIB report of findings and recommendations on October 15. The OIG identified an additional allegation and reviewed that allegation separately from this report.[2]

Based on the AIB detailing the failures of managers and leaders and the substantiation of some of the allegations, the OIG initiated an inspection on November 10. The OIG focused on the management of the AIB's findings and recommendations by the former Facility Director, who served as Facility Director between August 2015 and October 2021, and the acting Facility Director, who served between October 2021 and January 2022.

Facility policy requires that the facility director "reviews the AIB report, concurs or requests additional information, assigns responsibility for action and issues memos to applicable service chief/program manager." The memorandums are routed through senior facility leaders and the facility's director of organizational improvement follows up on any open action items until completion.[3]

The OIG found that when advised of allegations concerning failures in leadership, misconduct, and inappropriate relationships between facility leaders and staff and between staff and patients, the former Facility Director signed the charge letter on March 18, 2021, convening the AIB to investigate the allegations. The AIB was external, which means that the members were not from

[1] VA Directive 0700, *Administrative Investigations*, March 25, 2002, rescinded and replaced by VA Directive 0700 *Administrative Investigation Boards and FactFindings*, August 10, 2021. The directives have the same or similar language related to AIBs. An AIB is a type of administrative investigation that can be conducted for a specific need to identify and correct an individual or systemic deficiency. The convening authority, often the facility director, is responsible for establishing an AIB when an incident is identified warranting a review. AIB members should be given clear direction on the scope and purpose of the investigation and their roles in the process, and submit the investigative report to the convening authority within a specific time frame. Recommendations are not required for the investigative report, but if included, must be limited to the scope of the investigation.

[2] VA OIG, *Failures of Leaders to Respond to Reports of Sexual Harassment at the VA Black Hills Health Care System in Fort Meade and Hot Springs, South Dakota*, Report No. 22-00514-108, May 2, 2023.

[3] Facility Directive-39, *Administrative Investigations*, January 11, 2016.

the facility or Veterans Integrated Service Network (VISN). According to the former Facility Director, an external AIB was requested because previously completed internal reviews did not provide sufficient facts and evidence to correct deficiencies. The VISN 23 Chief Human Resources Officer also reported that the former Facility Director requested VISN assistance with assembling an AIB from outside the facility and VISN to ensure objectivity.

VA policy allows for the detailing of an employee under investigation to another position, if the employee's presence may pose a threat to other employees or patients.[4] The former Facility Director reported to the OIG that in accordance with this policy, two mental health leaders were detailed to other positions at the beginning of the AIB. The former Facility Director explained that the mental health leaders were detailed in order to protect the individuals who were being interviewed and to protect those individuals whose actions were being questioned. The detailing of these two mental health leaders complied with policy.

Upon submission of the AIB report dated June 25, 2021, the former Facility Director met with the AIB Chairperson on July 15 to review the AIB's findings and recommendations. In interviews with the OIG, the AIB Chairperson and the former Facility Director reported discussing the former Facility Director's concerns related to language choice and the perceived lack of evidence to substantiate testimony. The AIB Chairperson and members reviewed the former Facility Director's concerns, made some language changes that reportedly did not alter the context of the AIB report, and added supplemental evidence to support the findings. The AIB members reported to the OIG that the changes did not impact the findings or recommendations of the AIB report. Regarding the changes made to the AIB report, the former Facility Director reported to the OIG, "They removed some of it, but there was still a lot of emotion tied to it." The Board submitted the revised AIB report to the former Facility Director on August 23, 2021.[5]

The former Facility Director reported sharing the final AIB report with the OIG to ensure that there was no criminal activity based on the provided information contained within the AIB report, and to the Office of General Counsel to determine what actions could be taken by facility leaders. The former Facility Director reported shortly before retiring, that the OIG determined that no criminal activity occurred. During interviews with the OIG, senior facility leaders stated that the former Facility Director did not share the AIB report with other senior facility leaders. The former Facility Director reported not having time to share the report with other senior facility leaders before retirement. As a result of not sharing the AIB report with other senior facility leaders, a lapse of understanding and follow-up of the AIB's recommendations occurred when the former Facility Director retired.

As part of a transition meeting, the former Facility Director met with the acting Facility Director and VISN leaders on October 15, 2021, to discuss the AIB report. The former Facility Director

[4] VA Directive 5021, *Employee/Management Relations*, April 15, 2002.

[5] The OIG uses the term *Board* when referring collectively to the AIB Chairperson and the two AIB members.

advised that the AIB was closed with the exception of two action items that required follow-up: (1) maintaining a mentoring program for one mental health leader, and (2) determining the need to report another mental health leader to a state licensing board.

The acting Facility Director assumed the position on October 18, 2021, until January 30, 2022. The OIG contacted the acting Facility Director on November 29, 2021, to initiate the hotline inspection process regarding the facility's actions and responses to the AIB. The acting Facility Director reported reading the AIB report after being contacted by the OIG. The acting Facility Director then required that the other senior facility leaders read the AIB report, requested an exit briefing with the Board, and developed action plans to address the 11 recommendations. The OIG confirmed that the facility addressed each recommendation through a variety of methods including creating standard operating procedures, handouts, and in-person and virtual education presentations. In addition, the acting Facility Director took steps to address the mental health leader and a staff member identified within the AIB as having inappropriate relationships with patients. The facility reported the mental health leader to the state licensing board on April 5, 2022. For the identified staff member, who was a student working towards mental health licensure at the time, the facility accepted, but did not verify, that the staff member self-reported to the state licensing board the inappropriate relationship. The OIG would have expected the facility to have reviewed the evidence and determined what actions to take rather than accepting that the staff member had self-reported.

The OIG made two recommendations to the Facility Director related to monitoring and tracking the action plan through to completion and reviewing the evidence and independently determining if the state licensing board should be notified.

Comments

The Veterans Integrated Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

AIB	administrative investigation board
MH RRTP	mental health residential rehabilitation treatment program
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the VA Black Hills Health Care System (facility) in Fort Meade and Hot Springs, South Dakota, to determine how facility leaders addressed an administrative investigation board's (AIB) findings and recommendations.

Background

The facility is part of Veterans Integrated Service Network (VISN) 23 and has two campuses located in Fort Meade and Hot Springs, South Dakota. In addition, the facility has nine community-based outpatient clinics.[1] The facility provides primary, surgical, and mental health care, including mental health residential rehabilitation treatment programs (MH RRTPs). From October 1, 2021, through September 30, 2022, the facility served 20,754 patients and reported having a total of 249 operating beds, including 34 acute care beds, 10 inpatient mental health beds, 112 domiciliary (MH RRTP) beds, 104 nursing home beds, and 29 compensated work therapy/transitional residence beds. The Veterans Health Administration (VHA) classifies the facility as a Level 3, lowest complexity.[2]

VA Administrative Investigation Boards

An administrative investigation is a systematic process used when an incident would benefit from objective analysis of factual evidence and sworn testimony to determine how and why an event occurred.[3] An AIB is a type of administrative investigation that can be developed for a specific need to identify and correct an individual or systemic deficiency. The convening authority, often a facility director, is responsible for establishing an AIB when an incident is identified for review.[4] AIB members should be given clear direction on the scope and purpose of the investigation and their roles in the process, and should submit the investigative report to the

[1] The facility provides outpatient services in Nebraska: Gordon and Scottsbluff; South Dakota: McLaughlin, Mission, Pierre, Pine Ridge, Rapid City, and Winner; and Wyoming: Newcastle.

[2] VHA Office of Productivity, Efficiency and Staffing. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2 or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex.

[3] VA Directive 0700, *Administrative Investigations*, March 25, 2002. This directive was in effect for the time frame of the events discussed in this report. It was rescinded and replaced by VA Directive 0700, *Administrative Investigation Boards and FactFindings*, August 10, 2021. The 2002 and 2021 directives have same or similar language related to AIBs.

[4] VA Handbook 0700, *Administrative Investigations*, July 31, 2002. This handbook was in effect for the time frame of the events discussed in this report. It was rescinded and replaced by VA Handbook 0700, *Administrative Investigation Boards and FactFindings*, August 17, 2021. The 2002 and 2021 handbooks have same or similar language related to convening authority.

convening authority within a specified time frame. Recommendations are not required for the investigative report, but if included, must be limited to the scope of the investigation.

Mental Health Residential Rehabilitation Treatment Programs

MH RRTPs, which evolved from a domiciliary care program that was established in the 1860s, offer a residential therapeutic setting for patients with mental health disorders experiencing psychosocial concerns like homelessness and unemployment who would benefit from additional structure and support.[5] VHA requires that treatment is patient-centered to meet the individual needs of each resident.[6] Residents identify and address goals of rehabilitation, recovery, functional status, improved quality of life, and community integration.[7] MH RRTPs are required to maintain adequate staffing and 24-hour supervision to ensure residents' safety and provide appropriate clinical care.[8]

MH RRTPs may have a general program as well as specialized programs focusing on care for patients who are homeless, have substance use disorders, or posttraumatic stress disorder.[9] The facility's MH RRTP is located in Hot Springs, South Dakota.

Concerns

In January 2021, the OIG received complaints alleging failures in leadership and management and misconduct within the facility's Mental Health Service. The OIG requested additional information from the facility but received none. In February, the facility notified the OIG that an AIB was planned to investigate the allegations noted above. The former Facility Director convened an AIB on March 17. The AIB was completed on June 30, with the final report submitted to the former Facility Director on August 23.

The OIG received the final AIB report of findings and recommendations on October 15, 2021. The OIG noted that the AIB detailed failures in leadership and management and substantiated some of the allegations from the AIB. This healthcare inspection focused on the former and acting Facility Directors' responses to the AIB's findings and recommendations. The OIG identified an additional allegation and reviewed that allegation separately from this report.[10]

---

[5] VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, July 15, 2019.

[6] Within the context of this report, residents are patients who live in the MH RRTP and participate in rehabilitation and treatment services.

[7] VHA Directive 1162.02.

[8] VHA Directive 1162.02.

[9] VHA Directive 1162.02.

[10] VA OIG, *Failures of Leaders to Respond to Reports of Sexual Harassment at the VA Black Hills Health Care System in Fort Meade and Hot Springs, South Dakota*, Report No. 22-00514-108, May 2, 2023.

Scope and Methodology

The OIG initiated the inspection on November 10, 2021, and conducted a virtual site visit January 10–13, 2022. The OIG interviewed select VISN and facility leaders and staff.[11] The OIG reviewed relevant VA and facility policies and procedures; the AIB report, including supporting documentation; organizational charts; staffing methodology; patient safety reports; staff emails; MH RRTP meeting minutes from October 1, 2020, through March 31, 2021; and All Employee Survey data.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Inspection Results

1. Management under Former Facility Director

The OIG reviewed the former Facility Director's management of the AIB, including convening of the AIB and detailing leaders during the AIB. The OIG also examined additional findings and missed opportunities related to the management of the AIB.

The VISN 23 Chief Human Resources Officer informed the OIG that the former Facility Director served in the position from August 23, 2015, to October 15, 2021. The OIG found that the former Facility Director took some actions to identify and address allegations of failures in leadership and misconduct within the MH RRTP, including convening the AIB and detailing two MH RRTP leaders out of their positions during the investigation. Due to a pending retirement,

[11] From the VISN, the OIG interviewed the VISN Director, Quality Management Officer, Chief Human Resources Officer, Chief Mental Health Officer, Homeless Residential and Work Coordinator, RRTP Program Manager, human resources specialist, and an Integrity and Compliance Officer. From the facility, the OIG interviewed the former, acting, and current Facility Directors; Chief of Staff; acting Chief of Mental Health; Social Work Executive; Associate Director; acting Associate Director for Patient Care Services; Director of Organizational Improvement; former acting and current MH RRTP Program Managers and Nurse Managers; Compensated Work Therapy/Transitional Residence Program Manager; Chief Experience Officer; and AIB Chairperson and members.

the former Facility Director missed opportunities to address the AIB's findings by not including other senior facility leaders in reviewing the AIB or participating in the development of action plans.[12]

Convening the AIB

VA policy states a charge letter serves as a formal appointment of members, defines the scope of the investigation, and authorizes AIB members to investigate on behalf of the convening authority.[13] The convening authority shall select members who are impartial and objective with respect to the investigation subject matter.

The OIG found that the former Facility Director signed the charge letter on March 18, 2021, convening the AIB. In an interview with the OIG, the former Facility Director reported requesting an external AIB because previous internal reviews did not contain sufficient facts and evidence. The VISN 23 Chief Human Resources Officer also told the OIG that to maintain objectivity, the former Facility Director requested VISN assistance with assembling an AIB from outside the facility and VISN. Through interviews, the OIG was told that VISN staff identified an experienced AIB Chairperson and AIB members specializing in compliance, nursing, and mental health. The OIG was informed through emails that for assistance throughout the investigative process, the Board was assigned a human resources technical advisor, an Office of General Counsel attorney, and an administrative assistant, who was the facility's director of organizational improvement.[14]

The OIG concluded that the former Facility Director complied with VA policy by initiating an AIB and ensured objectivity by convening the AIB with members outside of the facility and VISN.

Detailing Leaders During the AIB

VA policy states that detailing an employee under investigation to another position may be considered when facility leaders determine that the employee's continued presence may pose a threat to other employees or patients.[15]

The former Facility Director reported and the OIG confirmed that after convening the AIB, two MH RRTP leaders were detailed to other positions in response to allegations of management

[12] The OIG uses the term senior facility leaders to refer to the Facility Director, Chief of Staff, Associate Director for Patient Care Services, and the Associate Director.

[13] VA Handbook 0700, *Administrative Investigations*, July 31, 2002. This handbook was in effect for the time frame of the events discussed in this report. It was rescinded and replaced by VA Handbook 0700, *Administrative Investigation Boards and FactFindings*, August 17, 2021. The 2021 and 2022 handbooks have same or similar language related to convening authority and final investigative reports.

[14] The OIG uses the term *Board* when referring collectively to the AIB Chairperson and the two AIB members.

[15] VA Directive 5021, *Employee/Management Relations*, April 15, 2002.

misconduct and inappropriate relationships between clinical staff and patients.[16] The former Facility Director explained that the MH RRTP leaders were detailed to other positions in order to protect the individuals who were being interviewed as well as to protect those individuals whose actions were being questioned. On October 14, 2021, the former Facility Director notified the two MH RRTP leaders that the Board concluded the AIB. Through an interview, the OIG learned that one of the two MH RRTP leaders had transferred to another VA medical center earlier in the year. The other resumed the position of MH RRTP leader and was assigned a mentor to help guide the employee as a leader.

The OIG concluded that the former Facility Director complied with VA policy by detailing the MH RRTP leaders to other positions at the convening of the AIB due to allegations of misconduct.

Sharing and Responding to the AIB

The former Facility Director missed several opportunities to include other senior facility leaders in reviewing the AIB's findings and recommendations and participating in the development of action plans.

VA policy states "the convening authority shall take any necessary action based on the results of the investigation, including appropriate dissemination of the results of the report to other officials within VA."[17] VA policy states that "the Convening Authority may add, delete, otherwise modify or comment upon the findings of fact, conclusions, or other matters in the report."[18]

Facility policy requires that the facility director "reviews the AIB report, concurs or requests additional information, assigns responsibility for action and issues memos to applicable service chief/program manager."[19] The memorandums are routed through senior facility leaders and the director of organizational improvement follows up on any open action items until completion.

The OIG received two versions of the AIB report. The initial report was dated June 25, 2021, and the final report was dated August 23. On July 15, the former Facility Director and the AIB Chairperson reported meeting to discuss the initial report, and concerns related to language choices and lack of evidence to corroborate testimony. According to interviews, the Board reviewed the former Facility Director's concerns, agreed to some language changes that did not alter the context of the AIB report, and added supplemental evidence to support the findings. The

[16] Based on information provided from Human Resources, other employees who were investigated for inappropriate behavior transferred within the facility or had resigned or retired from the organization.

[17] VA Directive 0700, *Administrative Investigations*, March 25, 2002. This directive was in effect at the time of the events discussed in this report. The language quoted above is contained within this version of the directive. The revised directive, VA Directive 0700, *Administrative Investigative Boards and FactFindings*, August 10, 2021, does not contain the same language about the dissemination of the results of the AIB.

[18] VA Handbook 0700, July 31, 2002; VA Handbook 0700, August 17, 2021. The VA handbooks contain similar language related to the convening authority.

[19] Facility Directive-39, *Administrative Investigation*, January 11, 2016.

Board members told the OIG that these modifications did not affect the AIB findings or recommendations. Regarding the changes made to the AIB report, the former Facility Director reported to the OIG, "They removed some of it, but there was still a lot of emotion tied to it."

In an interview, the former Facility Director reported sharing the final report with the OIG to ensure that there was no criminal activity based on the provided information contained within the report, and the Office of General Counsel to determine what actions could be taken by facility leaders. According to the former Facility Director, the OIG's determination that no criminal activity occurred was made shortly before the former Facility Director retired. Senior facility leaders stated that the former Facility Director did not provide them with a copy of the AIB report for review. A senior facility leader reported deferring to the former Facility Director's human resources knowledge and did not request to review the AIB. The former Facility Director reported not having time to share the report with other senior facility leaders because of the former Facility Director's pending retirement.

The former Facility Director told the OIG that during the transition meeting, the AIB report was discussed and there were some outstanding actions to be taken. In an interview with the OIG, the VISN 23 Chief Human Resources Officer reported that during the October transition meeting with the former and acting Facility Director and the VISN chief mental health officer, the former Facility Director shared that the AIB was closed except for two action items that needed follow-up: (1) maintain a mentoring program for one MH RRTP leader, and (2) determine the need to report another MH RRTP leader to a state licensing board. Based on the information provided by the former Facility Director as well as discussion with senior facility leaders, the acting Facility Director considered the AIB closed aside from those two action items.

According to the Chief of Staff, the former Facility Director did not share the AIB report with other senior leaders, and as a result, relevant leaders were not advised to develop action plans to address the recommendations contained within the AIB report. This lack of action by the former Facility Director violated facility policy. The former Facility Director also failed to utilize the director of organizational improvement to track and monitor action items, aside from the two action items the former Facility Director shared with the acting Facility Director during the October 15 meeting. In addition, the former Facility Director did not fully disclose the AIB results to the acting Facility Director and VISN leaders during a transition meeting.

2. Management under the Acting Facility Director

The OIG reviewed the acting Facility Director's management of the AIB. During an interview, the acting Facility Director reported serving in the position from October 18, 2021, through January 29, 2022.

Addressing Recommendations from the AIB

The OIG determined that, following awareness of the OIG's interest in the actions taken to address the AIB findings, the acting Facility Director took steps to review the AIB report and work with senior facility leaders to develop action plans to address the recommendations.

VA and facility policy requires the convening authority to review final reports and take any necessary action based on results of an AIB.[20] VHA policy requires clinicians be reported to state licensing boards when there is substantial evidence that a professional's clinical practice failed to meet accepted standards, raising concerns for patient safety.[21] Facility directors are assigned the authority for making these determinations. The policy does not have a requirement or provide guidance on reporting a student to a state licensing board.

The acting Facility Director provided the following information to the OIG. The acting Facility Director learned of the AIB during the October 15, 2021, transition meeting. Following the October 15 meeting, the acting Facility Director met with other senior facility leaders, who recommended no action be taken with regards to reporting the former MH RRTP leader to the state licensing board because the evidence was based on verbal testimony and hearsay. Based on that discussion, the acting Facility Director took no further action. The acting Facility Director later learned that the other senior leaders never received or read the AIB report.

On November 29, 2021, the OIG contacted the acting Facility Director to initiate the OIG inspection process regarding the facility's action plans to address the findings and recommendations listed in the AIB. At that point, the acting Facility Director reported reading the AIB report and discovering that recommendations outlined in the report had not been addressed. The acting Facility Director later reported to the OIG being concerned after reading the AIB report and describing the recommendations as reasonable and being surprised more action had not been taken to address the recommendations. The acting Facility Director reported providing the AIB report to senior facility leaders with the requirement to read the report and work together to develop an action plan addressing the recommendations. Additionally, the acting Facility Director coordinated a meeting between senior facility leaders and the Board to review the findings and recommendations, and obtain clarification where needed.

The acting Facility Director advised that on December 7, 2021, the acting Facility Director and senior facility leaders developed an action plan to address the 11 recommendations identified in the AIB report. The OIG reviewed the facility's action plan and found that senior facility leaders created actionable tasks for each recommendation noted within the AIB. Through a review of facility documents that accompanied the action plan and additional information provided by the facility, the OIG confirmed that senior facility leaders were addressing each recommendation

[20] VA Directive 0700. Facility Directive-39.

[21] VHA Directive 1100.18, Reporting and Responding to State Licensing Boards, January 28, 2021.

through a variety of methods, including creating a standard operating procedure, handouts, and in-person and virtual education presentations. The Chief of Staff explained to the OIG that senior facility leaders had discussed ways to sustain the educational changes and had considered embedding trainings into new employee orientation with plans to repeat the trainings periodically.

Missed Opportunity in Reviewing AIB Evidence and Making a Determination

The OIG learned via emails that in addition to addressing the AIBs recommendations, the acting Facility Director took steps to address an MH RRTP leader and a staff member identified within the AIB as having inappropriate relationships with patients.

Through an interview, the OIG was advised that in January 2022, the acting Facility Director initiated the process to consider reporting the identified MH RRTP leader to the state licensing board. The identified staff member was both an employee and a student at the time of the inappropriate relationship with a patient. The staff member's position as an employee was not required to be licensed by a state licensing board. However, the identified staff member, who was also a student at the time, was working towards a degree in the mental health profession that would require licensure to practice. The identified staff member resigned from the facility and was no longer employed by VA. The acting Facility Director reported to the OIG the understanding that the identified staff member self-reported to the state licensing board. The OIG could not independently confirm that the identified staff member notified the state licensing board of engaging in an inappropriate relationship. The OIG confirmed through online license verification and communication with the respective state licensing board that the identified staff member was not licensed within the State of South Dakota or Wyoming; however, the staff member had a provisional license in the State of Nebraska. The OIG would have expected the facility leaders to have reviewed the evidence and determined what actions to take rather than accepting that the staff member self-reported to the state licensing board.

The OIG concluded that the acting Facility Director took action after learning of the AIB's unaddressed findings and recommendations. The actions included ensuring senior facility leaders read the AIB report, coordinating an exit briefing with the Board, creating a comprehensive action plan to address the AIB's recommendations, and initiating the process to report the identified MH RRTP leader to the state licensing board. The OIG acknowledges the absence of a requirement or guidance in VHA policy to report a student to a state licensing board. However, the OIG would have expected facility staff to have reviewed the evidence and made an independent determination of whether to notify the state licensing board.

3. Management under the New Facility Director

In interviews, the OIG was told that the new Facility Director assumed the position on January 30, 2022.

The acting Facility Director included the new Facility Director in the OIG exit briefing held on January 18, 2022. On February 24, the OIG interviewed the new Facility Director. The OIG found the new Facility Director to be knowledgeable about the AIB and supportive of the action plans to address the AIB's findings and recommendations. The new Facility Director reported a process to have the AIB action plans tracked to completion by the director of organizational improvement.

In an interview and through emails, the OIG was provided with the following information. The new Facility Director continued the review process of the MH RRTP leader. The facility's credentialing and privileging department developed the evidence file and submitted the evidence file to the new Facility Director for a decision. On April 5, 2022, the facility submitted the final evidence package to the state licensing board for the identified MH RRTP leader.[22]

The OIG concluded that the new Facility Director appeared to understand the AIB and supported the developed action plan.

Conclusion

The former Facility Director took some actions to identify and address allegations of misconduct and leadership failure within the MH RRTP by convening an objective AIB and detailing to other positions two MH RRTP leaders who were under investigation. The former Facility Director met solely with the AIB Chairperson to discuss the initial report and request changes to certain language used. The former Facility Director did not include other senior facility leaders in the meeting. Upon receipt of the final AIB report, the former Facility Director conferred with the OIG and the Office of General Counsel to determine if criminal activity occurred and what actions could be taken. The former Facility Director reported that the OIG determined that no criminal activity occurred shortly before the former Facility Director retired. During a transition meeting with the acting Facility Director and VISN leaders, the former Facility Director did not disclose the full findings and recommendations of the AIB but did note that two action items, determining the need to report an MH RRTP leader to the state licensing board and monitoring the mentoring of the other MH RRTP leader, needed to be further addressed.

Upon learning of an OIG inspection, the acting Facility Director reviewed the AIB report, coordinated an exit briefing with the Board, shared the report with other senior facility leaders, and together developed an action plan to address the 11 recommendations. The facility reported a

[22] The identified MH RRTP leader no longer works for the facility but remains an employee at another VA medical center.

former MH RRTP leader to the state licensing board. For another former staff member, who was a student at the time, the facility accepted that the former staff member self-reported to the state licensing board. The OIG acknowledges the absence of a requirement or guidance in VHA policy to report a student to a state licensing board but would have expected the facility to review the evidence and take appropriate action rather than accept that the staff member self-reported to the state licensing board.

The new Facility Director continued with the already developed action plan to address the AIB's findings and recommendations.

Recommendations 1–2

1. The VA Black Hills Health Care System Director continues to monitor and track the identified action plan through to completion.

2. The VA Black Hills Health Care System Director reviews the evidence and independently determines if the state licensing board should be notified.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 16, 2023

From: Executive Director, VA Midwest Health Care Network (10N23)

Subj: Healthcare Inspection—Issues Related to an Administrative Investigation Board at VA Black Hills Health Care System, Ft. Meade and Hot Springs, South Dakota

To: Director, Office of Healthcare Inspections (54HL08)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. This memo is in response to an OIG Care Referral No. 2022-00540-HI-1226.

2. I concur with the findings and recommendations of the OIG report and the facility director response.

3. If you have any further questions or concerns, please contact the Chief of Quality, Safety, and Value.

(*Original signed by:*)

Robert P. McDivitt, FACHE
Executive Director
VA Midwest Healthcare Network (VISN 23)

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 16, 2023

From: Director, VA Black Hills Health Care System Fort Meade (568) and Hot Springs (568A4)

Subj: Healthcare Inspection—Issues Related to an Administrative Investigation Board at VA Black Hills Health Care System, Ft. Meade and Hot Springs, South Dakota

To: Executive Director, VISN VA Midwest Health Care Network (10N23)

1. The safety of our staff and Veterans remains our highest priority as we strive to provide a zero-harm environment at the VA Black Hills Health Care System.
2. I have reviewed the documentation and concur with the findings.
3. If you have further questions or concerns, please contact the Chief of Quality, Safety and Value.

(*Original signed by*:)

Lisa R. Curnes
Director
VA Black Hills Healthcare System

Facility Director Response

Recommendation 1

The VA Black Hills Health Care System Director continues to monitor the identified action plan through to completion.

Concur.

Target date for completion: May 31, 2022

Director Comments

The safety of our staff and Veterans remains our highest priority as we strive to provide a zero-harm environment. The action plan created in December of 2021 and completed in May 2022, continues to be monitored for organizational sustainment. Additional annual training requirements, along with updated processes and HRO [High Reliability Organization] based, facility-wide team training have been incorporated into the VA Black Hills Health Care System (BHHCS) culture. The changes have been made organizationally and not limited to an individual service area.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 2

The VA Black Hills Health Care System Director reviews the evidence and independently determines if the state licensing board should be notified.

Concur.

Target date for completion: April 30, 2023

Director Comments

The VA BHHCS Credentialing and Privileging staff, in coordination with facility leadership and Human Resources, are conducting a review of records pertaining to the former student who self-reported to the state licensing board. The records show that the assignment of a provisional license did not occur until after the student left their employment at VA BHHCS. Upon completion of a thorough review of the facts, a determination will be made about the appropriateness of reporting the events that occurred in 2019 prior to the student being licensed.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Joanne Wasko, MSW, LCSW, Director Debbie Davis, JD, RN Kevin Hosey, MBA, LCSW Hanna Lin, LCSW Aja Parchman, MHA, RN Elizabeth Winter, MD
Other Contributors	Josephine Biley Andrion, MHA, RN Shelby Assad, LCSW Sherry Becker, MSN, RN-BC Alicia Castillo-Flores Limin Clegg, PhD Sheena Mesa, MSN, RN Natalie Sadow, MBA Zaire Smith, LCSW Harold Stanek, MS Erica Taylor, MSW, LICSW

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Midwest Health Care Network (10N23)
Director, VA Black Hills Health Care System Fort Meade (568) and Hot Springs (568A4)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate:
Nebraska: Deb Fischer, Pete Ricketts
South Dakota: Mike Rounds, John Thune
Wyoming: John Barrasso, Cynthia M. Lummis
U.S. House of Representatives:
Nebraska: Don Bacon, Mike Flood, Adrian Smith
South Dakota: Dusty Johnson
Wyoming: Harriet Hageman