US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Veterans Integrated Service Network 7 Leaders' Effectiveness in Resolving Operational and Leadership Challenges at the VA Dublin Healthcare System in Georgia

Healthcare Inspection | **24-02347-40** | **January 27, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection to evaluate Veterans Integrated Service Network (VISN) 7 leaders' effectiveness in identifying and resolving significant concerns regarding the VA Dublin Healthcare System's (system's) leadership and operational challenges reported during an unrelated OIG inspection in 2024.[1]

Due to the nature and complexity of the concerns, the OIG initiated this inspection on June 24, 2024. The OIG completed the on-site inspections at VISN 7 and the system from July 7 through 9, 2024, and continued to receive and review documents until March 25, 2025. The OIG conducted a briefing with Veterans Health Administration (VHA), VISN, and system leaders on July 31, 2025, to review and discuss the findings and recommendations of this inspection.

As of November 2, 2025, the system has a new permanent Director, while the remaining members of the executive team continued to serve either in an acting or interim capacity.

Efforts of VISN Leaders to Resolve System Operational and Leadership Challenges

The OIG determined that VISN executive leaders were aware of and had the opportunity to address concerns with the system's leadership and operations before 2024. VISN executive leaders were engaged with system senior leaders and identified clinical vulnerabilities and operational deficiencies throughout 2022 and 2023; however, many system vulnerabilities and deficiencies persisted, culminating in the system's state of operations in 2024.[2]

VISN directors have direct supervisory authority over the facility directors within their region. Other VISN executive leaders such as the Chief Medical Officer (CMO) and Chief Nursing Officer (CNO) provide guidance to facility-level leaders, including the Chief of Staff (COS) and Associate Director of Patient Care Services (ADPCS), and their respective services regarding facility-level clinical programs and services, but do not have direct supervisory authority.

The OIG found that VISN executive leaders did not hold system senior leaders accountable for resolving the VISN site visit findings. VISN site visit findings from December 2021 through July 2024 identified deficiencies, included recommendations for improvement, and required

[1] The associated report has since been published. VA OIG, *Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia*, Report No.24-00592-60, March 6, 2025.

[2] At the time of the OIG's July 2024 on-site inspection, the system had experienced substantial changes in senior leaders and patient admissions to the inpatient acute care, community living center (CLC), and domiciliary units were curtailed, after a VA Office of Nursing Service's team identified unsafe practices. Throughout the report, the OIG refers to this time and these events as the system's state of operations.

action plans to address deficiencies. However, some medical and nursing services deficiencies were unresolved and reidentified during subsequent VISN site visits.

When questioned about follow-up for VISN site visit findings, the CNO reported that although the system initially made progress toward resolution, the momentum slowed when VISN leaders decreased oversight. The CNO explained having no direct supervisory authority over system nursing leaders, including the ADPCS, and stated that accountability ultimately "rests in the hands of the [System Director]."

The OIG also found VISN executive leaders were aware of significant performance and conduct issues with the COS and Deputy COS but never pursued assurance from the former System Director that these issues were being actively addressed and corrected. The former CMO noted that the lack of direct supervisory authority limited the ability to hold the COS and Deputy COS accountable for performance or conduct.

Although executive leaders are responsible for ensuring systems within their VISN are compliant with specified VHA requirements, the OIG found the former CMO and CNO believed their lack of direct authority over system leaders impeded their ability to enforce accountability. This finding is not unique to VISN 7. Prior oversight reports have identified the need for VHA to define VISN leaders' roles and authority, including a recent OIG survey of staff from across VHA.[3] The survey identified a lack of VISN staff authority as a "major barrier" to effective oversight, including ensuring the implementation of actions.[4]

Although VHA has taken steps to delineate levels of authority for decision-making, VHA has not established clearly defined roles, responsibilities, and authorities for VISN leaders to provide proactive oversight and hold system leaders accountable for addressing and resolving deficiencies.

The OIG made one recommendation to the Under Secretary for Health related to standardizing VISN CMO and CNO roles and responsibilities; and two recommendations to the VISN 7 Director related to sustained system support and oversight, and ensuring system action plans from VISN site visits are reviewed by VISN staff through resolution.[5]

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

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[3] Examples of oversight reports include, GAO, *Veterans Health Administration Regional Networks Need Improved Oversight and Clearly Defined Roles and Responsibilities,* Report No. GAO-19-462, June 2019; VA OIG, *Inadequate Governance Structure and Identification of Chief Mental Health Officers' Responsibilities*, Report No. 23-02350-95, March 31, 2025.

[4] VA OIG, *Inadequate Governance Structure and Identification of Chief Mental Health Officers' Responsibilities*.

[5] The recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

VA Comments and OIG Response

The Acting Under Secretary for Health concurred in principle with recommendation 3 to consider standardizing the VISN CMO and CNO roles and responsibilities to include the authority to hold system leaders accountable for resolving identified deficiencies. The VISN 7 and System Directors concurred with the recommendations and provided acceptable action plans related to providing sustained system support and resolution of identified deficiencies (see appendixes B, C, and D).

The OIG will continue to evaluate and report on VISN leaders' consistency and effectiveness in supporting the operations of VHA facilities. The OIG is hopeful that the information in this report will inform future organizational changes. In that the Acting Under Secretary for Health's response documents a consideration of developing clearly defined roles and responsibilities for the Chief Medical Officer and Chief Nursing Officer, the OIG will close recommendation 3.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Contents

Abbreviations

ADPCS	Associate Director of Patient Care Services
CLC	community living center
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COS	Chief of Staff
EHR	electronic health record
OAWP	Office of Accountability and Whistleblower Protection
OIG	Office of Inspector General
ONS	Office of Nursing Services
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted an inspection to evaluate Veterans Integrated Service Network (VISN) 7 leaders' effectiveness in identifying and resolving concerns regarding the VA Dublin Healthcare System's (system's) leadership and operational challenges. The OIG initiated the inspection in June 2024, completed on-site inspections at VISN 7 and the system in July 2024, and continued off-site inspection activities through late March 2025. On July 31, 2025, the OIG conducted a briefing with Veterans Health Administration (VHA), VISN, and system leaders to review and discuss the findings and recommendations of this inspection.

Background

System

Part of VISN 7, the system is classified as a level 3 complexity and consists of the Carl Vinson VA Medical Center in Dublin and seven outpatient clinics throughout Georgia.[1] The System Director has direct supervisory authority over an executive leadership team, which consists of the Chief of Staff (COS), Associate Director of Patient Care Services (ADPCS), Associate Director, and Assistant Director. The system also has a Deputy COS and a Deputy ADPCS who report to the COS and ADPCS, respectively. Throughout this report, the OIG refers to these seven positions as system senior leaders.

VISN

VISN 7, headquartered in Duluth, Georgia, covers a region that spans across 244 counties and includes eight VA medical facilities throughout Alabama, Georgia, and South Carolina. The VISN 7 Director (Network Director) leads an executive team, including, but not limited to, a Chief Medical Officer (CMO) and a Chief Nursing Officer (CNO).[2] The OIG will refer to members of this team as VISN executive leaders.

[1] The model rates facilities as "1a, 1b, 1c, 2 or 3, with level 1a being the most complex and level 3 being the least complex." VHA Office of Productivity, Efficiency, and Staffing (OPES), "VHA Facility Complexity Model History," October 1, 2023, accessed October 15, 2024. A level 3 facility has "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency, and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," accessed June 26, 2025

[2] The VISN executive leadership team also includes a Deputy Network Director, Quality Management Officer, and Chief Operating Officer.

VISN Leaders' Roles and Responsibilities

According to VHA Directive 1217, *VHA Operating Units,* VHA is divided into 18 regional networks, referred to as VISNs, that "are responsible for in-person and virtual coordination of Veteran care through various service delivery locations, including care that is purchased in the community."[3] Each VISN is led by a director "who provides operational oversight of VA medical facilities" within the region.[4] VISN directors have direct supervisory authority over the facility directors within their region. Other VISN executive leaders such as the CMO and CNO provide guidance to facility-level leaders, including the COS and ADPCS, and their respective services regarding facility-level clinical programs and services, but do not have direct supervisory authority (see figure 1).

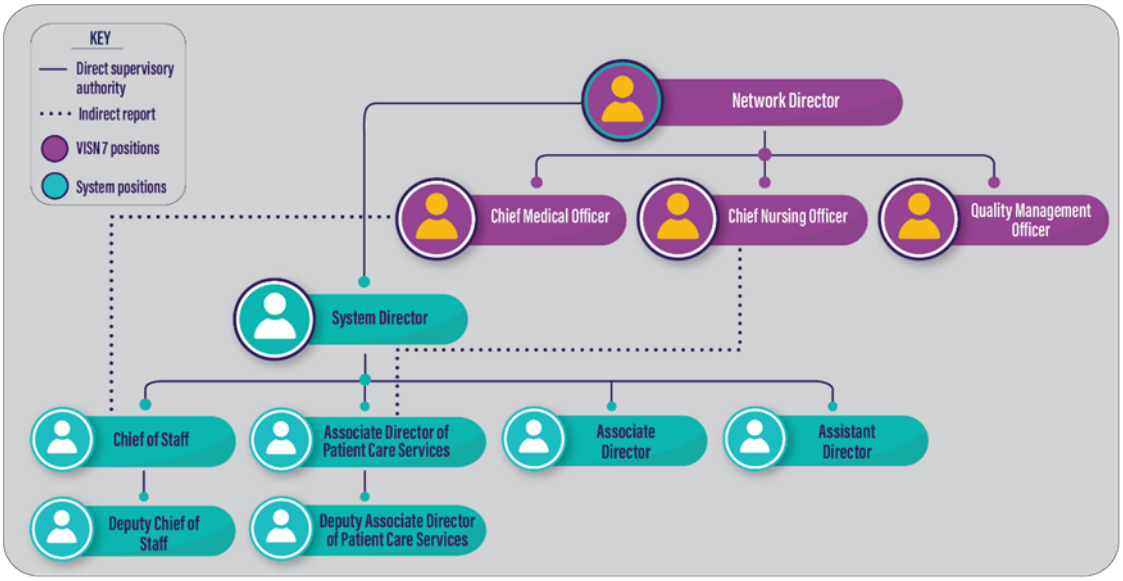

Figure 1. *VISN 7 and system organizational structure.*
Source: OIG review and analysis of VISN 7 and system documents and information gleaned during OIG interviews. The organizational chart reflects the reporting structure of VISN 7 and the system as described in this report.

VISN directors are responsible for implementing VISN and VHA policies.[5] Various VHA policies delineate specific roles and responsibilities for other VISN executive leaders based on their positions. For example, VHA Directive 1100.20(2), *Credentialing of Health Care Providers* and VHA Directive 1190(1), *Peer Review for Quality Management*, outline that VISN CMOs have oversight and compliance responsibilities for credentialing, privileging, and peer

[3] VHA Directive 1217, *VHA Operating Units*, August 14, 2024, was amended to VHA Directive 1217 (1), *VHA Operating Units*, January 19, 2025. The policies contain similar language unless otherwise noted.

[4] VHA Directive 1217; VHA Directive 1217(1).

[5] VHA Directive 1217; VHA Directive 1217(1). This directive replaced VHA Directive 1217, the previous directive did not contain language outlining VISN Director responsibilities.

review at VA medical facilities within their VISN.[6] VISN executive leaders' roles and responsibilities may be further delineated in their position descriptions or functional statements.[7] For example, the CNO's functional statement identifies the leader as responsible for oversight of nursing activities at facilities within the VISN, which includes assuring "the provision of nursing care by staff with the appropriate levels of clinical competency (including population-specific competency) required by the population served."

Prior OIG Reports

On March 6, 2024, the OIG published a report related to VISN 7 and system leaders' not remediating sterile processing deficiencies. The OIG made one recommendation relevant to this report, specifically that the "Sterile Processing Services chief conducts comprehensive staff competency assessments for the reprocessing of reusable medical equipment, and monitors for compliance," which was closed on February 10, 2025.[8]

Subsequently, the OIG published another report on sterile processing services at the system on March 6, 2025. The OIG found that frequent turnover in leadership positions likely contributed to continued sterile processing-related deficiencies. One recommendation related to VISN 7 oversight to ensure "implementation of facility-level action plans and sustainability of identified outcomes" is relevant to this inspection; this recommendation was closed in November 2025.[9]

Scope and Methodology

The OIG conducted an on-site inspection at the VISN 7 office in Duluth, Georgia, on July 9, 2024, and at the system in Dublin, Georgia, from July 10 through 11, 2024. The OIG completed additional interviews virtually from July 24, 2024, through January 7, 2025.

The OIG team interviewed and corresponded with VISN leaders; a former VISN leader; permanent, acting, and interim system senior leaders; service line leaders; administrative staff; and the chief of quality management.[10]

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[6] VHA Directive 1100.20(2), *Credentialing of Health Care Providers*, September 15, 2021, amended September 11, 2024; VHA Directive 1100.21(1). Credentialing and privileging are processes used to ensure VA clinical providers are qualified and authorized to provide patient care; VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

[7] VA Handbook 5003, *Position Classification, Job Grading, and Position Management*, April 15, 2002. Position descriptions and functional statements are used to delineate the major duties and responsibilities assigned by management to a position.

[8] VA OIG, *Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin, Georgia,* Report. No. 22-01315-90, March 6, 2024.

[9] VA OIG, *Continued Sterile Processing Services Deficiencies and Facility Leaders' Failures at the Carl Vinson VA Medical Center in Dublin Georgia,* Report No.24-02277-69, March 6, 2025.

[10] The former CMO reported serving as the VISN CMO from August 2020 until retiring in late February 2024.

The OIG reviewed relevant VHA, VISN 7, and system policies and procedures along with administrative reviews, organizational charts, email correspondence, and VISN 7 system site visit reviews and related action plans. The OIG also reviewed the VA Office of Nursing Service (ONS) site visit findings and recommendations and relevant VA Office of Accountability and Whistleblower Protection (OAWP) investigation reports. The OIG did not independently verify VA data or conclusions for accuracy or completeness.

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.

Concerns

In mid-April 2024, while on-site, an OIG Healthcare Facility Inspection team learned of multifaceted concerns regarding leaders' actions or inaction and a lack of accountability that seemed to negatively affect employees and interrupt operations.[11] Further, the former System Director had resigned from the position and the COS and Deputy COS had been administratively reassigned from their positions, pending administrative investigations. Because the nature and complexity of the concerns were beyond the scope of the April 2024 Healthcare Facility Inspection, the OIG initiated this inspection on June 24, 2024, to

- evaluate system leaders' effectiveness in identifying and resolving significant challenges (see appendix A), and
- determine whether VISN leaders provided timely and effective oversight of system leaders to ensure the resolution of quality of care concerns. [12]

At the time of the OIG's July 2024 on-site inspection, the system had and continued to experience substantial changes in senior leaders, and patient admissions to the inpatient acute

[11] The associated report has since been published. VA OIG, *Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia*, Report No.24-00592-60, March 6, 2025.

[12] The OIG findings regarding system leaders, specifically the former System Director's leadership deficiencies are located in appendix A.

care, community living center (CLC), and domiciliary units were curtailed after a VA ONS team identified unsafe practices.[13] A summary of these events (state of operations), which included personal misconduct, alleged leadership deficiencies, and quality of care concerns, is provided in appendix A.

Inspection Results

This OIG inspection reviewed VISN 7 executive leaders' actions to understand whether there were missed opportunities to mitigate repeat system deficiencies.

1. Efforts of VISN Leaders to Resolve System Operational and Leadership Challenges

The OIG determined that VISN executive leaders were aware of and had the opportunity to address concerns with the system's operations and leadership before 2024. VISN executive leaders were engaged with system senior leaders and identified clinical vulnerabilities and operational deficiencies throughout 2022 and 2023; however, many system vulnerabilities and deficiencies persisted, culminating in the system's state of operations in 2024.

Although VHA Directive 1217, *VHA Operating Units* sets the expectation that VISN executive leaders are responsible for ensuring systems within their VISN are compliant with specified VHA requirements, the OIG found the former CMO and CNO believed their lack of direct authority over system leaders impeded their ability to enforce accountability. This finding is not unique to VISN 7. Prior oversight reports have identified the need for VHA to define VISN leaders' roles and authority, including a recent OIG survey of staff from across VHA.[14] The survey identified a lack of VISN staff authority as a "major barrier" to effective oversight, including ensuring the implementation of planned actions.[15]

VISN leaders conduct site visits at the medical facilities within their VISN to assess whether certain medical center operations or specific programs are compliant with VHA requirements.

The OIG found that VISN executive leaders did not hold system senior leaders accountable for resolving VISN site visit findings. The OIG reviewed VISN site visit findings and related system action plans dated from December 2021 through July 2024 and found VISN executive leaders identified deficiencies, provided recommendations, and required system leaders to develop time-

[13] Following the OIG site visit, system leaders curtailed surgical services on July 12, 2024, after identifying the need for further staff training.

[14] VHA Directive 1217; VHA Directive 1217(1); Examples of oversight reports include, GAO, *Veterans Health Administration Regional Networks Need Improved Oversight and Clearly Defined Roles and Responsibilities,* Report No. GAO-19-462, June 2019; VA OIG, *Inadequate Governance Structure and Identification of Chief Mental Health Officers' Responsibilities*, Report No. 23-02350-95, March 31, 2025.

[15] VA OIG, *Inadequate Governance Structure and Identification of Chief Mental Health Officers' Responsibilities*.

limited action plans to address the issues. However, some system deficiencies were not resolved and were identified as noncompliant during multiple subsequent VISN site visits.[16]

When asked about VISN oversight, the CNO explained the system had been progressing toward completion of the action items but acknowledged the momentum slowed and seemed to fall "by the wayside" when VISN leaders decreased direct oversight.[17] The CNO reported relying on the system's ADPCS to provide updates on the action plan. Further, the CNO reported having no direct supervisory authority over system nursing leaders, including the ADPCS, and stated accountability ultimately "rests in the hands of the [System Director]."

During an interview with the Network Director, the OIG asked about repeat site visit findings and unresolved system deficiencies. The Network Director reported being concerned that items were incomplete and noted that tracking action items at the VISN executive leaders' level is critical; however, the Network Director noted not being aware of the extent of the nursing service challenges until ONS conducted their site visit. The Network Director and Quality Management Officer shared that some efforts were made to improve VISN oversight processes, such as developing a site visit procedure that outlines roles and expectations and creating a VISN oversight position with responsibility for tracking action plans.

The OIG also found that VISN executive leaders were aware of ongoing concerns regarding the COS and Deputy COS's performance and interpersonal conflict and the effect on facility operations but did not ensure the former System Director took actions to correct the concerns. The former CMO described believing that because of a lack of direct supervisory authority, the ability to actively intervene and enforce correction was limited. The former CMO explained that CMOs are responsible for the clinical oversight of each facility within the VISN but added, "I don't have authority over [the COS and Deputy COS] … there's not a reporting structure to me. If there were, I would have intervened aggressively." The former VISN CMO noted using "support and influence" to gain compliance and "when all else fail[ed]," going up the chain of command.

During an interview, the Network Director described becoming aware over time of issues with the COS's performance. The Network Director explained that system directors are responsible to take action at their facilities "if things are not working." The Network Director confirmed that the former System Director sought guidance. After providing guidance and support, the Network Director explained the need to create distance and refrain from direct involvement in senior leader personnel matters due to the potential that the Network Director could become a deciding official for future disciplinary actions.

[16] Further, the June 2024 ONS site visit revealed many of the previously identified vulnerabilities persisted contributing to the closure of the system's acute care, community living center, and domiciliary.

[17] The CNO is responsible for oversight of nursing activities within the VISN, which includes ensuring nursing staff have appropriate clinical competencies.

2. VHA Governance Policy

In August 2024, VHA updated their governance policy VHA Directive 1217 to delineate levels of authority for decision-making across VHA's operating units. The policy also includes an overview of VISN directors' roles and responsibilities.[18]

However, in a September 2024 congressional hearing, the VA OIG testified that

> the OIG did not find the new directive to be substantive or adequate to address the long-standing concerns of a passive VISN oversight role. Furthermore, the directive fails to delineate responsibilities of other key VISN roles. The policies and procedures regarding VISN oversight of medical facilities continues to lack clearly defined and standardized responsibilities, which allows inconsistent oversight and deficient engagement with facility leaders to persist.[19]

Throughout this review, the OIG identified multiple factors related to VISN roles and responsibilities that contributed to prolonged system operational deficiencies and leadership challenges:

- VISN executive leaders' lack of follow-through to ensure identified deficiencies were resolved and changes sustained.
- CNO and former CMO's perception that the lack of direct authority impeded their ability to hold senior system leaders accountable.
- Network Director's refrainment from monitoring the former System Director's progress toward resolving COS and Deputy COS performance and conduct concerns, in an effort to maintain neutrality if future disciplinary actions were taken.

VISN directors remain the only VISN leaders with direct supervisory authority over system-level staff. VHA has not established clearly defined roles, responsibilities, and authorities for VISN leaders to provide proactive oversight and hold system leaders accountable for addressing and resolving deficiencies.

3. System State of Operations Update

As of December 2024, the system's domiciliary, CLC, operating room surgical procedures, acute care, and endoscopy were open for patient admissions and services.

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[18] VHA Directive 1217, *VHA Central Office Operating Units*, September 10, 2021, was rescinded and replaced by VHA Directive 1217, *VHA Operating Units*, August 14, 2024.

[19] *Hearing on VA Accountability: What Has Happened to Hampton? Before the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs*, 118th Cong. (September 24, 2024) (statement of Jennifer Baptiste, MD, Deputy Assistant Inspector General, Office of Healthcare Inspections, VA Office of Inspector General), accessed November 20, 2024.

On November 2, 2025, a new System Director was permanently appointed; this individual had served as the interim System Director from August 2024 to August 2025. The remaining members of the executive leadership team are either acting or interim leaders.

Conclusion

The OIG concluded that VISN executive leaders engaged with system senior leaders and identified clinical vulnerabilities and operational deficiencies through VISN site visits throughout 2022 and 2023 but did not hold system leaders accountable for resolving deficiencies. The CNO shared having no direct supervisory authority over system nursing leaders, including the ADPCS, and noted that System Directors are ultimately accountable for resolving system deficiencies. VISN leaders' lack of continued oversight contributed to the ongoing unsafe clinical practices that ONS identified in June 2024 and led to the curtailment of admissions to inpatient care, CLC, and the domiciliary units.

Although aware of concerns regarding the COS and Deputy COS's performance and conduct, VISN executive leaders did not ensure that the former System Director took the actions necessary for correction. The former CMO's perception that the lack of direct authority limited the ability to ensure accountability and the Network Director's decision to remain neutral pending possible disciplinary actions contributed to their lack of action. The OIG concluded that VISN executive leaders' inaction contributed to prolonged system operational deficiencies and leadership challenges.

Although VHA has amended their governance policy to further delineate levels of authority for decision-making, policies and procedures regarding VISN oversight lack clearly defined and standardized VISN leaders' responsibilities. Consistent VISN oversight and engagement with facility leaders is critical to prevent reoccurrence of the system's operational deficiencies and leadership challenges discussed in this report.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–3

1. The Veterans Integrated Service Network Director develops and implements a plan to provide sustained support and oversight in a constructive manner to VA Dublin Healthcare System leaders and programs.

2. The Veterans Integrated Service Network Director ensures that following Veterans Integrated Service Network site reviews with findings, Veterans Integrated Service Network staff review the associated VA Dublin Healthcare System action plans to confirm proposed actions

adequately address findings, track action items through implementation, evaluate effectiveness to ensure resolution, and monitor for sustainment.

3. The Under Secretary for Health considers standardizing the Veterans Integrated Service Network Chief Medical Officer's and Chief Nursing Officer's role and responsibilities to include the authority to hold systems leaders accountable for resolving identified deficiencies.

Appendix A: System's State of Operations

System's State of Operations, July 2024

At the time of the OIG's July 2024 on-site inspection, the system had and continued to experience substantial changes in senior leaders and significant interruptions in multiple areas of healthcare operations. A summary of these events (state of operations), which included personal misconduct, alleged leadership deficiencies, and quality of care concerns, is provided below.

Former System Director's Misconduct

Prior to this OIG inspection, the former System Director resigned from federal service after OAWP completed an investigation into allegations of senior leader misconduct.[20] In January 2024, the Network Director administratively reassigned the System Director (former System Director) pending a review of the results from the OAWP investigation. Based on the results, the Network Director proposed the former System Director undergo an adverse personnel action. The former System Director resigned, in lieu of adverse action, from VA service.

Additional System Senior Leaders Reassigned amid Investigations

Following the reassignment of the former System Director, the Network Director administratively reassigned the system Associate Director to serve as the interim System Director in January 2024. The interim System Director, in partnership with VISN 7 executive leaders, took actions to evaluate and address personnel and operational challenges.[21]

The OIG learned that between February and July 2024, four of the remaining six system senior leaders had been temporarily administratively reassigned from their positions while various concerns related to each of the four leaders' effectiveness were being investigated.[22]

- February 2024: The interim System Director administratively reassigned both the COS and the Deputy COS.
- June 2024: The interim System Director administratively reassigned the ADPCS.
- July 2024: The acting ADPCS administratively reassigned the Deputy ADPCS.

[20] "Welcome to the Office of Accountability and Whistleblower Protection (OAWP)," VA, accessed December 5, 2024, https://department.va.gov/accountability/. OAWP investigates allegations of VA senior leader misconduct and poor performance along with allegations of whistleblower retaliation against VA supervisors.

[21] The interim System Director served in the role for approximately seven consecutive months. A new interim System Director was appointed in August 2024.

[22] At the time of this OIG inspection site visit, two system senior leaders remained in place: the Associate Director, who was serving as the interim System Director, and the Assistant Director.

Curtailment of Inpatient, CLC, Domiciliary, and Surgical Services

In June 2024, VISN 7 executive leaders requested ONS conduct a consultative site visit "to address concerns related to the delivery of competent and skilled nursing care in the primary and specialty health services provided to inpatients at [the system]."[23]

From June 25 through 27, 2024, an ONS team conducted a site visit with specific focus on the system's inpatient acute care unit (inpatient unit), CLC, and domiciliary.[24] Concerns identified at the ONS exit brief included but were not limited to

- unsafe clinical practice,
- deficient education and competency, and
- lack of oversight and accountability from nursing leaders at all levels.

The ONS report identified 75 issues and findings and made 51 recommendations. The ONS team recommended that admissions to three clinical areas be curtailed while nursing staff completed "training, education, and competency validation." VISN leaders made the final decision to initiate this recommendation on the CLC, inpatient unit, and domiciliary units. On June 27, 2024, system leaders curtailed patient admissions to these three clinical areas.

At the time of the July 2024 OIG site visit, the three clinical areas remained closed to patient admissions. Following the OIG site visit, system leaders curtailed surgical services on July 12, 2024, after identifying the need for further staff training.

Former System Director's Leadership Deficiencies

The OIG determined the former System Director did not resolve significant operational and personnel challenges and quality of care concerns that, when left unaddressed, posed risks to patient care and ultimately led to the system's July 2024 state of operations.

The OIG found directly related to the system's state of operations was the former System Director's inaction to ensure resolution of previously identified operational limitations and vulnerabilities, which compromised safe and effective care for acutely ill patients. In a December 23, 2022, memorandum from the chief of medicine addressed to the system's senior leaders, the chief of medicine raised significant concerns regarding physician and nurse skills and competencies to care for acutely ill patients.

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[23] "Office of Nursing Services (ONS)," VA, accessed June 30, 2025, https://www.va.gov/NURSING/About/About_ONS.asp. The VA Office of Nursing Services is a national nursing program office that "provides leadership, guidance and strategic direction on all issues related to nursing practice, education, research & workforce for clinical programs across the continuum of care and care delivery sites that impact" veterans.

[24] According to the ONS site visit report, the ONS team consisted of ONS program staff and advisors from relevant clinical disciplines from other VHA facilities.

In response, the former System Director requested VISN staff conduct a site visit to review the system's inpatient care and assess potential safety concerns. In March 2023, VISN clinical leaders conducted a site visit and made 19 recommendations with specified time frames for resolution. Recommendations included: standardizing competencies for providers and nurses covering the inpatient unit, utilizing training and educational resources to develop and maintain clinical competencies, establishing metrics for continuing education requirements, and holding clinical staff accountable to the metrics.

System senior leaders developed an action plan to address recommendations and resolve identified vulnerabilities; however, the former System Director did not ensure the COS and ADPCS fully implemented the plan. In June 2024, the ONS site visit revealed that many identified vulnerabilities persisted. The ONS site visit report cited the lack of follow-up by leaders to address the concerns identified by the chief of medicine including "patient safety, nursing practice, and lack of competency to take care of patients admitted to the Acute Care [inpatient] Unit."

Additionally, the OIG found that the former System Director did not take sufficient action to address the COS and Deputy COS alleged performance and conduct concerns, which were negatively affecting clinical operations and staff morale. System staff described an ongoing interpersonal conflict between the COS and Deputy COS that included verbal arguments, an alleged physical confrontation, and undermining one another in public through disparaging comments, which interfered with both leaders' effectiveness and ability to lead the medicine service. System staff also shared concerns that the COS did not perform core functions such as chairing and attending designated committees and did not have access to electronic health records.

Although the former System Director drafted letters of expectations to the COS and Deputy COS that addressed performance and conduct concerns, the OIG found no evidence the former System Director took corrective or disciplinary actions. Shortly after being appointed, the interim System Director, in partnership with VISN 7 executive leaders, temporarily reassigned the COS and Deputy COS and initiated administrative investigations to review their performance and conduct. Because administrative investigations were underway at the time of this inspection, the OIG did not duplicate these efforts.

The OIG concluded that despite being aware of significant vulnerabilities in acute care services, the former System Director did not ensure timely corrective actions or provide the necessary oversight to resolve known deficiencies, thereby undermining the organization's culture of safety and effective governance.

Appendix B: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: August 15, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General Report, Review of System and Veterans Integrated Service Network 7 Leaders' Effectiveness in Resolving Operational and Leadership Challenges at the VA Dublin Healthcare System in Georgia (VIEWS# 13526354)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on the Review of System and Veterans Integrated Service Network 7 Leaders' Effectiveness in Resolving Operational and Leadership Deficiencies at the VA Dublin Healthcare System in Georgia. The Veterans Health Administration (VHA) concurs in principle with the recommendation made to the Under Secretary for Health and provides an action plan in the attachment.

2. The insights and recommendations provided are appreciated. Our commitment to excellence and dedication to providing the highest quality healthcare for our veterans remains paramount. We recognize that improvement is an ongoing process, and we are dedicated to implementing the necessary changes to ensure that our leadership meets the highest standards of accountability and effectiveness.

3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D., MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on August 15, 2025.]

Office of the Under Secretary for Health Response

Recommendation 3

The Under Secretary for Health considers standardizing the Veterans Integrated Service Network Chief Medical Officer's and Chief Nursing Officer's role and responsibilities to include the authority to hold systems leaders accountable for resolving identified deficiencies.

Concur in Principle

Target date for completion: August 2025

Under Secretary for Health Comments

VHA Directive 1217 defines VISN Directors' roles and responsibilities for managing and overseeing medical centers. VISN Directors have the line of authority to hold VA medical facility leaders accountable for resolving deficiencies, including the deficiencies identified by the VISN Chief Medical Officers and Chief Nursing Officers. When appropriate, VISN Directors establish necessary Corrective Action Plans in concert with VA medical facility representatives and ensure immediate corrective actions are taken to address identified risks and issues.

VHA requests closure of this recommendation based on the evidence provided.

OIG Comments

The OIG will continue to evaluate and report on VISN leaders' consistency and effectiveness in supporting the operations of VHA facilities. The OIG is hopeful that the information in this report will inform future organizational changes. In that the Acting Under Secretary for Health's response documents a consideration of developing clearly defined roles and responsibilities for the Chief Medical Officer and Chief Nursing Officer, the OIG will close recommendation 3.

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 15, 2025

From: Director, Department of Veterans Affairs (VA) Southeast Network (10N7)

Subj: Office of Inspector General (OIG) Draft Report, Review of System and Veterans Integrated Service Network 7 Leaders' Effectiveness in Resolving Operational and Leadership Challenges at the VA Dublin Healthcare System in Georgia (VIEWS 13526354)

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54HL03)
Chief Integrity and Compliance Office (10OIC)

1. We appreciate the opportunity to review and comment on the OIG Draft Report - Healthcare Inspection— Review of System and Veterans Integrated Service Network (VISN) 7 Leaders' Effectiveness in Resolving Operational and Leadership Challenges at the VA Dublin Healthcare System in Georgia. I have completed a full review of the draft report and concur with the findings. We are committed to ensuring Veterans receive quality care that utilizes the high-reliability pillars, principles, and values.

2. I concur with the recommendations and action plan submitted by VISN 7.

3. I appreciate the opportunity for this review as part of a continuing process to improve the care of the Nation's Veterans.

4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(*Original signed by:*)

David M. Walker, MD, MBA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on September 16, 2025.]

VISN Director Response

Recommendation 1

The Veterans Integrated Service Network Director develops and implements a plan to provide sustained support and oversight in a constructive manner to the VA Dublin Healthcare System leaders and programs.

_X_ Concur

____Nonconcur

Target date for completion: October 2025

Director Comments

The Veterans Integrated Service Network (VISN) Director will utilize Executive Leadership Huddles for VISN 7 leaders to escalate concerns and discuss Dublin operational issues for any required actions. The Executive Leadership Huddle is used by VISN 7 leaders daily to escalate and discuss issues raised by facility leaders. The huddle will also be a forum for decisions and any needed actions to be taken. The Network Director and VISN 7 leaders will utilize scheduled meetings with Dublin leaders and their key stakeholders to track issues that require actions and/or VISN support to completion. Oversight of the issues requiring actions and VISN support will be tracked utilizing an Excel tracking tool.

Recommendation 2

The Veterans Integrated Service Network Director ensures that following Veterans Integrated Service Network site reviews with findings, Veterans Integrated Service Network staff review the associated VA Dublin Healthcare System action plans to confirm proposed actions adequately address findings, track action items through implementation, evaluate effectiveness to ensure resolution, and monitor for sustainment.

_X_ Concur

____Nonconcur

Target date for completion: October 2025

Director Comments

The VISN has established monthly Executive Leadership Briefings. The leadership briefing incorporates the requirement for a status update on open recommendations for internal and external reports. Monthly reporting by Dublin leadership provides an oversight process for

tracking open recommendations, tracking them through implementation, and closure of recommendations. Sustainment of actions will be reviewed during VISN oversight visits.

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: September 16, 2025

From: Interim Director, Department of Veterans Affairs (VA) Dublin Healthcare System (557)

Subj: Office of Inspector General (OIG) Draft Report—Review of System and Veterans Integrated Service Network 7 Leaders' Effectiveness in Resolving Operational and Leadership Challenges at the VA Dublin Healthcare System in Georgia (VIEWS 13526354)

To: Director, VA Southeast Network (10N7)

1. I have had the opportunity to review the Healthcare Inspection—Review of System and Veterans Integrated Service Network 7 Leaders' Effectiveness in Resolving Operational and Leadership Challenges at the VA Dublin Healthcare System in Georgia, I concur with the recommendations in the report.

2. I appreciate the opportunity for this review as part of a continuing process to improve the care of the Nation's Veterans.

3. If you have any questions or require further information, please contact the Chief, Quality Management.

(*Original signed by*:)

Lenearo Ashford
Interim Medical Center Director | CEO
Dublin VA Health Care System

[OIG comment: The OIG received the above memorandum from VHA on September 16, 2025.]

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	Stacy DePriest, MSW, LCSW, Director Ashley Dobrovech, MJ, RN Kristin Huson, MSW, LICSW Seema Maroo, MD Amanda Newton, MSN, RN
Other Contributors	Shelby Assad, LCSW Debbie Davis, JD Tammy Linton, DNP, MSN-Ed Carol Lukasewicz, BSN, RN Carrie Mitchell, MSW, LCSW Natalie Sadow, MBA

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