

United States Senate

WASHINGTON, DC 20510

COMMITTEES:
APPROPRIATIONS
COMMERCE
HEALTH, EDUCATION,
LABOR, AND PENSIONS

September 18, 2026

The Honorable Cheryl L. Mason
Inspector General
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Inspector General Mason,

My office received multiple reports from employees at the Tomah VA Medical Center raising serious concerns about patient safety, staffing and management at the facility. These reports include allegations of inadequate staffing contributing to falls, pressure injuries, food choking incidents, failures to conduct appropriate patient checks and other adverse patient outcomes. They also raise particularly troubling concerns about the care of hospice patients, including inadequate provider coverage and delays in ensuring that seriously ill veterans receive medications necessary for comfort and end-of-life care. Veterans receiving hospice care are among the most vulnerable patients in the VA system, and they and their families should be able to trust that they will receive safe and compassionate care and be treated with dignity during the final days of their lives.

These are serious allegations that warrant an independent investigation by your office. I ask that the Office of Inspector General (OIG) investigate whether staffing shortages, provider shortages, management failures or other deficiencies at the Tomah VA Medical Center are jeopardizing patient safety and the quality of care provided to veterans. As part of this investigation, I ask that your office examine:

- the adequacy of current staffing levels to provide safe and appropriate care;
- the impact of staffing shortages on patient safety, including falls, pressure injuries, food choking incidents, missed patient checks, medication delays or other adverse patient outcomes;
- hospice care and provider coverage, including timely access to medications and other necessary end-of-life care;
- recent provider departures and vacancies and their impact on patient care;
- facility leadership's response to patient safety concerns raised by frontline employees, including whether those concerns were appropriately identified, addressed and corrected; and
- management and leadership practices that may be contributing to unsafe conditions at the facility.

I ask that OIG investigators meet directly and confidentially with frontline employees and others with firsthand knowledge of conditions at the Tomah VA and do so in a manner that allows individuals to be forthcoming. My office will provide OIG with the information we have received, including contact information for employees who have authorized us to share it. I expect OIG investigators to reach out directly to these employees as part of this investigation. My office will remain in contact with them and will continue to monitor whether their concerns are being heard and addressed.

These current allegations warrant investigation on their own. Separately, the criminal charges announced this week against a former Tomah VA nurse raise serious questions about the care of the hospice patients at the facility and how VA responded after learning of that incident. I understand that the ongoing criminal proceedings may limit what OIG can share, but I ask that you keep my office informed about the investigation and provide any information that can be shared about what occurred, what it revealed about patient care at Tomah and what steps are needed to prevent a similar incident from ever happening again.

Separate from the ongoing criminal investigation, I also want to understand how the VA responded after learning of this deeply disturbing incident. I ask that your review determine:

- what administrative, clinical, patient safety or management reviews were conducted;
- what deficiencies were identified;
- what corrective actions were required; and
- whether those actions were implemented and sustained.

A veteran receiving hospice care at the Tomah VA was allegedly abused and later died. A year later, employees are raising serious concerns about the safety and quality of hospice care at the same facility, in the same hospice unit. That demands close scrutiny. I ask OIG to determine whether there are broader failures in staffing, supervision, management, or patient safety practices, what VA learned from the 2025 incident and whether the actions taken afterward were sufficient to protect veterans from similar harm.

Veterans and their families must be able to trust that the VA will provide safe, timely and high-quality care that they have earned. Employees must also be able to raise concerns about the care of veterans and know that those concerns will be taken seriously. I ask for your prompt attention to these matters and look forward to hearing what steps OIG intends to take in response.

Sincerely,

A handwritten signature in blue ink that reads "Tammy Baldwin". The signature is fluid and cursive, with the first name "Tammy" and last name "Baldwin" clearly distinguishable.

Tammy Baldwin
United States Senator