TAMMY BALDWIN
WISCONSIN

United States Senate
WASHINGTON, DC 20510

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

September 18, 2026

The Honorable Doug Collins
Secretary of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Collins,

I write to express my grave concern regarding serious allegations about the treatment of veterans and conditions at the Tomah VA Medical Center. Employees at the Tomah VA contacted my office to report severe lapses in patient care at this facility. Their reports are specific and alarming. They include allegations of poor management and 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.

I have requested the VA Office of the Inspector General (OIG) conduct an independent investigation into these allegations. That investigation is important, but the VA cannot wait for that investigation before ensuring veterans are receiving safe care today. I expect prompt and thorough action from your office to protect the dignity and safety of veterans receiving care at this facility.

To that end, I request that you immediately direct the Veterans Health Administration (VHA) and Veterans Integrated Service Network (VISN) to conduct a full review of staffing levels, provider coverage, medication delays, hospice care, and patient safety. To be clear, this review should not rely on assurances from leadership at the Tomah VA. Given the range and severity of the allegations, there must be an independent and thorough examination of conditions at the Tomah VA. At a minimum, I ask that VA determine:

- the adequacy of current staffing levels and provider coverage 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 and other adverse patient outcomes;
- the adequacy of 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;
- whether management and leadership practices are contributing to unsafe conditions at the facility;
- the immediate actions VA is taking to address any identified patient safety risks; and
- the VHA and the VISN 3 officials responsible for ensuring that necessary corrective actions are implemented and sustained.

Separately, the criminal charges recently announced 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 ask that you provide my office with a full accounting of VA's response upon learning of the alleged abuse including:

- when VA and Tomah facility leadership first became aware of the incident and what immediate steps were taken to protect other patients;
- what administrative, clinical, patient safety or management reviews were conducted;
- what deficiencies, if any, were identified;
- what corrective actions were required; and
- whether those corrective 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 you 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.

I also want to be unequivocal about the employees who are raising these concerns. There must be zero tolerance for retaliation or reprisal against any employee for raising concerns about patient care, making a protected disclosure, communicating with Congress, contacting OIG or the Office of Accountability and Whistleblower Protection (OAWP), or cooperating with an investigation. I ask that you immediately direct VHA and VISN leadership to communicate clearly to all Tomah employees that they may raise concerns through protected channels and that retaliation or reprisal will not be tolerated. Facility leadership must not attempt to identify employees who have communicated confidentially with any congressional offices or take action against employees because they are believed to have raised concerns. My office will not provide the identities of employees who have contacted us without their express authorization.

I am copying OAWP on this letter so that it is formally aware of these disclosures and prepared to respond promptly to any allegation of retaliation or reprisal. I also ask that OAWP work with my office to ensure employees who have raised concerns understand their rights and the confidential reporting channels available to them.

The Tomah VA and the veterans it serves have spent years working to rectify and recover from the serious failures uncovered at the facility more than a decade ago. VA employees, veterans and the surrounding community worked hard to improve care, strengthen accountability and rebuild trust. We cannot allow serious patient safety or management problems to take root again or allow that hard earned trust to erode. Veterans and their families must be able to trust that VA

will provide the safe, timely and high-quality care they have earned. Employees must also be able to raise concerns when that standard is not being met and know that speaking up will not put their careers at risk.

I ask for your prompt attention to these matters and a written response detailing the immediate actions VA is taking at the Tomah VA, providing the requested accounting of VA's response following the August 2025 incident, the steps being taken to protect employees who raise concerns and the senior VA officials responsible for overseeing this response.

Sincerely,

Tammy Baldwin
United States Senator

CC: The Honorable John Figueroa, Acting Under Secretary for Health, Veterans Health Administration

The Honorable Michael Tierney, Assistant Secretary of Veterans Affairs for the Office of Accountability and Whistleblower Protection

Dr. Dan Zomchek, Network Director, Veterans Integrated Service Network 3

Judy Johnson-Mekota, Executive Director, Health Service Area 3.3