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Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Audit of VISN 22 Supply Chain Management

Audit | **25-02834-142** | **June 18, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) conducted this audit to assess supply chain management operations at the West Los Angeles and San Diego VA medical facilities in California and the Phoenix VA medical facility in Arizona, all in Veterans Integrated Service Network (VISN) 22. The team focused on four areas that had recurring weaknesses identified in prior audits: expendable supplies inventory (disposable, typically single-use items); nonexpendable equipment inventory (durable equipment with a service life of two or more years); supply chain leadership; and the storage of supplies. The audit included expendable supply operations during the third quarter of fiscal year (FY) 2025, as well as equipment purchased from October 1, 2019, through May 27, 2025.

The OIG found that all three medical facilities had difficulty meeting Veterans Health Administration (VHA) requirements for managing expendable supplies and nonexpendable equipment and two of the three facilities stored supplies in a manner that left them vulnerable to theft, inventory loss, and potential misuse. Without proper management of inventory, VHA is at risk for increased costs and instances of fraud, waste, and abuse.

The audit team briefed VHA's chief officer of support operations in January 2026 and the VISN 22 network director in December 2025 on this report's findings and recommendations. The chief officer and interim network director were receptive to the findings and recommendations, and the network director said he would work with staff to develop an action plan to address the recommendations. The OIG is aware that at the time of the publication of this report, VHA had announced significant changes to the structure of its management and operations, including VISNs. The OIG's findings can help guide VHA's reorganization efforts to more effectively oversee the facilities' corrective actions. The OIG made seven recommendations to improve supply chain management in VISN 22 facilities. The interim network director for VISN 22 concurred with and submitted corrective action plans for each recommendation. The full list of recommendations is in the report; VA's response and action plans are in appendix E.

What the Audit Found

The team estimated that at least 820 of the 5,400 items (15 percent) in expendable inventory, valued at about $1.4 million, reflected fewer actual on-hand quantities than reported in the inventory management system across the three VISN 22 facilities. Additionally, the team estimated that at least 550 items (10 percent), valued at about $369,000, had more on-hand quantities than reported in the system. Furthermore, an estimated 50 percent of the 5,400 expendable supplies were above VHA's required normal stock levels, and at least 4 percent were below the reorder point. Furthermore, staff at the West Los Angeles and Phoenix facilities did not consistently safeguard expendable medical supplies, which increased risk of

loss, theft, or unauthorized use of expendable supplies. The audit team determined that inventory discrepancies occurred in part because supply chiefs did not consistently enforce inventory monitoring and reconciliation procedures or establish oversight mechanisms.

Additionally, the audit team estimated that about 9,000 of 21,800 nonexpendable equipment items (41 percent) were in a different location than what was recorded in the inventory management system, and at least 1,100 items (5 percent), with a value of at least $8.7 million, were missing based on system records and observations during the team's site visits. This occurred because facility leaders did not enforce custodial officer responsibilities for updating equipment locations, and medical facility staff frequently moved nonexpendable equipment without notifying supply chain staff to update the location in the system. The three facilities also did not consistently initiate and complete reports of survey to investigate the circumstances of missing equipment or monitor this process, weakening overall asset accountability. A report of survey is the process used to obtain an explanation for lost, damaged, or destroyed property.

Finally, the team reviewed the results of the VISN's quality control reviews for FYs 2024 and 2025 and determined that all three facilities had repeat findings of noncompliance because they did not implement or sustain corrective actions. Despite VISN 22's engagement with these three facilities, the recurring deficiencies in supply chain operations suggest that internal processes could be strengthened to ensure corrective actions are fully implemented and are sustained. It is vital for VHA to address these recommendations to mitigate risk of increased costs to VHA and potential fraud, waste, and abuse.

Next Steps

The OIG will continue to evaluate VHA's actions and will close the recommendations once VHA provides sufficient evidence that it has addressed the intent of the recommendations and the issues identified in this report.

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Abbreviations

AEMS/MERS	Automated Engineering Management System/Medical Equipment Reporting System
FY	fiscal year
GIP	Generic Inventory Package
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted this audit to assess supply chain management in Veterans Integrated Service Network (VISN) 22; specifically, the OIG examined whether network and facility managers provided effective oversight of supply chain management and ensured compliance with Veterans Health Administration (VHA) policies. The team selected three VISN 22 facilities to review based on total expenditures for supplies and equipment, quality control reviews with repeat noncompliant findings, and repeat issues related to the management of expendable supplies (disposable, typically single-use items, such as syringes) and nonexpendable equipment (durable equipment with a service life of two or more years, such as an ultrasound machine). The audit included expendable supply operations during the third quarter of fiscal year (FY) 2025 and nonexpendable equipment purchased from October 1, 2019, through May 27, 2025.

VHA Directive 1761 sets policy related to the VA Secretary's authority to procure healthcare items under 38 U.S.C. §§ 8121 and 8125. According to VHA Directive 1761, VA medical facilities must establish, operate, and maintain an effective supply chain management program to minimize costs and ensure sufficient stock of healthcare-related supplies to meet demand.[1] For the management of nonexpendable equipment, VHA facilities must comply with VHA Directive 7002 (*Logistics Management Policy*), which incorporates requirements for federal management of property set forth in 41 C.F.R. §§ 101 and 102.[2]

VHA currently divides the United States into 18 regional networks, known as VISNs, which consist of various types of VA medical facilities that work together to provide veterans access to health care.[3] Each VISN is led by a director who provides oversight of medical facilities, including oversight of each facility's compliance with VA supply chain management policy. Medical facility chief supply chain officers (supply chiefs) are responsible for ensuring that supply chain management staff use the established VHA-approved inventory management system to maintain automated inventories. Supply chiefs must also complete a year-end certification of inventory values and equipment inventory for each facility. In short, a facility's supply chief has overall responsibility for all expendable supplies and nonexpendable equipment from purchase to final disposition; these responsibilities can be delegated in writing to other staff. The supply chief must ensure all inventories are accurate and maintained in accordance with VHA Directive 7002 and ensure property is appropriately used, maintained, and conserved based on VA Handbook 7002.[4]

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[1] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[2] VHA Directive 7002, *Logistics Management Policy*, January 8, 2020.

[3] VHA, "Veterans Integrated Service Network (VISN)," (web page), accessed December 22, 2025.

[4] VA Handbook 7002, *Logistics Management Procedures*, January 8, 2020.

The OIG is aware that at the time of the publication of this report, VHA had announced significant changes to the structure of its management and operations, including VISNs. The OIG's findings can provide information that VHA can consider as it undergoes reorganization efforts to more effectively oversee the facilities' corrective actions. To assist in that effort, the team shared all discrepancies with the VISN 22 network director in December 2025, allowing them to review the results and provide supporting documentation.

Oversight of Supply Chain Management at VA Medical Facilities

VISN chief logistics officers are required by the Procurement and Logistics Office to conduct annual quality control reviews to assess each medical facility's inventory management program.[5] If the VISN identifies deficiencies, the medical facility must develop an action plan and complete corrective actions within 90 business days from the date of the review. According to quality control review instructions for supply chain management, VISN chief logistics officers must ensure deficiencies are corrected by the end of the fiscal year.[6] The quality control reviews include both expendable and nonexpendable inventory management.

In September 2024, the OIG recommended that VISNs improve oversight of medical facilities' supply chain management.[7] In this report, the OIG found that some VISN chief logistics officers did not ensure their facilities complied with policy and fixed problems identified through quality control reviews because they did not have direct authority over the medical facilities.

Management of Expendable Clinical Supplies

Expendable clinical supplies are disposable items that are critical in everyday medical practices such as gloves, syringes, and catheters. According to VHA Directive 1761, expendable supplies are to be inventoried each quarter, semiannually, or once per year depending on their classification. Physical counts are not required for stand-alone inventory points if inventory is taken monthly with a scanner or other electronic means. The primary inventory point is a storeroom that houses all expendable supplies for an inventory account. VHA Directive 1761 goes on to say staff should use the inventory account to determine what has been used and then order replacements for the used supplies. Inventory at secondary points should be scanned and reconciled every month. A secondary inventory point is a distribution point for services in a facility that is typically replenished using supplies from the primary inventory point.

Medical facilities use the Generic Inventory Package (GIP) software to track primary and secondary inventory points. Barcode data are used to track expendable inventory, allowing

[5] VHA Procurement & Logistics Office, "Joint Commission Quality Control Review Readiness for EX Staff" (fact sheet), undated.

[6] VHA Supply Chain Management Quality Control Review Instructions, September 1, 2024.

[7] VA OIG, *Improved Oversight Is Needed to Correct VISN-Identified Deficiencies in Medical Facilities' Supply Chain Management*, Report No. 23-02123-202, September 12, 2024.

facility staff to monitor the use of supplies. VHA requires barcode labels on all expendable supplies and storeroom shelves.

Medical facility staff must establish and maintain three key inventory thresholds in GIP:

- **Normal stock level** is the maximum amount of an item the facility is supposed to maintain.
- **Reorder point** is the minimum quantity of an item that should prompt facility staff to reorder it.
- **Emergency stock level** is the minimum quantity of an item the facility must have available for emergency situations.

Facility staff must base these stock levels on usage data, ordering lead times, and facility-specific needs, and must periodically review these thresholds to ensure accurate inventory control.

Additionally, VHA Directive 1761 requires that expendable supplies be stored in secure, access-controlled areas to protect government property and prevent loss or misuse. According to VA Handbook 0730, storage locations must have physical safeguards such as locked doors or restricted badge access.[8] Supply chain staff are responsible for ensuring inventory points are secure and that only authorized personnel have access. Facilities must also monitor access to inventory areas and take corrective action to address supplies that may be vulnerable to loss, theft, or misuse.

Management of Nonexpendable Equipment

Nonexpendable equipment is durable, for continuous use, generally has a service life of two or more years, and costs $300 or more. All nonexpendable equipment must be accounted for in an approved automated inventory system, such as the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS) or Maximo. Custodial officers must complete annual inventories of nonexpendable equipment that has a purchase cost of at least $5,000. Furthermore, medical facilities are required to report the loss, damage, or destruction of government property through reports of survey, which is VA's process to investigate the circumstances surrounding such incidents and to hold responsible officials accountable.

VISN 22

VISN 22, also known as the Desert Pacific Healthcare Network, comprises eight healthcare systems and 80 community clinics that serve over 1.5 million veterans in Arizona, New Mexico, and Southern California. According to VHA data, VISN 22 expenditures for all types of

[8] VA Handbook 0730, *Security and Law Enforcement*, March 29, 2013.

equipment increased over the last five fiscal years from about $834 million in FY 2020 to about $1.2 billion in FY 2024. Of VHA's 18 VISNs, VISN 22 ranked second in spending on medical and surgical supplies and equipment for FY 2024.

For this audit, the team judgmentally selected three medical centers to visit and evaluate: West Los Angeles, California; Phoenix, Arizona; and San Diego, California (see figure 1).

Figure 1. *Location of VA medical facilities evaluated for inventory management oversight and processes. VHA uses a facility complexity model that classifies its facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex.*

Source: VA OIG analysis of VISN and facility websites.

Results and Recommendations

Finding: VISN 22 Medical Facility Staff Did Not Consistently Manage and Secure Expendable Supplies or Nonexpendable Equipment

The audit team found that all three facilities visited had issues managing expendable supplies and nonexpendable equipment. The team estimated that at least

- 820 of the 5,400 items (15 percent) reviewed, valued at about $1.4 million, reflected fewer on-hand quantities than reported in the inventory management system and
- 550 of the 5,400 items (10 percent), valued at about $369,000, had more on-hand quantities than reported in the system.[9]

An estimated 2,700 of the 5,400 items (50 percent) were above VHA's required normal stock levels, and in that subset, at least 210 (about 4 percent) items were below the reorder point. Some expendable supplies at the West Los Angeles and Phoenix facilities were susceptible to loss, theft, or misuse because they were not stored in compliance with VA Handbook 0730. These issues occurred because supply chiefs did not consistently monitor or verify that local processes met established benchmarks and standards. Without proper management of expendable inventory, there is a heightened risk of increased costs to VHA.

For nonexpendable equipment, the audit team estimated that 9,000 of 21,800 items (41 percent) were not at the system-recorded locations. Ultimately, the team estimated that at least 1,100 equipment items (5 percent), with a value of at least $8.7 million, could not be located. These inaccuracies occurred because facility leaders did not enforce the custodial officers' responsibilities to validate and report changes when equipment was moved, ensure supply chain staff properly tagged equipment, and enforce or monitor the reports of survey process. It is vital for VHA to address the issues identified by the audit team to improve control weaknesses and mitigate risk of fraud, waste, and abuse.

What the OIG Did

The audit team visited the West Los Angeles, Phoenix, and San Diego VA medical facilities in June 2025, reviewed relevant policies and procedures, interviewed supply chain chiefs and staff, and evaluated facility inventory management practices for both expendable supplies and nonexpendable equipment. The team also surveyed 259 medical providers at the three facilities from July 15, 2025, through August 18, 2025.

[9] The percentages in the report were calculated using unrounded figures, so percentages may not add precisely due to rounding.

The team sampled 104 expendable medical items across the three facilities and compared inventory records to the quantities observed on hand. For nonexpendable equipment, the team selected 141 items from across the three facilities to determine whether the recorded equipment location matched each item's actual physical location. See appendix A for a summary of items reviewed, appendix B for more on the audit's scope and methodology, and appendix C for more on the statistical sampling methodology.

The audit team briefed VHA's chief officer of support operations in January 2026 and the VISN 22 network director in December 2025 on this report's findings and recommendations. The chief officer and network director were receptive to the findings and recommendations, and the network director said he would work with staff to develop an action plan to address the recommendations.

Management of Expendable Inventory

The team found that medical facility staff did not effectively manage expendable supply inventory or consistently ensure supplies were safeguarded from potential loss, theft, or misuse. The team found several patterns of noncompliance with VHA Directive 1761. Inaccurate inventory records, discrepancies in labeling, and unsecure storage increased the risk of shortages, expired items, incorrect availability, and unaccounted losses. Additionally, as some facility providers explained in their survey responses, patient care could be delayed when required supplies are not available.

The audit team determined that the physical count of expendable supplies at the three facilities did not always match the inventory system. Figure 2 summarizes the projected results by deficiency category based on the team's sample testing.

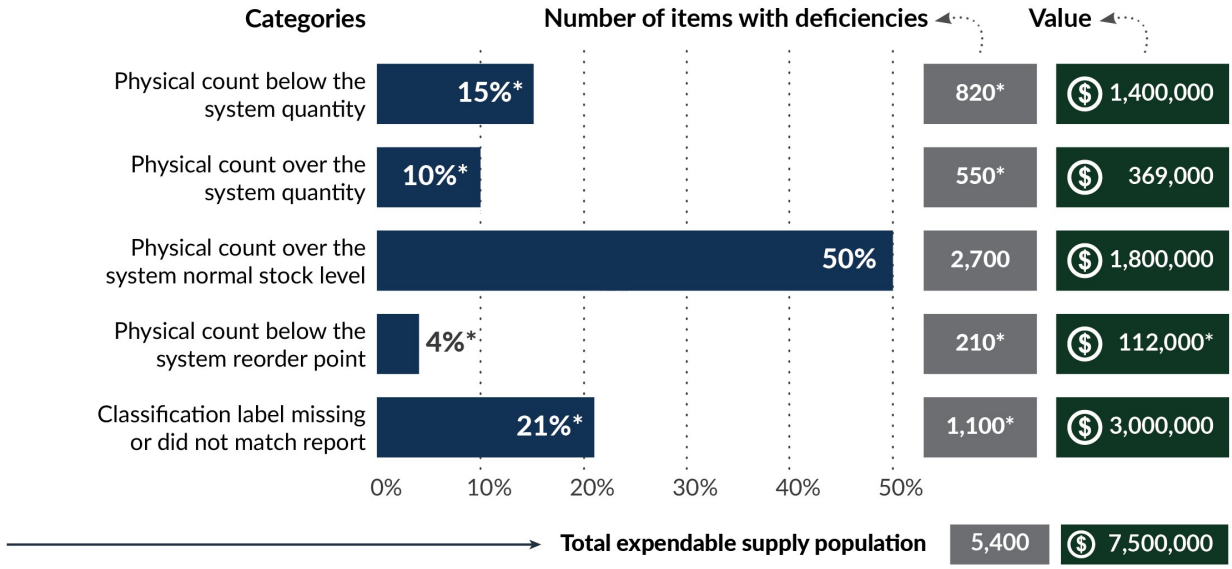

Figure 2. *Estimated deficiencies across the West Los Angeles, Phoenix, and San Diego facilities.*

Source: VA OIG statistician's analysis.

Note: Values in the figure are rounded. These categories do not fully represent the total value of $7,500,000 due to the use of the $112,000 one-sided lower-limit estimate. To see how the OIG came to this number see appendix C, table C.3.

** Denotes one-sided lower-limit estimates. The audit team used this conservative estimate to show the minimum number of items with deficiencies. Point estimates were used for other projections where they reasonably reflected expected impact. Totals may not sum precisely due to the use of one-sided lower-limit estimates for some categories.*

Inventory Records Compared to On-Hand Supplies

The audit team found that the quantities recorded in GIP did not always match on-hand supplies at all three facilities. According to 41 C.F.R. §§ 101-27.101, agencies shall establish and maintain controls to ensure primary inventories are managed effectively and support program requirements. VHA Directive 1761 requires medical facilities to routinely monitor reports for inventory accuracy and take steps to ensure performance measures are maintained in compliance with published inspection criteria.[10] Based on a statistical sample of expendable items from the primary inventory point at the three facilities, the team estimated that at least 820 of the 5,400 items (15 percent), valued at about $1.4 million, reflected fewer on-hand quantities than reported in GIP. These differences ranged from one to 11,467 items in the sample review.

Additionally, of those 5,400 items, at least 550 (10 percent), with a value estimated at $369,000, had more on-hand quantities than reported in GIP. These errors could result in facilities

[10] Performance measure requirements are contained in the quality control review checklist published by VHA's Procurement & Logistics Office.

purchasing more supplies when they are not necessary rather than using the funds for other needs. Thus, the team estimated that these items with physical counts higher than the quantities recorded in the system could represent about $369,000 in better use of funds. See appendix D for more information on monetary benefits.

Figure 3 shows the on-hand quantity and the system quantity for the five sampled items with the greatest underreporting discrepancies and the five with the greatest overreporting discrepancies. The figure also includes an aggregate row, which shows the difference across all 99 in-scope items; this value is negative because the magnitude of the underreported discrepancies exceeds the overreported. While the figure includes both types of discrepancies, several of the underreported supply items reflect large differences, which may increase the risk of unexpected shortages if staff are unaware the supplies are out of stock.

Sample	Physically on hand	System quantity	Difference	Percent difference
AAA batteries	1,368	774	594	77%
Saline flush	22,100	13,240	8,860	67%
Thick sole slippers (adult)	872	600	272	45%
Blood collection tube	738	645	93	14%
Sterile water	5,120	4,944	176	4%
Protective gown	5,394	16,861	-11,467	-68%
Safety needle with butterfly	4,128	13,242	-9,114	-69%
Bath washcloth	2,867	11,720	-8,853	-76%
Electrocardiogram lead wire	1,400	6,013	-4,613	-77%
Intravenous solution	860	5,252	-4,392	-84%
Aggregate of sampled items (not projected)	90,513	143,519	-53,006	-37%

Figure 3. *Inventory discrepancies of 10 sampled items where on-hand quantity and the system quantity differed (five greatest overreporting and five greatest underreporting in OIG sample review).*

Source: VA OIG analysis of physical inventory counts for a selected sample of 99 in-scope expendable medical surgical supplies compared to GIP inventory system data.

Inadequate inventory monitoring could result in a facility running out of necessary medical equipment for patient care at an inopportune moment. The VISN 22 chief logistics officer stated this could also result in the facility paying higher costs for emergency orders of items. OIG survey results showed an estimated 1,300 of 3,900 healthcare providers who used expendable supplies to provide patient care over the past year (about 35 percent) did not have certain expendable supplies when needed to provide care for patients.[11] Unavailable items included surgical supplies, catheters, and wound care supplies. For example, a provider reported being unable to conduct a scheduled biopsy because there were no biopsy containers available to send the tissue sample to the laboratory. While some providers reported that a lack of supplies delayed patient care, none reported patients having been harmed due to the issue.

Physical Inventory Counts Compared to Normal Stock Levels and Reorder Points

The team found discrepancies in the normal stock levels and reorder points at all three facilities. The team estimated that 2,700 of 5,400 expendable supplies (50 percent) had quantities higher than VHA's required normal stock levels. According to VHA Directive 1761, the normal stock level is the largest quantity of an item that should be maintained in the inventory point, and the reorder point level is the level at which an item should be reordered. The supply chief from the West Los Angeles facility told the team that the reasons for supplies being over normal stock levels included medical supply level changes and staff turnover. The supply chief from the Phoenix facility said higher-than-normal stock levels could be due to staff not confirming stock availability before ordering or staff not reviewing usage patterns on a quarterly basis. Regardless of the explanation, excessive inventory leads to financial and operational risks, including unnecessary costs, storage challenges, and potential for supplies to expire before being used.

In contrast, the team also estimated that at least 210 items (about 4 percent) with a value of at least $112,000 were stocked below the reorder point. This showed the facilities the team reviewed were generally compliant with VHA policy on maintaining minimum stock levels.

Inventory Monitoring and Reconciliation Procedures

These inventory discrepancies resulted from supply chiefs inconsistently checking whether local processes met the benchmarks and standards outlined in VHA Directive 1761. Specifically, the directive requires the VISN and facility supply chiefs to set up local processes and procedures to ensure all necessary inventory reports are monitored routinely and appropriate steps are taken to ensure all supply chain performance measures are maintained in compliance. For example, the supply chief at the Phoenix facility said a former inventory manager was ordering the same quantity of a product each week without evaluating how fast the product was being used. This

[11] There are an estimated 5,500 healthcare providers at the three facilities reviewed.

occurred because the orders were placed without being compared to current usage and stock levels. He also said some staff do not place supply orders until they reach the emergency level. The acting supply chief at the San Diego facility said it was a challenge to conduct reliable inventory checks because clinical staff did not always effectively track and monitor supplies. Despite policy requirements, facility leaders at all three facilities did not establish consistent oversight mechanisms, such as spot checks, audits, or follow-up reviews to ensure staff complied with reconciliation requirements.

Inaccurate inventory levels put medical facilities at increased risk for supply shortages as well as expired items, inaccurate supply availability, and unaccounted losses. Shortages or expiration of critical supplies may disrupt clinical operations as the supply chief from the West Los Angeles facility explained to the team. As evidence, an estimated 440 of the 3,900 healthcare providers surveyed by the OIG who used expendable supplies over the past year (about 12 percent) encountered expired expendable supplies when needed for patient care. For example, one provider reported having to use a shorter than optimal stent during a patient's procedure because the appropriately sized stent was expired.

To address inventory errors, the OIG's first recommendation is to require medical facility directors to develop and implement procedures to maintain stock levels within the thresholds required by VHA policy.

Reported Impact of Staffing Challenges

According to supply chiefs at the three facilities, staffing challenges from the Deferred Resignation Program, voluntary early retirement authority, Office of Personnel Management federal hiring freeze, and existing vacancies for staff such as purchasing agents, inventory management specialists, supply technicians, and material handlers have hindered the effectiveness and sustainability of supply chain management operations across their sites. The OIG did not evaluate the extent to which staffing losses and vacancies contributed to the issues found in this report, as many of these losses occurred late in the team's review, and facilities have taken steps to try to improve the operational efficiency of the remaining staff. Supply chain managers at all VISN 22 facilities surveyed have implemented strategies to manage workload and sustain operations. These include increasing the use of voluntary overtime, assigning additional job duties, and decreasing the number of staffed shifts.

Labeling Practices for Expendable Supplies

At all three facilities, the team found that inventory labels were missing or were inaccurate according to ABC classification guidance stated in VHA Directive 1761. VHA uses the ABC classification method for inventory management. Inventory items with the highest annual usage spending (the top 80 percent) are classified as "A" and must be counted each quarter. Supplies with the next highest annual usage (the next 10 percent) are considered "B" items and are

counted in the first and third quarters, and items representing the remaining 10 percent (lowest usage) are in the "C" category and are inventoried in the second quarter. The team reviewed the ABC classification designations affixed to the barcode labels for the 99 sampled supply items and, based on the results, estimated that the ABC classification label was either missing or inaccurate for at least 1,100 of the 5,400 items (about 21 percent) valued at about $3 million. See appendix A for sample results by facility. The VISN 22 chief logistics officer said reasons for missing or inaccurate ABC labels could include staff not updating them to their new classifications, labels falling off and not being replaced, or a new item not yet receiving a classification.

Outdated inventory labeling impaired staff's ability to accurately track, prioritize, and replenish supplies. When items are not accurately classified, required inventory counts may not occur, and supply rotation practices may be disrupted. The San Diego supply chief said when items are classified incorrectly, the risk of improper management increases, which can lead to items being over or under the normal stock level. Although labeling procedures were in place, facility leaders did not ensure staff consistently applied or updated barcode and ABC classification labels to reflect the current inventory status.

To address these deficiencies, the OIG's second recommendation is to require supply chain staff to review and update ABC classification labels on expendable supplies and to establish a process to routinely verify that the labels match the ABC classification report.

Physical Security Controls of Expendable Supplies

VA Handbook 0730 states that effective physical security requires planning to protect resources and property and to prevent loss or theft of vulnerable supplies. The San Diego facility safeguarded expendable supplies by storing them in rooms that were not accessible to patients or unauthorized staff. However, staff at the West Los Angeles and Phoenix facilities did not consistently safeguard expendable medical supplies. VHA Directive 1761 restricts access to primary inventory points (clean/sterile storerooms) to authorized staff. VHA Directive 1761 requires other persons with official business, and when accompanied by an appropriate supervisor or designee, to be authorized to enter storage areas. For example, at the West Los Angeles facility, the entrance door to the medical facility distribution area was propped open, and access to the dock entrance was not controlled from the outside. Additionally, the team observed cluttered, unorganized, and unclean storage. Figure 4 shows these concerns.

Figure 4. *Entrance to the medical distribution area propped open (left) and cluttered, unclean, unmarked storage areas (middle and right) at the West Los Angeles VA Medical Center in Los Angeles, California.*
Source: VA OIG photograph, June 5, 2025.

At the Phoenix facility medical equipment distribution area, the team observed expendable medical supplies stored in an unsecured area, with an open, unmonitored access point, accessible to anyone walking in the hallway, as shown in figure 5.

Figure 5. *Open entrance door to the medical supply area in the main hallway at the Carl T. Hayden VA Medical Center in Phoenix, Arizona.*

Source: VA OIG photograph, June 3, 2025.

Until the identified issues are addressed, the facilities are at increased risk of inventory loss, theft, or unauthorized use of expendable supplies. *The OIG's third recommendation is for medical facilities to develop a process to ensure facility staff safeguard expendable supplies in accordance with VHA policy*.

Management of Nonexpendable Equipment

The audit team found that staff at the West Los Angeles, Phoenix, and San Diego facilities did not ensure all nonexpendable equipment was properly recorded and accounted for in the inventory management systems, as required by VA Handbook 7002. Figure 6 summarizes the projected results by deficiency category based on the team's sampling.

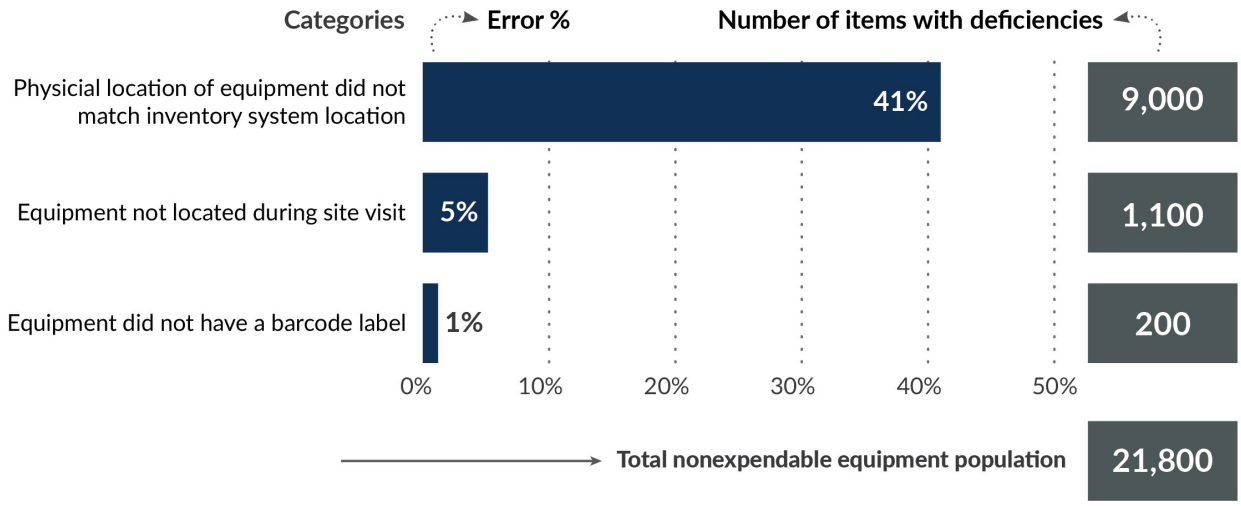

Figure 6. *Estimated deficiencies for nonexpendable equipment records across the West Los Angeles, Phoenix, and San Diego facilities.*

Source: VA OIG statistician's analysis.

Note: The number shown for "Total nonexpendable equipment population" (21,800) reflects the estimated number of in-scope nonexpendable equipment population used in the projections. Values in the figure are rounded.

The nonexpendable inventory management team consists of a supervisor, specialists, and technicians who work under the supply chief. This team is responsible for overseeing property and equipment management, warehouse operations, and staff training. The supervisor directs these activities, while specialists handle the creation and maintenance of equipment records in AEMS/MERS, generate inventory reports, and review inventory documentation for completeness. Custodial officers annually conduct the physical inventory of nonexpendable equipment valued at $5,000 or more and designated sensitive items; manage equipment turn-ins and dispositions; process inventory updates such as updating equipment locations; and coordinate reports of survey. A report of survey is the process used to obtain an explanation for lost, damaged, or stolen property.

Medical Facilities' Tracking and Monitoring of Nonexpendable Equipment

To assess the accuracy of nonexpendable equipment records, the team evaluated a statistical sample of 141 nonexpendable equipment items across the three facilities, valued at about $45 million. The team worked with facility staff to locate the nonexpendable equipment. Based on the results, the team estimated that about 9,000 of 21,800 nonexpendable equipment items (41 percent) were in a different physical location than what was recorded in the inventory management systems. In addition to these items being found in different locations, four items (a computerized tomography scanner, an ultrasound device, an aortic heart pump system, and a water dispenser) were not being used.

The team estimated that at least 5 percent of the items could not be located during the site visits in June 2025 based on 11 sampled items that were missing during the site visits. As of September 16, 2025, facilities had located six of the 11 missing items. However, neither San Diego nor West Los Angeles facility staff nor the audit team could locate the other five items. Although moving equipment around the facility is routine, it is important that staff either return moved equipment to its original location for other staff to use and for inventory accountability purposes, or document permanent location changes in the system. The five items that could not be located during the site visit included a gastroscope, an adjustable bed, a printer, a blanket warmer, and a network connector. These items were either no longer present, not readily identifiable, or lacked sufficient documentation for identification.

Medical facility supply officers responded with the following explanations as to why it took time to find the following two items:

- The audit team could not locate an esophageal probe at the Phoenix medical facility and determined that the medicine service was notified in August 2024 that they were required to complete a report of survey for 18 items, including the esophageal probe. Twelve of the items had not been seen since FY 2023. According to the Phoenix medical facility's supply chief, the medicine service refused to complete and sign the report of survey, so the items remained listed in inventory. Staff at the facility informed the team that the medicine service chief will address this and will complete a report of survey that includes the items. However, no further documentation was provided to the OIG showing a report of survey was conducted.
- At the San Diego medical facility, the team could not locate an ophthalmic camera listed as "In Use." After further review, the supply chief informed the team that the item had been moved to another location outside the medical facility without notification. The supply chief corrected the location record and provided the OIG with documentation verifying the equipment.

Based on the sample of 141 items, the team estimated that at least 1,100 nonexpendable equipment items (at least 5 percent), valued at about $8.7 million, could not be located using system records or site visit observations. These inaccuracies occurred because facility leaders did not enforce custodial officer responsibilities for updating equipment locations. According to VA Handbook 7002, custodial officers are required to validate and report changes in equipment location.

Additionally, medical facility staff frequently moved nonexpendable equipment without notifying supply chain staff. The OIG acknowledges that medical facility staff frequently move nonexpendable equipment during patient care and when patients are transported. As a result, supply chain staff did not update equipment location records in the inventory management systems or did not do so in a timely manner. Nonexpendable equipment inventory managers at

all three facilities cited this as a key reason for discrepancies between system records and actual equipment locations.

These medical facilities are at risk of equipment loss, misplacement, or unauthorized use, which could delay the availability of critical medical equipment needed for patient care. Inaccurate equipment and location data compromise the ability of staff to locate and manage assets effectively. This can delay equipment availability for clinical services and hinder maintenance and repair schedules, resulting in operational inefficiencies. For example, based on OIG survey results, an estimated 500 providers out of 3,000 who use nonexpendable equipment (about 17 percent) reported that some items were unavailable when needed to deliver patient care. The necessary equipment was present in an insufficient quantity, was inoperable, or missing.

Barcode Labeling on Nonexpendable Equipment

VA Handbook 7002 states that equipment inventories will be conducted using barcode technology compatible with the automated inventory management system. Thus, nonexpendable equipment is required to have barcode labels for annual inventory scans and accurate tracking. The audit team estimated that at least 200 out of 21,800 nonexpendable equipment items (less than 1 percent), with a value of at least $8.1 million, across the three facilities did not have the required barcode labels. Some sampled items identified during the site visit include a scanning system (valued at about $2.4 million), an air compressor (valued at about $1.2 million), and a patient cart (valued at about $2.3 million). While the error rate is low, facility staff should properly tag nonexpendable equipment to ensure accountability and monitor the condition of these higher-cost items. It is also necessary for inventory and tracking purposes to ensure equipment is available when needed for patient care. Facility supply chain staff explained that some equipment was missing a bar code label because of frequent movement that caused the bar code label to fall off.

The OIG's fourth recommendation is to ensure equipment items are properly tagged, to establish protocols to notify supply chain staff when equipment is moved, and to validate and update the equipment location.

Annual Inventory Assessments of Nonexpendable Equipment

VA Handbook 7002 requires facility supply chain management staff to conduct an annual inventory of nonexpendable equipment. However, the audit team found that an estimated 950 of 21,800 nonexpendable equipment items (about 4 percent), valued at about $18.5 million, had not been inventoried within 12 months of its last inventory date. Supply chain management staff rely on custodial officers in each department to conduct annual inventories and to follow policy when they cannot account for an item. Staff cannot properly account for the equipment items if they do not perform the required annual inventory, which increases the risk of it not being available when needed.

To ensure accountability of nonexpendable equipment, the OIG's fifth recommendation is to ensure facilities conduct annual inventory of nonexpendable equipment.

Reports of Survey for Missing Equipment

At all three facilities, reports of survey were not completed in a timely manner to address equipment losses. VA Handbook 7002 states that when a piece of equipment is found to be missing, it should be reported to the supervisor immediately, who will then notify property management staff and VA police if necessary. A formal report of survey should be initiated within one day of the supervisor's notification and submitted to the supply chief within 72 hours. According to VA Directive 7002, the overall process should take no more than 60 days unless there is an ongoing law enforcement investigation.

The audit team requested the reports of survey for the five items that facility staff and the team could not locate. Facility staff could not provide evidence they completed reports of survey for five of the items. However, staff did provide documentation to show they initiated the report of survey process for one of the items as described below.

At the Phoenix facility, an ultrasound device was not found during the team's site visit. This device was valued at over $200,000 and assigned to surgical service. During a previous review, it was identified as missing in FY 2022; however, the system was not updated. Upon further review, it was determined that the item had been replaced by the manufacturer, but the system was not updated with the new serial number. Due to the audit team's review, the facility updated the system in July 2025 with the replacement item and had a staff member sign a property turn-in form to indicate the item had been turned in. The staff member had no previous knowledge of the old ultrasound equipment and was only asked to sign the report of survey showing it had been replaced.

In addition to assessing whether reports of survey had been completed for the five items in the audit team's sample, in August and September 2025, the three facilities provided the team report of survey registers from October 1, 2024, to June 30, 2025. Each facility is required to maintain a report of survey register, which can contain several missing equipment items. The results are as follows:

- **West Los Angeles:** none of the 91 reports of survey had been completed.
- **Phoenix:** 23 of the 30 reports of survey had been completed, although two of the reports did not contain a date of completion, and five took longer than the required 60 days for the investigation to be completed.
- **San Diego:** eight of the 15 reports of surveys had been completed, although one of the reports took longer than the required 60 days for the investigation to be completed.

When equipment is misplaced or lost, it is imperative that the reporting process is followed to properly document, track, and process the missing item in a timely manner. However, the process for initiating and completing reports of survey was not consistently followed or monitored at the three facilities reviewed. As a result, equipment losses were not promptly reported or investigated, weakening overall asset accountability. Without accurate reports of survey, the facilities are at an increased risk of financial loss and inventory inaccuracies, potentially affecting their ability to maintain accurate financial reporting and asset management. Inaccurate records of nonexpendable equipment in the inventory system can hinder VA's capacity to safeguard assets and ensure accountability.

The OIG's sixth recommendation is to require facilities to enforce completing reports of survey in a timely manner in accordance with VHA policy and to implement mechanisms to monitor the initiation, approval, and closure of these reports.

Medical Facilities' Response to VISN Quality Control Reviews

The VISN chief logistics officer fulfilled his oversight responsibilities in accordance with VHA Directive 1761 by conducting annual quality control reviews of supply chain operations at the three facilities. In response to deficiencies identified during these reviews, facilities were required to develop corrective action plans that the VISN then monitored for progress. However, despite the VISN's active monitoring and follow-up, recurring inventory management issues suggest a need to further strengthen implementation efforts and internal controls at the three facilities.

During interviews with the OIG team, the VISN chief logistics officer described the VISN's monitoring process. Facility staff upload evidence that an action item has been completed to a SharePoint site where he reviews it and either closes the action plan if the evidence is sufficient or meets with facility staff to discuss what other information is needed. Additionally, he promotes resolution and compliance through regular communications with facility supply staff.

The acting facility supply chief from the San Diego facility and the supply chiefs from the West Los Angeles and Phoenix facilities consistently described the VISN's oversight to the audit team as proactive, helpful, and responsive. For example, according to the West Los Angeles supply chief, at the time of the audit, they did not have a deputy chief, so the VISN steps in and helps when she is out of the office and informs leaders when help is needed. The Phoenix supply chief told the team that the VISN is giving them advice and tools, and he feels supported by the VISN chief and assistant chief. The acting San Diego supply chief stated that VISN leaders have been supportive and help them accomplish tasks and improve. They have scheduled meetings with the VISN chief to discuss how each section is doing.

These efforts show the VISN fulfilled its oversight responsibilities and actively engaged with facilities to improve supply chain performance. However, despite structured monitoring, the VISN chief logistics officer does not have direct authority to enforce corrective actions, which

may limit the long-term effectiveness of VISN oversight when facilities do not take timely action. It is important that VISN and facility directors work together to ensure facility supply chain staff develop and implement action plans to address deficiencies found during the VISN's quality control reviews.

Despite VISN engagement, the recurring deficiencies in supply chain operations at the three facilities suggest internal processes could be strengthened to ensure full and sustained implementation of corrective actions. When facilities do not implement or sustain corrective actions, they may be found noncompliant in the same area of the quality control reviews in consecutive years, which is referred to as a repeat finding.

The OIG's findings support the results of previous quality control reviews. For example, all three facilities were reported as noncompliant with using VHA's approved inventory management system for all expendable inventory in FY 2024 and FY 2025. This repeat finding implies a continuous breakdown in the control environment. While there may be some changes to the questions on the quality control review checklists each year, there were 113 questions that were on both the FY 2024 and FY 2025 quality control reviews. For 21 of these 113 questions (about 19 percent), all three facilities experienced this continuous breakdown and had repeat findings of "noncompliant," as shown in table 1.

Table 1. Quality Control Review Repeat Findings

Facility	Noncompliant in FY 2024	Noncompliant in FY 2025	Repeat findings in FY 2025
West Los Angeles	61	62	52
Phoenix	56	48	44
San Diego	55	52	38

Source: VA OIG analysis of the FY 2024 and FY 2025 quality control reviews for each facility.

The OIG's final recommendation is to ensure VISN 22 facilities implement corrective actions to effectively address deficiencies during the quality control reviews.

Conclusion

Supply chain staff at VISN 22 medical facilities in West Los Angeles, Phoenix, and San Diego did not consistently manage expendable supplies or nonexpendable equipment in accordance with VA Directive 7002. All three facilities had inaccurate inventory records in GIP, missing or incorrect ABC classification labels, and outdated stock levels. In addition, several supply storage areas at two of the facilities lacked secure access, increasing the risk of unauthorized access and potential loss, theft, or misuse of supplies. For nonexpendable equipment, supply chain staff did not accurately maintain location data in the inventory management system or consistently apply barcode labels. These conditions contributed to inaccurate inventory data and weakened supply chain oversight. Together, these weaknesses increase the likelihood that suboptimal expendable

supplies and nonexpendable equipment may be used and increase the risk of supplies and equipment being lost, stolen, or reordered too soon.

Recommendations 1–7

The OIG made the following recommendations to the VISN 22 network director:

1. Require medical facility directors in Veterans Integrated Service Network 22 to develop and implement procedures to maintain stock within the required thresholds as outlined in Veterans Health Administration Directive 1761.
2. Require medical facility directors in Veterans Integrated Service Network 22 to ensure supply chain staff review and update ABC classification labels on expendable supplies in accordance with Veterans Health Administration guidance and establish a process to routinely verify that labeling aligns with the official ABC classification report.
3. Ensure medical facility directors in Veterans Integrated Service Network 22 develop a process to ensure facility staff safeguard expendable supplies in accordance with Veterans Administration Handbook 0730.
4. Ensure medical facility directors in Veterans Integrated Service Network 22 develop and implement local procedures that require clinical service areas to notify supply chain staff when equipment is relocated, establish protocols to validate and update the equipment location, and ensure equipment items are properly tagged.
5. Require medical facility directors in Veterans Integrated Service Network 22 to ensure facilities conduct annual inventory of nonexpendable equipment.
6. Require medical facility directors in Veterans Integrated Service Network 22 to enforce timely completion of reports of survey in accordance with Veterans Health Administration policy and implement oversight mechanisms to monitor the timely initiation, approval, and closure of reports.
7. Ensure facilities implement corrective actions to effectively address deficiencies identified during the Veterans Integrated System Network's quality control reviews.

VA Management Comments

The interim network director for VISN 22 concurred with all seven recommendations and submitted corrective action plans.

For recommendation 1, VISN 22 will verify staff are properly trained to manage supplies appropriately and will submit evidence of this verification to VISN 22.

For recommendation 2, VISN 22 will make sure its facilities provide refresher training to expendable inventory staff for the ABC classification process, and the VISN's chief logistics officer will assess and report compliance on a monthly basis.

Regarding recommendation 3, VISN 22 will ensure its facilities are safeguarding supplies by having facilities submit plans that explain how they will secure their primary storage areas.

To address recommendation 4, VISN 22 will evaluate options for using equipment location tracking systems to improve accountability of mobile equipment. VISN 22's facilities will also submit a plan for equipment accountability and conduct random audits to evaluate compliance.

In response to recommendation 5, VISN 22 will make sure its facilities submit a plan to ensure all Equipment Inventory Listings inspections will be completed on time. The VISN 22 chief logistics officer will evaluate and report compliance on a quarterly basis.

In response to recommendation 6, VISN 22 will ensure medical facility directors enforce initiation, approval, and closure of reports of survey in accordance with VHA policy. Each facility will implement oversight mechanisms, and the VISN will assess and report compliance on a monthly basis.

Regarding recommendation 7, VISN 22 will address all outstanding quality control review corrective actions from previous fiscal years within 90 days of this report's release. The VISN will assess and report compliance on a monthly basis.

OIG Response

The VISN's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will close the recommendations when VISN 22 provides sufficient evidence that the action plans have been completed. The full text of the interim VISN 22 network director's comments and target completion dates can be found in appendix E.

Appendix A: Background

The tables below summarize the samples tested for expendable supplies and nonexpendable equipment items across the three selected Veterans Integrated Service Network (VISN) 22 facilities, in accordance with the VA Office of Inspector General's (OIG) findings. The information presented indicates the number of items tested at each facility along with the raw results captured in each testing category. Table A.1 presents discrepancies by facility, illustrating instances where supply chain management staff did not adequately manage expendable inventory.

Table A.1. Categories of Expendable Supplies Deficiencies by Facility

Categories	691: West Los Angeles	644: Phoenix	664: San Diego	Total
Items sampled	34	32	33	**99**
Physical count did not match the system quantity on hand	30	17	24	**71**
Physical quantity over the system normal stock level	15	20	16	**51**
Physical quantity below system reorder point	8	1	5	**14**
Physical quantity below emergency stock level	2	0	1	**3**
Missing ABC classification label	13	8	0	**21**
ABC classification label did not match the ABC classification report	4	7	8	**19**

Source: VA OIG statistician's stratified population and VA OIG team's analysis results. Data were obtained from the Corporate Data Warehouse.

Note: This table describes raw sample counts of deficiencies by facility. These are not projections. Differences in counts do not denote statistically significant differences by facility. The sample design and sample size by station were not intended for projections and comparisons at the facility level.

The audit team also tested the accuracy of the equipment locations recorded in the systems. Table A.2 presents location discrepancies by facility.

Table A.2. Nonexpendable In-Scope Sampled Items Found in the Wrong Location

Categories	691: West Los Angeles	644: Phoenix	664: San Diego	Total
Items sampled	47	47	47	**141**
Items in the correct location	22	29	23	**74**
Items not in the correct location	21	16	19	**56**
Items not found	4	2	5	**11**

Source: VA OIG statistician's stratified population and VA OIG team's analysis results. Data were obtained from VA's Corporate Data Warehouse.

Note: This table describes raw sample counts of deficiencies by facility. These are not projections. Differences in counts do not denote statistically significant differences by facility. The sample design and sample size by station were not intended for projections and comparisons at the facility level.

Appendix B: Scope and Methodology

Scope

The VA Office of Inspector General (OIG) team conducted its work from June 2025 through April 2026, focusing on expendable supplies and nonexpendable equipment at the Veterans Integrated Service Network (VISN) 22 VA medical facilities in West Los Angeles and San Diego, California, and Phoenix, Arizona. These three facilities were judgmentally selected based on total expenditures for supplies and equipment as well as prior quality control reviews with repeat noncompliant findings. The audit included expendable supply operations during the third quarter of fiscal year (FY) 2025 as well as nonexpendable equipment purchased from October 1, 2019, through May 27, 2025.

Methodology

The team interviewed the VISN 22 chief logistics officer and supply chain management leaders from three facilities to assess oversight of each facility's supply chain management program. They also interviewed facility staff responsible for the management and accountability of supplies and equipment. The team identified and reviewed applicable laws, regulations, and policies related to Veterans Health Administration (VHA) supply chain management. They also reviewed FY 2024 and FY 2025 quality control reviews from the West Los Angeles, Phoenix, and San Diego facilities, as well as other relevant documentation.

In June 2025, the team conducted site visits at the West Los Angeles, Phoenix, and San Diego facilities. The team also reviewed a statistical sample of expendable supplies to test the accuracy of the inventory data in the Generic Inventory Package (GIP) and the accuracy of the nonexpendable equipment inventory data in the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS) system. The team also physically observed the facilities' storage areas, which held expendable supplies.

Survey Methodology

The team conducted a web survey of 259 providers at the West Los Angeles, Phoenix, and San Diego facilities from July 15, 2025, to August 18, 2025, and received 210 responses. The survey objective was to determine whether healthcare providers experienced any effects on patient care due to shortages or expired expendable supplies or due to missing or inoperable nonexpendable equipment. For the purposes of the survey, healthcare providers included physicians, dentists, nurse practitioners, physician assistants, certified registered nurse anesthetists, optometrists, psychologists, pharmacists, advanced practice nurses, registered nurses, nurses, audiologists, social workers, and technicians.

The survey was restricted to a predetermined set of email addresses, and the team reviewed and analyzed the responses. The results of the survey are based on self-reported information, which the team could not validate without performing site visits or monitoring all individuals during the survey process. Responses were weighted to create population estimates. More detail about the sample design and estimates is included in appendix C.

Internal Controls

The team assessed the internal controls to determine whether they were significant to the audit objective. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.[12] In addition, the team reviewed the principles of internal controls associated with the objective and identified four components and six principles as significant. Since the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit. The team identified internal control weaknesses during this audit and proposed recommendations to address those listed in table B.1.

Table B.1. VA OIG Analysis of Internal Control Components and Principles Identified as Significant

Component	Principle	Deficiency identified by this audit
Control environment	5. Management should evaluate performance and hold individuals accountable for their internal control responsibilities.	VISN 22 facilities did not hold supply chain management staff accountable for properly managing and securing expendable and nonexpendable items.
Risk assessment	7. Management should identify, analyze, and respond to risks related to achieving the defined objectives.	Medical facility leaders did not ensure timely oversight to address risks.
Control activities	12. Management should implement control activities through policies.	Medical facility leaders did not ensure VA supplies and equipment were accurately recorded in the inventory management systems.
Monitoring	16. Management should establish and operate monitoring activities to monitor the internal control system and evaluate the results.	Medical facility leaders did not enforce consistent monitoring to ensure accurate accountability for supplies and equipment in the inventory systems.

[12] Government Accountability Office (GAO), *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

Component	Principle	Deficiency identified by this audit
	17. Management should remediate identified internal control deficiencies on a timely basis.	Medical facility leaders did not enforce accurate and timely completion of reports of survey.

Source: VA OIG analysis of internal control components and principles. The principles listed are consistent with the GAO's Standards for Internal Control in the Federal Government.

Data Reliability

The team assessed the reliability of inventory data extracted from GIP for expendable supplies and from AEMS/MERS for nonexpendable equipment. The team tested key data fields for completeness, accuracy, and reasonableness; reviewed system documentation; and compared recorded data to physical inventory observations. Based on the results of these procedures, the team determined that the data were sufficiently reliable for the purpose of this audit.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards.[13] Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

[13] Government Accountability Office, *Government Auditing Standards 2024 Revision*, GAO-24-106786, February 2024.

Appendix C: Statistical Sampling Methodology

Approach

To accomplish the audit objective, the team reviewed a statistical sample of expendable supplies recorded in the Generic Inventory Package (GIP) at Veterans Integrated Service Network (VISN) 22 medical facilities in West Los Angeles and San Diego, California, and Phoenix, Arizona. The team used statistical sampling to estimate the extent of discrepancies between recorded inventory and actual quantities on hand. The team also reviewed a stratified sample of nonexpendable equipment recorded in the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS) and used statistical sampling to estimate the number of unaccounted-for equipment items.

Population

The team obtained the universe of total expendable supplies and quantities on hand as of June 3, 2025. The team excluded certain categories, such as supplies at community-based outpatient clinics or those with zero quantities in normal stock levels and quantities on hand. After these exclusions, the remaining universe included 5,398 items, valued at about $7,456,980.

The team also obtained a universe of nonexpendable equipment items with a purchase date from October 1, 2019, through May 27, 2025. From that universe, the team excluded dispositioned records, equipment assigned to the Office of Information and Technology, building service equipment (for example, air conditioning systems, elevators, and fire alarms), police service equipment, records with a total asset value of less than $300, and station numbers/locations associated with community-based outpatient clinics, veteran centers, and other off-site locations. Following those exclusions, the universe consisted of 21,874 nonexpendable equipment items valued at about $199,957,456.

Based on the review of a probability sample (described further below) from the expendable equipment sampling frame, the team estimated that this target population consisted of 5,400 in-scope items. The difference between the review population size and the estimated target population size is due to the sampled records that did not meet project scope requirement (for example, locations outside the medical center) as shown in table C.1.

Table C.1. Estimated Out-of-Scope and In-Scope Expendable Equipment Items with a 90 percent Confidence Interval

Request	Estimate	Margin of error	Lower limit	Upper limit	Sample size	Rounded estimate
Out of scope (percent)	10.3 (0.2)	8.1 (0.2)	2.2 (0.0)	18.5 (0.3)	5	10 (0.2)
In scope (percent)	5,387.7 (99.8)	8.1 (0.2)	5,379.5 (99.7)	5,395.8 (100)	99*	5,400 (99.8)
Total (percent)	**5,398 (100)**	—	—	—	**104**	**5,400**

Source: VA Office of Inspector General (OIG) statistician's analysis. Data were obtained from the Corporate Data Warehouse.

Note: Totals do not sum due to rounding.

** One sampled item's location was in an operating room. Multiple attempts were made to identify the item, but the operating room was in use in each instance. For the purposes of the OIG team's analysis, this item was considered in scope with no errors.*

Based on the review of a probability sample (described further below) from the nonexpendable equipment sampling frame, the team estimated that the target population consisted of 21,800 in-scope items. The difference between the review population size and the estimated target population size is due to the sampled records that did not meet project scope requirement (for example, locations outside the medical center) as shown in table C.2.

Table C.2. Estimated Out-of-Scope and In-Scope Nonexpendable Equipment Items with a 90 percent Confidence Interval

Request	Estimate	Margin of error	Lower limit	Upper limit	Sample size	Rounded estimate
Out of scope (percent)	108 (0.5)	127 (0.6)	0 (0.0)	235 (1.1)	2	110 (0.4)
In scope (percent)	21,766 (99.5)	127 (0.5)	21,639 (98.9)	21,893 (100.0)	141	21,800 (100)
Total (percent)	**21,874 (100)**	—	—	—	**143**	**21,900**

Source: VA OIG statistician's analysis. Data were obtained from the Corporate Data Warehouse.

Note: Totals do not sum due to rounding.

Expendable Supplies Sampling Design

To assess the accuracy of inventory records for expendable supplies, the team selected a stratified sample of 104 supply items from data extracted from GIP. The sample was divided into 15 strata based on their value ranges (see table C.3).

Table C.3. Stratified Inventory Summary by Medical Facility

Location	Station	Stratum	Value range	Number of items	Total value	Number of sampled items
Phoenix	644	1	Less than $300	1,301	$160,211	2
	644	2	$300 to less than $1,000	807	$472,903	4
	644	3	$1,000 to less than $5,000	606	$1,249,828	10
	644	4	$5,000 to less than $10,000	85	$615,604	5
	644	5	$10,000 or more	52	$1,327,588	16
San Diego	664	6	Less than $300	810	$108,337	2
	664	7	$300 to less than $1,000	446	$249,731	5
	664	8	$1,000 to less than $5,000	352	$715,352	11
	664	9	$5,000 to less than $10,000	60	$412,674	6
	664	10	$10,000 or more	30	$610,920	9
West Los Angeles	691	11	Less than $300	383	$42,010	2
	691	12	$300 to less than $1,000	217	$118,907	3
	691	13	$1,000 to less than $5,000	191	$398,593	9
	691	14	$5,000 to less than $10,000	33	$230,331	5
	691	15	$10,000 or more	25	$743,991	15
Total				5,398	**$7,456,980**	**104**

Source: VA OIG statistician's stratified population. Data were obtained from the Corporate Data Warehouse.

Note: Totals do not sum due to rounding.

The sample included expendable supplies stored and distributed by the C-Distribution or Medical/Surgical primary inventory point. For each sampled item, the team physically observed the on-hand inventory to verify the recorded quantity, labeling, and storage locations, and compared the observed results to the corresponding GIP records to identify discrepancies. While the team did not suspend operations during physical inventory counts, the team mitigated the associated risk of inaccurate counts by capturing and reviewing the transaction register report at the beginning and end of each day.[14] For any sampled items with activity on the day of the count, the team verified transaction posting times and compared them to the time the item was physically counted. This process allowed the team to account for any inventory movement and avoid double counting or missing items that moved in or out of inventory during the physical counts. The team shared all discrepancies with facility staff for visibility, allowing them to review and respond with supporting documentation.

Nonexpendable Equipment Sampling Design

To assess the accountability of nonexpendable equipment, the team selected a stratified sample of 143 nonexpendable equipment items from data extracted from AEMS/MERS. The sample was divided into 12 strata as shown in table C.4 based on the station and asset value ranges (see table C.4).

Table C.4 shows the population, value, and number of nonexpendable equipment samples from each stratum.

Table C.4. Stratified Equipment Sample Summary by Station and Stratum

Location	Station	Stratum	Value range	Number of items	Total value	Number of sampled items
Phoenix	644	1	$300 to less than $1,000	2,480	$1,625,192	2
	644	2	$1,000 to less than $5,000	2,160	$4,928,905	4
	644	3	$5,000 to less than $10,000	990	$7,381,698	6
	644	4	$10,000 or more	904	$45,529,751	36
San Diego	664	5	$300 to less than $1,000	2,414	$1,586,033	2

[14] GIP User Training Guide, December 2015. The transaction register report provides detailed transactions and activity for a specified item within a selected month, as well as the display of opening and closing balances.

Location	Station	Stratum	Value range	Number of items	Total value	Number of sampled items
San Diego (cont'd)	664	6	$1,000 to less than $5,000	2,734	$6,634,776	5
	664	7	$5,000 to less than $10,000	1,114	$8,278,235	6
	664	8	$10,000 or more	1,144	$48,460,190	34
West Los Angeles	691	9	$300 to less than $1,000	3,338	$2,067,061	2
	691	10	$1,000 to less than $5,000	2,495	$6,465,034	4
	691	11	$5,000 to less than $10,000	639	$4,461,016	3
	691	12	$10,000 or more	1,462	$62,539,566	39
Total				**21,874**	**$199,957,456**	**143**

Source: VA OIG statistician's stratified population. Data were obtained from the Corporate Data Warehouse.

Note: Totals do not sum due to rounding.

The team physically observed each sampled equipment item to verify its location and key identifying fields, such as serial number, electronic equipment record number, and room number. For visibility, the team shared all discrepancies with the nonexpendable supervisory inventory management specialists and the supply chiefs, allowing them to review and respond with supporting documentation.

Weights

Samples were weighted to represent the population from which they were drawn, and the weights were used in the estimate calculations. For example, the team calculated the error rate estimates by first summing the sampling weights for all sample records that contained the given error, then dividing that value by the sum of the weights for all sample records. The VA Office of Inspector General (OIG) statistician employed statistical analysis software to calculate estimates, margins of error, and confidence intervals.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this audit with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value about 90 percent of the time.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistic concerns of the sample review. While precision improves with larger samples, the rate of improvement decreases significantly as more records are added to the sample review.

Figure C.1. shows the effect of progressively larger sample sizes on the margin of error.

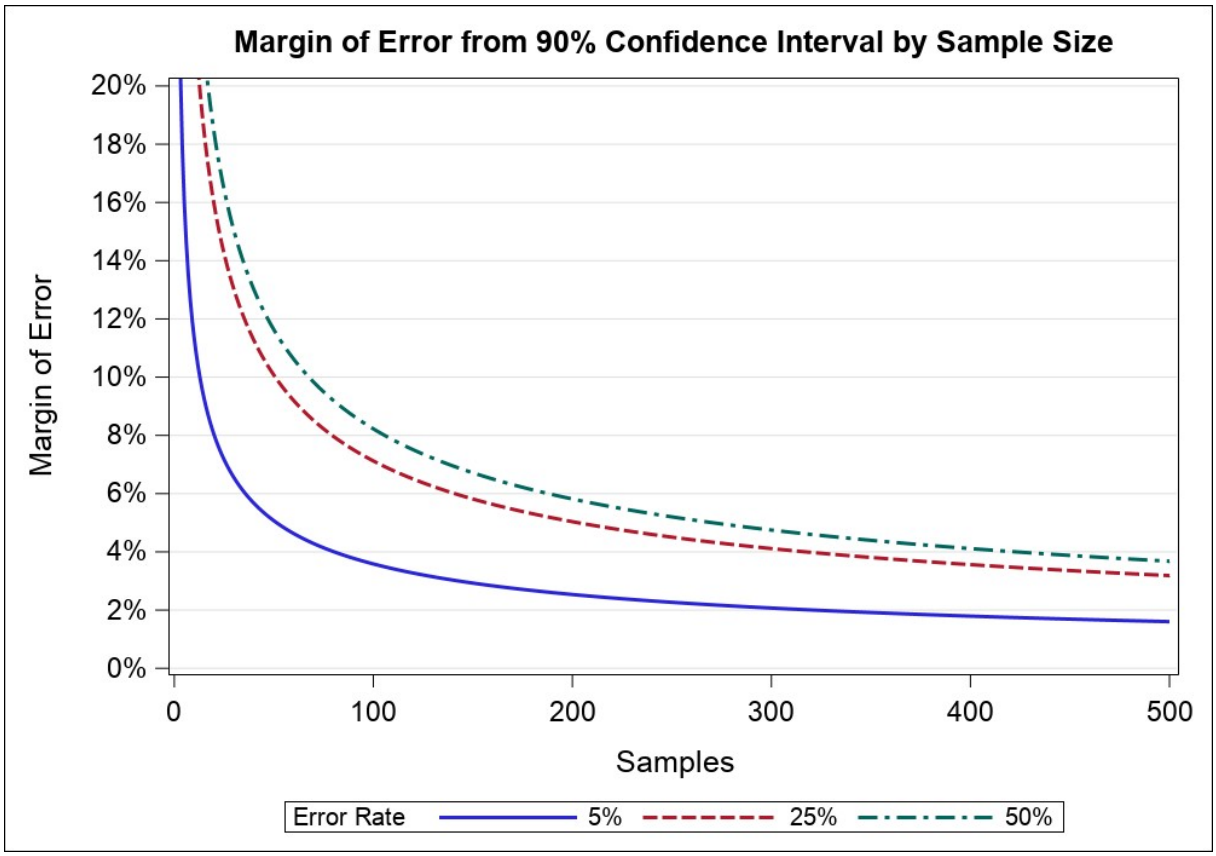

Figure C.1. *Effect of sample size on margin of error.*

Source: VA OIG statistician's analysis.

Projections

Table C.5 presents the 12 categories of expendable supply items along with the OIG's corresponding estimates.

Table C.5. Statistical Projections Summary for Expendable Supply Items, with a 90 Percent Confidence Interval

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count (sample size)	Rounded estimate
1. Count of items in which the physical count did not match the recorded quantity on hand (percent)	3,228 (59.9)	768 (14.2)	2,460 (45.7)	3,996 (74.2)	71 (99)	3,200 (60)
2. Value of items in which the physical count did not match the recorded quantity on hand	$1,755,026	$253,480	$1,151,970	$1,620,322	71 (99)	$1,800,000
3. Count* of items in which the physical count was less than the recorded quantity recorded (percent)	1,679 (31.2)	860 (16.0)	820 (15.2)	N/A	50 (99)	820 (15)
4. Value of items in which the physical count was less than the recorded quantity	-$1,386,146	$234,176	-$1,620,322	-$1,151,970	50 (99)	-$1,400,000
5. Count* of items in which the physical count was more than the recorded quantity (percent)	1,548 (28.7)	1,001 (18.6)	548 (10.2)	N/A	21 (99)	550 (10)

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count (sample size)	Rounded estimate
6. Value of items in which the physical count was more than the recorded quantity	$368,880	$109,409	$259,471	$478,288	21 (99)	$369,000
7. Count* of items in which the physical count was less than the system reorder point (percent*)	480 (8.9)	270 (5.0)	210 (3.9)	N/A	14 (99)	210 (3.9)
8. Value* of items in which the physical count was less than the system reorder point	$235,817	$123,619	$112,198	N/A	14 (99)	$112,000
9. Count of items in which the physical count was more than the system normal stock level (percent)	2,715 (50.4)	1,344 (25)	1,370 (25.4)	4,059 (75.3)	54 (99)	2,700 (50)
10. Count* of items with ABC Classification Label that were missing or incorrect (percent*)	2,042 (37.9)	899 (16.7)	1,143 (21.2)	N/A	40 (99)	1,100 (21)
11. Value of items with ABC Classification Label missing or incorrect	$2,984,166	$381,962	$2,602,205	$3,366,128	40 (99)	$3,000,000
12. Count of items with any error (percent)	5,200 (96.5)	258 (3.5)	4,942 (91.7)	5,458 (100)	95 (99)	5,200 (96.5)

*Source: VA OIG statistician's analysis. * Denotes one-sided lower-limit estimates.*

Table C.6 lists the five categories of nonexpendable equipment items and the OIG's associated estimates.

Table C.6. Statistical Projections Summary for Nonexpendable Equipment, with a 90 Percent Confidence Interval

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count (sample size)	Rounded estimate
1. Count of items in which the location did not match the system (percent)	9,019 (41.4)	3,087 (14.2)	5,931 (27.3)	12,106 (55.6)	56 (141)	9,000 (41)
2. Count* of missing items (percent*)	3,087 (14.2)	1,991 (9.1)	1,096 (5.0)	N/A	11 (141)	1,100 (5)
3. Value* of missing items	$14,273,249	$5,555,254	$8,717,995	N/A	11 (141)	$8,700,000
4. Count* of items with no barcode label	1,710 (7.9)	1.510 (6.9)	200 (0.9)	N/A	9 (141)	200 (0.9)
5. Value* of items with no barcode label	$14,641,845	$6,516,338	$8,125,507	N/A	9 (141)	$8,100,000
6. Count of items not inventoried within 12 months	3,141 (14.4)	2,189 (10.1)	952 (4.4)	N/A	14 (141)	950 (4.3)
7. Value of items not inventoried within 12 months	$18,480,328	$7,744,457	$10,735,871	26,224,785	14 (141)	$18,500,000

Source: VA OIG statistician's analysis.

** Denotes one-sided lower-limit estimates.*

Survey Sampling Methodology

The team received a total universe of 7,406 healthcare providers from the West Los Angeles, San Diego, and Phoenix medical centers. The team excluded self-identified healthcare providers who do not provide direct patient care and those who do not use expendable supplies or nonexpendable equipment to provide care to patients. The providers were stratified by specialty clinics in each facility.

The survey was distributed to 273 stratified statistically sampled healthcare providers. Fourteen healthcare providers were excluded due to out-of-office status during the survey period or undeliverable email. The team received 210 surveys for a response rate of 81 percent.

Sixteen of the providers who completed the survey stated that they do not provide direct patient care. The team's analysis is based on 194 survey responses of healthcare providers who provide direct patient care or clinical services in support of patient care. Since the healthcare providers excluded above represent others in the survey population that may also be out of scope, the audit team estimates that the eligible survey population is about 5,468 healthcare providers. Table C.7 summarizes survey stratification by specialty clinics in each facility, including the population and number of healthcare providers sampled from each stratum.

Table C.7. Survey Stratification Summary by Facility

Stratum	West Los Angeles n (N)	Phoenix n (N)	San Diego n (N)	Total n (N)
Community Care	8 (58)	8 (126)	8 (24)	24 (208)
Diagnostic	8 (91)	8 (31)	8 (43)	24 (165)
Mental Health	16 (780)	15 (538)	16 (546)	47 (1,864)
Nursing	24 (1,132)	25 (882)	21 (697)	70 (2,711)
Other	8 (320)	8 (51)	8 (51)	24 (422)
Primary Care	8 (37)	8 (134)	8 (112)	24 (283)
Specialty Care	16 (775)	8 (191)	12 (394)	36 (1,360)
Surgery	8 (134)	8 (137)	8 (122)	24 (393)

Source: VA OIG statistician's stratified survey population. Distribution data were obtained from the Phoenix, West Los Angeles, and San Diego medical facilities.

Note: n denotes sample size, (N) denotes population size.

Table C.8. Survey Statistical Projections Summary

Question (answer)	Estimate	Margin of error	Lower limit	Upper limit	Sample count (sample size)	Rounded estimate
Do you provide direct patient care or clinical services in support of patient care? (Yes)	5,468 (96%)	405 (2%)	5,063 (94%)	5,873 (98%)	194 (210)	5,500 (96%)
Do you use expendable supplies in the services you provide to your patients? (Yes)	3,873 (71%)	426 (6%)	3,447 (65%)	4,299 (77%)	134 (194)	3,900 (71%)
In the past year were expendable supplies always available for use when needed to provide care to patients? (No)	1,347 (35%)	325 (8%)	1,023 (53%)	1,672 (68%)	46 (134)	1,300 (35%)
In the past year were any on-hand expendable supplies necessary for patient care expired? (Yes)	445 (12%)	187 (5%)	258 (7%)	632 (16%)	19 (133)	440 (12%)
Do you use nonexpendable equipment for services you provide to your patients? (Yes)	3,035 (56%)	412 (6%)	2,623 (49%)	3,447 (62%)	110 (193)	3,000 (56%)

Question (answer)	Estimate	Margin of error	Lower limit	Upper limit	Sample count (sample size)	Rounded estimate
In the past year, were nonexpendable equipment always available for use when needed to provide care to your patients? (No)	504 (17%)	221 (7%)	283 (10%)	725 (24%)	16 (109)	500 (17%)
In the past year, has the unavailability of nonexpendable equipment impacted patient appointments? (Yes)	—	—	—	—	5 (16)*	—

Source: VA OIG statistician's analysis.

** Based on the small sample count, the margin of error for this question would be very wide such that this estimate would not be precise. Therefore, the OIG is reporting the sample count and size.*

Appendix D: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[15]
1	Physical count was higher than system quantity on hand	$369,000	$0
	Total	**$369,000**	**$0**

[15] The OIG questions costs when VA action or inaction (such as spending or not fully compensating eligible beneficiaries) is determined by the OIG to violate a provision of law, regulation, contract, grant, cooperative agreement, or other agreement; when costs are not supported by adequate documentation; or when they are expended for purposes that are unnecessary or unreasonable under governing authorities. Within questioned costs, the OIG must, as required by section 405 of the IG Act, report unsupported costs. Unsupported costs are those determined by the OIG to lack adequate documentation at the time of the audit.

Appendix E: VA Management Comments

Department of Veterans Affairs Memorandum

Date: May 4, 2026

From: Interim Network Director, Department of Veterans Affairs (VA) Desert Pacific Healthcare Network (10N22)

Subj: VA Office of Inspector General (OIG) Report, Audit of VISN 22 Supply Chain Management (VIEWS 14620289)

To: Director, Office of Audits and Evaluations (52A03)
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report, Audit of VISN 22 Supply Chain Management. I have reviewed the action plan provided by VISN 22 and concur with the response.

The OIG removed point of contact information prior to publication.

(Original signed by)

Bryan E. Arnette, FACHE

VETERANS HEALTH ADMINISTRATION (VHA) Action Plan

OIG Draft Report— Audit of VISN 22 Supply Chain Management

2025-02834-AE-0114

Recommendation 1: Require medical facility directors in Veterans Integrated Service Network 22 to develop and implement procedures to maintain stock within the required thresholds as outlined in Veterans Health Administration Directive 1761.

VHA Comments: Concur. To verify all Expendable Supply Chain Management (SCM) staff are appropriately trained and have a base level of skills required to complete job requirements of maintaining stock levels in accordance with VHA Directive 1761, facility SCM will validate expendable staff skill levels regarding proper management of expendable supplies. Each facility will submit evidence of this validation to VISN 22 SCM when complete. Facilities will submit station-specific workflow showing how they implement and audit procedures in accordance with VHA Directive 1761 regarding management of expendable supplies which will standardize these procedures to ensure consistent monitoring and corrective action across all VISN 22 facilities.

The VISN 22 Chief Logistics Officer will report monthly compliance with action plan items through VISN 22 governance structure. Compliance will be measured through monitoring of required facility supply chain staff who have received training/skills certification with a goal of 90%. Compliance of workflow will be measured through monitoring of submissions to VISN 22 SCM with a goal of 90%. Compliance of the audits will also be tracked monthly for 6 consecutive months with a goal of 90% compliance.

Status: In Progress Target Completion Date: December 2026

Recommendation 2: Require medical facility directors in Veterans Integrated Service Network 22 to ensure supply chain staff review and update ABC classification labels on expendable supplies in accordance with Veterans Health Administration guidance and establish a process to routinely verify that labeling aligns with the official ABC classification report.

VHA Comments: Concur. VISN 22 facilities will submit evidence of refresher training to Expendable staff for the ABC classification process. Facilities will submit station-specific workflows and Standard Operating Procedures (SOP) showing how they implement and audit procedures in accordance with VHA Directive 1761 regarding the use of the ABC classification report. VISN 22 will create a process to review the facilities that were deficient on their ABC classification quality control review question in FY 2026.

The VISN 22 Chief Logistics Officer will report monthly through VISN 22 governance structure. Compliance will be measured through monitoring of required facility supply chain staff who have received training and skills certification with a goal of 90%. Compliance of workflow will be measured through monitoring of submissions to VISN 22 SCM with a goal of 90%. Compliance will be measured through monitoring of required correct ABC classifications with a goal of 100% in accordance with VHA Directive 1761.

Status: In Progress Target Completion Date: January 2027

Recommendation 3: Ensure medical facility directors in Veterans Integrated Service Network 22 develop a process to ensure facility staff safeguard expendable supplies in accordance with Veterans Administration Handbook 0730.

VHA Comments: Concur. To ensure safeguarding supplies VISN 22 facilities will submit plans to VISN 22 SCM on ways to secure primary (clean/sterile) storage areas. For areas of SCM that do not have standard doors (warehouse), SCM staff will be trained on the importance of stopping non-SCM staff if

they try to enter SCM areas. Facility SCM leadership will randomly audit compliance with safeguarding supplies and entry/egress points of supply chain and report through SCM/facility governance any deviation trends.

The VISN 22 Chief Logistics Officer will report monthly compliance through VISN 22 governance structure. Compliance will be measured through monitoring of plan submission of securing doors with a goal of 90% compliance. Compliance of the audits will also be tracked monthly for 6 consecutive months with a goal of 90% compliance.

Status: In Progress Target Completion Date: February 2027

Recommendation 4: Ensure medical facility directors in Veterans Integrated Service Network 22 develop and implement local procedures that require clinical service areas to notify supply chain staff when equipment is relocated, establish protocols to validate and update equipment location, and ensure equipment items are properly tagged.

VHA Comments: Concur. VISN 22 SCM and VISN 22 Healthcare Technology Management (HTM) will evaluate options for the use of equipment location tracking systems to assist in accountability of mobile equipment as it may follow the patient through the continuum of care. VISN 22 facilities will submit a plan for equipment accountability to VISN 22 SCM and conduct random audits.

The VISN 22 Chief Logistics Officer will report options for equipment location tracking systems through VISN 22 governance structure. Compliance of audits for equipment location and proper tagging will also be tracked monthly for 6 consecutive months with a goal of 90% compliance.

Status: In Progress Target Completion Date: December 2026

Recommendation 5: Require medical facility directors in Veterans Integrated Service Network 22 to ensure facilities conduct annual inventory of nonexpendable equipment.

VHA Comments: Concur. To ensure facility oversight of the annual equipment inspection compliance, each VISN 22 facility will submit a plan to ensure all Equipment Inventory Listings (EIL) inspections will be completed on time. Each facility will submit the signed EIL reports to VISN 22 SCM quarterly.

The VISN 22 Chief Logistics Officer will report quarterly through VISN 22 governance structure. Compliance of the audits will also be tracked quarterly for 3 consecutive quarters with a goal of 100% compliance in accordance with VHA Directive 1761.

Status: In Progress Target Completion Date: July 2027

Recommendation 6: Require medical facility directors in Veterans Integrated Service Network 22 to enforce timely completion of reports of survey in accordance with Veterans Health Administration policy and implement oversight mechanisms to monitor the timely initiation, approval, and closure of reports.

VHA Comments: Concur. Medical facility directors in VISN 22 will enforce timely initiation, approval, and closure of Reports of Survey (ROS) in accordance with VHA policy. To ensure all Custodial Officials and ROS Investigation Board Members understand their responsibilities each facility will complete and upload ROS training certificates to the VISN 22 SCM SharePoint. Each facility will implement oversight mechanisms, including an internal dashboard that tracks ROS timelines, aging, and compliance.

The VISN 22 Chief Logistics Officer will report monthly through VISN 22 governance structure. Compliance of the training will also be tracked monthly with a goal of 90% compliance. ROS process will be tracked for 6 consecutive months with a goal of 100% compliance in accordance with VHA Directive 1761.

Status: In Progress Target Completion Date: March 2027

Recommendation 7: Ensure facilities implement corrective actions to effectively address deficiencies identified during the Veterans Integrated System Network's quality control reviews.

VHA Comments: Concur. VISN 22 will address all outstanding Quality Control Review corrective actions from previous fiscal years within 90 days of this report's release. To ensure quality control review corrective action plan (CAP) deficiencies are corrected, each open CAP item will be tracked monthly through facility governance until completion. If an item is nearing the 90-business day mark and cannot be closed, the Medical Center Director will submit a request through the VISN 22 Chief Logistics Officer to the Network Director requesting an extension. At the end of the fiscal year, if a deficiency cannot be closed, a Deferral to next Fiscal Year request will be submitted by the Medical Center Director through the VISN 22 Chief Logistics Officer to the Network Director for approval. Both extensions and deferments to next fiscal year will include risk mitigation plans related to that open item. These requests will also be incorporated in the facility governance process. The minutes of these meetings will be uploaded to the VISN SCM SharePoint for validation.

The VISN 22 Chief Logistics Officer will report monthly through VISN 22 governance structure. Compliance of addressing deficiencies will be tracked until closure, extension or request to defer to next FY in accordance with VHA Directive 1761.

Status: In Progress Target Completion Date: October 2026

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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