US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA New Jersey Healthcare System in East Orange

Healthcare Facility Inspection	**25-00242-195**	**September 25, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA New Jersey Healthcare System (the facility) from August 25 through 28, 2025. The OIG had a follow-up meeting with facility staff in April 2026 to address many of the OIG's findings and found some progress was made. The facility is rated as *mid-high complexity* and in fiscal year 2025, provided direct care to about 55,559 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG team found limited parking availability, including accessible spaces for those with disabilities. The facility also had persistent environmental and infection control problems despite prior corrective actions. A significant finding affecting fire and life safety led the OIG to issue a preliminary result advisory memorandum in December 2025.[3] The team followed up with facility staff in April 2026 and found they had made some progress in addressing these problems. However, the OIG

[1] VHA classifies facilities based on their complexity level. Mid-high-complexity facilities have "medium-high volume, medium risk patients, some complex programs, and medium sized research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack-Operational Statistics Table FY2025 Through June," VHA Support Service Center (VSSC), last updated March 13, 2026, https://reports.vssc.med.va.gov/ReportViewer. (This web page is not publicly accessible.)

[2] See appendix A for a description of the OIG's inspection methodology.

[3] VA OIG, *Review of Fire System and Life Safety Programs/Processes at the East Orange VA Medical Center in New Jersey*, Report No. 26-00105-22, December 11, 2025.

made eight recommendations, including one to the Veterans Integrated Service Network Director, for areas that still need improvements.[4]

- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The facility did not have workflows that describe staff members' roles in the test result communication process for each service, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[5] Additionally, facility leaders lacked a formal system to monitor and communicate overdue actions from root cause analyses. There were also adverse events (increasing risk of harm or causing actual harm to patients related to their care) that may have warranted institutional disclosures to patients or their personal representatives, as required by VHA Directive 1004.08, *Disclosing Adverse Events to Patients*.[6] In the April 2026 follow-up meeting, the team learned that facility actions remained in progress, so the OIG made three recommendations to monitor progress toward full implementation.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[7] The OIG made no recommendations.
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness or have recently been incarcerated. The OIG made no recommendations.

[4] VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). "Veterans Integrated Service Networks," VA, accessed December 2, 2024, https://department.va.gov.visns. In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise. VISN 2, "Annual Facility (Safety, Industrial Hygiene, Environmental and Fire Protection) Evaluation," May 29, 2025.

[5] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[6] VHA Directive 1004.08, *Disclosing Adverse Events to Patients*, October 31, 2018.

[7] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

What the OIG Recommended

1. The Director takes appropriate actions to strengthen staff accountability for maintaining clean and safe patient care areas as required by Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.[8]
2. The Director takes appropriate actions so staff validate and document airflow testing in supply rooms annually as required by Veterans Health Administration Directive 1761, *Supply Chain Management Operations*.[9]
3. The Director takes appropriate actions so staff conduct a risk assessment to identify areas that require temperature and humidity monitoring and implement changes as required by Veterans Health Administration Directive 1761, *Supply Chain Management Operations* and Veterans Health Administration Directive 1108.07(2), *General Pharmacy Service Requirements*.[10]
4. The Director implements controls so staff repair or replace malfunctioning fire doors to ensure proper closure during emergencies as required by the National Fire Protection Association's *Standard for Fire Doors and Other Opening Protectives*, *NFPA 80.*[11]
5. The Director implements measures so staff conduct all required fire safety inspections and document the results as required by the National Fire Protection Association's *Standard for Fire Doors and Other Opening Protectives*, *NFPA 80*.
6. The Director takes appropriate actions to implement measures to test sprinkler systems as required by the National Fire Protection Association's *Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems*, *NFPA 25.*[12]
7. The Director takes appropriate actions so staff evaluate processes to prevent repeat environment of care findings and take actions as warranted.
8. The Veterans Integrated Service Network Director monitors for similar or repeat environment of care findings and takes appropriate actions so facility leaders

[8] VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

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

[10] VHA Directive 1108.07(2), *General Pharmacy Service Requirements*, November 28, 2022, amended December 6, 2024.

[11] National Fire Protection Association, *Standard for Fire Doors and Other Opening Protectives*, NFPA 80, 2025.

[12] National Fire Protection Association, *Standard for the Inspection*, *Testing*, *and Maintenance of Water-Based Fire Protection Systems*, NFPA 25, 2026.

develop and implement facility-wide corrective action plans and sustain improvements.

9. The Director takes appropriate actions so each service chief develops a workflow that describes staff members' roles in the process of communicating test results to providers and patients as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.
10. The Director takes appropriate actions so staff track root cause analysis–driven improvement actions through to completion, monitor outcome measures, and implement processes to sustain improvements to comply with Veterans Health Administration National Center for Patient Safety's *Guide to Performing Root Cause Analysis*.[13]
11. The Chief of Staff takes appropriate action for evaluation and improvement of processes to identify adverse events that warrant institutional disclosures to patients or their representatives as required by Veterans Health Administration Directive 1004.08, *Disclosure of Adverse Events to Patients*.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the findings and recommendations and provided acceptable action plans (see the responses in the report body and appendixes C and D for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.

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[13] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, last updated February 2026.

Abbreviations

ADPCS	Associate Director of Patient Care Services
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Introduction

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[14] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions leaders and staff can take. Each inspection focuses on five domains and assesses facilities' adherence to VA standards and other governing authorities:

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[15]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[16]

Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[17]

Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[18]

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[14] "About VHA," VA, last updated June 2, 2026, https://www.va.gov/aboutvha.

[15] Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11, https://doi.org/10.1136/bmjopen-2017-017708.

[16] VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

[17] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[18] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The VA New Jersey Healthcare System (the facility) consists of two medical centers: the East Orange VA Medical Center (East Orange), which originally opened in July 1952, and the Lyons VA Medical Center (Lyons), which began as a neuropsychiatric hospital in November 1930. In 1996, the two hospitals merged to form the VA New Jersey Healthcare System. The facility also has nine community-based outpatient clinics.[19] Both medical centers and outpatient clinics operate under a unified leadership structure with a single Medical Center Director overseeing the entire facility.

Figure 1. *East Orange VA Medical Center (left); Lyons VA Medical Center (right).*
Source: "Locations," VA, accessed April 17, 2026, https://www.va.gov/new-jersey-health-care/locations.

The OIG team inspected the facility from August 25 through 28, 2025. The OIG had a follow-up meeting with facility staff in April 2026 to address many of the OIG's findings and found some progress was made. According to VHA data, East Orange had 39 internal medicine, 24 psychiatry, 18 spinal cord, 38 surgery, 30 domiciliary, and 30 community living center beds; and Lyons had 42 psychiatry, 138 domiciliary, and 270 community living center beds.[20] The facility's budget was approximately $641 million in fiscal year (FY) 2025.[21]

The executive leaders referred to throughout this report include the Interim Executive Medical Center Director (Interim Director), Chief of Staff, Associate Director of Patient Care Services (ADPCS), Deputy Chief of Staff, Associate Director (assigned as interim to East Orange), and Interim Associate Director (assigned to Lyons). The Chief of Staff had the longest tenure, since January 2022, while the Interim Director reported being in the position since June 2025.

[19] The clinics are in Hackensack, Hamilton, Jersey City, Morristown, Paterson, Piscataway, Newton, Tinton Falls, and Toms River.

[20] A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/CLC. A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, last updated June 23, 2026, https://department.va.gov/homeless/dchv.

[21] VA, *Medical Center Allocation System Reports and Documentation Report*, accessed April 7, 2026, https://vaww.arc.med.va.gov/reports/MCAS_25. (This web page is not publicly accessible.)

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[22] The OIG reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[23] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[24]

System Shocks

Executive leaders described the January 2025 in-person work requirement as a system shock.[25] The Associate Director explained they faced challenges in accommodating employees returning to the office because of aging infrastructure; many areas had been unoccupied for an extended period. During inspections, employees identified issues with the heating, air conditioning, and ventilation systems; sewer pipes; and boiler plant. The Associate Director also stated that facilities management employees have done a tremendous job with limited resources by fixing problems that could have been prevented with proper funding to replace old systems.

The Chief of Staff said staff also left the facility because they were subject to the in-person work requirement, especially affecting services where providers' private sector peers could work from home, such as psychologists. The chief said that a VHA memorandum to reduce staffing the prior year contributed to employment uncertainty.[26] Executive leaders said these mandates have caused feelings of job insecurity among employees and negatively affected morale.

Additionally, the Interim Director reported turnover in several executive positions as well as among many service chiefs. The prior Director, Associate Director, and chief of quality, safety, value retired around the same time. Facility leaders hired new service chiefs for the medicine, environmental management, and facilities management services. Several employees temporarily

[22] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, https://doi.org/10.1136/bmjqs-2017-007573.

[23] "Veteran Trust in VA," VA, last updated June 4, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

[24] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," VA, last updated May 9, 2022, https://www.va.gov/HEALTH/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

[25] Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

[26] Under Secretary for Health (USH) (10), "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23), Medical Center Directors (00), and VHACO [VHA Central Office] Program Office Leadership, May 31, 2024.

covered chief positions during the recruitment process when there were vacancies in that role for community care, surgery, and primary care.[27]

Employee Experiences

Because some leaders were new to executive roles at the facility and VA did not conduct an All Employee Survey in 2025, the OIG evaluated executive leaders' efforts to improve employee engagement and assess satisfaction without that recent survey data.[28] When possible, the OIG prefers to report direct employee feedback; however, in instances where low response rates cannot be considered representative, as was the case here, the team instead relied on leader interviews to characterize how they believe employees are experiencing the issues. Executive leaders used several methods to communicate with employees, including tiered huddles (brief meetings with staff and leaders), town halls, service chief meetings, and in-person visits to employees in their work areas.[29]

The Interim Director stated that although delayed, the facility adopted the High Reliability Organization tiered huddle model in June 2025, and employees now have dedicated time at the end of each huddle to ask questions.[30] One executive leader explained that previous executive leaders did not support the huddle initiative when introduced, and acting executive leaders' inconsistent priorities contributed to the delays.

The OIG team asked executive leaders how they assess employee satisfaction and what steps they have taken to improve it. Executive leaders stated that before July 2025, they lacked a structured governance process and did not have an executive leadership board. At the time of the inspection in August 2025, the executive leaders said they had recently implemented an executive leadership council and supporting councils to create a formal environment that promotes communication, collaboration, and decision-making among leaders and employees.

[27] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

[28] Drew Friedman, "After Months of Postponing, OPM [Office of Personnel Management] Opts to Fully Cancel 2025 FEVS [Federal Employee Viewpoint Survey]," *Federal News Network*, August 15, 2025.

[29] Naseema B. Merchant, et al., "Creating a Process for the Implementation of Tiered Huddles in a Veterans Affairs Medical Center," *Military Medicine* 188, no. 5-6 (May 16, 2023): 901-906, https://pubmed.ncbi.nlm.nih.gov/35312000.

[30] High reliability organizations focus on minimizing errors "despite highly hazardous and unpredictable conditions," such as those found in healthcare delivery settings. Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles," *Evidence Synthesis Program*, May 2019.

Veteran Experiences

Patient advocate responses to an OIG questionnaire noted a common concern among veterans was unanswered phone calls. Executive leaders acknowledged that some outpatient clinics did not have voicemail capabilities, and the facility did not have sufficient staff to answer veterans' calls requesting transportation. In response, executive leaders initiated a systems redesign project to identify ways to improve telephone access and said at the time of the inspection in August 2025 that they planned to hire a transportation coordinator to assist veterans.

The OIG reviewed the facility's VSignals scores from FY 2024 through the second quarter of FY 2025 and found they were slightly higher than VHA averages. The Interim Director described the scores as useful for immediate feedback from veterans but noted frontline staff and some leaders did not fully understand the scores. In response, leaders trained them on VSignals during Friday tiered huddles.

To further engage with veterans, executive leaders reported visiting various facility locations and holding topic-specific meetings twice a year, such as those focused on women's health. The Associate Director added that a veterans service organization had recently hosted a barbecue event at Lyons, which included executive and service leaders, employees, and over 100 veterans.[31]

Attention to environmental design improves veterans' and staff's safety and experience.[32] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[33]

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[31] "Veterans Service Organizations (VSOs) are organizations that aid and serve veterans, servicemembers, dependents, and survivors." Congressional Research Service, *Veterans Service Organizations (VSOs): Frequently Asked Questions*, updated February 6, 2024.

[32] "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

[33] VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, 2025; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

General Inspection

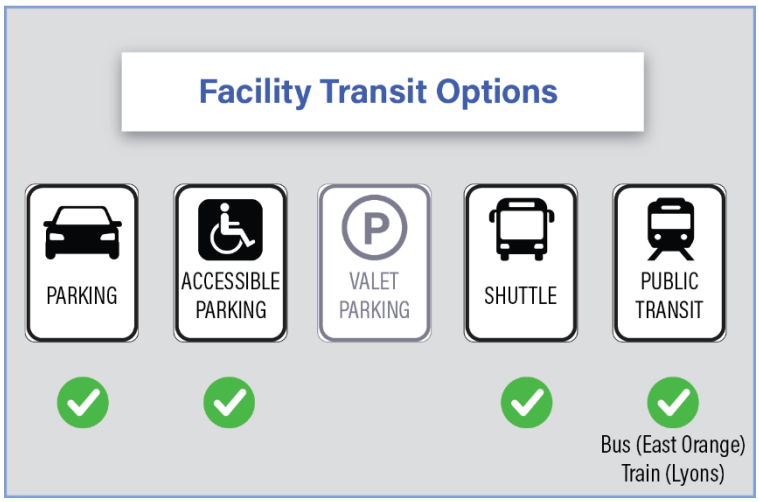

Figure 2. *Transit options for arriving at the facility. Source: OIG analysis of facility parking lot map, shuttle and valet documents, and a questionnaire response.*

Each medical center had clear signs to designated parking areas. However, the OIG team noted that veterans' concerns about transportation included the limited availability of parking spaces, as well as those accessible to individuals with disabilities. The OIG observed that the East Orange medical center had multiple parking spaces reserved for staff near the main entrance and others reserved for staff near the emergency department entrance. These reserved spaces reduced the number of available spaces close to entrances for veterans. The facility also did not have a service to transport veterans to parking locations at the East Orange medical center. The OIG is concerned that veterans do not have sufficient spaces to park near the main building and raised this issue with facility leaders.

In April 2026, the OIG team conducted a follow-up meeting with facility staff, who provided evidence of parking changes that allowed veterans to use spaces closer to the medical center, moved staff parking to a different lot to free up previously reserved parking, and expanded the number of accessible spaces. Based on this update, the OIG did not make a recommendation.

The main entrance lobbies at both medical centers were welcoming and clean. Inside, staff members and volunteers at information desks assisted veterans. However, the inspection team noted that the main lobby at East Orange was noisy, which can compromise patient and visitor privacy and comfort.

During the inspection in August 2025, staff at the East Orange emergency department did not continuously maintain coverage at the check-in desk. VHA Directive 1101.14(1), *Emergency Medicine* states that "appropriately trained administrative staff must be available to support the administrative needs of the ED [emergency department], including but not limited to patient check-in, registration, communications, arranging transfers and follow up appointments and admissions, 24 hours a day, 7 days a week."[34] The assistant nurse manager said the employee had left for the day due to an unplanned circumstance. During the April 2026 follow-up, facility

[34] VHA Directive 1101.14(1), *Emergency Medicine*, March 20, 2023, amended March 7, 2025.

staff provided nursing schedules that showed one or two registered nurses assigned to the check-in desk. Therefore, the OIG did not make a recommendation.

At the East Orange medical center, inspectors noted directories were posted on walls and inside elevators, which help guide veterans to different services. However, at both locations, some exterior signs were faded and difficult to read (see appendix B, figure B.1).

Also at East Orange, the OIG team found problems with access to the emergency department, unless veterans used the exterior entrance. From the main entrance, veterans must go outside and navigate a ramp or stairs to reach the emergency department because there is no unlocked interior route to the department. This exterior path may pose a significant challenge for individuals with mobility limitations and could delay veterans seeking emergency care. Because the team noted that leaders were aware of the issue and maintained a locked interior route accessible only by badge or using the intercom system, the team did not make a recommendation.

Figure 3. *Accessibility tools available to veterans with impairments at both locations.*
Source: OIG analysis of questionnaire responses and observations.

Although staff secured medications and supply rooms in clinical areas, inspectors identified several environmental and safety issues at both medical centers. For example, there were bugs inside light fixtures, which can indicate poor maintenance or pest control issues. The OIG team also found emergency pull cords that were wrapped around handrails, which made them difficult to access in an emergency and did not comply with the National Fire Protection Association's *Health Care Facilities Code*, *NFPA 99*, which requires pull cords to be reachable by someone lying on the floor.[35]

Further, at the East Orange medical center, an eye wash station was blocked by trash cans, and another was located behind a locked door, which can limit access during an emergency. According to the Code of Federal Regulations, title 29, section 1910.151(c), eye wash stations must be nearby so that anyone exposed to harmful chemicals can immediately rinse off.[36] Additionally, the OIG team reviewed the log for an eye wash station and found staff had not inspected it weekly, as required by VHA Directive 7704, *Emergency Eyewash and Shower*

[35] National Fire Protection Association, *Health Care Facilities Code*, NFPA 99, 2024.
[36] 29 C.F.R. § 1910.151(c) (2011).

Program.[37] In addition, there were several supply-related issues, such as empty soap dispensers and expired hand sanitizers and other medical supplies.

The inspectors also found facility maintenance issues. At East Orange, multiple ceiling tiles were stained or damaged. At Lyons, a protective sprinkler plate was missing, and others were not installed flush to the ceiling, which created gaps. At East Orange, walls showed visible damage, with dust on some sprinkler heads, whereas at Lyons, ventilation grills also had dust on them. Furthermore, Lyons also had exposed wiring on walls, and a hand sanitizer installed above an electrical outlet, and East Orange had rust on several sinks. According to the National Fire Protection Association's *Life Safety Code*, *NFPA 101*, hand sanitizer dispensers should not be installed above an ignition source.[38] Additionally, the Occupational Safety and Health Administration standard 29 CFR 1910 Subpart S requires that electrical equipment be free from recognized hazards that are likely to cause death or serious injury.[39]

In patient care areas at both medical centers, the OIG team found dusty bed frames beneath mattresses, and at East Orange, they also observed dirty floors. VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires facilities to ensure a "safe, clean health care environment that provides the highest standards in the health care setting."[40] These conditions pose infection risks and reflect inadequate cleaning practices. The Associate Director assigned to East Orange attributed the issues to position vacancy rates of 18 percent for the Environmental Management Service and 11 percent for the Facilities Management Service, although they were actively recruiting for these positions and had plans to implement a janitorial contract in FY 2026. In the April 2026 follow-up meeting, the OIG team learned these actions are ongoing.

Recommendation 1

The Director takes appropriate actions to strengthen staff accountability for maintaining clean and safe patient care areas as required by Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

__X__Concur

_____Nonconcur

Target date for completion: March 31, 2027

[37] VHA Directive 7704, *Emergency Eyewash and Shower Program*, October 12, 2021.

[38] National Fire Protection Association, *Life Safety Code*, *NFPA 101*, 2024.

[39] Occupational Safety and Health Administration, *29 CFR 1910 Subpart S,* accessed June 24, 2026. https://www.osha.gov/etools/hospitals/hospital-wide-hazards/electrical-safety.

[40] VHA Directive 1608(1).

Director Comments

VA New Jersey Healthcare System (VANJHS) has experienced a substantial change in Senior leadership team members. A new Environmental Management Services (EMS) Chief started in July 2025 and immediately implemented a comprehensive action plan to address deficiencies identified during a recent visit from the national EMS team. VANJHS has made tremendous progress on improving and overseeing the cleaning processes since the OIG Healthcare Facility Inspection (HFI) visit, completing a 34-point action plan spanning the entire healthcare system. Additionally, checklists have been created to include OIG recommendations, to track and monitor actions, and ensure effective cleaning processes. These checklists are used by supervisors to ensure accountability for maintaining clean and safe patient care areas. Supervisors complete routine checklists multiple times per week. Results of the audits will be reported monthly to the VANJHS Healthcare Operations Council (HOC) until 90% compliance is achieved for six consecutive months.

The OIG team further identified an issue related to temperature controls for several medication dispensing cabinets at both medical centers. Staff could not provide documents to show they continuously monitored temperatures in these cabinets, which is necessary to ensure medication safety and effectiveness. VHA Directive 1108.07(2), *General Pharmacy Service Requirements* states the chief of pharmacy must ensure medication storage areas maintain temperature and humidity within a certain range.[41] In addition, staff did not have evidence they monitored temperature and humidity in supply rooms daily or documented airflow testing in supply rooms annually, which is necessary to confirm proper ventilation and compliance with infection control standards, and required by VHA Directive 1761, *Supply Chain Management Operations*.[42]

Recommendation 2

The Director takes appropriate actions so staff validate and document airflow testing in supply rooms annually as required by Veterans Health Administration Directive 1761, *Supply Chain Management Operations*.

__X__Concur

_____Nonconcur

Target date for completion: March 31, 2027

[41] VHA Directive 1108.07(2), *General Pharmacy Service Requirements*, November 28, 2022, amended December 6, 2024.

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

Director Comments

VA New Jersey Healthcare System (VANJHS) Associate Director of Operations East Orange campus (AD-EO) has identified air flow testing equipment for purchase that will provide efficient ongoing airflow analysis for all supply rooms. Additionally, the VA New Jersey (VANJ) Chief of Supply Chain Management (SCM) has a commitment to validate compliance with annual airflow testing in all supply rooms and has modified the temperature and humidity verification log to document the airflow testing biannually in each supply room. Compliance of 90% for six consecutive months will be reported to Environment of Care committee.

Recommendation 3

The Director takes appropriate actions so staff conduct a risk assessment to identify areas that require temperature and humidity monitoring and implement changes as required by Veterans Health Administration Directive 1761, *Supply Chain Management Operations* and Veterans Health Administration Directive 1108.07(2), *General Pharmacy Service Requirements*.

__X__ Concur

_____ Nonconcur

Target date for completion: March 31, 2027

Director Comments

VA New Jersey Healthcare System (VANJHS) hired a new Chief of Engineering in June 2025 and a new Associate Director of Operations, East Orange (EO) in November 2025. The new leadership's risk assessment found multiple different types of sensors and monitors in place, including paper logs found by the OIG Healthcare Facility Inspection (HFI) team to be deficient. The Associate Director of Operations-EO has pursued a Temp Trak temperature and humidity monitoring system purchase and awaits execution of the contract. The Chief of Supply Chain Management (SCM) ensures temperature and humidity logs are completed daily for all supply rooms and the Associate Director for Patient Care Services (ADPCS) is ensuring that all medication rooms have documented daily temperature. Compliance of 90% compliance for six consecutive months will be reported to Environment of Care committee each month.

Further, at the Lyons medical center a refrigerator shared by patients in the Community Living Center was operating outside the acceptable temperature range, which may compromise safe food storage. The Joint Commission, *Standards Manual*, PC [Provision of Care, Treatment, and Services] standard 02.02.03 requires that "the hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature,

light, moisture, ventilation, and security."[43] The chief of operations for facility management service reported that staff had not placed any work orders to address the issue. At East Orange, a blanket warmer's thermometer gauge was not working, which prevents staff from verifying whether the unit maintained a safe and consistent temperature. The Joint Commission recommends maximum blanket warmer temperatures of 130 degrees Fahrenheit.[44] Facility staff reported during the April 2026 follow-up meeting that corrective actions for each of these findings were in progress.

Inspectors noted that some biohazard rooms at both locations did not have signs to alert staff and visitors to potential hazards, as required by the Code of Federal Regulations, title 29, section 1910.145.[45] In addition, staff used some rooms for both biohazard and non-biohazard purposes, which increases the risk of cross-contamination and does not follow VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*.[46] Inspectors also found clean items stored inside biohazard bags. This practice may confuse staff and lead to the improper handling or disposal of clean supplies. Because facility staff provided evidence of these problems being corrected during the follow-up in April 2026, the OIG did not make a recommendation.

Additionally, the OIG team identified several issues related to life safety (safeguarding the lives of patients, staff, and visitors) and published a preliminary result advisory memorandum in December 2025 to inform the VHA Under Secretary for Health of the significant and recurring issues identified at East Orange.[47] Inspectors found that staff did not test smoke doors and missed some fire door inspections required by the National Fire Protection Association's *Standard for Fire Doors and Other Opening Protectives*, *NFPA 80*; also, some smoke and fire doors did not close properly.[48] The National Fire Protection Association standard states that doors must be tested at least once a year and fire doors must latch when closed. In East Orange, the fire doors did not close at all for two rooms labeled as hazardous, which may prevent them from containing

[43] The Joint Commission, *Standards Manual*, E-dition, PC.02.02.03, July 1, 2025 (this standard was in place at the time of the August 2025 OIG inspection). Similar guidance now appears at The Joint Commission, "Standards FAQs Refrigerator Temperature – Patient Care Food Storage, What is the Requirement or Standard that Addresses Thermometers or Temperature Logs for Refrigerators or Freezers Used for Food Storage?," last updated April 21, 2026, https://www.jointcommission.org/faqs.

[44] "Standards FAQ: Medical Equipment–Blanket Temperature Risk Assessment, What Standards Apply to the Requirement for Organizations to Maintain Blanket Temperatures?," The Joint Commission, accessed November 26, 2024, https://www.jointcommission.org/faqs.

[45] 29 C.F.R. § 1910.145 (2025).

[46] VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 27, 2023.

[47] "Hospital Life Safety & Environment of Care Document List and Review Tool," The Joint Commission, accessed November 17, 2025, https://www.jointcommission.org/life-safety; VA OIG, *Review of Fire System and Life Safety Programs/Processes at the East Orange VA Medical Center in New Jersey*, Report No. 26-00105-22, December 11, 2025.

[48] National Fire Protection Association, *Standard for Fire Doors and Other Opening Protectives*, NFPA 80, 2025.

smoke or fire during an emergency. The team also noted an exit sign was difficult to read (see appendix B, figure B.2), and one pointed toward a door marked "Not an Exit."

In addition, the facility did not have an annual fire and safety management plan for its facility, which is essential for leaders to identify risks, outline preventive measures, and ensure staff are prepared to respond to fire-related emergencies. The Joint Commission standard EC [Environment of Care] 04.01.01 states, "every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness."[49] Further, the OIG team reviewed facility documents that revealed staff conducted components of the last sprinkler test at East Orange in 2018, not every three years as required by the National Fire Protection Association's *Standard for the Inspection*, *Testing*, *and Maintenance of Water-Based Fire Protection Systems*, *NFPA 25*.[50] During the follow-up in April 2026, facility staff submitted evidence they had corrected the exit sign and provided an updated fire response and evacuation procedure, so the OIG did not make recommendations for further action.

Recommendation 4

The Director implements controls so staff repair or replace malfunctioning fire doors to ensure proper closure during emergencies as required by the National Fire Protection Association's *Standard for Fire Doors and Other Opening Protectives*, *NFPA 80*.

__X__ Concur

_____ Nonconcur

Target date for completion: March 31, 2027

Director Comments

In May 2026, the VA New Jersey Healthcare System (VANJHS) Occupational Safety Officer and Fire Chief completed a full assessment of VANJHS's 600 sets of fire doors resulting in 22 malfunctioning doors being repaired to ensure proper closure and 17 malfunctioning fire doors contracted for vendor replacement. At the time of this report, VANJHS Chief of Engineering is awaiting delivery of the 17 custom made replacement fire doors for installation and provides updates for pending installs to the VANJHS (Healthcare Operations Council) HOC quarterly.

[49] The Joint Commission, *Standards Manual*, E-dition, EC.04.01.01, July 1, 2025 (this standard was in place at the time of the August 2025 OIG inspection, but The Joint Commission updated it to PE.03.01.01 in 2026).

[50] National Fire Protection Association, *Standard for the Inspection*, *Testing*, *and Maintenance of Water-Based Fire Protection Systems*, NFPA 25, 2026.

Recommendation 5

The Director implements measures so staff conduct all required fire safety inspections and document the results as required by the National Fire Protection Association's *Standard for Fire Doors and Other Opening Protectives*, *NFPA 80*.

__X__Concur

_____Nonconcur

Target date for completion: June 30, 2027

Director Comments

The VA New Jersey Healthcare System (VANJHS) Fire Chief and Occupational Safety Manager were newly appointed to their roles prior to the OIG Healthcare Facility Inspection (HFI) visit and had not yet completed an inspection of the 600 fire doors, creating a lapse in annual testing requirements. They have since completed safety inspection of all 600 fire doors for both the East Orange and Lyons campuses in May 2026 with resulting repairs completed and replacements pending vendor arrival and installation. The Fire Chief and Occupational Safety Manager have created a standard annual cycle of fire door inspection to be completed by May of each year with results reported to the VANJHS Healthcare Operations Council.

Recommendation 6

The Director takes appropriate actions to implement measures to test sprinkler systems as required by the National Fire Protection Association's *Standard for the Inspection*, *Testing*, *and Maintenance of Water-Based Fire Protection Systems*, *NFPA 25.*

__X__Concur

_____Nonconcur

Target date for completion: September 30, 2027

Director Comments

The Chief of Engineering and Associate Director of Operations, East Orange initiated a comprehensive action plan to remediate the findings, including implementing interim life safety measures (ILSM). Concurrently, VA New Jersey Healthcare System (VANJHS) sought guidance and input from national subject matters experts in the Veterans Administration to be able to provide the safest environment of care for Veterans and staff alike. Robust progress has resulted in completion of the ILSMs and actions remain on track to completion of successful sprinkler testing. Progress for the action plan is reported monthly to the VANJHS Healthcare Operations Council.

The OIG team reviewed The Joint Commission's 2024 inspection report and found similar problems in its August 2025 inspection:[51]

- Untested fire doors
- Damaged ceiling tiles
- Emergency pull cords wrapped around handrails
- Expired hand sanitizers
- A hand sanitizer dispenser installed directly above an electrical outlet
- Visible wall damage
- Missing sprinkler head plates
- Unmonitored temperature and humidity levels
- Fire doors that did not close properly

VHA Directive 1608(1) requires facilities to adhere to regulatory and accrediting bodies' standards and ensure the healthcare environment is safe and clean. Although facility staff provided action plans and documented corrections to specific Joint Commission findings, the OIG determined executive leaders did not ensure staff had evaluated other areas of the facility for the same problems.

OIG inspectors also reviewed the Annual Safety, Industrial Hygiene, Environmental, and Fire Protection Evaluation conducted by the Veterans Integrated Service Network (VISN) from April 28 through May 2, 2025, and found similar issues:[52]

- Exposed electrical wiring
- Missing sprinkler head plates
- Incorrect or misleading exit signs

[51] The Joint Commission performed a hospital, behavioral health care and human services, and home care accreditation inspection April 30 through May 3, 2024. The Joint Commission, *Final Accreditation Report VA New Jersey Health Care System,* May 21, 2024.

[52] VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). "Veterans Integrated Service Networks," VA, accessed December 2, 2024, https://department.va.gov.visns. In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise. VISN 2, "Annual Facility (Safety, Industrial Hygiene, Environmental and Fire Protection) Evaluation," May 29, 2025.

- Biohazard bags used for non-biohazard storage
- Lack of weekly eye wash station tests

The OIG team also noted similar concerns identified in the 2024 annual VISN evaluation, such as missing sprinkler head plates and untested eye wash stations.[53] Collectively, the findings reflect persistent or recurring areas of concern.

At the time of the August 2025 OIG inspection, the Associate Director explained that leaders identified champions to address individual Joint Commission findings. The champions then worked directly with staff to create action plans, monitor them for three to six months, and then close the actions after completion; however, they focused solely on the areas identified and did not inspect all the related systems or processes, as noted above. The safety manager added that safety office staff tracked annual VISN report findings weekly and followed up with staff in individual departments.

Recommendation 7

The Director takes appropriate actions so staff evaluate processes to prevent repeat environment of care findings and take actions as warranted.

__X__Concur

_____Nonconcur

Target date for completion: March 31, 2027

Director Comments

After onboarding in August 2025, the new Chief of Quality and Patient Safety (QPS) recognized that VA New Jersey Healthcare System (VANJHS) had undergone multiple surveys with repeated environment of care findings. The Chief of QPS implemented a survey readiness program which includes completing weekly environment of care tracer evaluations focusing on repeated identified deficiencies. The tracer results will be reported to the VANJHS Quality Leadership Council monthly until 90% compliance for 6 consecutive months is met.

Recommendation 8

The Veterans Integrated Service Network Director monitors for similar or repeat environment of care findings and takes appropriate actions so facility leaders develop and implement facility-wide corrective action plans and sustain improvements.

[53] VISN staff conducted an inspection of the facility's Occupational Safety, Health, and Fire Protection Program Compliance from April 15, 2024, through April 26, 2024. VISN 2, "Annual Facility (Safety, Industrial Hygiene, Environmental and Fire Protection) Evaluation," May 22, 2024.

__X__Concur

_____Nonconcur

Target date for completion: March 31, 2027

Director Comments

The Veterans Integrated Service Network (VISN) Healthcare Operations Committee (HOC) diligently monitors required metrics for Environment of Care (CEOC). These metrics encompass the closure of deficiencies within 14 days, participation of the Executive Leadership Team, member participation, and ensuring less than 7.5% miscellaneous deficiencies. Beginning in September 2, 2026, the VISN HOC incorporated the monitoring of facility trended performance improvement projects, along with associated action plans, into its oversight responsibilities. Monitoring of action plans will be conducted to reach 90% compliance for six consecutive months.

The OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results, the sustainability of changes made by leaders in response to previous oversight recommendations, and improvement projects.

Communication of Urgent but Noncritical Test Results

The facility had a policy for staff to communicate test results but did not develop service-level workflows (which describe staff members' roles in the process), as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[54] The Chief of Staff was aware of the VHA requirement and stated the local policy assigns responsibility for who must communicate all test results to providers, and therefore service-level workflows were unnecessary. The Chief of Staff and the acting associate chief of staff for ambulatory care reported at the time of the inspection in August 2025 that executive leaders planned to develop protocols to allow nurses to communicate certain test results. In the April 2026 follow-up meeting, facility staff reported they had taken no action to date on service-level workflows, so the OIG made a recommendation.

[54] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

Recommendation 9

The Director takes appropriate actions so each service chief develops a workflow that describes staff members' roles in the process of communicating test results to providers and patients as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

__X__ Concur

_____ Nonconcur

Target date for completion: December 31, 2026

Director Comments

The new Chief of Staff has prioritized compliance with Veterans Health Administration Directive 1088(1) for all clinical services resulting in creating service level workflows for communication of test results for each clinical service that provides test results to Veterans. The workflows are being routed for approval by the VA New Jersey Healthcare System (VANJHS) Executive Committee of the Medical Staff and medical center policy, MCP PS-05 Communication of Test Results, is being updated with the workflow attachments.

The chief of diagnostic radiology reported that service staff audit 20 critical test results each month, while the chief of pathology and laboratory medicine said their staff audit all critical test results. Both chiefs submit their data to Quality, Safety, Value staff, who present the findings to the Executive Council of the Medical Service. The acting associate chief of staff for ambulatory care monitors test result communications through electronic health record reviews, as part of the Ongoing Professional Practice Evaluation process.[55]

Also, the external peer review program coordinator uses the program's data to assess test result communications, then meets with leaders to review and discuss the findings. The OIG reviewed the facility's external peer review data for FY 2024 through quarter two of FY 2025 and found staff did not consistently communicate abnormal test results within seven days; however, since year-to-date 2026 data showed improvement, the OIG did not make a recommendation.

[55] Leaders use the Ongoing Professional Practice Evaluation process to monitor a licensed independent healthcare practitioner's clinical performance. "Any findings of failure to meet expected benchmarks for successful clinical performance during the OPPE [Ongoing Professional Practice Evaluation] review may trigger a clinical performance concern resulting in further review and potential privileging actions." VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

Action Plans and Process Improvements

There were no open (unimplemented) recommendations from the prior OIG Comprehensive Healthcare Inspection Program 2022 report.[56] The patient safety manager explained that staff identify trends related to any unsafe conditions and incidents of harm through the Joint Patient Safety Reporting system (a database for employees to document patient safety events) and share them with executive leaders in various committees.[57] The manager added that staff complete root cause analyses and share action items with executive leaders but did not report overdue actions to facility's quality oversight committee. The VHA National Center for Patient Safety's *Guide to Performing Root Cause Analysis* requires action plans to be monitored and tracked to completion and reported to the quality and patient safety committee.[58]

During the inspection week in August 2025, the OIG reviewed documents listing 29 overdue actions from root cause analysis findings. Executive leaders confirmed they were unaware of these overdue actions. The patient safety manager stated the prior chief of Quality, Safety, Value was aware of these past due actions, and the new chief, who had been in the role for 14 days at the time of the interview, also received notification. In the April 2026 follow-up meeting with OIG inspectors, facility staff stated they had developed a new process for reporting overdue actions. However, they were unable to provide documentation, so the OIG made a recommendation to monitor progress on their implementation efforts.

Recommendation 10

The Director takes appropriate actions so staff track root cause analysis–driven improvement actions through to completion, monitor outcome measures, and implement processes to sustain improvements to comply with Veterans Health Administration National Center for Patient Safety's *Guide to Performing Root Cause Analysis*.

__X__Concur

_____Nonconcur

Target date for completion: December 31, 2026

[56] VA OIG, *Comprehensive Healthcare Inspection of the VA New Jersey Health Care System in East Orange*, Report No. 21-00296-145, May 5, 2022.

[57] VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook*, *Version 6.0*, October 2025.

[58] A root cause analysis is a formal, "comprehensive, team-based, systems-level investigation" for reviewing "health care adverse events and close calls." VHA Directive 1050.01(1). VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, last updated February 2026.

Director Comments

At the time of the OIG Healthcare Facility Inspection survey, the Chief of Quality and Patient Safety was made aware of deficiencies in the Root Cause Analysis (RCA) action follow-up process. Since the survey, every RCA action has received follow-up by the Patient Safety team. Subsequently the RCA action owners have completed 61% of the overdue actions. Ongoing monitoring for resolution is tracked through quarterly updates to the VA New Jersey Healthcare System (VANJHS) Quality Leadership Council with expected closure prior to December 31, 2026. A structural change has been made to the RCA report template for RCA teams to provide a sustainment recommendation for each action.

The OIG team interviewed risk managers and executive leaders and reviewed documents and processes related to the institutional disclosure process. An institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care."[59] Risk managers explained they became aware of adverse events through meetings with patient safety staff or notification from the prior chief of Quality, Safety, Value.[60] They said they discussed these events with patient safety managers and then the Chief of Staff, who determined if an institutional disclosure was warranted.

The inspection team reviewed adverse events reported in the 12 months preceding the August 2025 site visit and found events that may have warranted institutional disclosure. A risk manager confirmed that executive leaders did not conduct any institutional disclosures during the 12 months before the August 2025 inspection, despite adverse events involving one delayed diagnosis, one serious injury, and one death.[61] The risk manager said leaders had varying interpretations of what types of adverse events required institutional disclosures. VHA Directive 1004.08, *Disclosure of Adverse Events to Patients* requires executive leaders to disclose any harmful or potentially harmful adverse event "that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[62] The Chief of Staff and risk managers acknowledged the institutional disclosure process needs improvement.

[59] VHA Directive 1004.08, *Disclosing Adverse Events to Patients*, October 31, 2018.

[60] Adverse events are incidents, injuries, "or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers." VHA Directive 1004.08.

[61] The OIG review period for institutional disclosures was July 2024 through July 2025.

[62] VHA Directive 1004.08.

Recommendation 11

The Chief of Staff takes appropriate action for evaluation and improvement of processes to identify adverse events that warrant institutional disclosures to patients or their representatives as required by Veterans Health Administration Directive 1004.08, *Disclosure of Adverse Events to Patients*.

__X__Concur

_____Nonconcur

Target date for completion: December 31, 2026

Director Comments

The Chief of Staff and the Chief of Quality and Patient Safety implemented a weekly meeting to review adverse events identified for possible disclosure. Consistent engagement in these meetings has resulted in five (5) Institutional disclosures to date in FY26. Meetings will continue to take place weekly to determine any disclosure opportunities are identified and documented.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[63] The OIG evaluated facilities' primary care and community care staffing, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

The facility delivers primary care services through 49 teams across its 11 sites. During the inspection week in August 2025, the OIG team reviewed documents that showed the facility had approval to hire four providers, six registered nurses, six licensed practical nurses, and nine medical support assistants. Facility documents indicated that only 29 of the primary care teams were fully staffed at that time. Primary care employees covered vacancies, which at times meant they supported their own team and the team with the vacant position, often leading to overtime.

[63] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care.

The OIG team found that 27 of the 49 primary care panels (number of patients assigned to a care team) exceeded 100 percent capacity; the overall average exceeded 104 percent.[64] To reduce panel sizes, the Chief of Staff reported transitioning patients to new geriatric primary care teams in the year prior to the August 2025 site visit, and the acting associate chief of staff for ambulatory care said during the inspection that the facility planned on using a VISN Clinical Resource Hub—a program that supports access to care through contingency staffing for facilities with gaps in coverage.[65]

The inspectors also found that average appointment wait times for the facility were just over 21 days for new patients and under 4 days for established patients during the second quarter of FY 2025. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the wait time is greater than 20 days.[66] To reduce new patient wait times, the acting associate chief of staff for ambulatory care stated that when patients agree, primary care employees schedule an initial 30-minute video appointment to gather pertinent health information and order diagnostic tests. They then schedule a follow-up 30-minute face-to-face appointment with the provider. The acting chief stated this approach has decreased wait times for new patients.

Community Care Staffing and Access to Care

During the inspection week in August 2025, documents provided to the OIG team identified community care staffing vacancies for one provider, three nurses, one social worker, and two medical support assistants. Community care employees reported that inadequate staffing was the most significant issue affecting workflow and their workload, and it delayed them in scheduling specialty care appointments.

From April 2024 through March 2025, community care employees took an average of 12 days to schedule an appointment, although the requirement in VHA's *Consult Timeliness Standard Operating Procedure* is 7 days.[67] A medical support assistant said wait times also depend on other factors, such as the type of care requested; specialties such as endocrinology and dermatology usually have longer wait times because fewer community providers are available.[68] The OIG did not make a recommendation because, at the time of the inspection, executive leaders were already restructuring community care by combining administrative and clinical staff

[64] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. On April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

[65] "Clinical Resource Hubs (CRH)," VA, accessed September 8, 2025, https://www.patientcare.va.gov/CRH.

[66] 38 C.F.R. § 17.4040 (2024).

[67] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 2025.

[68] *Merriam-Webster*, "Endocrine," accessed May 15, 2026, https://www.merriam-webster.com/endocrine; *Merriam-Webster*, "Dermatology," accessed May 15, 2026, https://www.merriam-webster.com/dermatology.

under a single leader, which they believed would improve overall efficiency and assist with reducing wait times.

The OIG reviewed Health Care for Homeless Veterans (HCHV), Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH), and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The inspection team analyzed enrollment and performance data and interviewed facility program staff.

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[69]

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of homeless veterans who received an HCHV program intake assessment.[70] However, this fiscal year (FY 2026), VHA no longer uses intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[71] Finally, HCHV2 measured the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program

[69] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[70] VHA's goal is for facility program staff to perform intake assessments for all identified veterans by the end of each fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures,* October 1, 2023; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures,* November 2024.

[71] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens, a veteran can typically stay between 4 and 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[72]

Performance and Improvement Highlights

- The facility missed the FY 2025 target for discharging veterans to permanent housing (HCHV1) by less than two percent but met the target in FY 2026 through the third quarter.[73] The facility's program met all performance targets for reducing negative exits (HCHV2) in FY 2025, and through quarter three of FY 2026.
- The chief of homeless services reported that program staff provided guidance to contract staff to help identify veterans' needs, such as employment. This collaborative approach helps veterans receive support and maintain permanent housing and reduces the likelihood of negative exits from the program.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[74] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[75]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[76]

Performance and Improvement Highlights

- The facility's program met the voucher use (HMLS3) target in FY 2025, however, missed the FY 2026 target through quarter three. The homeless services program

[72] VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

[73] FY 2026 quarter three data reflect cumulative results for quarters one through three, covering October 1, 2025, through June 30, 2026.

[74] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[75] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[76] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

manager reported that staff identified an increase in veteran evictions due to nonpayment of rent, so they helped find housing for the affected veterans and offered financial management training to help them maintain that placement. To assist aging veterans, staff collaborated with medical foster homes (where a trained caregiver provides needed support).[77]

- The manager also shared that despite New Jersey having one of the highest unemployment rates in the country, the program has consistently met the employment (VASH3) target from FY 2025 through quarter three of FY 2026. The manager attributed this success to the homeless programs' employment services, which help veterans obtain and maintain jobs.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[78] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[79]

Performance and Improvement Highlights

- The facility's program met the enrollment (VJP1) target in FY 2025 but missed the target by less than three percent in quarter three of FY 2026.
- A veterans justice outreach specialist confirmed that although New Jersey does not have veterans treatment courts, the state initiated a Veterans Diversion Program in 2017 to help veterans with mental illness navigate the legal system.[80]

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[77] "Geriatrics and Extended Care, Medical Foster Homes," VA, last updated May 29, 2025, https://www.va.gov/MedicalFosterHomes.

[78] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[79] VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

[80] "A veterans treatment court is a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024. "Statewide Veterans Diversion Program," State of New Jersey Department of Law & Public Safety, accessed September 3, 2025, https://www.njoag.gov/programs/statewide-veterans-diversion-program.

Conclusion

To assist leaders in evaluating the quality of care at the VA New Jersey Healthcare System, the OIG conducted an inspection across five domains. The OIG made 11 recommendations related to safety and cleanliness, temperature and humidity monitoring, airflow testing, fire safety inspections, fire doors, sprinkler tests, repeat environment of care findings, service-level workflows for test result communications, root cause analysis–driven improvement actions, and adverse events that risk or cause patient harm warranting institutional disclosures. The OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Healthcare Facility Inspection program of VHA medical facilities across the nation, OIG leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility from August 25 through 28, 2025. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

The team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[81] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*[82]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[83] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[84] The OIG reviews available evidence within a

[81] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

[82] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

[83] Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants "give inaccurate answers for a variety of reasons." Dirk M. Elston, "Participation Bias, Self-Selection Bias, and Response Bias," *Journal of American Academy of Dermatology* (2021): 1-2, https://doi.org/10.1016/j.jaad.2021.06.025.

[84] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

Appendix B: Additional Facility Photos

Figure B.1. *Example of a faded sign.*
Source: Photo taken by OIG inspector at the time of the site visit in August 2025.

Figure B.2. *Difficult to read exit sign.*
Source: Photo taken by OIG inspector at the time of the site visit in August 2025.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 8, 2026

From: Network Director, VISN 1

Subj: Healthcare Facility Inspection of the VA New Jersey Healthcare System in East Orange

To: Director, Office of Healthcare Inspections (54HF03)

Chief Integrity and Compliance Officer (10OIC)

Thank you for the opportunity to review the VA OIG Draft Report - Healthcare Facility Inspection of the VA New Jersey Healthcare System in East Orange, NJ. I have reviewed the document and concur with the recommendations noted.

The leadership teams at the VA New Jersey Healthcare System and the Veterans Integrated Network Office are committed to implementing Corrective actions and will diligently pursue all measures to ensure safe, high-quality care for the Veterans we serve.

(Original signed by:)

Ryan Lilly, MPA
Network Director, VISN 1

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 6, 2026

From: Director, VA New Jersey Healthcare System in East Orange (561)

Subj: Healthcare Facility Inspection of the VA New Jersey Healthcare System in East Orange

To: Network Director, VISN 1

Executive Director, HSA 1.2

Thank you for the opportunity to review the draft report of the VA OIG Draft Report - Healthcare Facility Inspection of the VA New Jersey Healthcare System (VANJHS) in East Orange. I have reviewed the document and concur with the recommendations noted.

As the new Medical Center Director starting January 2026, I recognize that the VA New Jersey Health Care System has undergone significant senior leadership changes throughout last year. These changes are helping us build on our foundation to strengthen oversight and enhance accountability while positioning VANJHS for success with these established corrective action plans as detailed in the report. If additional information or assistance is needed, please do not hesitate to contact our Chief of Quality Management.

(Original signed by:)

Steven Lieberman, MD
Medical Center Director
VA New Jersey Healthcare System

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