US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Salisbury VA Health Care System in North Carolina

Healthcare Facility Inspection	26-00030-213	September 4, 2026

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To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

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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 Salisbury VA Health Care System (the facility) from December 9 through 11, 2025. Additional information was received and analyzed in May and August 2026. The facility is rated as *highest complexity* and in fiscal year 2025, provided direct care to 124,518 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 team found dirty operating room suites, supply storage areas, and primary care clinics. Although facility leaders corrected some issues immediately and implemented a plan for ongoing monitoring, the observations across multiple areas indicate a pattern. Additionally, inspectors found issues with the facility's process to replace privacy curtains, which created an infection risk for patients and staff. The OIG made two recommendations for further action.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG made no recommendations.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[3] The OIG made no recommendations.

[1] VHA classifies facilities based on their complexity level. A highest-complexity facility has "high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs," VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack – Operational Statistics Table FY2026 Through February," VHA Support Service Center, last updated April 2, 2026, https://reports.vssc.med.va.gov. (This web page is not publicly accessible).

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

[3] 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.

- **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 been recently incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Director takes appropriate actions to maintain a clean environment to reduce the risk of infection, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program.*
2. The Director takes appropriate actions so staff change privacy curtains to reduce the risk of infection and supervisors monitor compliance, in accordance with the facility's *Infection Prevention and Control Manual*.

VA Comments and OIG Response

The Health Service Area Director and facility Director concurred with the recommendations and provided acceptable action plans (see the responses in the report body and appendixes B and C). The OIG will follow up on the planned actions until they are completed.

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Abbreviations

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 (OIG), 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.[4] 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.[5]

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.[6]

Patient Safety: VHA programs identify and reduce system vulnerabilities and risks of harm to veterans.[7]

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.[8]

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[4] "About Us," VA, last updated June 2, 2026, https://department.va.gov/vha/about-us.

[5] 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.

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

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

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

The Salisbury VA Health Care System (the facility) serves veterans in central North Carolina and includes the W.G. (Bill) Hefner Salisbury VA Medical Center and several community-based outpatient clinics. The facility has 238 total operating beds and about 3,862 employees. In fiscal year (FY) 2025, its budget was over $1.5 billion.[9]

Figure 1. *Facility photo.*
Source: "VA Salisbury Health Care," VA, accessed February 10, 2026, https://www.va.gov/salisbury-health-care.

The OIG team inspected the facility from December 9 through 11, 2025. Additional information was received and analyzed in May and August of 2026. The executive leaders referred to throughout this report include the acting Executive Director (Director), acting Chief of Staff, acting Associate Director, Associate Director for Patient Care Services (Nurse Executive), acting Assistant Director for Salisbury, Assistant Director/Administrator for the Kernersville Health Care Center, and acting Assistant Director/Administrator for the Charlotte Health Care Center and Community-Based Outpatient Clinic.[10] The Associate Director for Patient Care Services (Nurse Executive) had the longest tenure, with over nine years of service.

CULTURE

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.[11] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and

[9] "Trip Pack – Operational Statistics Table FY2026 Through February," VHA Support Service Center, last updated April 2, 2026, https://reports.vssc.med.va.gov. (This web page is not publicly accessible).

[10] A health care center is a VA facility that operates at least five days per week and provides primary care, mental health care, specialty care, and outpatient surgical procedures. A community-based outpatient clinic is located separately and can provide outpatient primary care, specialty care, and mental health services.
VHA Directive 1229(1), *Planning and Operating Outpatient Sites of Care*, July 7, 2017, amended October 4, 2019.

[11] 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.

assess their level of trust in VA).[12] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[13]

System Shocks

Executive leaders identified the return to in-person work mandate and VHA's reduction of the facility's authorized positions as system shocks.[14] Because of the in-person work requirement, executive leaders reported that approximately 700 employees, some from other VHA offices and Veterans Integrated Service Networks (VISNs), needed office space at the facility.[15]

In response, executive leaders said that strategic planners and the engineering chief assessed space to determine which positions needed private offices versus cubicle workstations. Additionally, employees who reported to the office received a mini orientation to gain information about the facility, and engineering employees ensured workspaces, keys, and computers were ready. Leaders also reported some employees left for fully remote private-sector positions.

Further, executive leaders said that in November 2025, VHA reduced the facility's number of authorized positions by 230. To comply, executive leaders collaborated with other facility leaders to determine which positions could be eliminated with the least effect on core services and cut 230 positions that were vacant at that time.

According to executive leaders, the main consequence of eliminating these positions was delayed growth in services to accommodate increasing demand. As additional positions become vacant over time, they plan to reexamine service needs and shift resources to high-demand areas. For example, they intend to add nursing positions to open more community living center (VA nursing home) beds without exceeding the staffing cap.

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

[13] 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/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

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

[15] Veterans Integrated Service Networks (VISNs) are "regional care systems working together to better meet local healthcare needs and provide greater access to care." "Veterans Integrated Service Networks," VA, last updated July 24, 2026, 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.

Employee Experiences

Executive leaders reported using several methods to communicate with employees, such as virtual meetings with the Director, visiting work areas, tiered huddles (short meetings between leaders and employees to share problems they are concerned with and identify solutions), and an executive order information hub on the facility's intranet to share up-to-date guidance on telework, staffing, and related policies.[16]

Leaders also identified employee stress and burnout as significant issues and attributed them to the federal hiring freeze (in effect from January 20, 2025, to October 15, 2025), deferred resignation program losses, and fears about job security.[17] The Director noted these pressures affected both employees and leaders. To improve employees' experiences, executive leaders explained they recognize employees for process improvement projects and give awards for exceptional nursing care. They also acknowledge employees' work during morning operational meetings.

Veteran Experiences

The OIG team noted that community care billing, lack of care coordination, and issues involving requests for provider changes were among the most frequent concerns patient advocates received from October through July 2025.[18] To address the billing problems, executive leaders reported they implemented year-long authorizations for community providers to care for veterans, which minimized back-and-forth communication between VHA and community providers and reduced the risk of bills for unapproved services. To improve care coordination, they added a referral coordination initiative team (a dedicated team created to empower veterans to choose where, when, and how they receive care) to contact veterans within a few days of a community care

[16] "Patient Safety Huddle Board," VHA National Center for Patient Safety, last updated April 3, 2018, https://www.patientsafety.va.gov/Patient_Safety_Huddle_Board.

[17] Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025. VHA placed full-time employees who accepted the deferred resignation program into paid administrative leave until September 30, 2025, "unless the employee has elected another earlier resignation date." Acting Director, Office of Personnel Management, "Guidance Regarding Deferred Resignation Program," memorandum to Heads and Acting Heads of Departments and Agencies, January 28, 2025.

[18] 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.

referral to educate them on the process, care options available at the facility, and associated appointment wait times.

According to executive leaders, most provider change requests happened after providers declined to prescribe opioids to veterans and they requested a second opinion. To handle these requests, the Chief of Staff explained that service chiefs communicated with veterans to clarify concerns and approved reassignments when appropriate.

Inspectors found the facility's VSignals outpatient trust score for the third quarter of FY 2025 was 95 percent, which was above the VHA average.[19] Executive leaders shared the following examples of employees' dedication to veterans' care: a technician worked three extra hours to finish a test socket (a prosthetic model) needed for an appointment the next day; employees from several buildings quickly responded to the emergency department to perform a critical tracheostomy (surgical opening in the neck to allow breathing); and the Director resolved a complaint after learning about it from talking to a veteran's spouse in the community.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[20] 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.[21]

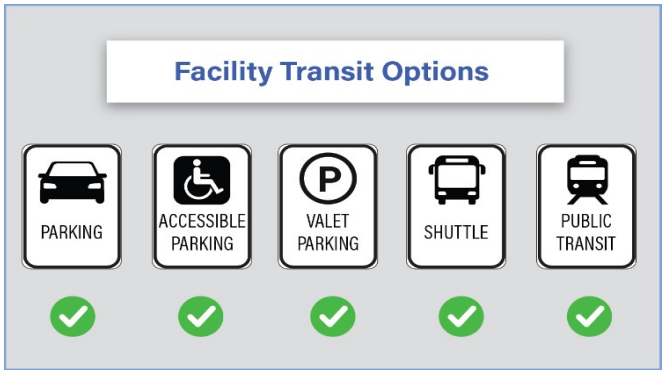

Figure 2. *Transit options for arriving at the facility. Source: Exterior facility maps and OIG observations.*

[19] Veteran trust in VA represents the percentage of respondents that strongly agree or agree to the statement "I trust VA to fulfill our country's commitment to Veterans.'" "Veterans Experience-Veteran Trust in VA," VA, last updated March 27, 2026, https://department.va.gov/veterans-experience/veteran-trust-in-va.

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

[21] 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

The OIG team inspected several patient parking lots and noted they had emergency callboxes and ample parking, including accessible parking. As figure 2 indicates, there were also alternative transportation options. The team found the facility easy to navigate, with large-print maps placed along sidewalks outside the buildings.

Figure 3. *Accessibility tools available to veterans with impairments.*
Source: Chief of quality and patient safety, engineering program analyst, volunteers, VA, and OIG observations.

The main entrance was easy to identify, clean, and well-lit, with power-assisted doors, readily available wheelchairs, and ample seating. An information desk was staffed by volunteers who escorted those with disabilities such as visual impairments to their destinations.

However, the OIG team found problems in multiple operating room suites and several supply storage areas. Equipment surfaces were dusty, and operation room floors had accumulated dust and grime. Supply storage carts in hallways also had dust on internal surfaces. Facility leaders addressed the operating room findings during the site visit in December 2025 and provided evidence of corrective actions, including pictures of cleaned floors and equipment and an improvement plan for ongoing monitoring.

Additionally, inspectors found significant cleanliness issues in the primary care clinics, community living center, intensive care unit, and emergency department. The team identified

- dirty floors and surfaces, including dust and debris on windowsills and in medication cabinets;
- soiled surfaces and gaskets in patient nutrition areas and medication refrigerators; and
- items stored on the floor in closets, which can contaminate these items and make it harder to maintain a clean environment.

VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires staff to maintain a clean and safe environment.[22] Staff corrected many of these issues during the week of

[22] VHA Directive 1608(1).

the inspection in December 2025, but the OIG remains concerned that these findings were in multiple clinical areas, which could indicate a pattern. Facility leaders attributed the problems to insufficient numbers of housekeeping staff and poor performance by the contractor previously responsible for cleaning.

Recommendation 1

The Director takes appropriate actions to maintain a clean environment to reduce the risk of infection, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

_X_ Concur

____ Nonconcur

Target date for completion: February 28, 2027

Director Comments

Consistent with Veterans Health Administration (VHA) Directive 1608(1), Comprehensive Environment of Care (CEOC) rounds are conducted weekly by the Assistant Director, CEOC Rounds Coordinator, and the multidisciplinary CEOC Rounds Team. To further engage staff in recognizing and reporting concerns with environmental cleanliness, on December 19, 2025, all employees were informed of housekeeping expectations and escalation channels, including use of the Light Electronic Action Framework (LEAF) portal. The Assistant Director began receiving LEAF notifications on December 12, 2025, ensuring leadership visibility.

Environmental Management Services (EMS) and unit leadership updated cleaning schedules and standards to align with Infection Prevention and Control (IPC), VHA, and applicable professional practice standards. All EMS staff, and non-EMS staff with assigned cleaning responsibilities in the Operating Room, completed training. To strengthen and sustain training compliance, EMS hired a full-time Training Instructor, ensuring consistent capacity for training delivery and standardized content.

Daily Quality Assurance inspections are completed by EMS supervisors, with senior EMS leadership conducting inspections routinely. Deficiencies identified during these inspections are corrected immediately through direct staff engagement.

Additionally, the EMS staffing vacancy rate has improved, and the facility replaced its prior janitorial services contract, both of which were cited as contributing factors to the identified deficiencies.

Beginning August 2026, targeted audits will be conducted to verify clean floors, surfaces, and windowsills; clean refrigerators, including gaskets; and proper storage of supplies off the floor. Compliance will be measured as the number of areas with no deficiencies (numerator) against

the total number of areas audited (denominator), with a goal of achieving and maintaining at least 90 percent adherence over six consecutive months, with results reported monthly to the Environment of Care Committee.

These layered oversight and audit processes are designed to identify and correct deficiencies promptly and to sustain compliance over time.

Additionally, the OIG team noted issues with patient privacy curtains. The acting chief of the environmental management service was unable to provide evidence to indicate when staff last replaced the curtains and was unsure when they had last been changed. If privacy curtains are not changed frequently, bacteria may accumulate and increase the risk of infection for patients and staff who use those spaces. The accreditation manager provided the OIG with the facility's *Infection Prevention and Control Manual*, which states staff must change privacy curtains twice per year, but does not explain how staff should track the curtain changes.[23] The acting chief acknowledged not monitoring curtain changes.

Recommendation 2

The Director takes appropriate actions so staff change privacy curtains to reduce the risk of infection and supervisors monitor compliance, in accordance with the facility's *Infection Prevention and Control Manual*.

_X_ Concur

____ Nonconcur

Target date for completion: October 31, 2026

Director Comments

Environmental Management Service (EMS) finalized Standard Operating Procedure (SOP) 659-137-EMS 20, Privacy Curtain Inspection and Replacement, increasing replacement frequency from twice yearly to quarterly—or sooner if soiled, damaged, or used in isolation rooms—and established documentation requirements through a Curtain Replacement Log. The Infection Prevention and Control (IPC) Manual has been revised to align with SOP 659-137-EMS 20. All staff requiring training on the revised process have completed it, and this training is now part of new employee orientation.

Curtain Replacement Logs are in place facility-wide and monitored by EMS Supervisors. Audits are completed quarterly, with compliance measured as the number of curtains changed

[23] W.G. (Bill) Hefner Department of Veterans Affairs Medical Center, *Infection Prevention and Control Manual*, June 6, 2021.

per schedule (numerator) over the total number of curtains scheduled for change (denominator), and a goal of 90 percent sustained for two consecutive quarters, reported to the Infection Prevention and Control Committee (IPCC). The first formal compliance report, reflecting curtain changes for April–June 2026, was presented at the July 2026 IPCC meeting and reflected 100 percent compliance.

These processes are designed to ensure curtain replacements are tracked, verified, and sustained over time.

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

After reviewing documents and interviewing staff, the OIG determined the facility had a policy and procedures for communicating test results to providers and patients that met the requirements of VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[24] The directive also requires the Chief of Staff and Associate Director for Patient Care Services to monitor performance data for communication of test results and ensure providers communicate all test results that require action to patients within seven calendar days after they become available. The facility's policy outlines staff practices for communicating urgent but not immediately life-threatening test results to providers. The process improvement coordinator also presented the facility's standard operating procedure showing the workflow policy for communicating test results to patients.

According to the acting Chief of Staff, the monitoring process includes providers reviewing each other's records every month for communicating urgent but noncritical test results to patients. These reviews are included in providers' performance evaluations. Additionally, the acting chief of quality and patient safety explained that each service is required to review medical records quarterly, track providers' communication of test results, and report findings through the Medical Records Committee. The OIG team found that facility leaders also monitor providers' test result communication through the External Peer Review Program.[25] Program scores from the first three

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

[25] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and take corrective action when needed. VHA Directive 1088(1).

quarters of FY 2025 showed that staff communicated actionable test results to patients within the required time frame 93–100 percent of the time.

However, the chief of ambulatory care and the chief of pathology and laboratory described delays in communicating test results to clinical providers because providers were often with patients and unavailable when laboratory staff attempted to notify them. To address this challenge, the chief of pathology and laboratory created instant messaging groups organized by clinical specialty, which enable laboratory staff to send results directly to the provider who ordered the test, who then acknowledges receipt.

Action Plans and Process Improvements

The chief of health informatics and the patient safety manager shared an example of a systems-based initiative to improve efficiency in scheduling appointments for magnetic resonance imaging (MRI). Previously, staff noticed that providers did not consistently identify patients with implanted devices (which make the procedure inadvisable because it could be harmful) before appointments, causing cancellations and wasted appointment slots. In response, the chief of health informatics and the chief of medicine created an alert in the electronic health record system to identify patients with implants before a provider orders the imaging procedure. The patient safety manager said three other VISN facilities adopted the alert, and multiple other VHA facilities have since requested information on the process.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[26] The OIG evaluated facilities' primary care and community care staff vacancies, 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 OIG team found that 54 of the facility's 91 primary care teams did not have enough support staff per provider according to VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, which recommends at least 3 full-time support staff per 1 full-time provider. Teams typically include a registered nurse, a licensed practical nurse, and a medical support assistant.[27] The associate chief of staff for primary care reported that as of December 2025, there were

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

[27] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

62.5 primary care vacancies; applicants had been selected for 19.5 positions, and recruitment was underway for 7 additional clinical staff.[28] On August 19, 2026, the OIG received an update from the deputy chief of quality and patient safety showing that leaders filled 47.5 positions and had an additional 12 applicants selected, leaving 3 vacancies for clinical staff in recruitment.

The acting Chief of Staff described provider recruitment and retention strategies. For example, a physician recruiter attended medical conferences to discuss the benefits of working for VHA, and experienced providers mentor resident physicians during their training. However, the chief nurse of ambulatory care identified a challenge with limited licensed practical nurse applicants, explaining that individuals often chose to complete a registered nurse degree instead. In response, the Associate Director for Patient Care Services (Nurse Executive) was considering hiring other occupations to fill these positions.

The OIG team also found that 22 of the 91 primary care teams exceeded the panel size (number of patients assigned to a care team) recommended in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, and 4 operated at over 110 percent of capacity. VHA's baseline primary care team capacity is 1,200 patients for physicians and 900 for nonphysician providers.[29] Primary care leaders explained that they accommodate patient growth by assigning new patients to small panels and increasing the number of teams as space allows.

The patient aligned care team (PACT) coordinator reported 1,270 new patients at the facility in the first two months of FY 2026 due to veterans moving into the area. The acting Chief of Staff said in December 2025 that the Charlottesville clinic was actively recruiting two new primary care teams. Additional primary care space at the medical center in Salisbury was also under construction and expected to provide room for additional teams when completed. In August 2026, the accreditation program manager reported that the construction in Salisbury was completed on July 13, 2026, and provided additional space for current staff; however, the manager did not include plans to add primary care teams at this time.

OIG inspectors reviewed primary care data indicating that new patients waited an average of 24 days for an appointment, and established patients waited 4 days. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the wait time is longer than 20 days.[30] To increase in-house access, the acting Chief of Staff explained the facility has a clinic for new patients with same-day appointments. Primary care staff reported that the facility previously offered a same-day access clinic for established patients. However, according to primary care staff, leaders closed the clinic in October 2025 because they reassigned its providers to vacant primary care panels waiting to be filled. The staff

[28] The facility's primary care vacancies included one part-time position.

[29] VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

[30] 38 C.F.R. § 17.4040 (2025).

said this change decreased access to primary care, and as a result, established patients sometimes received care at urgent care or emergency departments.

Community Care Staffing and Access to Care

On October 21, 2025, prior to the inspection, the acting chief of community care provided the OIG with the results generated by a community care staffing tool for the fourth quarter of FY 2025, which showed a deficit of 4 administrative positions (advanced medical support assistants) and 25 clinical staff. At the time of the OIG inspection in December 2025, the community care department was recruiting to fill 3 administrative vacancies.

On May 29, 2026, the chief of community care (who was permanently selected for the position in April 2026) provided an update to the October 21, 2025, staffing vacancies. The chief noted that the VISN requested information on community care staffing needs in January 2026 but did not approve any specific hiring actions. On August 19, 2026, the chief of community care provided the OIG with a community care staffing update showing 11 vacancies were in recruitment. The chief of community care believed that after filling these vacant positions, staffing should be sufficient to meet current workload.

The OIG found that the community care department received an average of 12,900 referrals per month in FY 2025. At the time of the inspection in December 2025, the acting chief of community care reported contracting for 2 medical support assistants from the VISN and actively working on any approved hiring for staffing vacancies to aid with the workload. Because of the large number of referrals and additional staff needed, the acting chief said staff prioritized scheduling appointments over contacting community providers to confirm appointment attendance and requesting medical documents to close referrals.

To close a referral, VHA's *Community Care Field Guidebook* requires staff to confirm the patient attended the appointment and make three requests for the community provider's medical documents within 90 days of the appointment.[31] The OIG identified an upward trend in referrals that remained open for more than 90 days, increasing from 1,629 on August 7, 2025, to 3,793 on January 29, 2026. If staff do not confirm appointment attendance and request medical documents, it may delay care and reduce the information facility providers have available when making ongoing treatment decisions. The inspection team reviewed data showing staff closed 86.4 percent of referrals in FY 2025 in less than 90 days, which was much higher than the VHA average of 66 percent, so the OIG did not make a recommendation.[32]

[31] VHA Office of Integrated Veteran Care, chap. 4 in *Community Care Field Guidebook*, updated November 14, 2025.

[32] "Consult-Activity Measures," VHA Support Service Center, updated May 28, 2026, https://app.powerbigov.us/groups/me/apps/reports/ReportSection. (This web page is not publicly accessible.)

Community care leaders reported they used 40 percent of their FY 2026 overtime budget during the first quarter to accommodate the workload. The acting chief of community care planned to meet workload demands by continuing to use contract personnel from the VISN, training additional facility staff to work in community care, and offering overtime on a limited basis.

The OIG team reviewed community care trends for FY 2025 and found most referrals met drive-time eligibility criteria and were for surgery, imaging, and dental services.[33] Additionally, most patients referred to the community based on wait-time eligibility were for dental, imaging and radiology, and rehabilitation care.[34]

For wait-time-eligible referrals, the OIG found that community care staff took an average of 23 days to schedule dental appointments, 15 days for imaging and radiology, and 22 days for rehabilitation services. However, VHA's *Consult Timeliness Standard Operating Procedure* requires community care staff to schedule appointments for veterans within 7 days of the referral's entry into the patient's electronic health record.[35] Additional community care staff could improve workload management and help decrease the time it takes to schedule community care appointments.

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 OIG 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

[33] Veterans are eligible for community care when their drive time to a VA facility is 30 minutes for "primary care, mental health, and non-institutional extended care services" or 60 minutes for specialty care. VHA Office of Community Care, "Veteran Community Care General Information" (fact sheet), September 9, 2019.

[34] A patient meets community care wait time eligibility when appointment wait time at a specific VA medical facility is 20 days for primary, mental health care, and non-institutional extended care services; and "28 days for specialty care from the date of request, unless the Veteran agrees to a later date." VHA Office of Community Care, "Veteran Community Care General Information" (fact sheet).

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

life goals. Staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[36]

VHA uses performance measures to determine the success of each medical facility's program. HCHV1 measures 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).[37] HCHV2 measures 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 rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[38]

Performance and Improvement Highlights

- The facility exceeded the target for discharge to permanent housing (HCHV1) for FY 2025, which the HCHV assistant director attributed to staff's ability to identify housing solutions and place referrals quickly, as well as their strong relationships with the facility's HUD-VASH program.
- However, the facility missed the negative exit (HCHV2) target for FY 2025. The HCHV assistant director discussed factors that increased these types of discharges, including untreated mental health and substance use disorders among residents. Also, at sites without many veterans, even a few negative exits significantly affect the percentages. The assistant director said staff developed improvement plans for underperforming sites. These included increased engagement with veterans to address barriers to maintaining housing.
- Facility HCHV staff said it was difficult to locate veterans for potential participation due to city and county encampment sweeps (forced removals of campsites used by people who are homeless). Therefore, they conducted street outreach with community partners, completed on-the-spot assessments and

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

[37] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024. 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 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

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

referrals, visited the remaining encampments, and participated in the annual January point-in-time count.[39]

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."[40] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[41]

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).[42]

Performance and Improvement Highlights

- The facility met the voucher use (HMLS3) target in FY 2025. Program supervisors said that voucher amounts increased, so landlords were more willing to accept them. Additionally, newly hired housing specialists could focus on finding housing and strengthening landlord relationships.
- Additionally, the facility exceeded the employment (VASH3) target in FY 2025, which the supervisors attributed to quarterly audits to ensure the employment status for enrolled veterans is accurate in the homeless program database. A supervisor explained this is important because retired veterans and those with disabilities who are unable to work are exempt from the metric.
- The supervisors said some veterans needed help with transportation; money management; and access to medical, substance use, and mental health services. To meet these needs, peer support specialists assist with transportation to medical appointments and encourage social engagement. Case managers help with money

[39] Community outreach engages homeless veterans in community settings, such as shelters and events, while street outreach engages veterans in nontraditional settings such as on the street or encampments. VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022. VHA uses HUD's point-in-time count to estimate the homeless population nationwide. Local HUD offices administer the annual point-in-time count, which includes those living in shelters and transitional housing. "VA Homeless Programs, Point-in-Time (PIT) Count," VA, last updated March 12, 2026, https://www.va.gov/homeless/pit_count.

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

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

[42] 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 2025 Homeless Performance Measures.*

management and refer veterans to VA and community resources, including those for mental health and substance use. Additionally, a program nurse coordinates medical care, and an occupational therapist conducts home assessments for veterans who require additional safety precautions.

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.[43] 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).[44]

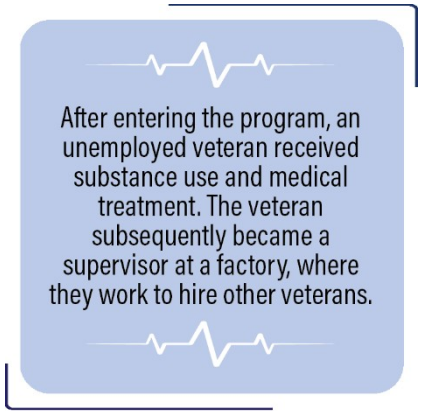

Figure 4. *Veteran success story. Source: OIG interview with a program coordinator.*

Performance and Improvement Highlights

- The facility met the enrollment (VJP1) target for FY 2025. Facility program coordinators stated that referrals increased with the addition of two treatment courts in the service area.[45] The coordinators collaborated with the treatment courts by providing outreach services to locate eligible veterans and regularly attending veterans' court sessions.
- Facility program coordinators reported challenges educating incarcerated individuals in jails and prisons about the Veterans Justice Program. In response, they focused on building relationships with leaders, mental health staff, and case managers at jails and prisons to ensure they linked veterans who need program services.

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

[44] 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 2025 Homeless Performance Measures.*

[45] "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.

Conclusion

To assist leaders in evaluating the quality of care at the Salisbury facility, the OIG conducted an inspection across five domains. The OIG made two recommendations related to cleanliness and maintenance of privacy curtains. 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.[46] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. The OIG physically inspected various areas of the medical facility from December 9 through 11, 2025. In May and August 2026, the OIG contacted the facility for staffing updates and current hiring actions. 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 inspection 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.[47] 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.*[48]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[49] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked

[46] The accreditation reports covered the time frame of October 1, 2023, through September 30, 2024—the most recent available at the time of the inspection.

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

[48] 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.

[49] 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.

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.[50] The OIG reviews available evidence within a 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.

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

Appendix B: Health Service Area Director Comments

Department of Veterans Affairs Memorandum

Date: August 26, 2026

From: Health Service Area 2.1 Director, (10N2)

Subj: Healthcare Facility Inspection of the Salisbury VA Health Care System in North Carolina

To: Director, Office of Healthcare Inspections (54HF04)

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the Salisbury VA Health Care System in North Carolina.
2. I have reviewed and concur with the recommendations provided by the VA Office of Inspector General (OIG), as well as the action plans submitted by the Salisbury VA Health Care System.
3. In our ongoing commitment to ensuring Veteran exceptional care, HSA 2.1 leadership will ensure that all corrective actions outlined in the responses are fully implemented and sustained.

(Original signed by:)

Judy Brannen, MD, MBA
Interim Regional Medical Officer, HSA 2.1
For
Alyshia Smith, DNP

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 24, 2026

From: Acting Executive Director, W.G. (Bill) Hefner VA Medical Center (659/00)

Subj: Healthcare Facility Inspection: Salisbury VA Health Care System (659)

To: Health Service Area 2.1 Director, VHA

1. Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the Salisbury VA Health Care System (Salisbury, North Carolina).
2. I have reviewed and concur with the recommendations provided by the VA Office of Inspector General (OIG), as well as the action plans submitted by the Salisbury VA Health Care System.
3. I will ensure that all corrective actions are completed and sustained as outlined in the responses.

   (Original signed by:)

   Charles D. Collins, MHA, MHRM, ACHE, USAF Retired
   Acting Executive Director
   Salisbury VA Health Care System

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.