



US DEPARTMENT OF VETERANS AFFAIRS **OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Finger Lakes Healthcare System in Bath, New York

Healthcare Facility
Inspection

26-00059-221

October 2, 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 Finger Lakes Healthcare System (the facility) from May 5 through 7, 2026. The facility is rated as *low complexity* and in fiscal year 2025, provided direct care to 33,076 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 identified several safety and compliance issues, including some repeat findings. These findings included crosswalks that did not have detectable warning surfaces, rainwater pooled on the floor, missing biohazard signs, blocked or confusing exit routes, inconsistent temperature and humidity monitoring in medication rooms, inaccessible sinks in soiled utility rooms, dusty sprinkler heads, and doors that did not latch.³ Additionally, the team observed expired supplies that were stored outside standard supply rooms, contrary to guidance in VHA Directive 1761, *Supply Chain Management Operations*.⁴ Staff corrected many issues during the inspection or had improvement projects underway. The OIG made three recommendations focused on slipping hazards, expired supplies, and repeat findings.
- **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.

¹ VHA classifies facilities based on their complexity level. Low-complexity facilities have “low volume, low risk patients, few or no complex clinical programs, and small or no 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 September,” VHA Support Service Center, last updated April 14, 2026, <https://reports.vssc.med.va.gov>. (This website is not publicly accessible.)

² See appendix A for a description of the OIG’s inspection methodology.

³ VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

⁴ VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.⁵ 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.

What the OIG Recommended

1. The Director performs a comprehensive safety risk assessment of enclosed walkways and implements necessary corrective actions to mitigate slip hazards, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.
2. The Director takes appropriate actions for staff to regularly identify and remove expired supplies in all areas outside standard supply rooms to comply with Veterans Health Administration Directive 1761, *Supply Chain Management Operations*.
3. The Veterans Integrated Service Network Director monitors the facility's processes to prevent repeat environment of care findings and takes any needed actions to meet the requirements of Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

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 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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⁵ 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.

Abbreviations

ADPCS	Associate Director for 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

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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.⁶ 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.⁷



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.⁸



Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.⁹



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.¹⁰

⁶ "About Us," VA, last updated June 2, 2026, <https://department.va.gov/vha/about-us>.

⁷ 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>.

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

⁹ VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

¹⁰ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.



Figure 1. Canandaigua VA Medical Center (left); Bath VA Medical Center (right).

Source: “VA FingerLakes Health Care,” VA, accessed May 19, 2026, <https://www.va.gov/finger-lakes-health-care>.

The VA Finger Lakes Healthcare System (the facility) serves a 12-county area in upstate New York and northern Pennsylvania. The facility includes the Canandaigua VA Medical Center (Canandaigua), the Bath VA Medical Center (Bath), and outpatient clinics.¹¹ Both medical centers and the outpatient clinics operate under a unified leadership structure with a single Medical Center Director overseeing the entire facility.

Canandaigua houses one of the National VA Suicide/Crisis Hotline Call Centers, and Bath includes a national cemetery that is the final resting place for service members dating back to the War of 1812. The financial manager reported that the facility’s budget for fiscal year (FY) 2026 is approximately \$507 million. Canandaigua has 62 community living center beds, while Bath has 80 community living center and 170 domiciliary beds.¹²

The OIG team inspected the facility from May 5 through 7, 2026. The executive leaders referred to throughout this report include the Acting Medical Center Director (Acting Director); Acting Associate Director; Acting Chief of Staff (who is the permanent Deputy Chief of Staff), and Associate Director for Patient Care Services (ADPCS).

¹¹ Two clinics are in Rochester and one each in Elmira and Wellsville, New York, and one is in Wellsboro, Pennsylvania. “VA FingerLakes Health Care, Locations,” VA, accessed April 12, 2026, <https://www.va.gov/finger-lakes-health-care/locations>.

¹² 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/Geriatrics/VA_CLC. A domiciliary is “an active clinical rehabilitation and treatment program” for veterans. “Domiciliary Care for Homeless Veterans,” VA, last updated June 23, 2026, <https://department.va.gov/homeless/dchv>.



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.¹³ 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 assess their level of trust in VA).¹⁴ The team also interviewed executive and facility leaders and employees and considered data from patient advocates.¹⁵

System Shocks

Executive leaders identified the 2025 return to in-person work requirement as a system shock.¹⁶ Executive leaders said this resulted in office and parking space shortages. The ADPCS added that executive leaders also needed to ensure there were workspaces for employees of the Veterans Integrated Service Network (VISN) call center, which operates at Canandaigua.¹⁷ The ADPCS further explained that some employees had adjusted to telework during the COVID-19 pandemic, and in-person work required them to share office space, which was challenging and uncomfortable.

To support employees during the transition, the ADPCS stated that executive leaders ensured they received reorientation briefings, including site-specific instructions such as telephone system operations and fire safety procedures. The ADPCS also said systems redesign employees developed a process improvement project to address parking issues at Bath. The Acting Director said executive leaders focused on employees’ well-being, ensured they had necessary resources

¹³ 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>.

¹⁴ “Veteran Trust in VA,” VA, last updated June 4, 2026, <https://www.va.gov/initiatives/veteran-trust-in-va>.

¹⁵ 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.

¹⁶ Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

¹⁷ VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). “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>.

and equipment, and promptly addressed concerns with office space privacy. The Acting Director added that VISN leaders shared return-to-office updates with executive leaders, who then passed the information to employees through meetings and emails.

Employee Experiences

Since VA has not administered the All Employee Survey since FY 2024, an OIG inspector asked executive leaders how they assessed employee engagement and satisfaction in its absence.¹⁸ Executive leaders said they conducted an internal employee survey in late 2025 and planned a second survey in May 2026 to collect additional information. The ADPCS said executive leaders met to review the initial survey results; its responses indicated that employees were comfortable speaking up and reporting patient safety issues. The Acting Director said the executive leaders intend to conduct employee surveys on a cyclical basis until the VA All Employee Survey resumes. The ADPCS added that executive leaders will review the results of the second survey and develop an action plan to present to employees for feedback.

As shown in figure 2, while only a quarter of the OIG questionnaire respondents believed the facility's culture was improving, nearly half still felt comfortable recommending actions to strengthen the work environment.¹⁹ Executive leaders said the Office of Personnel Management's (the federal government's human resource and personnel agency) national review of job descriptions, which resulted in downgraded positions, and national changes and reductions to the federal workforce, were contributing factors to respondents' general dissatisfaction.

¹⁸ The All Employee Survey is an annual, voluntary, anonymous survey of VA workforce experiences. "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development. 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.

¹⁹ The facility had approximately 1,550 employees when the OIG administered the questionnaire, and the response rate was approximately 18 percent.

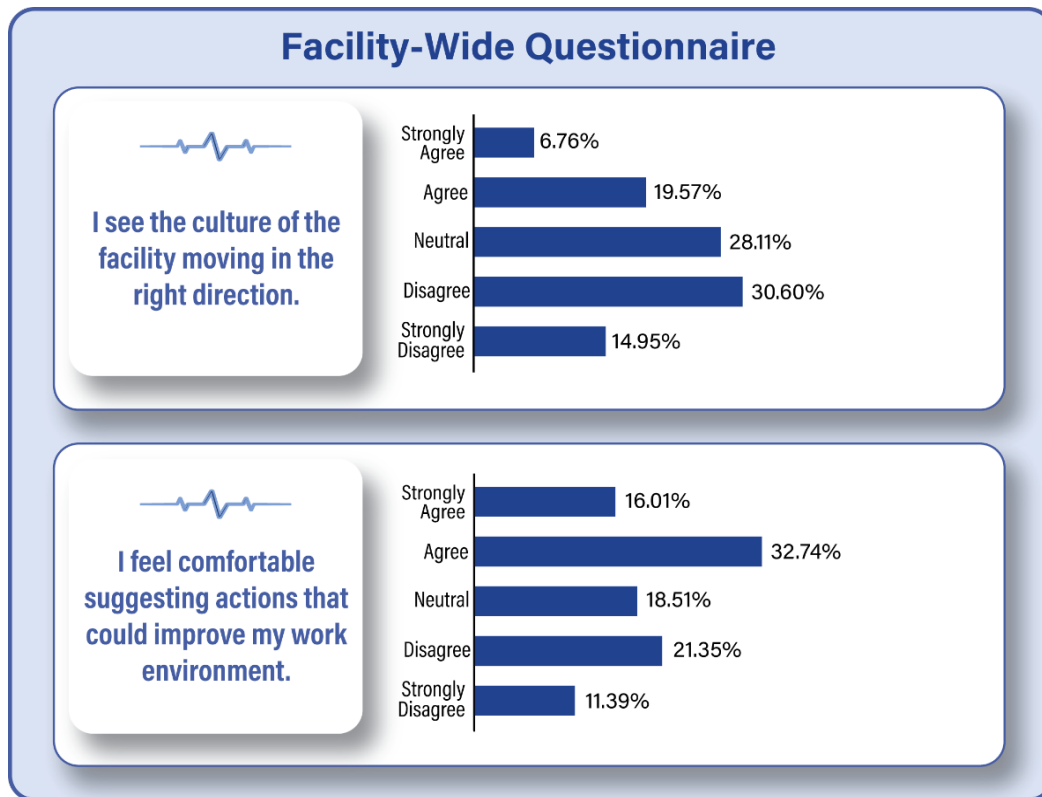


Figure 2. Employee perceptions of facility culture.
Source: OIG analysis of selected questionnaire responses.

Veteran Experiences

Executive leaders stated that they engage with veterans through visits to the medical centers and clinics, quarterly town halls, and outreach to local veterans’ organizations. They also said patient advocates, frontline employees, and daily patient safety reports alert them to veterans’ concerns.

Through an OIG questionnaire, patient advocates reported that veterans’ most common concern is a request to change providers. In response, the Acting Chief of Staff said an executive or service leader contacts each veteran to understand the problem and find a resolution. The acting chief shared that veterans often request a change because they are assigned to a temporary contract provider and added that executive leaders actively work to recruit permanent providers.

During the inspection week in May 2026, the OIG team observed two events for veterans at Canandaigua: Café Connection, which offered veterans an opportunity to socialize through various activities, and a health event for women veterans that included a mobile mammogram unit.

Additionally, the OIG team noted the facility’s VSignals scores exceeded VHA averages from FY 2025 through the second quarter of FY 2026, as shown in figure 3. The ADPCS attributed this to veterans’ satisfaction with the quality of care provided by facility employees.

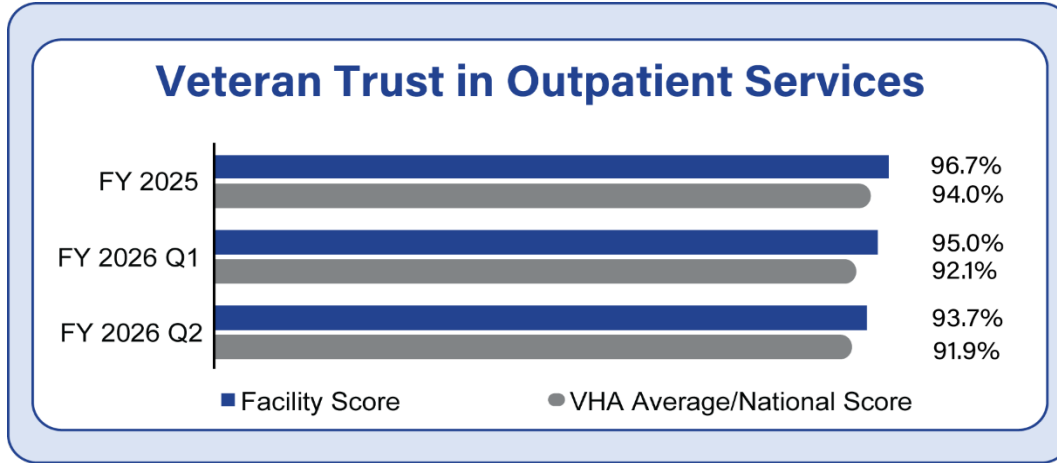


Figure 3. Veteran trust in outpatient services.

Source: VSignals data.



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

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

At the Bath site, the OIG team observed that some crosswalks did not have detectable warning surfaces. The *VA Site PG 18-10, Design Manual* requires these surfaces to alert visually impaired pedestrians before they enter a roadway.²² Because the chief engineer described a plan to install detectable warning surfaces as part of an active construction project, the OIG did not make a recommendation.

The OIG team found generally clean main entrances at both medical centers, with multiple features that aided veterans with impairments (see figure 5). The team also found the inspected clinical and nonclinical areas were clean overall, and employees kept supply and medication rooms secure.

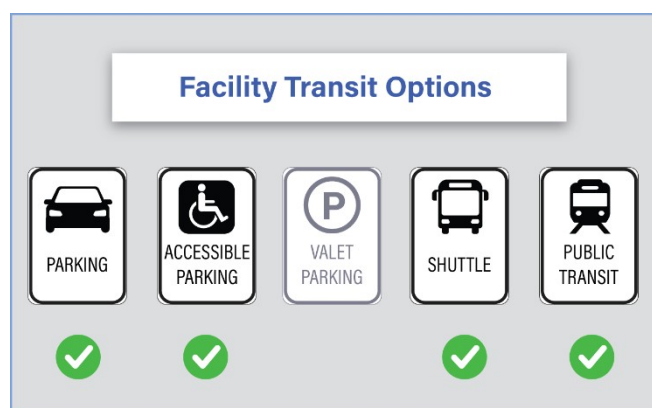


Figure 4. Transit options for arriving at the facility.

Source: OIG review of facility parking lot maps, shuttle schedule, leader response to document request, and a questionnaire response.

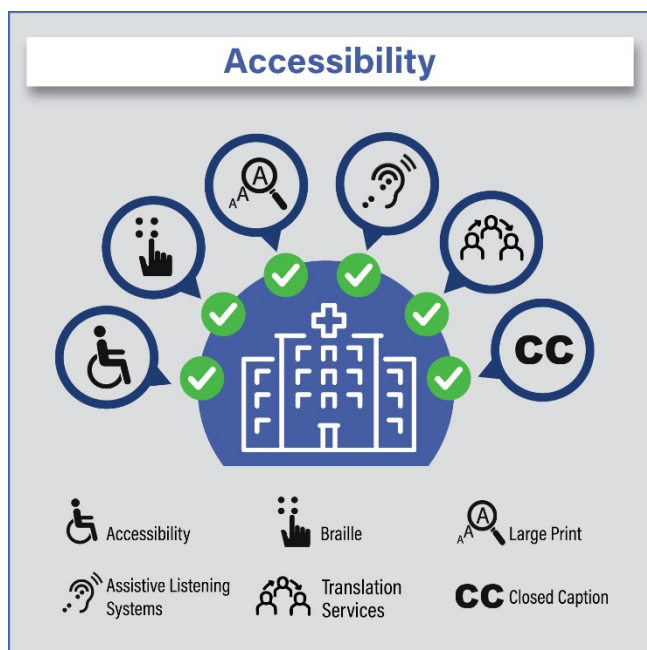


Figure 5. Accessibility tools available to veterans with impairments.

Source: OIG observations, discussion with volunteers, and a questionnaire response.

However, the OIG team found safety concerns at both medical centers. At Canandaigua, several buildings are connected by enclosed walkways (tunnels), and when it rains, water enters these areas through gaps in doorways and cracks in the walls, then pools on the floor. The team observed multiple wet areas but noted that only a single safety cone was available to mark the hazards. VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires facilities to have a “safe, clean health care environment that provides the highest standards in the health care setting” to keep patients, staff, and visitors safe.²³ Pools of water on the floors create a slip-and-fall risk.

During an interview, facility leaders acknowledged the issue, noting that because

²² VA, *VA Site PG 18-10, Design Manual*, February 1, 2013, revised March 1, 2024.

²³ VHA Directive 1608(1).

of the age of the structures, a major construction project would be the solution. To more effectively mitigate the current situation, the fire chief described using a beanbag-type absorber to soak up the water. The chief of environmental management services added that cleanup was delayed because only two staff members were available that morning, and both were assigned to the community living center. This left insufficient staff available to promptly address the water in the walkway. The chief also reported ordering additional caution signs to help mark the area.

Recommendation 1

The Director performs a comprehensive safety risk assessment of enclosed walkways and implements necessary corrective actions to mitigate slip hazards, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

☒ Concur

☐ Nonconcur

Target date for completion: December 30, 2026

Director Comments

The Medical Center Director will assign the Chief of Engineering to complete a comprehensive safety risk assessment of enclosed walkways based on VHA Directive 1608(1) by December 31, 2026.

The risk assessment, findings, and action plan will be reported to the Accreditation Committee that reports to the Quality and Patient Safety Committee (QPS). Action plans of any findings will be monitored for 90% compliance for six consecutive months.

At both medical centers, the OIG team found that some biohazard rooms 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).²⁴ Further, at Bath, the team could not open an emergency exit door near the urgent care center. The door had a sign that read, “Emergency Exit—Push,” but it did not open when an inspector applied force. The Code of Federal Regulations (title 29, section 1926.34) requires exit routes to remain unobstructed.²⁵ The team also observed an exit sign at Canandaigua that pointed toward a door marked “Exit Closed.” Blocked or incorrect exit routes can delay evacuation during an emergency and put patients, visitors, and staff at risk. Facility staff placed biohazard signs, repaired the door at Bath, and corrected the exit sign at

²⁴ 29 C.F.R. § 1910.145 (2025).

²⁵ 29 C.F.R. § 1926.34 (2025).

Canandaigua during the May 2026 inspection, so the OIG did not make recommendations to address these issues.

At Bath, the inspectors also found problems with medication rooms, utility rooms, and supplies. The OIG team noted that staff did not monitor temperature and humidity daily in medication rooms where supplies are stored, which is required by VHA Directive 1761, *Supply Chain Management Operations*.²⁶ Because of this observation, leaders took immediate actions: they requested a digital temperature meter for medication rooms from logistics and taught all staff how to monitor temperature and humidity, which they began doing. Additionally, the chief engineer said staff are installing a commercial temperature monitoring system that is already in use at Canandaigua, and the project is scheduled to be completed in October 2026. Therefore, the OIG did not make a recommendation.

Inspectors further noted that some soiled utility rooms were crowded with equipment, which blocked access to the sink. This creates sanitation risks because employees cannot easily wash their hands. An associate chief nurse explained that staff removed the equipment, so the OIG did not make a recommendation.

The OIG team also found expired supplies in medication rooms outside standard supply rooms. VHA Directive 1761 requires staff to monitor supplies regularly for expired items. Storing and using expired supplies can reduce treatment effectiveness and increase the risk of patient harm. The associate chief nurses said they believed the situation happened because supervisors did not verify that staff had checked the expiration dates.

Recommendation 2

The Director takes appropriate actions for staff to regularly identify and remove expired supplies in all areas outside standard supply rooms to comply with Veterans Health Administration Directive 1761, *Supply Chain Management Operations*.

☒ Concur

☐ Nonconcur

Target date for completion: March 30, 2027

Director Comments

The Medical Center Director reviewed the recommendation and will direct the Associate Director for Patient Care Services (ADPCS) to audit all areas outside standard supply rooms

²⁶ VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

for compliance with VHA Directive 1761. A standard focused audit tool will be created to review the areas for expired supplies.

Audit results will be reported to the Accreditation Committee which reports to the QPS committee and will be monitored for 90% compliance for six consecutive months.

Additionally, the OIG team found repeat findings throughout the Bath site, which included dusty sprinkler heads and doors that did not latch. A dusty sprinkler head was cited previously in the 2024 Joint Commission report, and a similar door-latching issue appeared in the 2025 Annual Safety, Industrial Hygiene, Environmental, and Fire Protection Evaluation conducted by VISN leaders.²⁷ VHA Directive 1608(1) requires facilities to follow regulatory and accrediting bodies' standards and keep the healthcare environment safe and clean. Facility leaders reported that staff cleaned the sprinkler heads and fixed the door latch while the OIG team was on-site in May 2026, yet the OIG remains concerned because the repeat findings show that staff did not consistently maintain corrective actions.

Recommendation 3

The Veterans Integrated Service Network Director monitors the facility's processes to prevent repeat environment of care findings and takes any needed actions to meet the requirements of Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

☒ Concur

☐ Nonconcur

Target date for completion: March 31, 2027

Director Comments

The VISN Healthcare Operations Committee (HOC) diligently monitors required metrics for Environment of Care (CEOC). These metrics encompass the closure of deficiencies within 14 days, action plan development for those deficiency closures requiring greater than 14 days, participation of the Executive Leadership Team, member participation, and ensuring less than 7.5% miscellaneous deficiencies. Beginning 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 by the VISN HOC to reach 90% compliance for six consecutive months.

²⁷ The Joint Commission, *Final Accreditation Report VA Finger Lakes Healthcare System*, March 4, 2024; VISN 2, "Annual Facility (Safety, Industrial Hygiene, Environmental and Fire Protection) Evaluation," August 12, 2025.



PATIENT SAFETY

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 service-level workflows (written documents that describe the role of various team members in the communication process) for all applicable services and a policy that outlined how staff communicate test results, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.²⁸ The directive also mandates that staff communicate test results that require action to patients within seven days of the results becoming available.²⁹ If providers do not communicate results in a timely manner, it could lead to delayed action, worsening disease progression, and patient harm.

The OIG team reviewed the facility's external peer review data, which tracks compliance with the seven-day notification requirement, and found an approximate 37 percent improvement from the first to the second quarter of FY 2026.³⁰ The systems redesign coordinator credited this improvement to an ongoing project focused on the test result communication process, which includes staff sending result letters to patients and increased medical record auditing to evaluate progress. The chief of quality management confirmed that staff share this data with executive leaders.

Action Plans and Process Improvements

When the OIG team inspected the facility in May 2026, all prior recommendations from the last OIG Comprehensive Healthcare Inspection Program report had been closed.³¹ A patient safety manager described using the Joint Patient Safety Reporting System (a database staff use to report patient safety events) to identify patient safety trends.³² The manager also stated that some safety events require a root cause analysis (a process used to identify factors that led to a patient safety

²⁸ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

²⁹ VHA Directive 1088(1).

³⁰ VHA established the External Peer Review Program's communicating test results measure as a way for facility leaders to review compliance and take corrective action when needed. VHA Directive 1088(1).

³¹ VA OIG, [Comprehensive Healthcare Inspection of the VA Finger Lakes Healthcare System in Bath, New York](#), Report No. 23-00121-158, April 30, 2024.

³² VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting System] Guidebook, Version 9.0*, March 18, 2026.

event).³³ The ADPCS described meeting with patient safety managers weekly to review action plans in response to root cause analyses and monitor their progress. The patient safety manager added that staff report outstanding and overdue action items, as well as patient safety trends, each month to the Quality Patient Safety Board, which the Medical Center Director chairs.

A patient safety manager told the OIG team that the National Center for Patient Safety awarded the Patient Safety Program of Excellence designation to the facility on April 30, 2026.³⁴ This award recognizes facilities with patient safety programs that show accountability, exceed program expectations, and empower staff with leaders' support.



INTEGRATED VETERAN CARE

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.³⁵ 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 facility delivers primary care services through 25 teams across its locations. Primary care leaders confirmed vacancies for providers, nurses, and medical support assistants. Leaders added that two nurses and one provider serve as float staff (who are not assigned to a specific team) to cover absences.

Primary care staff identified provider vacancies as the biggest challenge for primary care. When asked about challenges with recruiting and retention, staff explained that providers cited overall workload and an onboarding process that was too short to prepare them for the demands of the position as a reason for leaving. The Acting Chief of Staff explained that because of these concerns, executive leaders changed the onboarding process about six months before the OIG's May 2026 inspection. For example, an information technology employee now trains new providers on electronic alerts during onboarding and helps them set preferences to reduce the alert burden. Additionally, the acting chief health informatics officer said facility leaders reduced the number of mandatory electronic alerts and allowed providers to customize their view of non-

³³ VHA National Center for Patient Safety, *Guideto Performing Root Cause Analysis, Version 25*, February 2026.

³⁴ "VHA National Center for Patient Safety," VA, last updated September 29, 2025, <https://www.patientsafety.va.gov>.

³⁵ "Community Care," VA, accessed June 29, 2026, <https://department.va.gov/vha/community-care>; 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.

critical additional alerts as desired. The acting chief stated this resulted in a more than 50 percent reduction in alerts since fall 2025.

The OIG team found that the facility's primary care panels (the number of patients assigned to a care team) averaged 104 percent of VHA's expected capacity. VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, states that primary care panel capacity is based on variables such as staffing, number of rooms, and provider types.³⁶ The Acting Chief of Staff provided an example of how they managed a provider vacancy at a rural outpatient clinic: leaders divided the panel with the vacancy into two separate teams and staffed them with nonphysician providers, who were easier to recruit.

Despite the over-capacity panels, facility data from April 2026 showed new patient wait times averaged about 12 days and established patient wait times just under 3 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.³⁷

Community Care Staffing and Access to Care

During the May 2026 inspection, community care leaders stated that one registered nurse and one lead medical support assistant position were in the recruitment process. Leaders said they most often refer patients to community care for magnetic resonance imaging (MRI) procedures and urology and orthopedics surgery because the facility does not offer these services.

The OIG team found the average time staff took to schedule a community care appointment ranged from just over 15 days to about 17 days between October 2025 and March 2026; this was less than the VHA average of almost 26 days in March 2026. However, the requirement in VHA's *Consult Timeliness Standard Operating Procedure* is for staff to schedule a community care appointment in 7 days.³⁸ Community care leaders identified the following barriers to staff scheduling appointments timely:

- Difficulty reaching veterans by phone
- Incomplete information entered in referrals by facility providers
- Limited availability of community providers

Community care leaders stated executive leaders knew about the delays, and in response, they allowed staff to work overtime, temporarily assigned administrative staff to assist with referrals,

³⁶ VHA Directive 1406(3) *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

³⁷ 38 C.F.R. § 17.4040 (2025).

³⁸ VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 2025.

and moved referral coordination staff under the community care program to improve efficiency. The OIG did not make a recommendation because of the leaders' ongoing actions.



VETERAN-CENTERED SAFETY NET

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.³⁹

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).⁴⁰ 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)."⁴¹

Performance and Improvement Highlights

- The facility met the permanent housing (HCHV1) target for FY 2025 and sustained this performance through the second quarter of FY 2026. The homeless program

³⁹ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴⁰ 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 and 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

⁴¹ VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

manager attributed this success to close collaboration between homeless program staff and contracted emergency shelter staff.

- The facility also met the negative exit (HCHV2) target for FY 2025 but missed it through the second quarter of FY 2026. The homeless program manager explained that many veterans in contracted emergency shelter programs experience mental health conditions, substance use disorders, or age-related limitations that reduce their ability to stay engaged and focused on permanent housing goals. To review negative exits and identify opportunities to improve collaboration and engagement, the manager said program staff meet weekly with on-site contracted shelter staff.
- The manager said they engage veterans through referrals from facility staff and the National Call Center for Homeless Veterans hotline (a VA hotline that offers free, confidential, around-the-clock support); outreach; and community partners.⁴²
- Additionally, the manager stated that the facility’s service area includes isolated rural communities and small towns, which presents a challenge when engaging veterans. To provide outreach and resources to veterans in these areas, the manager said they partner with community organizations.

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.”⁴³ The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.⁴⁴

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).⁴⁵

⁴² “National Call Center for Homeless Veterans,” VA, last updated June 23, 2026, <https://department.va.gov/nationalcallcenter>.

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

⁴⁴ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴⁵ 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*.

Performance and Improvement Highlights

- The facility met the voucher use (HMLS3) target for FY 2025 but missed it by less than 2 percent through the second quarter of FY 2026. The homeless program manager attributed this to low housing inventory and limited landlord engagement. To address these challenges, program staff reported hosting a breakfast to inform potential landlords about HUD-VASH case management support and incentives for renting to veterans and their families.
- The manager stated that program staff manage 326 housing vouchers across three local public housing agencies. The manager added that the facility also operates Cadence Square Apartments, an on-site, project-based housing program (which attaches rental assistance to certain units or buildings) that provides independent supportive housing for veterans and their families.⁴⁶
- The facility met the employment (VASH3) target for FY 2025 but missed it in the second quarter of FY 2026. The homeless program manager blamed the shortfall on data entry errors; in response, staff received instructions to update data regularly to accurately reflect veterans' employment status.

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.⁴⁷ 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).⁴⁸

Performance and Improvement Highlights

- The facility met the enrollment (VJP1) target for FY 2025 and sustained the performance through the second quarter of FY 2026. Program staff attributed this success to educating facility staff on program eligibility and referrals. Additionally,

⁴⁶ “Cadence Square - 40 Units,” Christa Construction, accessed May 12, 2026, <https://christa.com/cadence-square>; “What is Project-Based Section 8? A Guide for Property Investors and Managers,” National Center for Housing Management, last updated April 28, 2026, <https://www.nchm.org/what-is-project-based-section-8>.

⁴⁷ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴⁸ 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*.

program staff conduct weekly domiciliary meetings with veterans needing legal assistance to engage new participants.

- Program staff said they engage veterans through referrals from facility, jail, and prison staff, community partners, and local law enforcement agencies. They also partner with three veterans treatment courts to coordinate veteran services such as medical, mental health, and substance use treatment.⁴⁹

Conclusion

To assist leaders in evaluating the quality of care at the VA Finger Lakes Healthcare System, the OIG conducted an inspection across five domains. The OIG made three recommendations related to slipping hazards, expired supplies, and repeat environment of care findings. 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.

⁴⁹ "Veterans treatment court is a long-term, judicially supervised, multi-phase program through which criminal offenders are provided with treatment and other services." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

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.⁵⁰ 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. Finally, the OIG physically inspected various areas of the medical facility from May 5 through 7, 2026. During site visits, the OIG 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.⁵¹ 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*.⁵²

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.⁵³ 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.

⁵⁰ The accreditation reports covered the time frame of February 26, 2024, through July 11, 2025—the most recent available at the time of the inspection.

⁵¹ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

⁵² 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.

⁵³ 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>.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.⁵⁴ 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.

⁵⁴ 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: September 11, 2026

From: Director, VA North Atlantic Health Network (10N1)

Director, Health Service Area 1.1

Subj: Healthcare Facility Inspection of the VA Finger Lakes Healthcare System in Bath, New York

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

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the VA OIG Draft Report - Healthcare Facility Inspection of the VA Finger Lakes Healthcare System in Bath, New York. I have reviewed the document and concur with the recommendations noted.
2. The leadership teams at the VA Finger Lakes 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:)

Brett D. Rusch, MD

Director, Health Service Area 1.1

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 10, 2026

From: Director, VA Finger Lakes Healthcare System (528A6)

Subj: Healthcare Facility Inspection of the VA Finger Lakes Healthcare System in Bath, New York

To: Director, VA North Atlantic Health Network (10N1)

Director, Health Service Area 1.1

1. Thank you for the opportunity to review the VA OIG Draft Report - Healthcare Facility Inspection of the VA Finger Lakes Healthcare System in Bath, New York. I have reviewed the document and concur with the recommendations noted.
2. I am submitting the facility plan to correct these findings and will monitor for compliance. I appreciate OIG's review and look forward to our partnership for continued compliance and improvements.

(Original signed by:)

Michelle R. Goetz, MBA/HCM, FACHE
Interim Medical Center Director

OIG Contact and Staff Acknowledgments

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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.