



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

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Central Arkansas Veterans Healthcare System in Little Rock

**Healthcare Facility
Inspection**

25-00203-180

September 30, 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 Central Arkansas Veterans Healthcare System (the facility) from July 15 through 17, 2025. In April 2026, the OIG team conducted a follow-up meeting with facility staff. The facility's main locations include the Eugene J. Towbin Healthcare Center (the healthcare center) and the John L. McClellan Memorial Veterans' Hospital (the hospital). It is rated as *highest complexity* and in fiscal year 2025, provided direct care to about 93,000 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 entrances and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG team found that staff had not monitored temperature and humidity in some supply and medication rooms in both the hospital and the healthcare center, as required by VHA Directive 1761, *Supply Chain Management Operations*; this finding was similar to the facility's 2024 Joint Commission accreditation survey report.³ The team also raised concerns about liquid nitrogen storage practices that did not comply with the National Fire Protection Association's *Compressed Gases and Cryogenic Fluids Code NFPA 55* and *Health Care Facilities Code NFPA 99*, and an obstructed exit from a patient care room, which did not align with the Code of Federal Regulations title 29, section 1926.34.⁴ The OIG made recommendations to address these issues.

¹ VHA classifies facilities based on their complexity level. Highest-complexity facilities have "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 FY2025 Through June," VHA Support Service Center, last updated March 16, 2026, <https://reports.vssc.med.va.gov/Report>. (This web page is not publicly accessible.)

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

³ VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020; The Joint Commission, *Final Accreditation Report, Central Arkansas Veterans Healthcare System*, March 11, 2024.

⁴ National Fire Protection Association, *Compressed Gases and Cryogenic Fluids Code*, NFPA 55, 2023 edition, <https://www.nfpa.org/nfpa-55>; National Fire Protection Association, *Health Care Facilities Code*, NFPA 99, 2024 edition, <https://www.nfpa.org/nfpa-99>; 29 C.F.R. § 1926.34 (2025).

- **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.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 takes appropriate action so staff conduct a risk assessment to identify areas that need temperature and humidity monitoring and implement changes accordingly to comply with Veterans Health Administration Directive 1761, *Supply Chain Management Operations*.
2. The Director takes appropriate action so staff secure liquid nitrogen tanks, maintain unobstructed access to exits, conduct a risk assessment on safe liquid nitrogen storage options to increase safety, and implement changes accordingly to align with the National Fire Protection Association's *Compressed Gases and Cryogenic Fluids Code NFPA 55*, *Health Care Facilities Code NFPA 99*, and Code of Federal Regulations title 29, section 1926.34.
3. The Director takes appropriate action so staff improve processes to prevent repeat environment of care findings as required by Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

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.

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 C and D for the full text of the directors' comments). Based on information provided, the OIG considers recommendations 1 and 2 closed. For the remaining open recommendation, the OIG will follow up on the planned actions until they are completed.

A handwritten signature in black ink, appearing to read "David C. Krulak", with a stylized flourish at the end.

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Abbreviations

ADPCS	Associate Director for Patient Care Services/Nurse Executive
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*.

The Central Arkansas Veterans Healthcare System (the facility) includes two main locations: the Eugene J. Towbin Healthcare Center (the healthcare center), located in North Little Rock, which originally opened in November 1950, and the John L. McClellan Memorial Veterans' Hospital (the hospital), which is in Little Rock and opened in 1984. The facility also has nine outpatient clinics in central Arkansas.¹¹ The facility's budget was approximately \$823 million in fiscal year (FY) 2025.¹² The healthcare center has the following designated beds: 36 for inpatient mental health, 119 for the community living center, 128 for the domiciliary, and 25 for patients needing a transitional residence (temporary places to live for people who are between housing). The hospital has 153 inpatient beds.



Figure 1. Eugene J. Towbin Healthcare Center (healthcare center) (left); John L. McClellan Memorial Veterans' Hospital (hospital) (right).

Source: "VA Central Arkansas Health Care," VA, accessed June 23, 2025, <https://www.va.gov/central-arkansas-health-care>.

The OIG team inspected the facility from July 15 through 17, 2025. In April 2026, the OIG team conducted a follow-up meeting with facility staff. The executive leaders referred to throughout this report include the Director, Acting Associate Director, Associate Director for Patient Care Services/Nurse Executive (ADPCS), and Chief of Staff. During an interview, executive leaders reported having extensive VA experience, and all but the Director had been at the facility for many years. The Director, who had been with VA for 25 years and was promoted to the position in October 2024, served first as the facility's deputy director beginning in March 2022. The ADPCS had been in the role for 10 years; the Acting Associate Director worked at the facility in various jobs over a 36-year career; and the Chief of Staff, who had served 11 months as the newest member of the executive team, had worked there for close to 14 years.

¹¹ The outpatient clinics are in Conway, El Dorado, Hot Springs, Little Rock, Mena, Mountain Home, Pine Bluff, Russellville, and Searcy.

¹² "MCAS 2025—Medical Center Allocation System Reports and Documentation," VA, accessed April 9, 2026, https://vawww.arc.med.va.gov/reports/FY25_MCAS. (This web page is not publicly accessible.)



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 reported that executive orders and presidential memorandums beginning in January 2025 disrupted facility operations. One leader added that the hiring freeze (in effect from January 20, 2025, to October 15, 2025) resulted in executive leadership gaps.¹⁶ At the time of the OIG inspection in July 2025, the deputy and associate director positions were vacant, so the Director appointed the Acting Associate Director and reorganized services under the remaining four executive leaders. Executive leaders communicated changes through all-employee emails and met with service chiefs to discuss their supervisory expectations.

According to executive leaders, the Department of Government Efficiency's *Cost Efficiency Initiative* also affected contracting: it changed contracting processes, created new submission requirements, and caused delays.¹⁷ In response, employees built a tracking system to help them monitor the status of each contract. Retirements and resignations after the deferred resignation program also left fewer employees to manage contracts, resulting in longer turnaround times for

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/HEALTH/patientadvocate>. For more information on the OIG's data collection methods, see appendix A.

¹⁶ 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.

¹⁷ Implementing the President's "Department of Government Efficiency" Cost Efficiency Initiative, 90 Fed. Reg. 11095 (Mar. 3, 2025).

contract processing.¹⁸ The Director said Veterans Integrated Service Network (VISN) 16 leaders helped resolve issues; for example, they assisted the facility in establishing a new contract for pharmaceutical waste disposal.¹⁹

Executive leaders said nearly 300 employees returned to the facility because of the in-person work requirement, which diverted some employees from their regular duties to prepare space and gather supplies for returning staff.²⁰ A leader explained that this order also resulted in some employees leaving. One example of the resulting impact was that due to staffing losses in the facility's office of community care program, the remaining employees worked mandatory overtime.²¹

Employee Experiences

The Director said employees do not hesitate to share concerns, and executive leaders noted they receive feedback through daily meetings, visits to employee work areas, reviews of patient safety reports, monthly town halls, and quarterly safety forums. Executive leaders said employees received recognition through biweekly videos, and the Great 100 Nurses Foundation honored 29 facility nurses in 2025.²² The Chief of Staff said leaders recognized employees who reported errors or close calls (the latter are patient safety events that could have resulted in patient harm but did not). The Director added that employees can also submit questions directly to executive leaders and receive their responses through an internal website.

¹⁸ The Office of Personnel Management offered federal employees the option of resigning from federal service while retaining their pay and benefits through September 2025. "Original Email to Employees," Office of Personnel Management, accessed February 17, 2026, <https://www.opm.gov/about-us/fork/original-email>. The Office of Personnel Management extended the deferred resignation program to many federal employees in January 2025.

¹⁹ 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>.

²⁰ Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025); Office of Management and Budget and Office of Personnel Management, "Agency Return to Office Implementation Plans," memorandum to Heads of Executive Departments and Agencies, January 27, 2025.

²¹ 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.

²² "Great 100 Nurses," Great 100 Nurses Foundation, accessed August 11, 2025, <https://g100nurses.org>.

Veteran Experiences

The ADPCS said leaders visit patient care areas to talk to veterans and address their concerns, and patient advocates visit veterans when they are admitted to inpatient care to introduce themselves. The Chief of Staff said employees hold frequent town halls for veterans and try to reach a broader audience, including members of Congress and veterans service organizations (groups that provide outreach and assistance to veterans and their families).²³ Executive leaders reported that subject matter experts from areas such as emergency medicine and community care share information and answer questions at these events. The Chief of Staff also said employees conduct outreach on topics such as women’s health and rehabilitation for those with visual impairments. The Director added that employees are exploring other outreach methods, such as social media, because of decreased attendance at in-person town halls.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans’ and staff’s safety and experience.²⁴ 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.²⁵

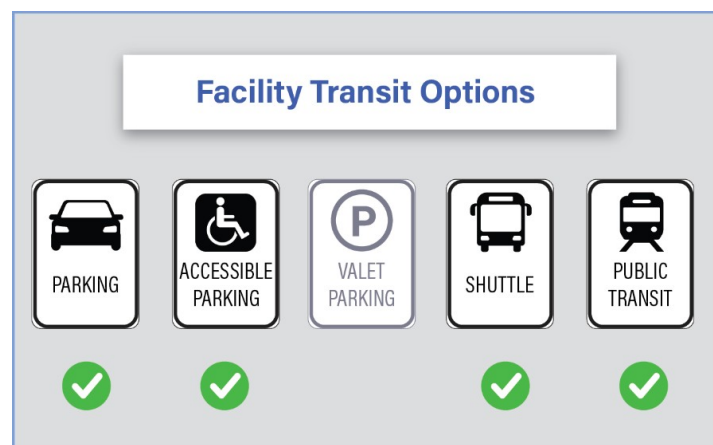


Figure 2. Transit options for arriving at the facility.

Source: OIG analysis of facility parking maps, staff responses to the OIG questionnaire, and observations.

²³ Congressional Research Service, *Veterans Service Organizations (VSOs): Frequently Asked Questions*, updated February 6, 2024.

²⁴ “Informing Healing Spaces through Environmental Design: Thirteen Tips,” VA, last updated May 1, 2024, <https://www.va.gov/WholeHealth/Healing-Spaces>.

²⁵ 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 both the healthcare center and hospital, the OIG team noted exterior signs that directed veterans to parking and some healthcare services. However, while driving around the healthcare center, the team did not see any directional signs to the urgent care center, as required by VHA Directive 1101.13(1), *VHA Urgent Care*, which could delay treatment.²⁶ An interior electronic map also lacked directions to the urgent care center. The Acting Associate Director acknowledged the lack of signs and stated the urgent care center opened in June 2025, a month prior to the inspection. The OIG team followed up in April 2026 and reviewed evidence showing that staff had placed these directional signs. Therefore, the OIG did not make a recommendation.

There were both north and main entrances at the healthcare center and hospital. At the healthcare center's main entrance, the underside of the passenger loading zone overhang was heavily stained and had hanging mineral deposits (see appendix B, figure B.1). The chief of the engineering service said the top of the overhang previously had a water feature, and when it rains, water leaks through and creates the deposits. A dirty overhang in front of the healthcare center could erode veterans' confidence in the quality of care the facility provides.

The four entrance lobbies were generally clean and well-lit, with seating areas and information desks. However, at the hospital, both lobbies were large open spaces that lacked sound-absorbing panels, which could make it difficult for individuals to hear and understand what is being said to

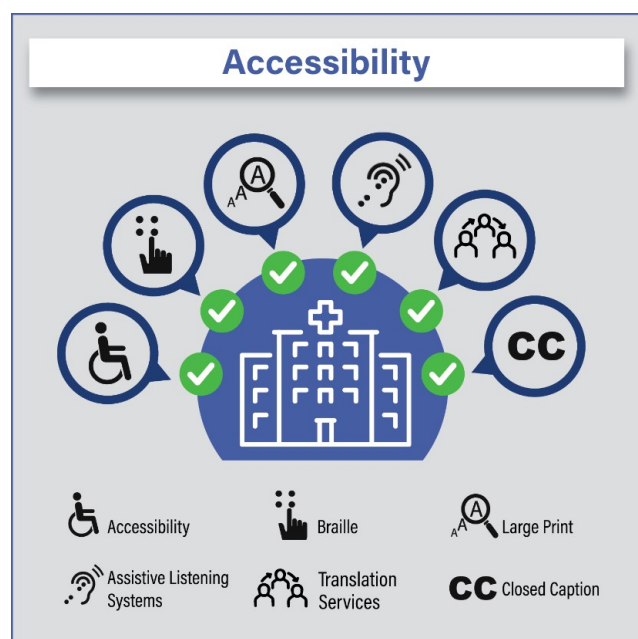


Figure 3. Accessibility tools available to veterans with impairments.

Source: OIG observations and a questionnaire response.

them. The hospital's north lobby contained an area where veterans receive pharmacy counseling, and the noisy surroundings could make it hard for them to follow the information being conveyed, especially for individuals with hearing impairments. The chief of the engineering service explained that leaders considered options to reduce noise in the lobbies, but because the proposals would require relocating fire sprinklers, they did not approve them.

During interviews with information desk staff at both locations, inspectors learned that staff and volunteers work at the hospital's north entrance desk during business hours, while volunteers cover the main entrance desk when available. The OIG team also observed

²⁶ VHA Directive 1101.13(1), *VHA Urgent Care*, March 20, 2023, amended March 7, 2025.

multiple features available to assist individuals with hearing and visual impairments. At both locations, staff and volunteers use on-demand interpreter services, help visually impaired veterans get to their destinations, and communicate in writing with those who have hearing impairments.

However, at the healthcare center, some crosswalks lacked detectable warning surfaces, which VA's *PG 18-10, Site Design Manual* requires to alert visually impaired pedestrians of potential hazards before they transition onto a roadway.²⁷ Because the chief of the engineering service said leaders plan to install detectable warning surfaces as part of an active construction project, the OIG did not make a recommendation.

The interior walls at both locations were generally free of damage, biohazard rooms had labels, and supply rooms were secure. However, the OIG team observed dust on items at multiple locations. These included sprinkler heads and bed frames (beneath the mattresses) at the hospital, a light fixture and a shade that covers a window at the healthcare center, and ventilation grills at both locations (some examples appear in appendix B, figures B.2 through B.4). Additionally, inspectors observed multiple stained ceiling tiles (see appendix B, figure B.5) and soiled floors at both the hospital and the healthcare center.

VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires facilities to ensure a "safe, clean health care environment that provides the highest standards in the health care setting" to help prevent the spread of infection and keep patients, staff, and visitors safe.²⁸ The assistant chief of environment management services said contracting delays and staff vacancies had affected the workload. Because facility staff provided the OIG team with documentation that leaders established a janitorial contract in September 2025, the OIG did not make a recommendation for further action.

Additionally, the OIG team observed inconsistent staff processes to monitor temperature and humidity of supply and medication rooms. Staff used a commercial centralized system to monitor temperature and humidity for medications stored in automated dispensing cabinets (which control access to medications, track inventory, and make medications available to clinical staff in patient care areas); however, they did not consistently monitor the primary care clinic room where staff stored medications outside those cabinets. VHA Directive 1108.07(2), *General Pharmacy Service Requirements* states the chief of pharmacy must ensure medication storage areas stay within the correct temperature and humidity ranges, so medicines remain safe and effective.²⁹

²⁷ VA, *PG 18-10, Site Design Manual*, February 1, 2013, revised March 1, 2024.

²⁸ VHA Directive 1608(1).

²⁹ VHA Directive 1108.07(2), *General Pharmacy Service Requirements*, November 28, 2022, amended December 6, 2024.

Similarly, inspectors found that some supply rooms in the surgical intensive care unit and urgent care center lacked a monitored environment, either through a centralized monitoring system or manual temperature and humidity logs. VHA Directive 1761, *Supply Chain Management Operations* requires staff to monitor and record temperature and humidity in storage rooms daily to maintain the quality and integrity of medical supplies.³⁰ There were also two patient food refrigerators that lacked temperature monitoring. The Joint Commission *Standards Manual*, PC [Provision of Care, Treatment, and Services] standard 02.02.03 requires facilities to store “food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.”³¹ The chief of the engineering service explained the facility policy requires services to submit a request for installation of centralized temperature monitoring, but at the time of the inspection in July 2025, no request had been submitted.

Recommendation 1

The Director takes appropriate action so staff conduct a risk assessment to identify areas that need temperature and humidity monitoring and implement changes accordingly to comply with Veterans Health Administration Directive 1761, *Supply Chain Management Operations*.

☒ Concur

☐ Nonconcur

Target date for completion: Completed

Director Comments

The Medical Center Director chartered an Environmental Monitoring Workgroup co-led by the Chief of Quality and Patient Safety (QPS) for areas requiring temperature and humidity monitoring. The ancillary workgroup included responsible stakeholders from Pharmacy, Supply Chain Management, Sterile Processing, Engineering, Nutrition & Food, Infection Control, Path & Lab, Quality Management, and the Implant Coordinator. The workgroup confirmed with responsible service/section chiefs in Pharmacy, Nutrition and Food Service, Supply Chain Management, Engineering, Sterile Processing, Pathology and Laboratory Medicine Service that medications and supplies requiring temperature and humidity control remain within acceptable limits and, if not, actions are taken within an acceptable timeframe by responsible parties to review, remove (if necessary), and remedy when temperature or

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

³¹ The Joint Commission, *Standards Manual*, E-edition, PC.02.02.03, July 1, 2025 (this standard was in place at the time of the July 2025 inspection); “Standards FAQs Refrigerator Temperature – Patient Care Food Storage,” The Joint Commission, last modified April 21 ,2026, <https://www.jointcommission.org/library/support-center>.

humidity is outside the acceptable range. Quality Management, Infection Prevention and Control, and the Implant Coordinator randomly assessed secondary supply closets, medication refrigerators, and nourishment refrigerators on the Little Rock and North Little Rock campus to ensure compliance with TempTrak sensors being present and functioning. The workgroup assessed the current process for TempTrak use for both Little Rock and North Little Rock campuses (software and hardware) and reviewed the local standard operating procedure (SOP). The workgroup learned that actions listed in the SOP were accurate, but multiple responsible team members were not assigned in the TempTrak system to monitor and respond to triggered sensor alerts or maintain the TempTrak software/hardware in their assigned area(s). Engineering at CAVHS had oversight of the program but responsible services had opportunities in maintaining the correct team member(s) to respond or manage the sensors assigned to them. In February 2026, the ancillary workgroup cleared historical triggers and began reviewing sensors daily (then weekly) and communicating outcomes with service chiefs through an MS Teams channel and Tiered Safety Huddles. Since this process began, responsible service team members have resolved over 96% (7215 of 7500 triggered alerts) and remained above 90% month-to-month February to August 2026. When alerts are triggered, a team member from the assigned service is made aware of the range variation and acts by working with the clinical and non-clinical team to either remedy the temperature or humidity or remove the supply or medication. The ancillary workgroup continues to meet bi-weekly to further develop system processes and connect answers to questions from team members. The workgroup reports monthly to the Comprehensive Environment of Care Committee (chaired by the Associate Medical Center Director) and the Quality and Patient Safety Board and the Joint Leadership Council (both chaired by the Medical Center Director) to ensure sustained compliance.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before the report's publication.

In the dermatology clinic at the hospital, the OIG observed two 180-liter liquid nitrogen tanks that were easily movable stored in a small, non-fire-rated room (see appendix B, figure B.6). The National Fire Protection Association's *Compressed Gases and Cryogenic Fluids Code NFPA 55* states that "portable containers subject to shifting or upset shall be secured," and the association's *Health Care Facilities Code NFPA 99* specifies that nonflammable gas storage must be separated by one-hour fire-rated walls and floors, with doors and openings rated for

45 minutes.³² Additionally, the Safety Data Sheet for liquid nitrogen requires staff to secure these tanks to prevent accidents and injuries.³³ If the tanks leak, liquid nitrogen can displace oxygen in the room and risk staff injury or death.³⁴

Staff explained they prop the door open for ventilation when they work in the room where they store the liquid nitrogen (see appendix B, figure B.7). However, inspectors noted the propped door blocks the exit from the adjacent patient care room. The Code of Federal Regulations title 29, section 1926.34 requires exit routes to always remain unobstructed.³⁵ While on-site in July 2025, the OIG team informed the Director about this safety concern to highlight the need for staff to quickly address it. When they met with the OIG team in April 2026, facility staff stated and provided evidence that air exchange testing of the room had occurred in July 2025.

Recommendation 2

The Director takes appropriate action so staff secure liquid nitrogen tanks, maintain unobstructed access to exits, conduct a risk assessment on safe liquid nitrogen storage options to increase safety, and implement changes accordingly to align with the National Fire Protection Association's *Compressed Gases and Cryogenic Fluids Code NFPA 55*, *Health Care Facilities Code NFPA 99*, and Code of Federal Regulations title 29, section 1926.34.

☒ Concur

☐ Nonconcur

Target date for completion: Completed

Director Comments

Engineering took the following actions to ensure safety and security of liquid nitrogen tanks. Storage options to increase safety were assessed and changes were implemented to comply with regulation NFPA 99 – 2024 Ed. – 11.5.2.2.3: Transfilling of any gases from one cylinder to another in the patient care vicinity shall be prohibited. Liquid nitrogen tanks were moved and secured in GB 123, unobstructed access to exits are maintained. Final implementation of the corrective action plan to move the liquid nitrogen tanks to Research Service area GB-123 occurred August 26, 2026. This necessitated close coordination with Dermatology, Supply

³² National Fire Protection Association, *Compressed Gases and Cryogenic Fluids Code*, NFPA 55, 2023 edition, <https://www.nfpa.org/nfpa-55>; National Fire Protection Association, *Health Care Facilities Code*, NFPA 99, 2024 edition, <https://www.nfpa.org/nfpa-99>. The reference to one-hour or 45-minutes fire-rated refers to a physical barrier between the gas room and other spaces that can withstand fire exposure for that duration of time.

³³ Air Liquide, *Safety Data Sheet*, MSDS [material safety data sheet] No. 10071, Nitrogen (Liquid), September 3, 2014, revised January 15, 2020.

³⁴ 29 C.F.R. § 1910.1200 (2024).

³⁵ 29 C.F.R. § 1926.34 (2025).

Chain Management Service, Research Service, Engineering and Safety. Essential elements of this coordinated activity included safe storage and handling training delivery, approval from the COR and Contracting Officer overseeing the liquid nitrogen tank delivery and compliance with the Research Service security protocols dictating that each employee designated to enter into the research lab be securely vetted and assigned badge access to enter the lab area. Successful implementation and verification of each of these process elements was critical in ensuring that this procedural change did not result in the disruption or delay of healthcare delivery to Veterans receiving care in the Dermatology clinic. The Safety and Occupational Health Manager reports monthly to the Comprehensive Environment of Care Committee (chaired by the Associate Medical Center Director) and the Quality and Patient Safety Board and the Joint Leadership Council (both chaired by the Medical Center Director) to ensure sustained compliance.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before the report's publication.

The OIG team also found staff did not complete preventive maintenance on some ceiling lifts (equipment staff use to safely move patients with limited mobility) and did not remove all untested lifts from service. The Joint Commission EC [Environment of Care] standard 02.04.03 requires staff to inspect, test, and maintain all high-risk equipment and document these activities.³⁶ Further, according to VHA Directive 1860, *Healthcare Technology Management Continuous Performance Monitoring and Improvement*, the facility's chief biomedical engineer must ensure staff follow maintenance guidelines for medical equipment.³⁷

The chief of the engineering service said the contractor usually hired to inspect the ceiling lifts is no longer in business, and at the time of the inspection in July 2025, staff were working with a third-party vendor to inspect the lifts until they secured a new contract. The nurse manager of special operations, public health, and safety stated staff use portable lifts in the interim. During the on-site inspection in July 2025, the OIG team also informed the Director about the ceiling lift safety problem, which staff should promptly resolve. In April 2026, facility staff reported and provided evidence showing they had tested ceiling lifts or taken them out of service until they could be tested, so the OIG did not make a recommendation for additional corrective action.

³⁶ The Joint Commission, *Standards Manual*, E-dition, EC.02.04.03, March 30, 2025. (The Joint Commission updated this standard to PE [Physical Environment] 04.01.01 in 2026).

³⁷ VHA Directive 1860, *Healthcare Technology Management Continuous Performance Monitoring and Improvement*, August 19, 2024.

Further, the OIG team reviewed a 2024 Joint Commission accreditation report that included findings for dust build-up and the lack of temperature monitoring.³⁸ Staff provided action plans to The Joint Commission and reported they had completed several of them. However, as noted above, OIG inspectors observed similar issues, which indicated staff had not sustained improvement actions. VHA Directive 1608(1) requires facilities to adhere to regulatory and accrediting bodies' standards and ensure the healthcare environment is safe and clean. The Acting Associate Director explained that facility staff use their environment of care inspection process to help prevent repeat negative findings. The OIG is concerned the facility lacks an efficient process to sustain improvements.

Recommendation 3

The Director takes appropriate action so staff improve processes to prevent repeat environment of care findings as required by Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

☒ Concur

☐ Nonconcur

Target date for completion: December 31, 2026

Director Comments

Please refer to Director comments under recommendation 1. In addition, Environmental Services implemented monthly rounds in clinical areas by service supervisors to identify and report environmental cleanliness opportunities. The Environmental Services' Chief assures opportunities identified are closed within the tracking program and reported monthly to the Comprehensive Environment of Care Committee (chaired by the Associate Medical Center Director) and the Veterans Experience Board (chaired by the Associate Director of Patient Care Services) until 90% compliance is maintained for three (3) consecutive months.

³⁸ The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation inspections in March 2024. The Joint Commission, *Final Accreditation Report, Central Arkansas Veterans Healthcare System*, March 11, 2024.



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

VHA Directive 1088(1), *Communicating Test Results to Providers and Patients* requires facility staff to develop a communication of test results policy and service-level workflows, which describe the way test results reach the provider and the patient.³⁹ The facility had a policy and workflows that were consistent with VHA requirements. The chief of pathology and laboratory explained the provider notification process: staff use a database to find the provider's phone number, call to report the test result, and document the date and time of the call in the patient's electronic health record. The chief of diagnostic and therapeutic imaging clarified that nurses ensure providers are aware of potentially malignant (cancerous) results and promptly act on them.⁴⁰

The chief of primary care and the associate chief of staff for specialty care said they use data from the External Peer Review Program (which uses a contracted agency to externally review patient electronic health records to assess quality of care), facility-based internal electronic health record reviews, and provider performance evaluations to monitor test result communication.⁴¹ The external peer review program coordinator added that staff discuss test result communication in quarterly meetings and focus on cases when staff did not communicate results to patients in a timely manner. The coordinator then notifies service-level and executive leaders about these cases, and any trends staff need to address via email and during meetings.

The OIG reviewed the facility's performance metrics for communication of test results, which monitor whether staff communicated test results that require action to patients within seven days.⁴² Data showed improvement between the second quarters of FYs 2024 and 2025. The acting chief of quality patient safety credited the improvement to software implemented in February 2025 that automatically generates test result letters, which staff mail to patients after

³⁹ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

⁴⁰ National Cancer Institute, *NCI Dictionary of Cancer Terms*, "Malignant," accessed February 17, 2026, <https://www.cancer.gov/publications/malignant>.

⁴¹ VA Analytics and Performance Integration, *External Peer Review Program Guide*, last updated February 13, 2025.

⁴² "Electronic Technical Manual (eTM) Measure Specification," VHA Office of Quality and Patient Safety, accessed November 25, 2025, <http://pm.rtp.med.va.gov/PerformanceMeasure>. (This website is not publicly accessible.)

providers review them. The chief of primary care added that staff also call or securely message patients to share results.

Action Plans and Process Improvements

Facility leaders and quality patient safety staff identified trends in the Joint Patient Safety Reporting system—a database used at VA facilities to document patient safety events, such as adverse events (that involve patient harm) and close calls (unsafe conditions)—then tracked action items and monitored improvement actions.⁴³ The ADPCS reported hosting monthly safety forums to share lessons learned and patient safety concerns. The patient safety manager said they discussed current incidents and trends with leaders at tiered huddles (daily communications to multiple levels of staff); provided weekly summaries of safety trends and reporting errors to executive leaders; and presented a monthly summary to the Quality, Safety, Value Board. The manager also said patient safety staff send email notifications twice a week to assigned staff to follow up on overdue actions.



INTEGRATED VETERAN CARE

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.⁴⁴ 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

During interviews, the Chief of Staff and the deputy associate chief of staff for primary care nursing said 48 teams deliver primary care services across the healthcare system. The chief of primary care and the health system specialist supervisor reported that 38 of the teams were fully staffed. At the time of the site visit in July 2025, primary care leaders stated they were approved to hire three providers, two registered nurses, one licensed practical nurse, and four medical support assistants. Primary care leaders and staff explained they covered some vacancies with float staff who were not assigned to a specific team.

The chief of primary care and the deputy associate chief of staff for primary care nursing reported that the number of patients who received primary care at the facility had increased. The

⁴³ VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook, Version 6.0*, October 2025.

⁴⁴ "Community Care," VA, accessed June 29, 2026, <https://department.va.gov/vha/community-care>.

deputy associate chief provided corroborating data that showed an almost 7 percent increase in primary care enrollment from October 2022 through July 2025.

In July 2025, the facility's primary care panels—the number of patients assigned to a care team—averaged 90 percent of the expected modeled panel capacity, per VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.⁴⁵ The directive defines the expected modeled capacity as the maximum number of patients on a primary care panel based on variables such as staffing, number of rooms, and provider type. Despite the average, 19 of the 48 teams exceeded 100 percent capacity.

Primary care leaders said they had added a new primary care team within the previous month and expected average panel sizes to decrease. The Chief of Staff stated leaders intended to add another primary care team at a location where most teams are over 100 percent capacity. Between July 2025 and May 2026, the facility added one primary care team, and as of May 2026, primary care panels averaged 88 percent of the expected modeled panel capacity and 17 of the 49 teams exceeded 100 percent capacity.

The OIG found that during the first two quarters of FY 2025, average appointment wait times were less than 4 days for established patients and less than 15 for new patients. As of April 2026, the average wait time for established patients was just under 3 days, and for new patients it was about 14 days; these wait periods are below the VHA averages of just under 7 days for established patients and about 32 days for new patients. 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.⁴⁶ Leaders explained that float providers see walk-in and new patients when not assigned to cover staff vacancies, which helps keep wait times short.

Community Care Staffing and Access to Care

The OIG reviewed staffing information provided by the acting chief of community care at the time of the site visit in July 2025. It showed facility leaders had approved hiring for six vacant community care administrative positions.

Although VHA's *Consult Timeliness Standard Operating Procedure* expects community care staff to schedule appointments for patients within 7 days of the request, the OIG found that on average, from April 2024 through March 2025, it took staff approximately 9.5 days to schedule a community care appointment.⁴⁷ As of April 2026, they took approximately 12 days. The acting chief provided June 2025 data that showed the average wait time from the referral to the actual

⁴⁵ VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

⁴⁶ 38 C.F.R. § 17.4040 (2025).

⁴⁷ VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 2025.

appointment date was 34 days; in April 2026, the wait was about 33 days. The acting chief explained that wait times vary based on several factors, such as the type of care requested, and noted specialties such as nephrology and neurology generally have longer wait times due to limited community provider availability.

The Chief of Staff and the deputy associate chief of staff for primary care nursing said two of the facility's community-based outpatient primary care clinics have a dedicated nurse to coordinate care and obtain test results from community providers. The chief of diagnostic and therapeutic imaging explained that some community providers were performing standard computed tomography (CT) scans as opposed to low-dose scans (a process that uses less radiation than a standard scan) for lung cancer screening, which did not align with VHA Directive 1417, *Lung Cancer Screening*.⁴⁸ The chief of diagnostic and therapeutic imaging reported facility staff collaborated with those community providers and educated them about the standards. The chief of primary care added that leaders plan to deploy a VHA mobile CT scanner to serve two distant community-based outpatient clinics that rely heavily on community care for these procedures.



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.

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of homeless veterans who received an HCHV program intake assessment.⁴⁹ However, this fiscal year (FY 2026), VHA

⁴⁸ VHA Directive 1417, *Lung Cancer Screening*, May 29, 2024; "Computed Tomography," National Institute of Biomedical Imaging and Bioengineering, accessed August 11, 2025, <https://www.nibib.nih.gov/science-education/computed-tomography>; "Saved by the Scan," American Lung Association, accessed July 29, 2025, <https://www.lung.org/lung-health-disease>.

⁴⁹ VHA's goal is for facility program staff to perform intake assessments for all identified veterans by the end of each fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024.

no longer uses intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).⁵⁰ Finally, HCHV2 measured the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules...failure to comply with program requirements...or [who] left the program without consulting staff (referred to as negative exits)."⁵¹

Performance and Improvement Highlights

- The facility's program met the permanent housing (HCHV1) target in FY 2025 and through quarter three of FY 2026.⁵² The program did not meet the negative exit (HCHV2) target for the first two quarters of FY 2025 but met it in the third quarter and again at the end of the fiscal year. In FY 2026, the program met the target in quarters one and two but missed it in quarter three. The HCHV program coordinator explained that some veterans with substance use disorders had relapsed after they received income checks and left before they secured housing. In response, the team provided extra support during these high-risk periods to help veterans manage triggers.
- The coordinator said staff identify some veterans through the National Call Center for Homeless Veterans (used by veterans who are homeless or at imminent risk of homelessness to receive support and services), but past staffing vacancies delayed intake for these veterans.⁵³

⁵⁰ VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens, a veteran can typically stay between 4 and 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

⁵¹ VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

⁵² FY 2026 quarter three data are cumulative for quarters one through three, covering October 1, 2025, through June 30, 2026.

⁵³ "National Call Center for Homeless Veterans," VA, accessed September 3, 2024, <https://www.va.gov/Homeless>.

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.”⁵⁴ The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.⁵⁵

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).⁵⁶

Performance and Improvement Highlights

- The facility’s program met the voucher use (HMLS3) and employment (VASH3) targets for FY 2025 and sustained this performance for both measures through quarter three of FY 2026. The program supervisor stated HUD-VASH staff collaborated with the facility’s employment coordinators, who maintained strong relationships with community partners to connect veterans with job opportunities.

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.⁵⁷ 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).⁵⁸

⁵⁴ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁵⁵ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁵⁶ 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*.

⁵⁷ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁵⁸ 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*.

Performance and Improvement Highlights

- The facility's program met the enrollment (VJP1) target for quarters one through three of FY 2025 and continued this performance through quarter three of FY 2026. A veterans justice outreach specialist said the homeless team meets every other week to share event information and discuss veterans' needs like housing and transportation. Outreach specialists also meet monthly with facility staff to explore partnerships and services, such as a civil legal clinic for low-income veterans.
- Facility program staff found that some jails and prisons did not use VA software to identify incarcerated veterans. Program staff educated correctional administrators about the software's purpose and value, and increased collaboration with correctional staff improved veteran identification. The homeless program manager said these connections also helped pass a 2025 Arkansas law requiring its use.⁵⁹

Conclusion

To assist leaders in evaluating the quality of care at the Central Arkansas facility, the OIG conducted an inspection across five domains. The OIG made three recommendations related to temperature and humidity monitoring, liquid nitrogen storage, and repeat environment of care problems. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendations 1 and 2. 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.

⁵⁹ House Bill 1077, 95th Gen. Assemb, Reg. Sess. (Ark. 2025); Ark. Code § 12-29-121.

Appendix A: Methodology

The OIG inspection team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.⁶⁰ 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 July 15 through 17, 2025, and met virtually to follow up in April 2026. 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.⁶¹ 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*.⁶²

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.⁶³ 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.

⁶⁰ Accreditation reports covered the time frame of October 1, 2023, through September 30, 2024—the most recent available at the time of the inspection.

⁶¹ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

⁶² 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.

⁶³ 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 1978.⁶⁴ 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.

⁶⁴ Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Appendix B: Additional Facility Photos



Figure B.1. Stained ceiling with hanging mineral deposits above the passenger loading zone at the main entrance of the healthcare center. Source: Photo taken by OIG inspector.



Figure B.2. Examples of dust on ventilation grills observed in both the hospital and healthcare center. Source: Photos taken by OIG inspector.



Figure B.3. Example of dust on sprinkler head noted in the emergency room at the hospital. Source: Photo taken by OIG inspector.

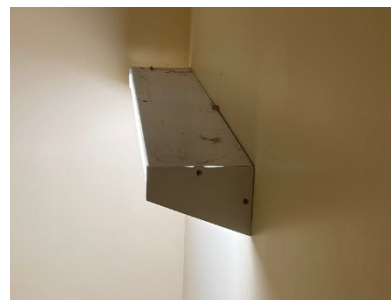


Figure B.4. Example of a dirty light fixture in a stairwell at the healthcare center. Source: Photo taken by OIG inspector.



Figure B.5. Examples of stained ceiling tiles at the healthcare center.
Source: Photos taken by OIG inspector.



Figure B.6. Unsecured nitrogen tanks in the dermatology clinic at the hospital.
Source: Photo taken by OIG inspector.

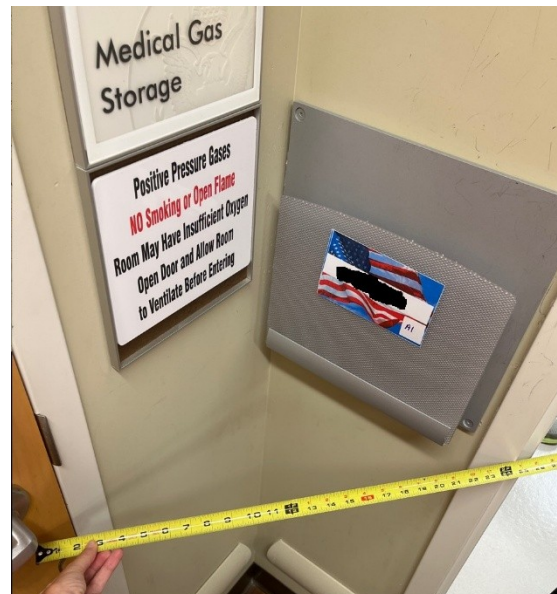


Figure B.7. Photograph that shows the distance between medical gas storage and patient care rooms in the dermatology clinic at the hospital.
Source: Photo taken by OIG inspector.

Appendix C: Health Service Area Director Comments

Department of Veterans Affairs Memorandum

Date: September 16, 2026

From: Executive Director, Health Service Area 4.1

Subj: Healthcare Facility Inspection of the Central Arkansas Veterans Healthcare System in Little Rock

To: Director, Office of Healthcare Inspections (54HF03)
Chief Integrity and Compliance Officer (10OIC)

The Health Service Area 4.1 has reviewed and concurs with the findings, recommendations, and submitted action plan for the Healthcare Facility Inspection of the Central Arkansas Veterans Healthcare System in Little Rock.

(Original signed by:)

Stephanie A. Repasky, Psy.D.

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 11, 2026

From: Director, Central Arkansas Veterans Healthcare System (598)

Subj: Healthcare Facility Inspection of the Central Arkansas Veterans Healthcare System in Little Rock

To: Director, VA Heart of America Health Network (10N4)

Director, Health Service Area 4.1

1. Thank you for the opportunity to review and comment on the Office of Inspector General Healthcare Facility Inspection of the Central Arkansas Veterans Healthcare System in Little Rock. I concur with this report.
2. Central Arkansas Veterans Healthcare System remains committed to ensuring our Veterans receive exceptional health care.

(Original signed by:)

Michael Moore, Ph.D.

Medical Center Director

Central Arkansas Veterans Healthcare System (598/00)

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