US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

Healthcare Facility Inspection	25-04052-222	August 11, 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 Asheville Health Care System (the facility) from October 7 through 9, 2025. The facility is rated as *high-complexity* and in fiscal year 2025, provided direct care to about 50,000 unique 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. When inspecting the emergency department and intensive care unit, the OIG found dirty eyewash stations.[3] Pallets and other materials also obstructed a walkway in a service hallway near the loading dock, which was a repeat finding from Veterans Integrated Service Network annual workplace evaluations for fiscal years 2023 through 2025.[4] The OIG made two recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The facility did not have a test result communication policy that aligned with VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, or service-level workflows which describe

[1] VHA classifies facilities based on their complexity level. High-complexity facilities have "medium-high-volume, high-risk patients, many complex clinical programs, and medium-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 September," VHA Support Service Center, accessed March 16, 2026, https://reports.vssc.med.va.gov/Pages/ReportViewer. (This web page is not publicly accessible.)

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

[3] Occupational Safety and Health Administration, "OSHA InfoSheet: Health Effects from Contaminated Water in Eyewash Stations," July 2015; VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

[4] VISN 6, *Annual Workplace Evaluation for Western North Carolina VA Health Care System Survey Conducted Monday*, *June 26, 2023 Through Friday*, *June 30, 2023*; VISN 6, *Annual Workplace Evaluation for Western North Carolina VA Health Care System Survey Conducted Monday*, *April 8*, *2024 Through Friday*, *April 12*, *2024*; VISN 6, *Annual Workplace Evaluation for Western North Carolina NC VA Health Care System Survey Conducted Monday*, *April 7*, *2025 Through Friday*, *April 11*, *2025*.

staff roles in the communication process, as required. The OIG made two recommendations.[5]

- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[6] 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 recently incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. Facility leaders implement measures to keep all eyewash stations clean and safe for emergency use.
2. Facility leaders implement measures to keep walkways free of obstructions to maintain clear exit routes.
3. The Director updates the facility's written policy for test result communications to comply with requirements in Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.
4. The Chief of Staff and Associate Director of Patient Care Services/Nurse Executive develop and implement written workflows for each service that comply with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

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

[6] 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 Veterans Integrated Service Network 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).[7] Based on information provided, the OIG considers recommendations 3 and 4 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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for Healthcare Inspections

[7] In December 2025, VA announced plans to reorganize and consolidate its Veterans Integrated Service Networks (VISNs) from 18 networks to 5. All 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 within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

Abbreviations

ADPCS	Associate Director of 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

Contents

Introduction

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[8] 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.[9]

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.[10]

Patient Safety: VHA programs identify and reduce system vulnerabilities and risks of harm to veterans.[11]

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.[12]

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

[9] 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.

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

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

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

The VA Asheville Health Care System (the facility) currently operates at four locations in western North Carolina.[13] The facility's budget was approximately $841 million in fiscal year (FY) 2025, with about $242 million allocated to pay for care provided in the community. It had 60 medical surgical, 25 intensive care, 16 inpatient mental health, 58 community living center, 15 hospice, and 6 domiciliary beds.[14]

Figure 1. *Facility photo.*
Source: "VA Asheville Health Care," VA, accessed September 29, 2025, https://www.va.gov/asheville-health-care.

The OIG inspected the facility from October 7 through 9, 2025. The executive leaders referred to throughout this report include the Director, Associate Director, Associate Director of Patient Care Services/Nurse Executive (ADPCS), Chief of Staff, and Assistant Director. The Associate Director was serving as acting director and the Assistant Director was covering the role of acting associate director during the on-site inspection. The ADPCS, assigned in February 2003, had the longest tenure. The Assistant Director, who started in July 2024, was the newest member of the leadership team.

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.[15] 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

[13] The locations are the Charles George VA Medical Center, built in 1967, and community-based outpatient clinics in Franklin, Hickory, and Forest City. "About Us," VA, last updated January 2, 2026, https://www.va.gov/asheville-health-care/about-us.

[14] A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated June 3, 2025, www.va.gov/CLC. A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/dchv.

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

assess their level of trust in VA).[16] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[17]

System Shocks

Executive leaders and employees told the OIG that Hurricane Helene (in September 2024) and the executive orders and memorandums on the hiring freeze (in effect from January 20, 2025, to October 15, 2025) and return-to-office (starting in January 2025) created system shocks.[18] The impacts continued to be felt at the time of the inspection in October 2025; staff and leaders applied lessons learned from the hurricane to prepare for future disasters and were continuously

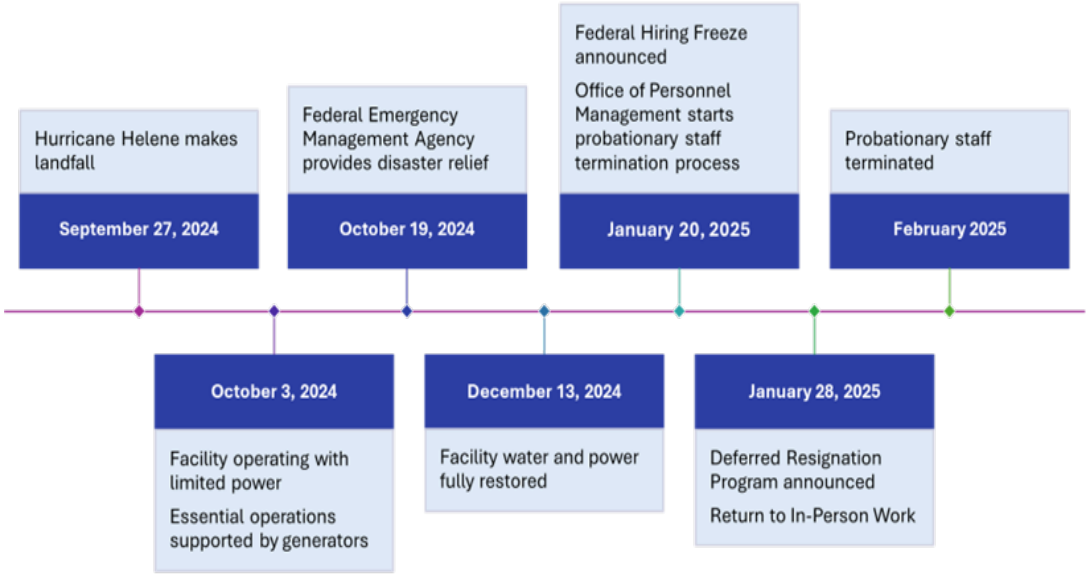

Figure 2. *Facility system shocks timeline.*
Sources: OIG analysis of the National Hurricane Center Tropical Cyclone Report for Hurricane Helene; email correspondence; federal workforce policy documents; interviews with executive leaders and engineers; and "How FEMA Works," Federal Emergency Management Agency, last updated February 12, 2026, https://www.fema.gov/about/how-fema-works.

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

[17] 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.

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

managing vacant positions. Hurricane Helene was a powerful storm with flooding, winds, and tornadoes that produced catastrophic damage and led to at least 250 deaths.[19] The storm left behind destruction in Asheville and surrounding areas with long-term effects.

Executive leaders and employees said the hurricane flooded over 300 facility rooms and closed its main access road when a bridge became impassable. The Acting Associate Director stated that power outages lasted over three weeks, and the facility was the last hospital in the area to regain full power. The Acting Associate Director clarified that the Deputy Secretary of Veterans Affairs had to intervene to restore power because the facility was not on the county's utility priority list. Leaders said they also lost external communication systems for two days, so they used two satellite phones while standing on the roof to communicate.

Facility leaders (such as managers, supervisors, and service chiefs) praised employees and said they showed resilience by returning to work and taking on unfamiliar roles, including clearing debris. Executive leaders reported the facility continued to provide essential services, including critical surgeries and patient care, despite challenges. From September 22 through November 16, 2024, employees worked over 8,000 overtime hours related to the hurricane and completed wellness checks for more than 2,500 high-risk veterans (those with spinal cord injuries, on home oxygen, or homebound).

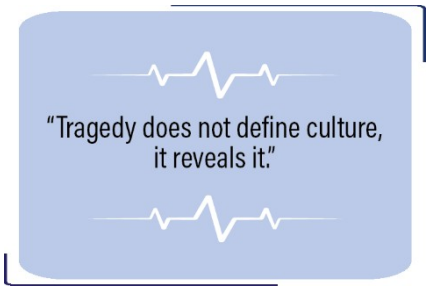

Figure 3. *Chief of Staff statement.*
Source: OIG interview.

VA deployed additional employees to the facility through its Disaster Emergency Medical Personnel System, which allows full-time employees to volunteer for national disaster missions and support emergency healthcare operations.[20] The Acting Associate Director described how employees converted waiting rooms into shelters and provided care at community and Federal Emergency Management Agency shelters (which assist people before, during, and after disasters through coordinated federal action).[21] Documents showed that employees served about 150 veterans and delivered over 500 medications at agency shelters.

Facility leaders and staff told the OIG team about lessons they learned from the catastrophic event. The Acting Associate Director acknowledged that while leaders had completed National Incident Management System training, which guides organizations on how to respond to and

[19] National Oceanic and Atmospheric Administration, *National Hurricane Center Tropical Cyclone Report*, *Hurricane Helene (AL092024)*, *24–27 September 2024*, April 8, 2025.

[20] "VHA Office of Emergency Management, Disaster Emergency Medical Personnel System (DEMPS)," VA, last updated January 30, 2025, https://www.va.gov/EmergencyManagement/DEMPS; David Walter, "DEMPS Volunteers Answer the Call to Help in Hurricane-Ravaged North Carolina," VA, December 2, 2024, https://www.va.gov/milwaukee-health-care/demps-volunteers-answer-the-call-to-north-carolina.

[21] "How FEMA Works," Federal Emergency Management Agency.

recover from incidents, they had not practiced using it in real time before the hurricane.[22] Since then, employees have completed hands-on training and use the system during all emergency drills. Employees said they also partnered with the Veterans Integrated Service Network (VISN) to establish prearranged contracts for critical resources—such as water, fuel, temporary housing, and sanitation—to use in a future crisis.[23]

Executive leaders said operations were mostly restored by December 13, 2024. However, the leaders asserted that federal workforce policy changes beginning in early 2025 created challenges that introduced new stresses that also contributed to fear and distrust of VHA and executive leaders among staff. These challenges included dealing with vacancies left by staff participating in the deferred resignation program, a hiring freeze, and return to in-person work requirements that all were related to January 2025 mandates. In addition, executive leaders stated that the Office of Personnel Management job reclassifications affected 17 occupational groups, some of which experienced reduced pay, and there were sudden terminations of probationary employees.[24] To respond, executive leaders explored recruitment incentives, met with affected employees, explained appeals processes, and increased communication through town halls and emails.

Leaders said they historically used the VA All Employee Survey to evaluate the effectiveness of leader communication, but VA did not administer it in FY 2025.[25] Leaders said they planned to conduct an internal survey and continued to gather feedback through other channels. Most OIG questionnaire respondents indicated executive leaders' communications improved and were clear, useful, and frequent.[26]

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[22] "National Incident Management System," Federal Emergency Management Agency, last updated July 28, 2025, https://www.fema.gov/emergency-managers/nims.

[23] 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 and consolidate its VISNs from 18 networks to 5. All 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 within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise. John J. Bartrum, Under Secretary for Health, "RISE Implementation Begins," email to Veterans Health Administration staff, May 1, 2026.

[24] Acting Director, Office of Personnel Management, "Guidance Regarding Deferred Resignation Program," memorandum to Heads and Acting Heads of Departments and Agencies, January 23, 2025; Hiring Freeze, 90 Fed. Reg. 8247; "Classification Review Project," VA, accessed August 18, 2025, https://dvagov.sharepoint.com/sites/Classification. (This website is not publicly accessible.); Strengthening Probationary Periods in the Federal Service, 90 Fed. Reg. 17729 (Apr. 24, 2025).

[25] The All Employee Survey is an annual, voluntary survey of VA workforce experiences. The data are anonymous and confidential. "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development.

[26] The facility had about 2,474 employees at the time the OIG distributed the questionnaire, and approximately 13 percent of employees responded.

Employee Experiences

The ADPCS stated that executive leaders foster a culture that supports employees' well-being and professional growth. Leaders send personal thank-you letters to employees who self-report actual and potential patient safety events to promote psychological safety.[27] They also host monthly all-employee safety forums and encourage personnel to report patient safety issues through the long-standing *Stop the Silence* campaign, which explains how to report ethical, quality, and safety concerns. Facility staff also receive a newsletter that shares information about key topics, practices, and initiatives.

Veteran Experiences

Patient advocate responses to an OIG questionnaire indicated facility leaders were responsive to veteran concerns and effectively addressed them. The OIG found that the facility's VSignals trust scores exceeded VHA averages for FY 2024 through quarter two of FY 2025, which shows strong veteran confidence in its outpatient services. Executive leaders reported they use VSignals outpatient and inpatient survey data to share positive feedback and guide improvements.

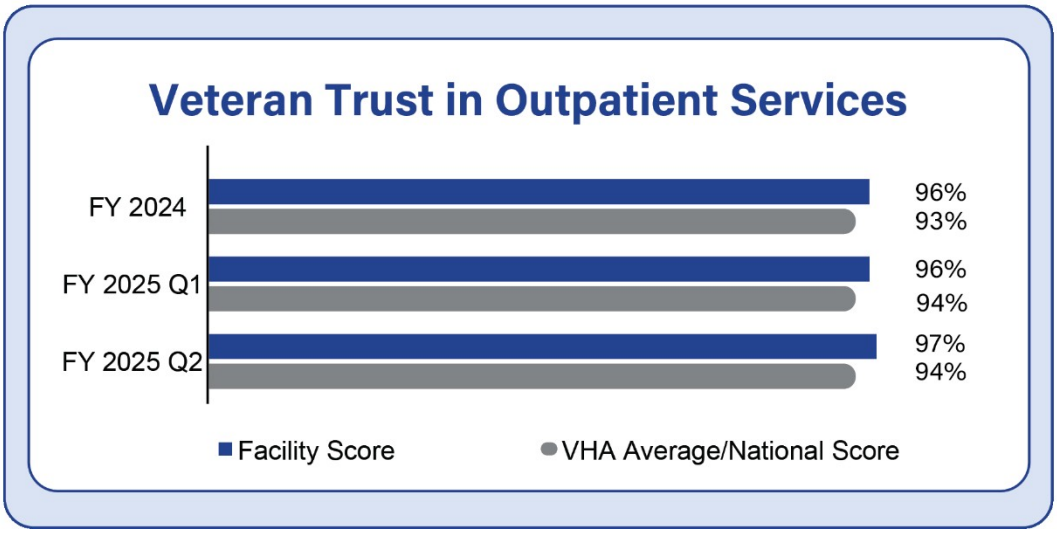

Figure 4. *Veteran trust in outpatient services.*
Source: VSignals data.

Leaders said the veterans experience officer reviews data monthly, shares the results with service chiefs, and creates action plans when scores fall below national averages. For example, after

[27] "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

veterans reported issues with nighttime noise on inpatient units, employees added white noise machines, which improved satisfaction.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[28] 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.[29]

General Inspection

The OIG team reviewed a 2023 facility parking study that found only 5.3 percent of parking spaces were accessible, but the *VA Barrier Free Design Standard* requires hospital outpatient facilities to designate 10 percent as accessible.[30] The Acting Associate Director acknowledged the facility still lacked sufficient standard and accessible parking and said they lost several spaces because they installed water wells in the parking lot (structures to store underground water) after the hurricane. The OIG did not make a recommendation because the chief of facility management service reported they submitted plans to build parking garages that would add approximately 800 spaces.

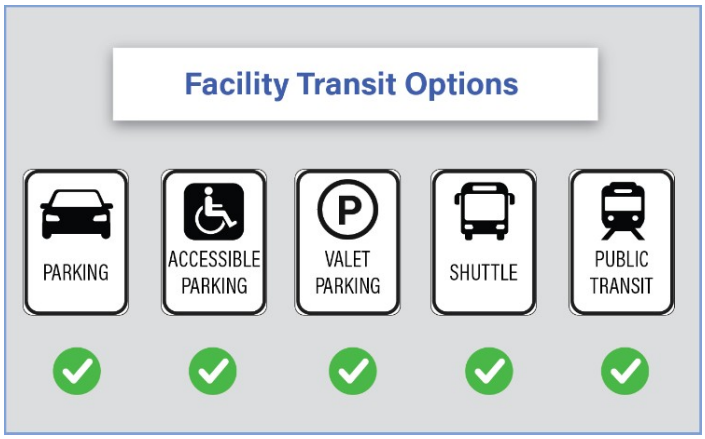

Figure 5. *Transit options for arriving at the facility. Source: Parking lot map, email correspondence, and a questionnaire response.*

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

[29] 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.

[30] VA, *Traffic and Parking Improvements Concepts Study for the Charles George VAMC [VA Medical Center], Asheville, NC*, December 15, 2023; VA, *VA Barrier Free Design Standard*.

Further, the inspection team was unable to locate emergency call boxes in the expansive parking areas and learned the facility had only one. Call boxes are not required unless warranted by the facility's own risk analysis. Specifically, VA's *Physical Security and Resiliency Design Manual* requires facilities to install emergency alert systems (such as emergency call boxes that connect patients and staff directly to help) when a risk analysis shows a need for them.[31] The chief of the facility management service described a project that was approved but did not have funding allocated that would renovate pathways around the site, including installing emergency call boxes and the electrical system needed to support them. A VA police officer reported there are regular patrols of the parking areas to maintain security. The Acting Associate Director added that staff also use a drone to monitor the parking lots. The OIG did not make a recommendation because leaders plan to install call boxes and mitigate risks to help ensure parking area safety.

The main entrance was welcoming and clean, with an information desk staffed by volunteers who provided veterans with directions or paper maps. The facility was easy to navigate using the maps, signs, and directories posted on walls.

The quality management nurse manager reported that in FY 2025, volunteers received training on how to assist hearing- and vision-impaired veterans. Additionally, the facility had audio amplifiers for veterans with hearing impairments to use. Additional assistive measures are included in figure 6.

Figure 6. *Accessibility tools available to veterans with impairments.*
Source: OIG observations and questionnaire responses.

The OIG team inspected several clinical areas and found the facility generally clean. However, there were dirty eyewash stations in the emergency department and intensive care unit. One had a clear, shiny film on the spouts and a dry black substance where the spout connected to the water pipe. Another had a wet black substance inside the spout caps. Substances on or around eye wash station spouts can reduce water flow, inhibit functionality in an emergency, and pose an infection risk to users. The Occupational Safety and Health Administration's *OSHA InfoSheet: Health Effects from Contaminated Water in Eyewash Stations* requires workplaces to maintain eyewash stations to prevent injury and illness, and VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires staff to ensure the

[31] VA, *Physical Security and Resiliency Design Manual*, October 1, 2020, revised May 1, 2024.

healthcare environment is safe and clean.[32] Staff in these areas documented that they checked eye wash station functionality weekly; however, based on the observations, the OIG made a recommendation.

Recommendation 1

Facility leaders implement measures to keep all eyewash stations clean and safe for emergency use.

__X__ Concur

_____ Nonconcur

Target date for completion: March 1, 2027

Director Comments

The facility policy 637-138-68 Emergency Eyewash and Shower Equipment was revised and updated via bulletin to clarify responsible parties and the procedure for correctly checking and testing an eyewash station. The bulletin was signed February 18, 2026. It is posted on the facility's SharePoint. Service leaders will designate eyewash inspectors. Inspectors will receive training from the facility's Safety Department by August 31, 2026. Quality and Patient Safety Service will complete monthly audits of eyewash stations for cleanliness and safe use in emergencies and will report compliance to the facility's Quality and Patient Safety Council and will monitor until 90 percent compliance is maintained for six consecutive months.

The OIG also found pallets and other materials that lined the walkway in a service hallway leading to the loading docks and blocked doorways that need to remain clear. The inspection team noted that VISN annual workplace evaluations for FYs 2023 through 2025 found blocked exits in the same area.[33] The National Fire Protection Association's *Life Safety Code* states exits should be free of obstructions in case of fire or other emergencies.[34] Additionally, The Joint Commission's *Means of Egress* guidance notes that cluttered hallways increase the likelihood

[32] Occupational Safety and Health Administration, "OSHA InfoSheet: Health Effects from Contaminated Water in Eyewash Stations," July 2015.

[33] VISN 6, *Annual Workplace Evaluation for Western North Carolina VA Health Care System Survey Conducted Monday*, *June 26, 2023 Through Friday*, *June 30, 2023*; VISN 6, *Annual Workplace Evaluation for Western North Carolina VA Health Care System Survey Conducted Monday*, *April 8, 2024 Through Friday*, *April 12, 2024*; VISN 6, *Annual Workplace Evaluation for Western North Carolina NC VA Health Care System Survey Conducted Monday*, *April 7*, *2025 Through Friday*, *April 11, 2025*.

[34] National Fire Protection Association, *NFPA 101: Life Safety Code*, 7.1.10.1, 7.3.4.1(2), September 2023. The Public Buildings Amendments of 1988, Pub. Law No. 100-678, 102 Stat. 4049 "requires all federal agencies to follow the latest editions of nationally recognized fire and life safety codes…VA has adopted the National Fire Codes (NFC) published by the National Fire Protection Association (NFPA), which establish a minimum acceptable level of life safety and property protection. Life safety requirements are specifically addressed in NFPA 101." VA, *Fire Protection Design Manual Ninth Edition*, November 1, 2023.

that staff carrying supplies may strike items stored in the hallway, which could result in injuries or dropped and damaged materials.[35] In an interview, the Acting Associate Director confirmed authorizing the staff to use walkways for storage due to limited space. The chief of the facilities management service described an ongoing project to extend the loading dock area to accommodate deliveries, which will reduce the need to use the service hallway for storage.

Recommendation 2

Facility leaders implement measures to keep walkways free of obstructions to maintain clear exit routes.

__X__ Concur

_____ Nonconcur

Target date for completion: March 1, 2027

Director Comments

The facility will conduct a healthcare system wide safety forum in July 2026 about ensuring that all walkways remain free of obstructions to maintain clear exit routes. After the safety forum, service chiefs will formally attest that they are ensuring all walkways remain free of obstructions to maintain clear exit routes. They will attest also that they are relaying this to their staff. Beginning in July 2026, the facility Public Affairs Office will send regular messaging to all employees about ensuring walkways remain free of obstructions to maintain clear exit routes. The Quality and Patient Service will ensure monthly audits are completed to assess compliance with walkways remaining free of obstructions to maintain clear exit routes and will report compliance to the facility's Quality and Patient Safety Council and will monitor until 90 percent compliance is maintained for six consecutive months.

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

Communication of Urgent but Noncritical Test Results

The OIG found the facility had a policy for test result communications, but it did not align with requirements in VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*,

[35] "Means of Egress," The Joint Commission, Environment of Care Resource Center, accessed March 16, 2026, https://www.jointcommission.org/en-us/knowledge-library/environment-of-care/means-of-egress.

and had not been updated since January 2022.[36] On July 11, 2023, VHA issued Directive 1088, which required facilities to develop a local policy and service-level workflows (which describe the role of various team members in the test result communication process) within 6 to 12 months. VHA later issued Directive 1088(1) on September 20, 2024, providing further clarification of the requirements.[37] The facility's policy lacked several required elements, including definitions to differentiate between emergent and imminently life-threatening results. In addition, the facility lacked workflows for the imaging service while primary care and the pathology and laboratory medicine services had the required service-level workflows.

The Chief of Staff said leaders were aware the facility's policy was outdated and facility staff did not update the policy in a timely manner; staff's competing priorities were the only reason provided. Facility documents showed the Chief of Staff tasked the chief of imaging in early 2025 to chair a workgroup on the communication of test results to revise the facility's policy to comply with VHA requirements. However, during the OIG's October 2025 inspection, the policy remained outdated.

Recommendation 3

The Director updates the facility's written policy for test result communications to comply with requirements in Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

__X__Concur

_____Nonconcur

Target date for completion: Completed

Director Comments

Facility policy was revised to align with Directive 1088(1) Communicating Test Results to Providers and Patients. The policy, MCP 637-11-124 Ordering and Reporting Diagnostic Tests was signed April 20, 2026 and posted to the facility's SharePoint April 20, 2026. The facility requests closure of this recommendation.

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.

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

[37] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, July 11, 2023.

Recommendation 4

The Chief of Staff and Associate Director of Patient Care Services/Nurse Executive develop and implement written workflows for each service that comply with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

__X__Concur

_____Nonconcur

Target date for completion: Completed

Director Comments

Services that receive test results created service level workflows. The service level workflows are posted in the "Asheville On Call" folder in the respective services' folders. Asheville On Call is the established pathway for communicating to all staff the on-call schedules for services and now is the communication pathway for notification of test results. The facility requests closure of this recommendation.

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 further learned that facility services used accepted auditing methods and VHA metrics to ensure providers communicated test results to providers and patients in a timely manner.[38] The chief of quality management described presenting test result data at oversight and governance board meetings, such as the Medical Executive Council and the Executive Leadership Board, to support accountability.

Action Plans and Process Improvements

The OIG reviewed and confirmed that all recommendations from the OIG's 2024 Comprehensive Healthcare Inspection Program report had been closed and there were no prior recommendations related to test result communication.[39] Additionally, there were no open

[38] "Electronic Technical Manual (eTM) Measure Library," VA Office of Quality and Patient Safety Performance Measurement, accessed September 10, 2025, http://pm.rtp.med.va.gov/eTM. (This website is not publicly accessible.)

[39] VA OIG, *Comprehensive Healthcare Inspection of the Charles George VA Medical Center in Asheville, North Carolina*, No. 23-00023-96, March 7, 2024.

recommendations from the facility's prior September 2024 VHA Office of the Medical Inspector.[40]

The chief of quality management described how staff implemented and sustained processes based on recommendations. For example, in response to a closed 2024 Office of the Medical Inspector recommendation, risk management staff have been meeting twice a month with the Chief of Staff to improve communication and review patient safety trends and concerns.[41] Notably, the facility received the Patient Safety Program of Excellence Designation in April 2025 from the National Center for Patient Safety.[42]

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[43] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

The OIG team reviewed facility documents that showed staff provided primary care services at the medical center and all three community-based outpatient clinics. The documents showed a total of 42 primary care teams, with 24 at the medical center and 18 at the clinics. The facility did not add any new primary care teams in the past year, but the Chief of Staff said the workload supported adding a team at the Hickory clinic. The Chief of Staff explained this action was postponed because the facility was operating under the systemwide hiring freeze (a suspension of hiring for new or vacant roles) at the time of the October 2025 site visit.[44]

During the OIG's October 2025 inspection, all primary care teams at the community-based outpatient clinics were fully staffed. However, the medical center had vacancies for four providers, one licensed practical nurse, and five medical support assistants. The ADPCS

[40] VA, *Report to the Office of Accountability and Whistleblower Protection Case Number 24-23468,* September 11, 2024.

[41] VA, *Report to the Office of Accountability and Whistleblower Protection Case Number 24-23468*.

[42] "About Us," VHA National Center for Patient Safety, last updated September 29, 2025, https://www.patientsafety.va.gov.

[43] "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.

[44] Hiring Freeze, 90 Fed. Reg. 8247.

explained that medical support assistant positions were the most difficult to fill and had high turnover because they offered low pay but required a medical background. The ADPCS reported that leaders used a multipronged approach to hire medical support assistants, including advertising through the federal government's job website and receiving referrals from the community and facility staff. Executive leaders said they use incentives and recruiters to address physician and nursing vacancies. Because it was historically difficult to hire licensed practical nurses, the chief nurse of primary care said facility leaders implemented a merit promotion program to increase their pay.

The OIG also reviewed facility documents that showed the average panel size (number of patients assigned to a care team) was 95 percent of VHA's expected size of 1,200 patients per VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.[45] Primary care staff described the workload as manageable; however, a provider reported that the large volume of view alerts (electronic health record notifications) were burdensome and often required after-hours attention. The Chief of Staff said leaders implemented a clinical message program across the facility that reduced the burden on providers by enabling all team members to receive and respond to alerts. A registered nurse said nurses also addressed duplicate alerts to assist providers. Despite reported vacancies, the OIG did not identify significant delays in care delivery.

Community Care Staffing and Access to Care

The OIG reviewed community care staffing and noted the program had 49 administrative and 16 clinical staff on board. The community care chief nurse reported that the VISN provided 7 additional contracted administrative staff. However, the chief nurse stated the program remains understaffed, and many staff work overtime to meet the workload demands, with some earning 30 overtime hours in a single pay period.

The chief nurse added that administrative staffing levels had not increased since FY 2020, despite a higher workload. Facility documents showed that referrals in FY 2025 were more than double the volume reported in FY 2020. Because the facility had been subject to the hiring freeze at the time of the inspection in October 2025 and was later placed under stricter staffing caps and approval protocols, the OIG did not make a recommendation related to addressing vacancies.[46]

Facility documents showed dermatology (skin), dental, and orthopedics (bones and muscles) were the top three services for which veterans were referred to community providers. In each case, long drive times were the primary reason for referrals, as veterans may be eligible for community care for specialty services when their average drive time to a VA medical facility is

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

[46] Hiring Freeze, 90 Fed. Reg. 8247; Ensuring Continued Accountability in Federal Hiring, 90, Fed. Reg. 48387.

at least 60 minutes. VHA's Office of Integrated Veteran Care, *Consult Timeliness Standard Operating Procedure* requires staff to schedule appointments within 7 days of referral; however, scheduling took longer than 35 days for these three services.[47] The chief nurse said some community providers would not schedule appointments until they reviewed the patient's completed VHA referral packet, which caused delays staff could not prevent. In addition, facility leaders had a current redesign project to streamline processes to improve scheduling timelines. Therefore, the OIG did not make a recommendation.

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.[48]

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).[49] 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

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

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

[49] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024 Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens a veteran can typically stay between 4 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

negative exits)."[50] The HCHV section chief and VISN network homeless program manager said the HCHV1 and HCHV2 measures do not apply because the program does not have contracted emergency residential services.

Performance and Improvement Highlights

- The section chief said the community lacks enough emergency shelters and works with partners to expand options. The HUD-VASH program supervisor said the hurricane destroyed Restoration Quarters—155 transitional housing beds. Within days, the Veterans Restoration Quarters organization secured a hotel contract to shelter veterans. HCHV staff visited the hotel daily for several weeks after the storm to ensure veterans were safe and had food and necessary supplies.

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."[51] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[52]

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).[53]

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

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

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

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

Performance and Improvement Highlights

- The program did not meet the voucher use (HMLS3) target for FYs 2024 and 2025. A program supervisor cited a shortage of affordable housing and low voucher limits as key challenges.
- The program supervisor reported that after the hurricane, staff worked with community partners to find veterans without power or water and delivered bottled water and food to those with mobility issues or no transportation. The hurricane displaced 20 veteran households, and staff coordinated with VA medical centers in nearby states to help them secure housing and stability.
- The program met the employment (VASH3) target for FYs 2024 and 2025, but the program supervisor noted there were fewer jobs available after the hurricane.

A veteran experiencing substance use challenges and feelings of hopelessness was living in a car while their children were in temporary foster care. Program staff engaged the veteran, who agreed to enroll in the program and entered transitional housing, where they actively participated in both substance use and mental health treatment. After achieving sustained sobriety, the veteran enrolled in educational classes and received a housing voucher. The veteran ultimately regained custody of their children, securing both stable housing and employment.

Figure 7. *Example of veteran engagement.*
Source: Questionnaire response.

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.[54] 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).[55]

Performance and Improvement Highlights

- The program met the enrollment (VJP1) target for FYs 2024 and 2025. Staff said they receive referrals through various sources including attorneys, jail staff, and the federal public defender's office.
- A program specialist said staff assess veterans in treatment courts, recommend therapy, share plans with the court, monitor compliance, and report progress.[56] One

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

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

[56] VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

judge held sessions at the Heart of Horse Sense barn, which offered equine therapy to calm veterans and create a more trusting, positive court atmosphere.[57]

Conclusion

To assist leaders in evaluating the quality of care at the VA Asheville Health Care System, the OIG conducted an inspection across five domains. The OIG made four recommendations related to eyewash station cleanliness, exit obstructions, and test result communications. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendations 3 and 4. Recommendations do not reflect the overall quality of all services delivered within the facility. However, 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.

[57] "About Us," Heart of Horse Sense, 2024, https://www.heartofhorsesense.org/about.

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.[58] 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 team inspected the facility from October 7 through 9, 2025. 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.

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.[59] 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.*[60]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[61] 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.

[58] Prior OIG and accreditation reports covered the time frame of October 1, 2022, through September 30, 2025—the most recent available at the time of the inspection.

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

[60] 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.

[61] 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.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. 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.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issues.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[62] 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.

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 14, 2026

From: Interim Director, VA Mid-Atlantic Health Care Network (10N6)

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

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

Chief Integrity and Compliance Officer (10OIC)

Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the Western North Carolina VA Health Care System (VA Asheville, North Carolina).

I have reviewed and concur with the recommendations as provided by the VA Office of Inspector General (OIG), as well as the action plans submitted by the Western North Carolina Health Care System. I concur with closing Recommendations #3 and #4.

In our ongoing commitment to ensuring Veterans receive exceptional care, Legacy VISN 6 leadership will ensure that all corrective actions outlined in the responses are fully implemented and sustained.

(Original signed by:)

Joanna Weber
Interim Director
for
Kevin P. Amick, MBA, MHRM, SES
Executive Director

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 13, 2026

From: Executive Director, Western North Carolina VA Health Care System (637)

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

To: Director, VA Mid-Atlantic Health Care Network (10N6)

Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the Western North Carolina VA Health Care System (VA Asheville, North Carolina).

I have reviewed and concur with the recommendations provided by the VA Office of Inspector General (OIG), as well as the action plans submitted by the Western North Carolina Health Care System.

I will ensure that all corrective actions are completed and sustained as outlined in the responses. I respectfully request closure of Recommendations 3 and 4; please refer to the submitted responses for details.

(Original signed by:)

Stephanie Young, MHA, FACHE

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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.