US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Fire System and Life Safety Programs/Processes at the East Orange VA Medical Center in New Jersey

Preliminary Result Advisory Memorandum	26-00105-22	December 11, 2025

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The Office of Inspector General (OIG) has released this issue statement to provide information on matters of concern that the OIG has gathered as part of its oversight mission. The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation.

November 26, 2025[1]

PRELIMINARY RESULT ADVISORY MEMORANDUM

TO: John Figueroa, Senior Advisor performing the delegable duties of VA Under Secretary for Health
Veterans Health Administration (10)

FROM: Dr. Julie Kroviak, Principal Deputy Assistant Inspector General, in the role of Acting Assistant Inspector General, Office of Healthcare Inspections (54), VA Office of Inspector General

SUBJECT: Review of Fire System and Life Safety Programs/Processes at the East Orange VA Medical Center in New Jersey

The VA Office of Inspector General (OIG) is issuing this preliminary result advisory memorandum to inform the Veterans Health Administration (VHA) Under Secretary for Health of significant and recurring fire system and life safety issues identified during a Healthcare Facility Inspection of the East Orange VA Medical Center (facility) in New Jersey, conducted the week of August 25, 2025.[2] These concerns pose ongoing risks to the safety of patients, staff, and visitors.

In response to the OIG's notification of these concerns, the Interim Facility Director acknowledged the issues, and a facility leader submitted a corrective action plan with target completion dates ranging from fiscal year 2026 to fiscal year 2028. This memorandum is intended to convey the information necessary for VHA leaders to determine whether additional and prompt intervention is warranted.[3] The OIG is not taking further action at this time; additional information will be included in the forthcoming published inspection report.

Summary of Findings

During the Healthcare Facility Inspection of the VA New Jersey Healthcare System, inspectors conducted interviews and an on-site review of the facility focusing on safety, hygiene, infection

[1] This memorandum was sent to VHA on November 26, 2025.

[2] The requested action addressed to the Under Secretary for Health is directed to anyone in an acting status or performing the delegable duties of the position.

[3] This memorandum provides information that has been gleaned from OIG inspections. The OIG issues preliminary result advisory memoranda when exigent circumstances or areas of concern are identified through OIG hotline allegations or in the course of its oversight work, particularly when immediate action by VA can help reduce further risk of harm to veterans or significant financial losses. Memoranda are published unless otherwise prohibited from release or to safeguard protected information.

prevention, and privacy. Inspectors identified several fire system and life safety deficiencies including[4]

- a fire-extinguishing standpipe that had not been tested every five years,[5]
- fire barrier doors that could not be closed, and
- incorrect exit signage.

These findings are consistent with, and in some cases repeat, deficiencies previously cited in VHA's fiscal years 2024 and 2025 Annual Workplace Evaluations (AWEs) and The Joint Commission's (TJC's) April 30 through May 3, 2024, inspection. Notable prior findings include

- a fire-extinguishing standpipe that had not been tested every five years (TJC),
- the fire-extinguishing system in the canteen kitchen not tested semiannually (2025 AWE),
- fire-rated doors not inspected annually (TJC),
- a fire-rated door not closing properly (TJC), and
- incorrect exit signage (2024 and 2025 AWEs).[6]

The recurrence of fire system and life safety deficiencies highlights the need for corrective action and stronger oversight to ensure a safe environment. Notably, the Veterans Integrated Service Network 2 Director was aware of the identified deficiencies, as documented in the fiscal years 2024 and 2025 AWEs, and communicated the report to the VA New Jersey Healthcare System Director.

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[4] "Life safety" refers to topics assessed by The Joint Commission (TJC) as part of its Life Safety survey, including building design, means of egress, fire protection features, alarm systems, fire suppression, building services, and safety considerations for furnishings and equipment. The Joint Commission, *Standards Manual,* E-dition, LS.01.02.01, January 1, 2025.

[5] A standpipe system is a network of pipes designed to provide water for firefighting through hose connections and, in some cases, automatic sprinklers. These systems come in various types and must undergo periodic testing per National Fire Protection Association (NFPA) standards, including flow and pressure tests every five years and annual valve inspections. "Standpipes," National Fire Sprinkler Association, accessed October 9, 2025, https://nfsa.org/itm-2-2/standpipes/.

[6] VHA Directive 7701, *Comprehensive Occupational Safety and Health Program*, December 12, 2022. VHA requires Veterans Integrated Service Network and VA medical facility directors to ensure "a safe and healthful work environment" and participate in facility AWEs. Veterans Integrated Service Network 2 staff initiated the fiscal years 2024 and 2025 AWE inspections during the weeks of April 15, 2024, and April 28, 2025, respectively; VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022. VHA also requires that VA medical facilities maintain accreditation by TJC. TJC uses an accreditation survey to assess "the day-to-day performance of an organization." The survey includes medical record reviews and observations of active patient care. TJC initiated its most recent accreditation survey of VA New Jersey Healthcare System on April 30, 2024. It is important to note that differences in inspection methods and assessed areas of the facility may underestimate the number of similar and repeat deficiencies.

The Associate Director assigned to the facility submitted an action plan on September 17, 2025, addressing the identified persistent deficiencies, with remediation efforts extending up to fiscal year 2028. The OIG is concerned about the timelines to remediate these serious and recurring issues. Additionally, the OIG received a list of interim life safety measures in use during the remediation timeline. While these measures are necessary, they require significant and sustained effort and resources.[7]

Conclusion

The OIG's identification of recurring fire system and life safety deficiencies at the facility underscores the urgent need for prompt and sustained corrective actions. While interim measures have been implemented, the protracted remediation timeline—combined with the resource-intensive nature of the plan—raises concerns about the feasibility of maintaining a safe environment.

Requested Action

The OIG requests the Under Secretary for Health evaluate the adequacy of fire system and life safety oversight at the East Orange VA Medical Center and ensure that all necessary steps are promptly implemented to protect the safety of veterans, staff, and visitors.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

[7] TJC's expectation is that the facility "has a written interim life safety measures (ILSM) policy that covers situations when Life Safety Code deficiencies cannot be immediately corrected." The standard "includes criteria for evaluating when and to what extent the hospital implements" life safety measures "to compensate for increased risk." TJC, *Standards Manual,* E-dition, LS.01.02.01, January 1, 2025.

OIG Contact and Staff Acknowledgments

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