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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Ralph H. Johnson VA Health Care System in Charleston, South Carolina

Healthcare Facility Inspection | 25-00237-112 | May 28, 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 Ralph H. Johnson VA Health Care System (the facility) from May 20 through 22, 2025. The facility is rated as high complexity and in fiscal year 2025, provided direct care to about 97,977 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

Overall, the OIG inspection did not reveal issues that warranted recommendations for corrective action in any of the five domains.

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement.
- **Primary Care.** The OIG assessed whether primary care teams were staffed according to VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care* and Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*.[3]
- **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.

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[1] VHA classifies facilities based on their complexity level. High-complexity facilities have "high volume, high risk patients, the most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." Fiscal year 2025 is the most recent available data. "Trip Pack - Operational Statistics Table FY2026 Through February," VHA Support Service Center, last updated March 17, 2026, https://reports.vssc.med.va.gov/OperationalStatisticsTable. (This web page is not publicly accessible.)

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

[3] VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026; VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

OIG staff and leaders are aware of the transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiency of VA programs and services that improve the health and welfare of veterans and their families.

What the OIG Recommended

The OIG made no recommendations.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the report (see appendixes C and D). No further action is required.

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Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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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.[4] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions leaders and staff can take. Each inspection focuses on five domains and assesses facilities' adherence to VA standards and other governing authorities:

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[5]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[6]

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

Primary Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.[8]

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[9]

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[4] "About VHA," VA, last updated January 20, 2025, https://www.va.gov/aboutvha.

[5] Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11, https://doi.org/10.1136/bmjopen-2017-017708.

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

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

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

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

The Ralph H. Johnson VA Health Care System (the facility) includes the medical center hospital and nine outpatient clinics in South Carolina and Georgia.[10] The facility is rated as high complexity and in fiscal year (FY) 2025, provided direct care to about 97,977 unique patients.[11] The facility had a medical care budget of approximately $1 billion, and 108 hospital and 28 community living center beds in FY 2025.[12]

Figure 1. *Ralph H. Johnson VA Medical Center. Source: "VA Charleston Health Care," VA, accessed June 11, 2025, https://www.va.gov/charleston-health-care/locations.*

The OIG inspected the facility from May 20 through 22, 2025. The executive leaders referred to throughout this report include the Director, Associate Director, and the Assistant Director for Hospital-Based Operations; as well as the Assistant Director for Community-Based Operations, Chief of Staff, and Associate Director for Nursing and Patient Care Services.

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 VA's All Employee Survey scores for

[10] "Locations," VA, accessed June 11, 2025, https://www.va.gov/charlestonhealthcare.

[11] VHA classifies facilities based on their complexity level. High-complexity facilities have "high volume, high risk patients, the most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." FY 2025 is the most recent available data. "Trip Pack - Operational Statistics Table FY2026 Through February," VHA Support Service Center, last updated March 17, 2026, https://reports.vssc.med.va.gov/OperationalStatisticsTable. (This web page is not publicly accessible.)

[12] 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. "Trip Pack - Operational Statistics Table FY2026 Through February," VHA Support Service Center, last updated March 17, 2026.

[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.

October 1, 2023, through September 30, 2024.[14] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[15]

System Shocks

Executive leaders described a decline in staff recruitment and retention as a system shock. The Assistant Director shared that an endocrinologist candidate stated that the reason for declining a position at the facility was due to uncertainty about federal employment.[16] As a result, executive leaders reported to the OIG team that existing endocrinology staff could not meet the demand for services, which led to longer wait times and more veterans seeking care in the community.[17] At the time of the OIG's inspection in May 2025, executive leaders said endocrinology was among the largest categories of care veterans received from community providers.

Executive leaders also told the OIG that probationary firings resulted in the loss of some supply technicians and nutrition team members. Thus, leaders assisted with tasks, and the chief of nutrition and an administrative officer worked outside regular hours to lend support.

According to the Director, facility leaders closed 10 medical-surgical and 5 mental health inpatient beds due to position vacancies and potential for unsafe care. Facility leaders also evaluated other staffing levels and determined the nursing service had more leaders than needed, so they reallocated some of them to frontline positions.

Employee Experiences

The OIG emailed a questionnaire to an employee group identified by the facility liaison, but because the distribution list included individual and group addresses, an exact response rate could not be determined. All responses were received from April 16 through 30, 2025.

With 578 respondents to the questionnaire, about 77 percent agreed they felt comfortable reporting a safety concern. This is consistent with the facility's All Employee Survey scores for

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[14] The All Employee Survey is an annual, voluntary survey of VA workforce experiences. "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development. The All Employee Survey was not administered in FY 2025.

[15] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," VA, last updated May 9, 2022, https://www.va.gov/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

[16] "Endocrinologist," Cleveland Clinic, last updated February 20, 2025, https://clevelandclinic.org/endocrinologist.

[17] 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.

FY 2024, which suggested employees felt psychologically safe.[18] As figure 2 also indicates, just more than half of the respondents felt comfortable suggesting actions to improve the work environment as well.

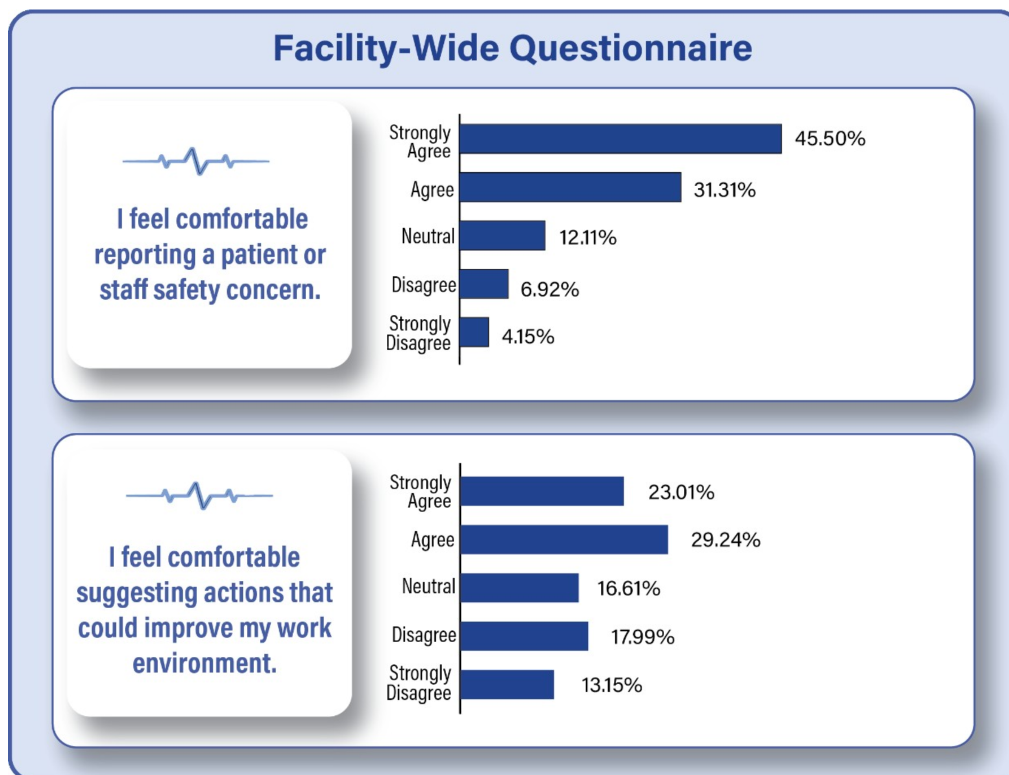

Figure 2. *Responses to questionnaire items related to facility culture.*
Source: OIG analysis of questionnaire responses.

In an interview, executive leaders said the scores were favorable because they act quickly on concerns. Executive leaders also said communication between employees and leaders occurs during visits to work areas, meetings, and one-on-one conversations. Leaders mentioned additional information-sharing venues, such as town halls where leaders addressed anonymously submitted questions from employees, and the public affairs team distributed messages from the Director. Leaders added that high attendance at the town halls suggests employees found them valuable and effective.

Veteran Experiences

The executive leaders described the facility's process when patient advocates receive a complaint. Patient advocates escalate the complaint to their supervisor; the appropriate service

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[18] "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.

representative; and executive leaders, when needed; who work together to resolve it. They also track the complaint in a group that focuses on improving veterans' experiences. With this process, timely resolution occurs at lower levels, and veterans submit fewer complaints directly to executive leaders.

Executive leaders also explained that veterans had expressed frequent complaints about limited parking downtown near the medical center. In response, they restored a valet parking service in 2024 that was suspended during the COVID-19 pandemic, and parking complaints subsequently decreased.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[19] 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.[20]

General Inspection

The campus had signs that directed veterans to the main entrance and additional parking (see appendix B, figure B.1). The nearest available public bus stop was in the middle of the block, across a busy street from the main entrance (see appendix B, figure B.2). The OIG observed individuals cross the street mid-block rather than walk to the nearest intersection, which had visible

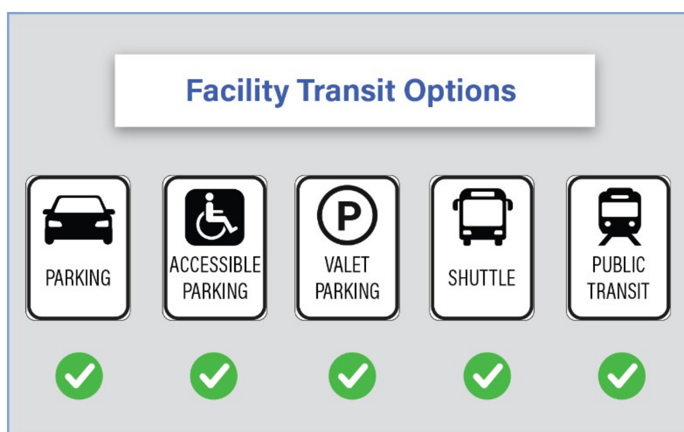

Figure 3. *Transit options for arriving at the facility.*
Source: OIG analysis of parking and shuttle documents and observations.

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

[20] 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.

road markings. Facility leaders shared that they were aware of the situation and have discussed it with local officials.

At the entrance, the OIG team observed a covered loading zone and motion sensor-activated sliding doors. The lobby was clean and had several seating areas and multiple volunteers who answered questions, provided directions to clinical areas, and offered wheelchairs to those with mobility needs.

The facility had printed maps available in the main elevator lobbies on every floor. There was also an interactive wayfinding kiosk at the main entrance that provided turn-by-turn directions, with additional kiosks planned for the elevator lobbies. The OIG team relied on the kiosk for directions on at least two occasions and found the interface intuitive.

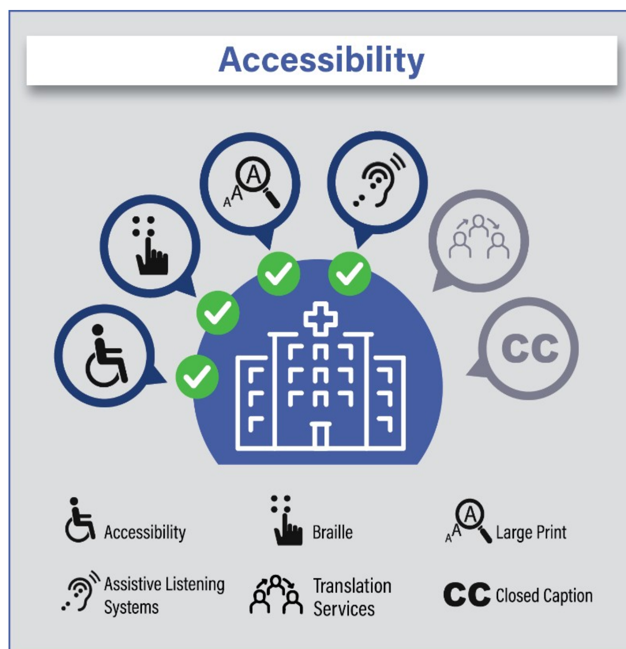

Figure 4. Accessibility tools available to veterans with sensory and other impairments.
Source: OIG observations.

As to accessibility tools, the team also noted detectable warning surfaces on sidewalks to alert those with visual impairments of intersections, crosswalks, and entrances to the facility. Main lobby elevators included visual and braille text, and recordings announced floor stops. Check-in kiosks in clinical areas had headphone jacks with volume and tone adjustments. Disposable headphones are available upon request at check-in locations for veterans with hearing impairments.

Overall, the facility was clean and well maintained, and patient kitchen areas were well organized. However, a medical-surgical unit kitchen had a dried spill in the microwave, countertop, and floor. There was also an unattended environmental services cart that propped open the door to a custodial closet containing cleaning supplies and equipment (see appendix B, figure B.3). The exposed housekeeping tools and cleaning agents pose a hazard to veterans. Facility staff corrected the issues during the inspection; therefore, the OIG did not make recommendations.

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.[21]

Communication of Urgent but Noncritical Test Results

The OIG found the Chief of Staff had not developed service-level workflows that described team members' roles in communicating test results, as required in VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[22] Following the inspection team's May 2025 site visit, facility leaders provided the OIG with documented service-level workflows. However, several workflows lacked clear descriptions of staff roles in the communication process, a gap that may delay or otherwise affect patients' care by the provider waiting for results. The chief of quality for the facility explained that turnover in the chief of staff position disrupted oversight and delayed standardization of these workflows.

The OIG reviewed updated information provided by the facility in January 2026 and determined that leaders had sufficiently updated their service-level workflows to include all team members' roles. Therefore, the OIG did not make a recommendation.

Action Plans and Process Improvements

The OIG noted that all five recommendations from the previous OIG comprehensive healthcare inspection in January 2023 were closed as implemented.[23] In an interview, facility leaders outlined a process for how they review environment of care findings, patient safety reports, and performance measures; identify trends or repeat findings; and develop process improvement projects as needed. Once leaders determine an action plan, an assigned project team implements it and updates the Quality Executive Council to sustain improvement.

According to documents addressing general patient safety concerns in 2023, facility staff identified a delay in communicating test results to patients and implemented a system to automate test result letters. Staff described to inspectors how the application generates letters with patients' results and populates their electronic health records. They then mail them within

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[21] An examination of compliance with the communication of other types of test results was not within the scope of the inspection.

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

[23] VA OIG, *Comprehensive Healthcare Inspection of the Ralph H. Johnson VA Medical Center in Charleston, South Carolina*, Report No. 23-00005-62, February 7, 2024.

seven business days. Reports provided by staff showed this improved notification timeliness, and the facility was consistently above both the Veterans Integrated Service Network (VISN) and national VHA averages since implementation.[24]

PRIMARY CARE

The OIG assessed whether primary care teams were staffed in compliance with the VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care* and Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*.[25] The OIG interviewed staff, analyzed primary care team staffing data, and examined new patient appointment wait times.

Primary Care Teams

Primary care and facility leaders reported having vacancies for 5 providers, 8 registered nurses, 20 licensed practical nurses, and 18 medical support assistants across 84 primary care teams as of May 2025. Primary care and facility leaders told the OIG team that Charleston's increasing cost of living and uncompetitive locality pay affected recruitment and retention. Leaders also said licensed practical nurses and medical support assistants often left primary care positions due to a lack of advancement opportunities. The leaders added that it was a challenge to recruit staff to rural locations, such as the community-based outpatient clinic in Hinesville, Georgia.

Primary care and facility leaders described further problems once they identified candidates. They asserted that consolidation of human resources staff from the local to regional level delayed hiring, which caused some candidates to seek other employment opportunities. Although the time to hire had improved when leaders were interviewed in May 2025, they acknowledged the process to onboard a provider could still take six months. Primary care leaders said staff and clinical resource hub providers helped cover vacant roles.[26]

Despite staffing challenges, new patient appointment wait times had steadily decreased from 32 days in the second quarter of FY 2023, to 14 days in the first quarter of FY 2025.[27] The chief of primary care attributed the improved wait times to adding dedicated new patient appointment

[24] Veterans Integrated Service Networks are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Network (VISN)," VA, last updated August 11, 2025, https://www.va.gov/visns.

[25] VHA Directive 1406(3); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[26] Clinical resource hubs "provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." "Clinical Resource Hubs (CRH)," VA, accessed March 26, 2025, https://www.patientcare.va.gov/CRH.

[27] VHA Support Service Center.

slots to each provider's daily schedule, which the chief said did not affect wait times for existing patients.

The OIG found that some panel sizes (number of patients assigned to a care team) were larger than expected. According to VHA Directive 1406(3), VHA expects full-time primary care teams with adequate staffing and space to maintain a baseline of 1,200 patients. The chief of primary care told the OIG that panel sizes at several sites exceeded expected levels due to increased demand for care. For example, at the Hinesville clinic, the largest panel had 1,540 assigned patients due to a large population of veterans in the area. Leaders said they reviewed panels at least monthly and reassigned patients as new providers came onboard.

VETERAN-CENTERED SAFETY NET

The OIG reviewed Health Care for Homeless Veterans (HCHV), Housing and Urban Development–Veterans Affairs Supportive Housing (HUD-VASH), and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The inspection team analyzed enrollment and performance data and interviewed facility program staff.

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[28]

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.[29] However, this fiscal year (FY 2026), VHA 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

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

[29] 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 2024 Homeless Performance Measures*, October 1, 2023.

residences for veterans with mental health or substance use conditions).[30] 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)."[31]

Performance and Improvement Highlights

- The program met the intake percentage (HCHV5) target for FY 2024. In an interview, the section chief for homeless programs said staff previously fell below the target because they inserted incorrect codes for the intake assessments into a national VHA database, which made the data inaccurate. The section chief subsequently trained staff how to enter the correct codes, which allowed them to meet the FY 2024 target. The program met both remaining targets (HCHV1 and HCHV2) for FY 2024. Staff attributed this success to collaboration with contract residential partners.
- Staff also described the program's community resource and referral center, located in North Charleston, where veterans receive assistance with permanent housing, health care, and employment. The program has a mobile medical unit, with a private exam room and commonly needed equipment. Staff drive the unit to various areas to provide healthcare services to veterans experiencing homelessness.

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."[32] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[33]

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

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

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

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

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).[34]

Performance and Improvement Highlights

- The program did not meet the voucher use (HMLS3) target for FY 2024. Facility staff attributed it to limited affordable housing and landlords who avoid tenants with a history of evictions or criminal records. Staff reported they hosted an event to educate landlords and veterans on program benefits. At the event, some veterans received vouchers and others were matched with a landlord and obtained housing. The section chief described tiny home villages in Brunswick, Savannah, and Myrtle Beach dedicated to housing for veterans, which improved voucher use in FY 2024.
- The program met the employment (VASH3) target for FY 2024. Program staff credited this to the facility's employment specialist who partnered with local businesses, attended job fairs, and provided transportation and job resources to veterans.
- Facility program staff said there were several vacant positions throughout FY 2025, which led to them working overtime and holding fewer outreach events. The OIG reviewed updated information provided by the facility in January 2026 and found leaders started hiring staff members to fill vacant positions for the program.

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.[35] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits.[36] VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[37]

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[34] 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*.

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

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

[37] 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,* November 2024.

Performance and Improvement Highlights

- The program did not meet the enrollment (VJP1) target for FY 2024. The program coordinator attributed this to staff forgetting to document veterans who entered the program. However, staff began documenting the required information, and the program exceeded the target for the first quarter of FY 2025.
- Program staff said they identify and enroll veterans through community outreach events and walk-in clinics in Charleston, Hinesville, and Savannah. They also receive referrals from various sources, such as jail and court staff and law enforcement officers. Further, program staff attend events in prisons to identify veterans who will be released soon to help them reintegrate into the community.

Conclusion

To assist leaders in evaluating the quality of care at the Charleston facility, the OIG conducted an inspection across five domains. Based on the overall positive findings, no recommendations for corrective action are included in this report. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Healthcare Facility Inspection program of VHA medical facilities across the nation, OIG leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[38] The OIG distributed a voluntary questionnaire to all employees through the facility's email groups to gain insight and perspective related to the organizational culture. Additionally, 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 team's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[39]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[40] The OIG acknowledges potential bias because the facility liaison selected staff 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.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The team inspected the facility from May 20 through 22, 2025. 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.[41] The OIG reviews available evidence within a

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

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

[40] 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.

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

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.

Appendix B: Additional Facility Photos

Figure B.1. *Sign at main street entry directs veterans to the main entrance and additional parking.*
Source: Photo taken by OIG inspector during site visit from May 20 through 22, 2025.

Figure B.2. *Public bus shelter mid-block across busy street from the medical center's main entrance.*
Source: Photo taken by OIG inspector during site visit from May 20 through 22, 2025.

Figure B.3. *Unattended environmental services cart that propped open a door to a custodial closet containing cleaning supplies and equipment.*
Source: Photo taken by OIG inspector during site visit from May 20 through 22, 2025.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 30, 2026

From: Acting Director, Department of Veterans Affairs (VA) Veterans Integrated Service Network 7 (VISN 7) Southeast Network (10N7)

Subj: Department of Veterans Affairs (VA) Office of Inspector General (OIG) Report, Healthcare Facility Inspection of the Ralph H. Johnson VA Health Care System in Charleston, South Carolina

To: Director, Office of Healthcare Inspections (54HF01)

Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to review and comment on the OIG draft report, Healthcare Facility Inspection of the Ralph H. Johnson VA Health Care System in Charleston, South Carolina. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I have reviewed the report and concur with the finding of no recommendations.
2. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
3. Should you have any questions or require further information, please contact the Veterans Integrated Service Network (VISN 7) Quality Management Officer.

(Original signed by:)

Benita K. Miller, FACHE, LISW-CP

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: April 20, 2026

From: Director, Ralph H. Johnson VA Health Care System (534)

Subj: Healthcare Facility Inspection of the Ralph H. Johnson VA Health Care System in Charleston, South Carolina

To: Director, VA Southeast Network (10N7)

Thank you for the opportunity to review the draft report of the Office of Inspector General (OIG) Healthcare Facility Inspection of the Ralph H. Johnson VA Health Care System. I have reviewed the document and concur with the finding of no recommendations.

I appreciate the partnership with the OIG ensuring the Veterans we proudly serve can continue to expect exceptional health care services.

(Original signed by:)

Scott R. Isaacks, FACHE

OIG Contact and Staff Acknowledgments

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