US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of VA's Oversight of a State Veterans Home at the Western North Carolina VA Health Care System in Asheville

Healthcare Inspection | **26-00509-126** | **June 2, 2026**

OUR MISSION

To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Western North Carolina VA Health Care System (system) in Asheville to assess concerns brought forward in October 2025 by an OIG Healthcare Facility Inspection team regarding issue briefs related to sentinel events and falls at the North Carolina State Veterans Home (SVH) in Black Mountain, North Carolina (Black Mountain SVH). The OIG initiated the inspection on January 5, 2026, conducted a virtual site visit from January 20 through 22, 2026, and continued inspection activities through early February 2026.

State Veterans Homes

An SVH is a state-owned facility that is recognized and certified by VA to provide nursing home, domiciliary, and adult day health care for veterans.[1] While the "SVH VISN Liaison and Medical Facility Representative Orientation Guide" states "VA does not have legal authority over the management or operation of a SVH," VA ensures compliance with applicable federal regulations through surveys, audits, and record reviews.[2] If an SVH fails to comply with VA standards, or applicable federal law, it may lose its certification, recognition, and the ability to receive per diem payments made by VA on behalf of veteran residents.[3]

SVH Issue Briefs and Sentinel Events

The OIG determined that Charles George VA Medical Center (facility), Veterans Integrated Service Network (VISN), and Geriatrics and Extended Care (GEC) leaders were aware of patient safety events, including sentinel events, that occurred in the fall of 2024 at the Black Mountain SVH, and took timely actions as required by the Veterans Health Administration (VHA).

VHA Notice 2024-11, "Oversight Requirements for State Veterans Homes," defines sentinel events as adverse events that result in the "loss of life, limb or permanent loss of function."[4] The "Enterprise Issue Reporting System Guide to VHA Issue Briefs" requires that SVH leaders report sentinel events, such as resident falls resulting in death or permanent loss of function, to

[1] VA, "State Veterans Homes Recognition Survey Process," (standard operating procedure), August 11, 2025.

[2] VHA, "SVH VISN Liaison and Medical Facility Representative Orientation Guide," January 2025; 38 C.F.R. § 51.210(v).

[3] 38 C.F.R. § 51.58 requires compliance with VA standards for SVHs to receive per diem payments for care rendered to veteran residents; 38 C.F.R. § 51.32 authorizes the director of the VA medical center of jurisdiction to terminate SVH recognition.

[4] VHA Notice 2024-11, "Oversight Requirements for State Veterans Homes," August 27, 2024.

the VA medical facility of jurisdiction. Once aware of a sentinel event, VHA staff prepare factual reports called *issue briefs* to inform leaders about the event.[5]

The OIG reviewed 13 facility-created issue briefs related to patient safety events reported by the Black Mountain SVH from August 2024 through December 2025, including two fall-related sentinel events in fall of 2024. The OIG determined that Black Mountain SVH leaders reported these sentinel events to facility leaders within 24 hours as required in "Enterprise Issue Reporting System Guide to VHA Issue Briefs."[6]

Additionally, the "Enterprise Issue Reporting System Guide to VHA Issue Briefs" states that SVH leaders must "review and analyze" a sentinel event and create a written investigational report within 10 business days to prevent future harm.[7] The OIG was unable to confirm compliance with a written investigational report following one of the two sentinel events. However, the OIG determined the missing documentation did not warrant a recommendation as the sentinel event occurred around the time of a major hurricane that disrupted communication.

Facility, VISN, and GEC Actions

According to VHA Notice 2024-11 and "Enterprise Issue Reporting System Guide to VHA Issue Briefs," following notice of a sentinel event at an SVH, the VA medical facility representative must notify the medical center director and the SVH VISN liaison (VISN liaison) within 24 hours.[8] Further, the VA medical facility representative must continue to clarify information and provide issue brief updates to the VISN liaison until resolution. The VISN liaison must review issue briefs for completeness and submit to GEC.[9] The SVH National Program Manager within GEC is responsible for "reviewing, documenting and analyzing all SVH reported adverse events and sentinel events."[10]

The OIG found that both SVH sentinel event issue briefs were created by facility staff within 24 hours and contained documented updates through resolution, which were reviewed by the VISN liaison and submitted to GEC as required. The OIG also found that SVH National Program Managers documented review and analysis of Black Mountain SVH sentinel event issue briefs.

VHA Notice 2024-11 outlines types of VA-administered surveys SVHs undergo to ensure compliance with VA standards, including annual and for-cause surveys.[11] For-cause surveys may be authorized by GEC based on concerns noted by the VA medical facility representative or

[5] VHA, "Enterprise Issue Reporting System Guide to VHA Issue Briefs," October 24, 2024.
[6] VHA, "Enterprise Issue Reporting System Guide to VHA Issue Briefs"; 38 C.F.R. § 51.120(a)(3).
[7] VHA, "Enterprise Issue Reporting System Guide to VHA Issue Briefs"; 38 C.F.R. § 51.120(a)(4).
[8] VHA Notice 2024-11; VHA, "Enterprise Issue Reporting System Guide to VHA Issue Briefs."
[9] VHA Notice 2024-11; VHA, "SVH VISN Liaison and Medical Facility Representative Orientation Guide."
[10] VHA Notice 2024-11.
[11] VHA Notice 2024-11; 38 C.F.R. § 51.30(b); 38 C.F.R. § 51.31(a) and (c).

VISN liaison.[12] VHA did not conduct a for-cause survey at the Black Mountain SVH in 2024 or 2025 and the VA medical facility representative, VISN liaison, and GEC leaders interviewed by the OIG denied Black Mountain SVH quality of care or safety concerns that would prompt a for-cause survey.

The OIG made no recommendations.

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

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the report (see appendixes A and B). No further action is required.

DAVID C. KRULAK, MD, MPH, MBA
Assistant Inspector General
for Healthcare Inspections

[12] VHA Notice 2024-11.

Contents

Executive Summary i

Abbreviations v

Introduction 1

Scope and Methodology 3

Inspection Results 4

Black Mountain SVH Issue Briefs and Sentinel Events 4

Facility Actions 5

VISN Actions 5

GEC Actions 6

Conclusion 7

Appendix A: VISN Director Memorandum 8

Appendix B: Facility Director Memorandum 9

OIG Contact and Staff Acknowledgments 10

Report Distribution 11

Abbreviations

GEC	Geriatrics and Extended Care
JPSR	Joint Patient Safety Reporting
OIG	Office of Inspector General
SVH	State Veterans Home
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Western North Carolina VA Health Care System (system) in Asheville in response to concerns brought forward in October 2025 by an OIG Healthcare Facility Inspection team. The inspection team identified several issue briefs related to sentinel events and falls at the North Carolina State Veterans Home (SVH) in Black Mountain, North Carolina (Black Mountain SVH). Additionally, the OIG reviewed concerns regarding Veterans Health Administration (VHA) leaders' awareness and response to these reported patient safety events. The OIG initiated the inspection on January 5, 2026, conducted a virtual site visit from January 20 through 22, 2026, and continued inspection activities through early February 2026.

Background

The system is part of Veterans Integrated Service Network (VISN) 6—the VA Mid-Atlantic Health Care Network—and is designated as a level 1b, high complexity facility.[1] The system includes the Charles George VA Medical Center (facility) and three outpatient clinics located within North Carolina, and provides comprehensive care, including medical, surgical, and specialty care services.[2] From October 1, 2024, through September 30, 2025, the system served nearly 50,000 patients.

State Veterans Homes

An SVH is a state-owned facility that is recognized and certified by VA to provide care for veterans through nursing home care, domiciliary care, and adult day health care.[3] While the "SVH VISN Liaison and Medical Facility Representative Orientation Guide" states "VA does not have legal authority over the management or operation of a SVH," VA ensures compliance with applicable federal regulations through surveys, audits, and record reviews.[4] If an SVH fails to comply with VA standards, or applicable federal law, it may lose its certification, recognition, and the ability to receive per diem payments made by VA on behalf of veteran residents.[5]

According to VHA Directive 1602SH.01, *State Home Per Diem Program,* VA assigns a VA medical facility of jurisdiction for each SVH as recommended by the Executive Director of the

[1] VHA Office of Productivity, Efficiency, and Staffing (OPES), "VHA Facility Complexity Model," October 1, 2023. VHA facilities are classified at levels 1a, 1b, 1c, 2, or 3, from most complex to least complex.

[2] The system's community-based outpatient clinics are in Franklin, Rutherfordton, and Hickory, North Carolina.

[3] VA, "State Veterans Homes Recognition Survey Process," (standard operating procedure), August 11, 2025.

[4] VHA, "SVH VISN Liaison and Medical Facility Representative Orientation Guide," January 2025.

[5] 38 C.F.R. § 51.58 requires compliance with VA standards for SVHs to receive per diem payments for care rendered to veteran residents; 38 C.F.R. § 51.32 authorizes the director of the VA medical center of jurisdiction to terminate SVH recognition.

Office of Geriatrics and Extended Care (GEC). A VA facility medical provider reviews and approves admission applications, level of care needs—including care related to service-connected disabilities—and serves as the medical representative to the SVH.[6] The facility is recognized as the VA medical facility of jurisdiction due to its close geographical location to the Black Mountain SVH.

VHA Notice 2024-11, "Oversight Requirements for State Veterans Homes," outlines types of VA-administered surveys SVHs undergo to ensure compliance with VA standards for receiving VA per diem payments.[7] The surveys may be announced recognition surveys; unannounced annual surveys, required every 12 months; or for-cause surveys, which are authorized by GEC and conducted to review specific concerns, deficiencies, or events that may cause patient harm.[8]

Section 404(a)(3) of the Inspector General Act of 1978 authorizes VA OIG to supervise activities financed by VA to promote efficiency and prevent fraud, waste, and abuse.[9] Although VA does not manage day-to-day operations of SVHs, VA provides per diem payments for qualified veterans to receive nursing home care at SVHs certified by VA. To obtain certification and receive VA per diem payments, SVHs are subject to annual and for-cause surveys by VA to ensure veterans receive quality nursing home care and quality medical care.[10] In accordance with its authority to supervise VA funded activities, the VA OIG conducted this review to evaluate the quality and efficiency of sentinel event reporting at the Black Mountain SVH in North Carolina.

VA Modernization of SVH

In 2022, VA centralized the oversight of SVHs to GEC.[11] SVH quality and oversight staff are organized geographically into four "National Pods" and per VHA Notice 2024-11, each pod is led by an SVH National Program Manager who reports to the GEC Chief for State Veterans Homes.[12] The facility falls under the Pod 2 SVH National Program Manager. As stated in VHA Notice 2024-11, one duty of the SVH National Program Manager is to participate in the SVH annual surveys, which are conducted by a VA-contracted private vendor.[13] Additionally, the facility director and VISN director are responsible for ensuring all SVH-related oversight processes are conducted. Directors can delegate tasks, such as communication regarding sentinel

[6] VHA Directive 1601SH.01, *State Home Per Diem Program*, December 1, 2022.

[7] VHA Notice 2024-11, "Oversight Requirements for State Veterans Homes," August 27, 2024.

[8] VHA Notice 2024-11.

[9] 5 U.S.C. § 404(a)(3).

[10] 38 U.S.C. § 1742. 38 C.F.R. Part 51.

[11] VHA Notice 2024-11.

[12] VHA Notice 2024-11.

[13] VHA Notice 2024-11. This notice serves as interim guidance until the publication of a new SVH oversight directive. During interviews in January 2026, the OIG learned the new VHA directive, previously VHA Directive 1145.01, is drafted and under review with an unknown anticipated publication date. Ascellon is the VA contracted vendor that surveys SVHs for compliance with VA regulations found at 38 C.F.R. § 51 and quality of care.

events at SVHs, to designees, such as the VA medical facility representative or the SVH VISN liaison (VISN liaison).[14]

OIG Concerns

In early October 2025, while reviewing documents from the system for a routine inspection, an OIG Healthcare Facility Inspection team discovered several issue briefs regarding falls resulting in injury or death at Black Mountain SVH. The OIG team reported concerns related to the number of sentinel event falls in a one-year period as well as an apparent lack of leaders' awareness of this trend. The OIG hotline triage team reviewed the concerns and recommended opening a hotline inspection. On January 5, 2026, the OIG announced the inspection to review how VA performs oversight of the Black Mountain SVH, and if facility, VISN, and national leaders responded to the reported sentinel events as required by VHA.

Scope and Methodology

The OIG announced the inspection and provided a document request to facility leaders on January 5, 2026. The OIG conducted a virtual site visit from January 20 through 22, 2026, and interviewed the VA medical facility representative, the VISN liaison, and GEC leaders, including SVH National Program Managers.

The OIG reviewed applicable VHA and system memoranda, policies, and procedures related to the oversight of SVHs. The OIG also reviewed SVH survey reports and corrective action plans, along with VHA documentation and correspondence related to patient safety events that occurred at the Black Mountain SVH from August 2024 through December 2025.

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 issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[14] VHA, "SVH VISN Liaison and Medical Facility Representative Orientation Guide"; VHA Notice 2024-11.

Inspection Results

The OIG determined facility and VISN leaders were aware of reported Black Mountain State Veteran Home (SVH) patient safety events, including sentinel events. The OIG further determined facility, VISN, and Geriatrics and Extended Care (GEC) leaders responded to the SVH sentinel events as required by VHA.

Black Mountain SVH Issue Briefs and Sentinel Events

According to VHA Notice 2024-11, sentinel events are adverse events resulting in "loss of life, limb or permanent loss of function."[15] The "Enterprise Issue Reporting System Guide to VHA Issue Briefs" and VHA Notice 2024-11 state that SVH leaders must report sentinel events, including a resident fall resulting in "death or major permanent loss of function as a direct result of the injuries sustained in the fall," to the VA medical center of jurisdiction director, or their designee, such as the VA medical facility representative, within 24 hours after identification.[16] Additionally, the "Enterprise Issue Reporting System Guide to VHA Issue Briefs" outlines that SVH leaders must "review and analyze" a sentinel event and create a written investigational report within 10 business days to prevent future harm.[17] In response to the SVH-reported sentinel event, facility leaders must prepare and submit issue briefs to inform VISN leaders, such as the VISN liaison.[18] Then, as outlined in the "SVH VISN Liaison and Medical Facility Representative Orientation Guide," the VISN liaison submits the issue briefs to GEC leaders for review.[19] The VHA National Center for Patient Safety "JPSR Guidebook" specifies sentinel events or other patient safety events that occur at an SVH should not be reported in the Joint Patient Safety Reporting (JPSR) system.[20]

From August 2024 through December 2025, facility staff completed 13 issue briefs in response to patient safety events reported by the Black Mountain SVH. The OIG reviewed and found 11 of the issue briefs were related to resident falls, while two were resident injuries unrelated to falls. The Black Mountain SVH determined 2 of the 13 events were sentinel events involving resident falls resulting in injury and subsequent death.

[15] VHA Notice 2024-11; 38 C.F.R. § 51.120(a)(1).

[16] VHA, "Enterprise Issue Reporting System Guide to VHA Issue Briefs," October 24, 2024; VHA Notice 2024-11; 38 C.F.R. § 51.120(a)(3).

[17] VHA, "Enterprise Issue Reporting System Guide to VHA Issue Briefs"; 38 C.F.R. § 51.120(a)(4).

[18] VHA, "Enterprise Issue Reporting System Guide to VHA Issue Briefs."

[19] VHA, "SVH VISN Liaison and Medical Facility Representative Orientation Guide."

[20] VHA, National Center for Patient Safety, "JPSR Guidebook," Version 6, October 1, 2025. VHA, National Center for Patient Safety, "JPSR Guidebook," December 2023. The language in both guidebook versions contain similar language regarding reporting of patient safety events at SVHs.

The OIG reviewed the two Black Mountain SVH sentinel events that occurred between August 2024 and December 2025 and determined Black Mountain SVH leaders timely reported (within 24 hours) the events to the VA medical facility representative. The VA medical facility representative provided to the OIG a copy of the written investigational report completed by Black Mountain SVH leaders for one of the sentinel events. However, neither the VA medical facility representative nor the VISN liaison could provide the OIG with a copy of the associated written investigational report that should have been completed by the Black Mountain SVH for the second sentinel event. The SVH VISN liaison told the OIG that this sentinel event occurred around the time of a major hurricane, which disrupted communication, power, and internet service.[21] While the OIG was unable to confirm Black Mountain SVH compliance with completion of the written investigational report, the OIG determined the administrative nature of the missing documentation did not rise to the level of a recommendation.

Facility Actions

According to VHA Notice 2024-11 and "Enterprise Issue Reporting System Guide to VHA Issue Briefs," once notified by SVH leaders about a sentinel event, the VA medical facility representative is responsible for "immediately notifying" (within 24 hours) the medical center director and the VISN liaison that a sentinel event has occurred via an issue brief.[22] Further, the VA medical facility representative must continue to clarify information and provide updates to the VISN liaison until resolution.[23]

Upon review of issue briefs, the OIG confirmed that both sentinel event issue briefs were created by facility staff within 24 hours of Black Mountain SVH leaders' notification. Additionally, the OIG confirmed that one sentinel event issue brief contained documented updates through resolution, such as the health status of the Black Mountain SVH resident, and the second documented planned SVH actions in response to the event. Further, the OIG confirmed that both sentinel event issue briefs and associated updates were provided to the VISN liaison for review, approval, and submission to GEC SVH National Program Managers.

VISN Actions

According to VHA Notice 2024-11, the VISN liaison is responsible for reviewing issue briefs for completeness.[24] Additionally, after reviewing the issue brief, the "SVH VISN Liaison and

[21] National Weather Service, "Tropical Storm Helene: September 26-27, 2024," accessed February 9, 2026, https://www.weather.gov/ilm/Helene2024. Hurricane Helene was a Category 4 storm that struck the east coast of the United States in late September 2024, causing strong winds, severe flooding, property damage, and fatalities.

[22] VHA Notice 2024-11; VHA, "Enterprise Issue Reporting System Guide to VHA Issue Briefs."

[23] VHA Notice 2024-11.

[24] VHA Notice 2024-11.

Medical Facility Representative Orientation Guide" states that the VISN liaison should submit issue briefs to GEC for review by SVH National Program Managers.[25]

During an interview with the OIG, the VISN liaison reported a practice of reviewing issue briefs and, when necessary, requesting information and updates from the VA medical facility representative to help ensure issue brief documentation completeness. Further, from review of issue briefs and email correspondence from fall 2024, the OIG confirmed that the VISN liaison reviewed both sentinel event issue briefs received from facility staff and approved the issue briefs for submission to GEC SVH National Program Managers as required.

GEC Actions

According to VHA Notice 2024-11, the GEC SVH National Program Manager is responsible for "reviewing, documenting and analyzing all SVH reported adverse events and sentinel events" via issue briefs.[26] Additionally, a for-cause survey of the SVH may be authorized by GEC leaders based on concerns noted by the VA medical facility of jurisdiction or VISN.[27]

The Pod 1 SVH National Program Manager, who conducts national SVH training, described reviewing the issue brief narrative for (1) the date when the patient safety event was identified as a sentinel event; (2) the date the sentinel event was reported to VA; and (3) the timeliness of the written report. The manager further described communicating with the VISN SVH liaison and VA medical facility representative if clarification was needed. The OIG reviewed GEC documentation tracking issue briefs received, which confirmed the manager's description of issue brief analysis. According to VHA Notice 2024-11, the VA medical facility representative and VISN liaison may provide GEC SVH staff with a recommendation to conduct a for-cause survey.[28] The OIG confirmed that VHA did not conduct a for-cause survey at the Black Mountain SVH in 2024 or 2025. Further, the VA medical facility representative, VISN, and GEC SVH staff interviewed by the OIG denied having quality of care or safety concerns with the Black Mountain SVH that would prompt a for-cause survey. Additionally, the Pod 2 SVH National Program Manager described bidirectional, open communication with the VA medical facility representative and the VISN liaison to discuss SVH concerns. The OIG also reviewed the Black Mountain SVH 2024 and 2025 annual surveys and confirmed there were no sentinel event-related findings.

[25] VHA, "SVH VISN Liaison and Medical Facility Representative Orientation Guide."
[26] VHA Notice 2024-11.
[27] VHA Notice 2024-11.
[28] VHA Notice 2024-11.

Conclusion

The OIG determined facility, VISN, and VHA leaders were aware of the reported sentinel events and falls at the Black Mountain SVH, as described in issue briefs from August 2024 through December 2025, and took action in accordance with VHA policy. The OIG found that the staff at the facility of jurisdiction timely completed issue briefs regarding sentinel events at the Black Mountain SVH and notified the VISN liaison. Although the OIG was unable to confirm SVH leaders' compliance with a written investigational report for one of two sentinel events, the OIG determined the administrative nature of the missing documentation did not rise to the level of a recommendation. Further, the OIG determined the VISN liaison reviewed and submitted issue briefs to the GEC SVH National Program Manager for review and analysis as required.

The OIG did not make recommendations based on this review.

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

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 15, 2026

From: Interim VA Mid-Atlantic Health Care Network Director, VISN 6 (10N06)

Subj: VA Office of Inspector General (OIG) Healthcare Inspection—Review of VA's Oversight of a State Veterans Home at the Western North Carolina VA Health Care System in Asheville

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54HL07)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections and review the OIG report—Review of VA's Oversight of a State Veterans Home at the Western North Carolina VA Health Care System in Asheville. The VA Mid-Atlantic Health Care Network notes that the OIG did not make any recommendations and has no comments.
2. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by*:)

Kevin P. Amick, MBA, MHRM

[OIG comment: The OIG received the above memorandum from VHA on May 7, 2026.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 16, 2026

From: Executive Director, Western North Carolina VA Health Care System (637/00)

Subj: VA Office of Inspector General (OIG) Healthcare Inspection—Review of VA's Oversight of a State Veterans Home at the Western North Carolina VA Health Care System in Asheville

To: Director, VA Mid-Atlantic Health Care Network (10N06)

1. Thank you for the opportunity to review and respond to the draft report OIG Review of VA's Oversight of a State Veterans Home at the Western North Carolina VA Health Care System in Asheville.
2. While the OIG made no recommendations for improvement, Western North Carolina VA Health Care System remains committed to continuously improving the quality and safety of Veteran care.
3. If you have any additional questions or need further information, please contact the Chief, Quality & Patient Safety.

(*Original signed by*:)

STEPHANIE YOUNG, MHA, FACHE

[OIG comment: The OIG received the above memorandum from VHA on May 7, 2026.]

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Alison Loughran, JD, BSN, Director Ashley Dobrovech, MJ, RN Vanessa Masullo, MD Carrie Mitchell, LCSW Tanya Oberle, LCSW, MSW Andrew Waghorn, JD
Other Contributors	Karen Berthiaume, RPh, BS Natalie Sadow, MBA Tammra Wood, MSSW, LCSW-S

Report Distribution

VA Distribution

Office of the Secretary
Office of Accountability and Whistleblower Protection
Office of Congressional and Legislative Affairs
Office of General Counsel
Office of Public and Intergovernmental Affairs
Veterans Health Administration
Director, VA Mid-Atlantic Health Care Network (10N06)
Director, Western North Carolina VA Health Care System (637/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: Ted Budd, Thom Tillis
US House of Representatives: Chuck Edwards, Virginia Foxx, Pat Harrigan, Tim Moore

OIG reports are available at www.vaoig.gov.

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.