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OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Audit of VISN 8 Supply Chain Management

Audit | **25-00885-144** | **June 18, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) conducted this audit to assess supply chain management operations at VA medical facilities in Miami, Orlando, and Gainesville, Florida, to determine whether network and facility managers effectively oversaw supply chain management to ensure compliance with applicable Veterans Health Administration (VHA) policies. The team focused on four areas that had recurring weaknesses identified in prior audits: expendable supplies inventory (disposable items typically used once); nonexpendable equipment inventory (durable equipment with a service life of two or more years); supply chain leadership; and medical distribution and warehouse controls. The audit included expendable supply operations during the second quarter of fiscal year 2025 and nonexpendable equipment purchased from October 1, 2019, through March 5, 2025.

Generally, the team found that all three medical facilities—which fall under Veterans Integrated Service Network (VISN) 8—did not always meet VHA's requirements for managing expendable supplies and nonexpendable equipment. Deficiencies that the OIG identified stemmed from inadequate oversight, risking the loss of supplies and equipment or products expiring.

In October 2025, the medical directors from all three reviewed facilities told the OIG team that they had implemented several recent initiatives to improve inventory and equipment accountability. In December 2025, the audit team briefed VISN 8 leaders responsible for overseeing supply chain management. In January 2026 and April 2026, the OIG briefed senior VHA leaders, including VHA's chief officer for support operations, on the results of this audit. At the time of the publication of this report, VHA had announced significant changes to the structure of its management and operations, including VISNs, effective May 1, 2026. The OIG's findings can help guide VHA's reorganization efforts to more effectively oversee the facilities' corrective actions.

The OIG made seven recommendations to improve supply chain management in VISN 8 facilities. In May 2026, the acting VISN 8 network director concurred with recommendations 1 through 4, as well as 6 and 7, concurred in principle with recommendation 5, and submitted corrective action plans to address issues identified in the report. The acting director's full response is provided in appendix E.

What the Audit Found

Overall, the OIG team estimated that inventory discrepancies in expendable supplies resulted in $3.1 million in funds that could be better used. Inaccurate inventories also could lead to expired supplies, premature purchases of more supplies, and delays in patient care if supplies are not available. These inventory discrepancies may have occurred because some facility supply chiefs may not have consistently used tools to monitor or verify that local processes met established

benchmarks and standards, such as spot checks, audits, or follow-up reviews. Supervisors at the three facilities reported that supply technicians did not record inventory in real time, which led to inaccuracies. Miami and Gainesville facility staff did not consistently safeguard some expendable medical supplies, leaving the items susceptible to loss, theft, or unauthorized use.

The team also found discrepancies in nonexpendable equipment inventory records. Based on the results of a statistical sample, the team estimated that 48 percent of nonexpendable items were in a different location than what was recorded in the inventory management systems. In some cases, facility staff eventually found these items. However, the OIG team estimated that at least 1,100 nonexpendable items (6 percent), valued at about $12.7 million, were missing. Inaccurate nonexpendable inventory records increase the risk that equipment needed for patient care cannot be found or that maintenance and repair schedules are delayed.

All three medical facilities did not consistently apply established controls to ensure nonexpendable equipment was properly received, tagged, and recorded. These inventory discrepancies resulted from facility leaders not ensuring custodial officers updated equipment locations for all property on their equipment inventory listing. Custodial officers at all three facilities also noted that clinical staff often move nonexpendable equipment without notifying supply chain staff, making it difficult to update equipment location records. Furthermore, the three facilities did not consistently initiate and complete reports of survey to investigate the circumstances of missing equipment or monitor this process, weakening overall asset accountability.

Although the VISN 8 chief logistics officer conducted required oversight, such as quality control reviews, the three facilities continued to struggle with supply chain management. The VISN chief logistics officer lacks direct authority to require corrective action at the facility level.

Next Steps

The OIG will continue to evaluate VHA's corrective actions and will close the recommendations once VHA provides sufficient evidence that it has addressed the intent of the recommendations and the issues identified in this report.

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Contents

Abbreviations

AEMS/MERS	Automated Engineering Management System/Medical Equipment Reporting System
FY	fiscal year
GIP	Generic Inventory Package
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted this audit to assess supply chain management in Veterans Integrated Service Network (VISN) 8; specifically, the OIG examined whether network and facility managers provided effective oversight of supply chain management and ensured compliance with Veterans Health Administration (VHA) policies. The team selected three VISN 8 facilities to review based on total expenditures for supplies and equipment, quality control reviews with ongoing noncompliant findings, and repeated issues related to management of expendable supplies and nonexpendable equipment.

The audit included expendable supply operations during the second quarter of fiscal year (FY) 2025 and nonexpendable equipment purchased from October 1, 2019, through March 5, 2025. In this context, expendable supplies are disposable items that are used in patient care, such as syringes, while nonexpendable equipment is durable and has a service life of two or more years, such as magnetic resonance imaging machines.

VHA Directive 1761 sets policy related to the VA Secretary's authority to procure healthcare items under 38 U.S.C. §§ 8121 and 8125.[1] For the management of nonexpendable equipment, VHA facilities must comply with VHA Directive 7002, which incorporates requirements for federal management of property set forth in 41 C.F.R. §§ 101 and 102.[2]

According to VHA Directive 1761, VA medical facilities must establish, operate, and maintain an effective supply chain management program to minimize costs and ensure sufficient stock to meet demand.[3] VHA currently divides the United States into 18 regional networks, known as VISNs, which comprise various types of VA medical facilities that work together to serve veterans in the region.[4] Each VISN is led by a director who provides operational oversight of VA medical facilities and is responsible for compliance with supply chain management policy.

At the time of the publication of this report, VHA had announced significant changes to the structure of VHA management and operations, including VISNs, effective May 1, 2026. The OIG's findings provide information that VHA can consider as it undertakes reorganization efforts to more effectively oversee the facilities' corrective actions. The team informed the VISN, medical facility leaders, and supply chiefs of the audit's preliminary findings during multiple briefings that took place in September, October, and December 2025.

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

[2] VHA Directive 7002, *Logistics Management Policy*, January 8, 2020.

[3] VHA Directive 1761.

[4] VHA, "Veterans Integrated Service Network (VISN)" (web page), accessed December 22, 2025.

Oversight of Supply Chain Management at VA Medical Facilities

VISN chief logistics officers are required by VHA Directive 1761 to assess programs at each medical facility through an annual quality control review.[5] If the VISN identifies deficiencies, the medical facility must develop an action plan and complete corrective actions within 90 business days from the date of the review. VISN chief logistics officers must ensure deficiencies are corrected by the end of the fiscal year according to the quality control review instructions for supply chain management.[6] Quality control reviews cover both expendable and nonexpendable inventory management, medical distribution, warehouse management, and supply chain management leadership.

For this audit, the OIG team focused on expendable supplies inventory, nonexpendable equipment inventory, supply chain leadership, and medical distribution and warehouse controls—as these areas had recurring weaknesses or control deficiencies identified in prior OIG audits, indicating a need for further review.[7] Since this audit started, the directors from all three reviewed facilities told the OIG team that they had implemented several recent initiatives to improve inventory and equipment accountability. These include using internal nonexpendable inventory dashboards, improving training, and conducting wall-to-wall inventories twice a year. For more information on VA's recent actions, see appendix A.

In September 2024, the OIG recommended VISNs improve oversight of medical facilities' supply chain management.[8] The OIG found that some VISN chief logistics officers did not ensure their facilities complied with policy and did not fix problems identified through quality control reviews because they did not have direct authority over the facilities.

At the medical facility level, the chief supply chain officer (supply chief) is responsible for establishing a supply chain management program that aligns with VHA policy, meets operational requirements, and uses the VHA-approved inventory management system. The supply chief's responsibilities also include inventory accounting and completing a year-end certification of inventory values and equipment inventory.

The supply chief serves as the accountable officer and has responsibility for all expendable supplies and nonexpendable equipment from acquisition to final disposition; these responsibilities can be delegated in writing to other staff, according to VA Handbook 7002.[9] That

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

[6] VHA Supply Chain Management Quality Control Review Instructions, September 1, 2023.

[7] VA OIG, *Deficiencies in Managing Supply, Equipment, and Implant Inventory at the Michael E. DeBakey VA Medical Center in Houston, Texas*, Report No. 24-00166-35, March 18, 2025; VA OIG, *Improved Oversight Is Needed to Correct VISN-Identified Deficiencies in Medical Facilities' Supply Chain Management*, Report No. 23-02123-202, September 12, 2024.

[8] VA OIG, Improved Oversight Is Needed to Correct VISN-Identified Deficiencies in Medical Facilities' Supply Chain Management.

[9] VA Handbook 7002, *Logistics Management Procedures*, January 8, 2020.

handbook, along with the pertinent fact sheet, explain that the accountable officer's primary role is to ensure all inventories are accurate and maintained in accordance with VA policy—including overseeing the receipt and inspection of all incoming shipments—and to ensure property is appropriately used and maintained.[10]

Management of Expendable Clinical Supplies

According to VHA Directive 1761, expendable clinical supplies are disposable items, such as gloves, syringes, and catheters, that are to be inventoried each quarter, semiannually, or once per year, depending on their classification. VHA staff use Generic Inventory Package (GIP) software to manage expendable supplies.

Facility staff use barcode data to track expendable inventory and monitor the use of supplies. VHA requires barcode labels on all expendable supplies and storeroom shelves. Physical counts are not required for stand-alone inventory points if inventory is taken monthly with a scanner or other electronic means. The primary inventory point is a storeroom that houses all expendable supplies for an inventory account. Staff use the inventory account to determine what has been used and to order replacements. Inventory at secondary points should be scanned and reconciled every month according to VHA Directive 1761. A secondary inventory point is a distribution point for services in a facility that is typically replenished using supplies from the primary inventory point.

Supply chain staff must enter correct conversion factor data into GIP to ensure the accuracy of days-of-stock-on-hand metrics.[11] The conversion factor is a critical component of inventory management that accounts for items that are received into inventory in large units of measure but distributed in smaller units.[12] The unit conversion factor is calculated by dividing the quantity received by the quantity issued. For example, a case of 1,200 gloves is divided by 100 gloves per box (unit of issue), resulting in a conversion factor of 12. This means one case can be issued as 12 individual boxes. This factor connects how a supply item is received to how it is issued. A "false" conversion factor in VHA's systems may be the result of an incorrect conversion factor being entered into GIP.

[10] VA Handbook 7002; VHA Procurement and Logistics Office, "Accountable Officer Overview" fact sheet, undated.

[11] VA Office of Information and Technology Product Development, *Integrated Funds Distribution, Control Point Activity, Accounting and Procurement*, IFCAP Application Coordinator User's Guide, Version 5.1, October 2000, revised October 2019.

[12] VHA Procurement and Logistics Office, "How to Identify Conversion Factor Errors and Correct Them" (nonpublicly accessible SharePoint website), accessed September 16, 2025.

To control inventory, medical facility staff must establish and maintain inventory thresholds in GIP:

- Normal stock level is the maximum amount of an item the facility is supposed to maintain.
- Reorder point is the minimum on-hand quantity of an item that should prompt facility staff to reorder it.
- Emergency stock level is the minimum quantity of an item the facility must have available for emergency situations.

Facility staff must base these stock levels on usage data, ordering lead times, and facility-specific needs and must review these thresholds quarterly to ensure accurate inventory control.

Management of Nonexpendable Equipment

Nonexpendable equipment is durable, for continuous use, generally has a service life of two or more years, and costs $300 or more. All nonexpendable equipment must be accounted for in an approved automated inventory system, such as the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS) or Maximo. VHA requires that all nonexpendable items be tracked through an equipment inventory listing for each service line, ensuring accountability and oversight. Each equipment inventory listing is overseen by a custodial officer, typically a service chief or equivalent, appointed by the facility director.

Custodial officers must complete annual inventories of nonexpendable equipment with a purchase cost of $5,000 or more according to VHA Directive 1761 and VA Handbook 7002. This process involves locating and scanning equipment barcode labels or verifying the presence of recorded items. After completing the inventory, custodial officers must certify the results electronically in AEMS/MERS or Maximo, ensuring accurate and up-to-date records. Custodial officers also manage equipment turn-ins and dispositions, process inventory updates (such as updating equipment location), and coordinate reports of survey—which are the process for investigating and notifying VA about the loss, damage, or destruction of government supplies and property.

VISN 8

VISN 8, also known as the VA Sunshine Healthcare Network, comprises seven medical centers and 90 community clinics that serve over 1.4 million veterans across Florida, southern Georgia, and the Caribbean, including Puerto Rico and the US Virgin Islands. According to VHA data, VISN 8 expenditures for all types of supplies and equipment increased over the last five fiscal years from about $1.05 billion in FY 2020 to about $1.5 billion in FY 2025. Of VHA's 18 VISNs, VISN 8 ranked highest in spending on medical and surgical supplies and equipment for FY 2025.

For this audit, the OIG team reviewed the Bruce W. Carter VA Medical Center in Miami, the Orlando VA Medical Center (the fourth largest VA medical center in the US), and the Malcom Randall VA Medical Center in Gainesville (figure 1).

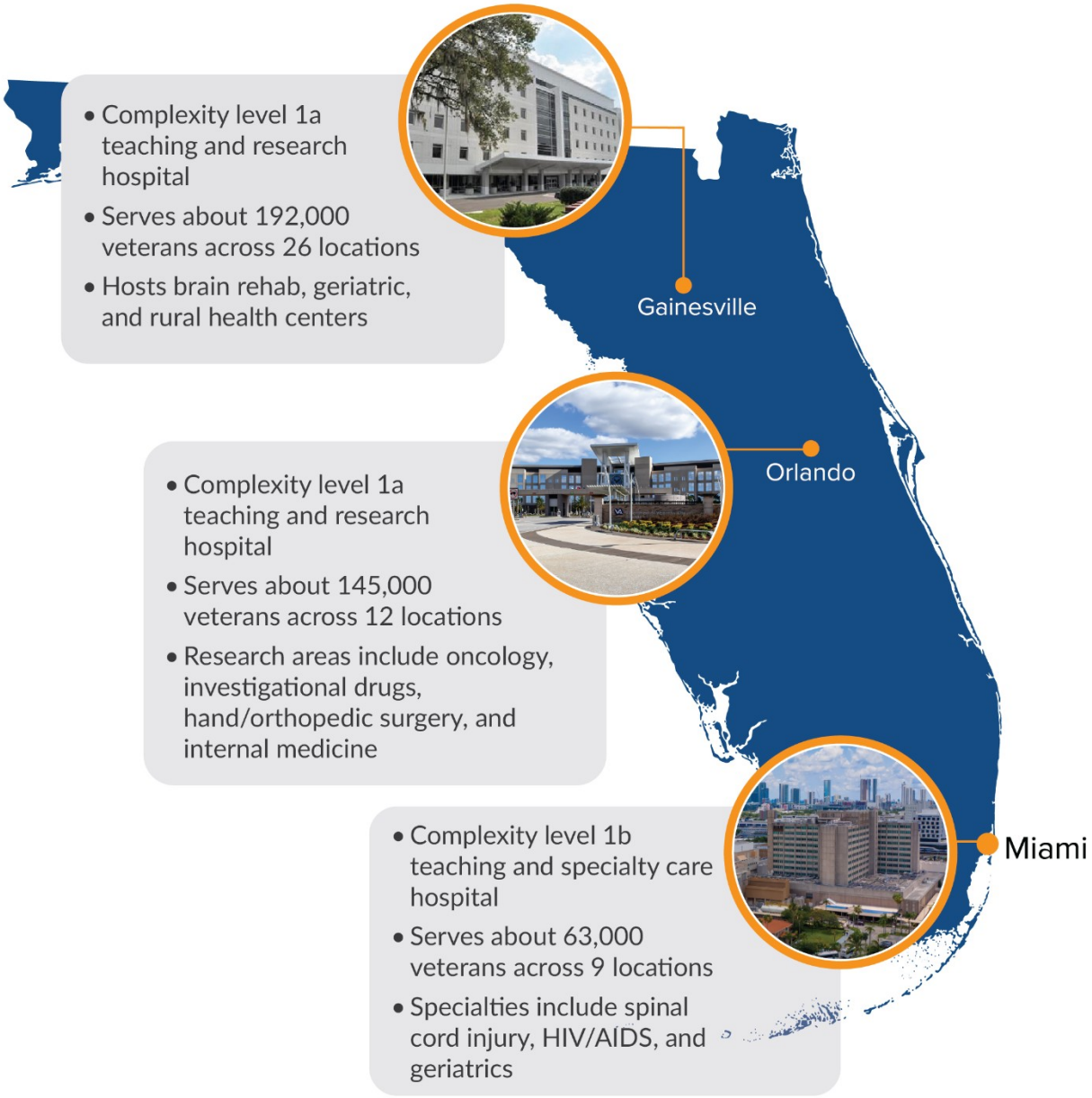

Figure 1. *Location of VA medical facilities evaluated for inventory management oversight and processes.*

Source: "VHA Facility Complexity Model Fact Sheet," undated.

Note: VHA uses a facility complexity model that classifies its facilities at levels 1a, 1b, 1c, 2, or 3, with level 1a being the most complex. All seven facilities in VISN 8 are rated as highly complex.

Results and Recommendations

Finding: VISN 8 Medical Facility Staff Did Not Consistently Manage and Secure Expendable Supplies or Nonexpendable Equipment

The OIG team found that the Miami, Orlando, and Gainesville facilities had issues managing expendable supplies and nonexpendable equipment—and expendable supplies were not physically secured at the Miami and Gainesville facilities, leaving them vulnerable to theft or loss. The team estimated that 78 percent of expendable supply items reviewed across the three facilities had inaccuracies between inventory records and supplies on hand. At least 3 percent had incorrect conversion factors, and at least 20 percent were inaccurately classified. Because of the conversion factor errors, the inventory system reflected different values for certain types of items than what the facilities had, and these differences amounted to a total estimated value of $1.1 million based on the sample analysis results.

About 48 percent of the reviewed expendable items were over VHA's required normal stock levels, and at least 13 percent were below the reorder point. The OIG team estimated that discrepancies between physical counts and system records, along with inventory maintained above normal stock levels, account for at least $1.2 million and about $2.9 million, respectively, in funds that could have been put to better use. Overstocking products could potentially increase the risk of supplies expiring, which could result in unnecessary costs and waste of taxpayer dollars. These issues occurred because supply chiefs did not monitor or verify that local processes met established benchmarks and standards.

For nonexpendable equipment, the team estimated that 48 percent of items reviewed were not in the system-recorded locations, though some were later found elsewhere. In total, the team estimated that at least 1,100 items (at least 6 percent), valued at about $12.7 million, could not be located. Additionally, facility staff did not complete reports of survey in a timely manner as required by VA Directive 7002. Unless these deficiencies are addressed, these facilities are at risk of equipment loss, theft, misplacement, or unauthorized use. The inaccuracies occurred because facility leaders did not enforce custodial officer responsibilities to validate and report changes to supply chain staff when equipment was moved; ensure supply chain staff tagged equipment; or enforce or monitor the report of survey process. While the VISN chief logistics officer monitored supply chain management at these facilities, neither the VISN nor facility directors ensured facility staff implemented action plans to correct the deficiencies as required by VHA Directive 1217(1).

What the OIG Did

The OIG team visited the Miami, Orlando, and Gainesville facilities in March 2025; reviewed relevant policies and procedures; interviewed supply chain staff; and evaluated facility inventory

management practices for expendable supplies and nonexpendable equipment. The team also interviewed the VISN 8 chief logistics officer and supply chain management leaders from six VISN 8 facilities to assess oversight of the facilities' supply chain management program.

The team selected a sample of 98 expendable supply items, split across the three facilities, from the facility-managed inventory system as of March 11, 2025, and compared inventory records to the quantities observed on hand. For nonexpendable equipment, the team tested 141 items from the three facilities to determine whether the recorded locations captured on March 5, 2025, matched the items' physical locations.

The team observed physical storage areas and controls at the facilities' warehouses and medical distribution areas. The team also examined VISN oversight activities and conducted a web survey of 461 medical providers from the three facilities. For more information about the audit's scope and methodology, see appendix A. For information on the audit's statistical sampling methodology, see appendix B.

Management of Expendable Inventory

The team found that facility staff did not effectively manage expendable supply inventory at all three facilities visited, and expendable supplies were insecurely stored at two facilities. Inaccurate inventory records, discrepancies in labeling of supplies, and unsecure storage all increased the risk of supply shortages, expired items, incorrect records of supply availability, and unaccounted-for losses. Additionally, as some facility providers explained in their survey responses, patient care was sometimes delayed when required supplies were not available.

Expendable Inventory Records

The OIG team evaluated the inventory management system to assess the accuracy and accountability of expendable supplies at the three facilities. Figure 2 summarizes the projected results by deficiency category based on the team's sample review.

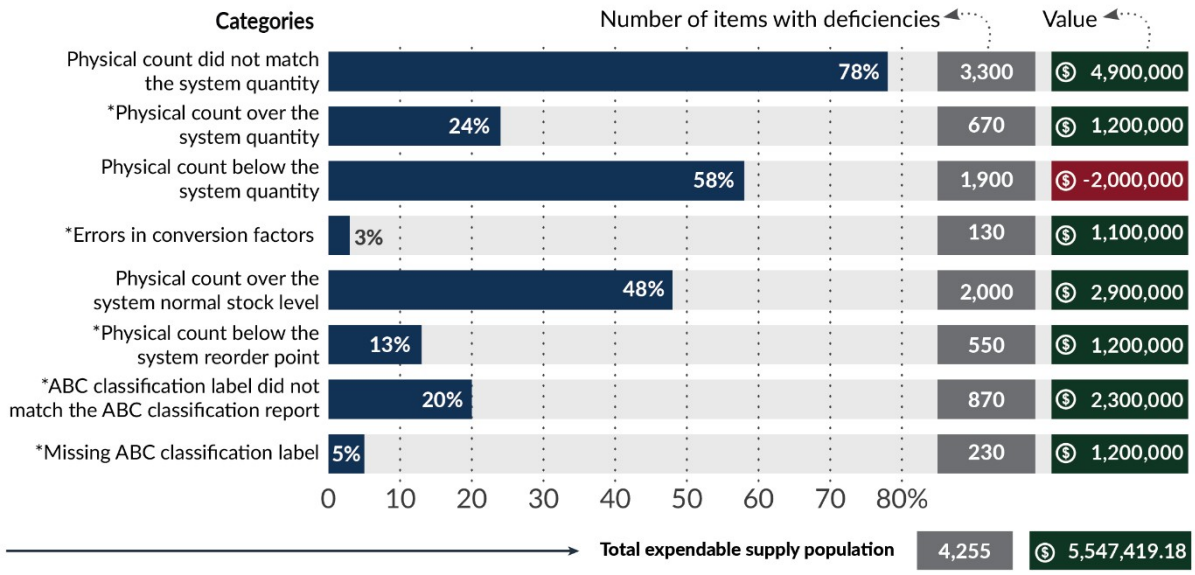

Figure 2. *Estimated deficiencies across the Miami, Orlando, and Gainesville facilities.*

Source: VA OIG statistician's analysis.

** Denotes one-sided lower-limit estimates. Point estimates were used for other projections where they reasonably reflected expected impact. Totals may not sum precisely due to the use of one-sided lower-limit estimates for some categories.*

The OIG team found that GIP records did not match on-hand supplies at all three facilities. VHA Directive 1761 requires medical facilities to routinely monitor reports for inventory accuracy. Based on a statistical sample of 98 various expendable items from the primary medical surgical inventory point at the three facilities, the team estimated that 3,300 of 4,255 items (78 percent) had a discrepancy between the recorded and the on-hand quantities.

Of those estimated 3,300 items, at least 670 (at least 24 percent) had *more* on-hand quantities than reported in GIP, with an estimated value of at least $1.2 million. Within the sample, these differences ranged from one to 2,341 units. Overstocked items included blood collection tubes, intravenous catheters, and surgical gloves. For example, the Gainesville facility had 3,739 blood collection tubes recorded in GIP, but the team counted 6,080—a difference of 2,341 tubes, valued at around $530. This error may reflect the premature purchase of supplies, increasing the risk of inefficient use of government funds. The OIG team estimated that overstocked items could represent at least $1.2 million in funds with better use (see appendix D).

The team estimates that about 1,900 of the 3,300 items (58 percent), valued at about $2 million, had *fewer* on-hand quantities than reported in GIP across the three facilities. Within the sample, these differences ranged from one to 29,271 units. Understocked items included intravenous needles, skin and wound hydrogel, and infusion sets. For example, GIP showed that the Miami facility had 6,891 pump infusion sets on hand, valued at around $26,550. But the team's physical count identified only 354 sets, with a value of about $1,360. These errors could result in supply shortages or delays in patient care.

Figure 3 on the next page compares the on-hand and system quantities for the five sampled supply items with the greatest underreporting discrepancies and the five with the greatest overreporting discrepancies. The figure also includes an aggregate row, which shows the difference across all 10 items; this value is negative because the magnitude of the underreported exceeds the overreported. Several of the underreported supply items reflect large differences, which may increase the risk of unexpected shortages if staff are unaware the supplies are out of stock.

Sample	Physically on hand	System reported quantity	Difference	Percent difference
Patient slippers (XL)	6	1,511	-1,505	-100%
Underpads	119	2,837	-2,718	-96%
Pump infusion set	354	6,891	-6,537	-95%
N95 masks	1,444	5,374	-3,930	-73%
Finger pulse sensor (adult)	2,527	3,265	-738	-23%
Medical procedure mask	638	557	81	15%
Exam gloves	1,137	856	281	33%
Intravenous catheter needle	1,550	995	555	56%
Blood collection tubes	6,080	3,739	2,341	63%
X-ray towels	740	280	460	164%
Aggregate of sampled items (not projected)	25,787	76,520	-50,733.00	-66%

Figure 3. *Inventory discrepancies of 10 sampled items.*

Source: VA OIG analysis of physical inventory counts for a selected sample of 98 expendable supplies compared to GIP inventory system data.

Note: The 10 supplies listed comprise the five sampled supply items with the largest underreporting discrepancies and the five with the greatest overreporting discrepancies. Items with conversion factor errors were excluded from this analysis. X-ray towels have a radiopaque strip in the hem so that the towel is visible on x-ray to reduce the risk of inadvertently sewing surgical items into patients during surgery.

Some of these discrepancies were conversion factor errors. The team estimated that at least 130 items (at least 3 percent) across the three facilities had incorrect unit conversions. The total estimated inventory value of these 130 items was about $1.1 million, meaning the recorded quantities were either overstated or understated because supply chain staff incorrectly calculated the conversion factor between the purchased and distribution units, as shown in example 1.[13]

Example 1

At the Gainesville facility, an adapter vial device used to transfer medication was incorrectly entered into GIP at a cost of $1,130.58 per box, which is the cost of a case containing four boxes. Therefore, each time a box was issued to a clinic, GIP overstated its value by $847.93: the difference between the per box cost of $282.65 and the cost of a case of four boxes of $1,130.58. This error significantly inflated the inventory value. Specifically, GIP showed 27 boxes on hand incorrectly valued at $1,130.58 each, totaling $30,525.66. But the team found only nine boxes, valued at $282.65 each (totaling $2,543.85). This meant that the inventory value was overstated by $27,981.81. This overstatement reduced the reliability of inventory records and could affect decisions related to purchasing, inventory replenishment, and resource allocation, potentially disrupting the availability of supplies used for patient care.

The team also found discrepancies between the physical on-hand quantities and the established normal stock level and reorder points at all three facilities. The team estimated that 2,000 of 4,255 items (48 percent) had quantities higher than VHA's required normal stock levels and at least 550 items (at least 13 percent) were stocked below the reorder point. The team found that items exceeding normal stock levels may result in an estimated $2.9 million in better use of funds.

These excess quantities may reflect overstocking, which can contribute to inefficient inventory management, increase the risk of supplies expiration, result in unnecessary costs, and waste taxpayer dollars. To assess whether the sampled items with physical quantities exceeding normal stock levels had a history of being removed due to expiration or excess, the team requested Turn-In documentation, used to track disposal of unneeded items. The Gainesville and Orlando facilities provided the requested records. In February 2025, Gainesville staff disposed of 23 cartons of electrical brain activity sensors (valued at about $440 each), worth about $10,000, illustrating the risk of product expiration due to overstocking. The OIG team did not receive a response from the Miami facility, and without this information, the team could not determine

[13] The audit team used the lower limit of the 90 percent confidence interval to estimate the number and percentage of items with conversion factor errors. For the total value affected, the team used the point estimate because the lower limit was not deemed necessary to conservatively reflect the potential operational impact.

whether identified overages resulted in wasted supplies at that facility. This information is important to ensure facilities are good stewards of taxpayer dollars.

OIG survey results revealed that inaccurate expendable supply inventory records in GIP sometimes affected patient care at the three facilities. Of the 210 providers who reported using expendable supplies for medical care, 42 (20 percent) stated that, in the past year, some expendable supplies needed for patient care were expired. For example, a provider from the Gainesville facility reported an instance in which expired items were brought into the operating room. After administering general anesthesia for a patient, the provider had to delay surgery until staff could bring replacement items.

Of the 210 survey respondents, 73 (35 percent) reported that, in the past year, certain expendable supplies were unavailable. For example, at the Miami facility, a provider reported numerous instances in which basic supplies required for care were not available. The provider said a clinic was canceled because podiatric nail clippers were not available, multiple smaller gauze strips had to be used because the necessary size was not available, and no bandage scissors were available to remove dressings. Limited availability of medical supplies may increase the risk of disruptions to patient care.

These inventory discrepancies occurred because supply chiefs did not establish monitors and local processes—such as spot checks, audits, or follow-up reviews—to ensure established supply chain benchmarks and standards were met as outlined in VHA Directive 1761. One inventory manager described the environment as "learn as you go," citing limited time and staffing barriers as two aspects that affected consistent oversight. The Orlando supply chief attributed inventory discrepancies to limited accountability, explaining that the lack of a dedicated supervisor for expendable inventory left a gap in daily monitoring. He noted that although someone had been hired for the role, the individual resigned shortly after starting, and the position was later cut. He said the assistant chief had assumed dual responsibilities, which may have affected enforcement. According to VHA Directive 1761, the supply chief is ultimately responsible for ensuring accurate inventory oversight and reconciliation.

Supervisors at all three facilities told the OIG team that supply technicians were not consistently posting inventory stock items in real time, which they said led to inaccurate inventory numbers. Supply technicians explained that they did not always ensure inventory counts were accurate and complete before posting results in the system, which can result in discrepancies. A supervisory inventory management specialist from Gainesville explained that delays can also result from multiple staff members attempting to access the same inventory point in the system, as the system restricts access, preventing others from posting their results. VHA noted that this challenge is common across facilities because it stems from inherent limitations in the inventory system. Similarly, a supervisor in Orlando noted that they are encouraging staff to improve time management and post inventory transactions throughout the day, rather than waiting until the end of the shift when timely posting becomes even more difficult as everyone tries to access the

system at the same time. These challenges illustrate the importance of increased monitoring and coordination throughout the inventory process.

Without reliable GIP inventory data, facility leaders cannot make informed decisions for operational planning and supply chain issues. Inaccurate expendable supply inventory records in GIP limit the VISN's ability to effectively monitor and manage supply chain operations. Additionally, poor data quality limits decision-making related to procurement, stock replenishment, and resource allocation.

To ensure the reliability of GIP inventory data and avoid delays in patient care, the OIG's first recommendation is to require supply chain staff to review unit conversion factors for accuracy and correct discrepancies.

The OIG's second recommendation is for facility directors to develop and implement procedures to maintain stock levels within the thresholds required by VHA Directive 1761.

Reported Impact of Staffing Challenges

According to supply chiefs at five of the seven VISN 8 medical facilities, staffing losses from the Deferred Resignation Program, the federal hiring freeze, and long-standing vacancies (some up to two years) for personnel such as supervisory supply technicians, supervisory inventory management specialists, supply technicians, inventory management specialists, mail supervisors, clerks, and purchasing agents have threatened the effectiveness and sustainability of supply chain management operations across their sites. The OIG did not evaluate the extent to which staffing losses and vacancies contributed to the issues found in this report, as many of these losses occurred late in the audit team's review, and facilities have taken steps to try to better use the remaining staff.

To address these staffing challenges and sustain operations, supply chiefs stated they have used strategies such as increasing voluntary overtime, focusing limited staff on high-impact clinical areas, and establishing an intra-facility labor pool by temporarily pulling staff from other departments. Shift adjustments and cross-coverage have also been used to maximize resources, including combining shifts and training staff from other functions to help where possible.

Labeling Practices for Expendable Supplies

At all three facilities, the team found that inventory labels were missing or had inaccurate ABC classifications. VHA uses the ABC classification method stated in VHA Directive 1761 for inventory management. Inventory items with the highest annual usage spending (the top 80 percent) are classified as "A" items and must be counted each quarter. Supplies with the next highest annual usage (the next 10 percent) are considered "B" items and are counted in the first and third quarters, and items representing the remaining 10 percent (lowest usage) are in the "C" category and are inventoried in the second quarter. The OIG team reviewed the ABC

classification designations on the barcode labels for the 98 sampled supply items and compared them to the classifications listed in the FY 2025 ABC classification report. Based on the results of this sample analysis, the team estimated that at least 870 items (at least 20 percent) were incorrectly labeled, and at least 230 (at least 5 percent) were missing labels entirely. See appendix C for the sample results by facility.

Although labeling procedures were in place, facility leaders did not ensure staff consistently applied or updated labels to reflect the current ABC designation. The Gainesville supply chief attributed inaccurate labeling to an ongoing transition involving new shelving installation and inventory movement. Miami facility staff explained to the audit team that the facility was addressing labeling errors in preparation for the VISN's quality control review that was scheduled to start two weeks after the team's visit.

Facility leaders did not treat labeling accuracy as a high-priority control and neglected to assign clear responsibility for maintaining it. Without defined ownership or consistent oversight, labeling tasks were inconsistently performed and often overlooked. For example, at the Miami facility, microscope glass slides had a "B" label affixed to the barcode, but the ABC classification report showed the item should have been classified as "A." It had been classified as "C" in FY 2023, further indicating that facility supply chain staff had not consistently updated the label in accordance with annual report changes. Figure 4 shows these different classifications.

Figure 4. *Barcode label affixed to the microscope glass slides shows a "B" classification (left), while the most recent ABC classification report listed the item as "A" for FY 2024 and as "C" the prior year (right).*

Source: VA OIG auditor photograph, March 11, 2025 (left) and screenshot of excerpt from VHA's ABC 2024 Report, which the OIG modified to display only relevant data for the item (right).

Outdated inventory labeling impaired staff's ability to track, prioritize, and replenish supplies. When items are not accurately classified, required inventory counts may not occur, and supply rotation practices may be disrupted.

To address these deficiencies, the OIG's third recommendation is to require supply chain staff to review and update ABC classification labels for expendable supplies and ensure this labeling matches the current ABC classification report.

Physical Security Controls for Expendable Supplies

VA Handbook 0730 states that effective physical security requires planning to protect resources and property and to prevent loss or theft of vulnerable supplies. The Orlando facility had physical security controls, but the Miami and Gainesville facilities did not consistently safeguard expendable medical supplies, which increases the risk of loss, theft, or unauthorized use.

At the Miami and Gainesville facilities, the team observed expendable medical supplies stored in rooms with doors that were propped open, giving access to patients, visitors, and unauthorized staff. Figure 5 shows a door propped open at the Gainesville facility, which gave unauthorized access to expendable supplies in the warehouse and supply overflow areas. An inventory management specialist from Gainesville expressed the concern that leaving the doors open all day allows anyone entering the facility through the warehouse doors to reach the main supply storeroom.

Figure 5. *Connecting door to warehouse and supply overflow area via medical distribution room at the Gainesville medical facility where the door was left open, allowing unrestricted entry.*

Source: VA OIG photograph, March 12, 2025.

During the March 2025 Miami site visit, the audit team also found an inoperable lock on the door from the staff work area to the medical distribution supply room. In April 2025, an inventory management specialist stated that for about two years, staff had been submitting work orders to repair the lock. But those requests had not been addressed, and the inventory manager said he

was unsure why no action had been taken. In December 2025, the supply chief informed the audit team that the lock had been fixed and provided photographic evidence of the repair.

Meanwhile, at the Miami facility in March 2025, the team identified expendable medical supplies stored in the hallway, which was accessible by patients, visitors, and staff (as shown in figure 6). According to the inventory management specialist, supplies were stored in the hallway due to space constraints. After the OIG site visit, the supply chief informed the audit team in April and again in October 2025 that the supplies had been removed from the hallway and the medical distribution extension storage room and sent the team photographic evidence.

Figure 6. *Boxes of expendable supplies stacked almost to the ceiling in a hallway at the Miami medical facility (left). The image on the right shows the door to this hallway, which was publicly accessible and unsecured.*

Source: VA OIG photographs, March 11, 2025.

Until the identified issues are addressed, these facilities are at increased risk of loss, theft, or unauthorized use of expendable supplies. Without routine monitoring, the facilities are also at increased risk of being unable to identify inventory losses.

The OIG's fourth recommendation is for the medical facilities to develop a process to ensure staff safeguard expendable supplies in accordance with VA Handbook 0730.

Management of Nonexpendable Equipment

The OIG team found that staff at the Miami, Orlando, and Gainesville facilities did not ensure all nonexpendable equipment was properly recorded and accounted for in AEMS/MERS or

Maximo, as required by VA Handbook 7002. Figure 7 summarizes the projected results by deficiency category based on the team's sample testing.

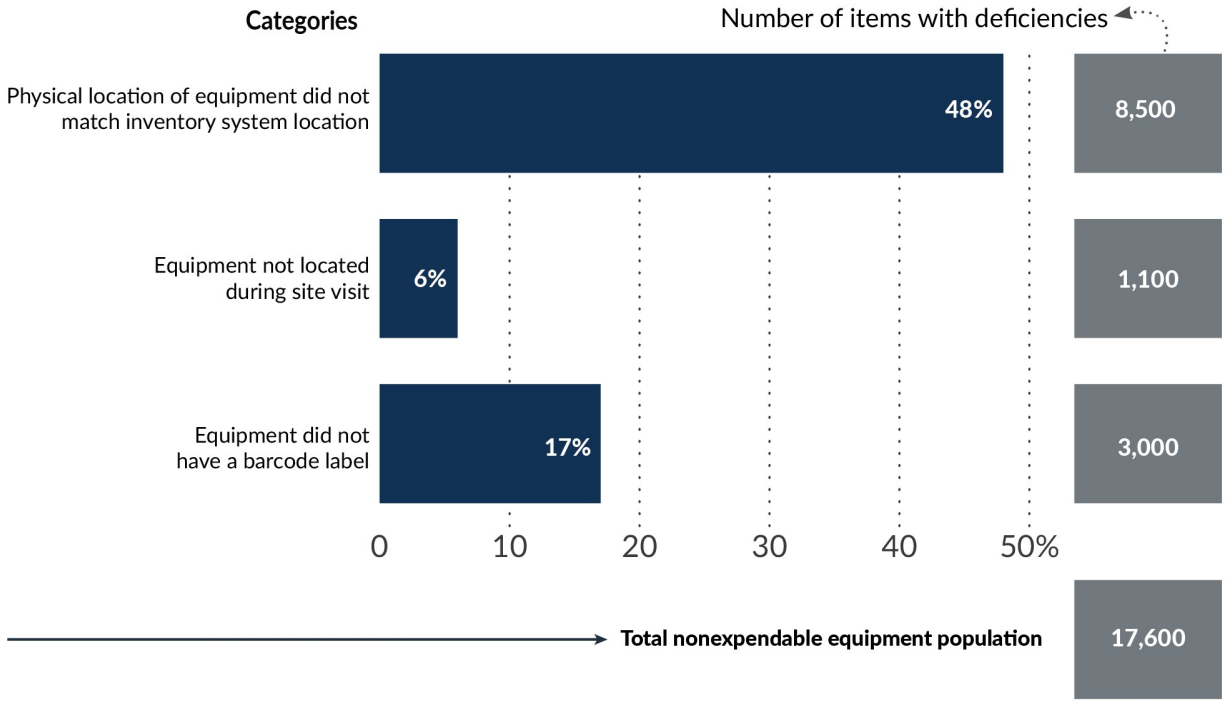

Figure 7. *Estimated deficiencies for nonexpendable equipment records across the Miami, Orlando, and Gainesville facilities.*

Source: VA OIG statistician's analysis.

Note: The number shown for "Total nonexpendable equipment population" reflects the estimated number of in-scope nonexpendable equipment population used in the projections.

Medical Facilities' Tracking and Monitoring of Nonexpendable Equipment

To assess the accuracy of nonexpendable equipment records, the OIG team evaluated a statistical sample of 141 nonexpendable equipment items across the three facilities. Based on the results, the team estimated that 8,500 of 17,600 items (48 percent) were in a different physical location than what was recorded in AEMS/MERS or Maximo. Items not found in the location listed in the system included a magnetic resonance imaging machine, a uniform-dispensing machine, and a surgical robot. These items were later found elsewhere in the facility.

During site visits in March 2025, the team collaborated with facility staff to verify the physical location of selected nonexpendable equipment. In some cases, staff located items that were not initially found in their recorded locations. While moving equipment to different areas is routine, staff should return equipment to its original location or document any permanent location changes in the system, as described in VA Handbook 7002.

The team estimated that at least 1,100 nonexpendable equipment items (at least 6 percent), valued at about $12.7 million, were not found at all, based on system records and from observations during site visits. The team, in collaboration with facility staff, determined that four sampled items were either no longer at the facility or could not be found at the time of this review. The items were a portable ultrasound device (valued at about $870), a sleep monitor (valued at about $3,800), a medical monitor (valued at about $23,000), and a wound therapy unit (valued at about $32,700). In April 2025, the OIG team inquired about the status of each of these items. Facility staff had completed the report of survey process to document the loss of one of the four items, and facility supply chain staff were continuing to search for the remaining three items. Miami facility staff provided photographic evidence that the medical monitor was found in May 2025 and the portable ultrasound device was found in July 2025.

These inaccuracies occurred because facility leaders did not enforce custodial officer responsibilities for updating equipment locations. According to VA policy, the facility's accountable officer, who is also the facility chief supply chain officer, is responsible for making sure inventories are accurate and properly maintained. Custodial officers are responsible for all property listed on their signed equipment inventory listing. This includes validating and reporting changes in equipment location during the required annual inventory as described in VA Handbook 7002.

According to facility supply chain staff from all three facilities, custodial officers were either nonresponsive or did not respond promptly to requests from supply chain managers to complete the required inventories. The Miami facility supply chief explained that, since supply chain management staff lack direct oversight of custodial officers, he communicates with them to address concerns raised by his staff. If custodial officers remain unresponsive, he escalates the issues to the facility's executive leadership team.

Custodial officers at all three facilities expressed concerns about the accuracy of the equipment inventory listings, which can affect the timeliness and reliability of inventory records. They noted that some items no longer in use still appear active on the equipment inventory listing and that transferring equipment to the appropriate responsible service has been challenging. A Gainesville custodial officer highlighted difficulties in updating inventory records when equipment is later found. For example, at the same facility, the OIG team identified two pieces of equipment that were marked as "lost or stolen" in 2023 following a report of survey but were located and scanned in 2024. However, the inventory records were not updated to reflect their return to "in use" status until the issue was identified by the OIG team. A custodial officer at the same facility told the team that he had noticed items on the equipment inventory listing being marked as "inventoried/scanned" even though the items were either not accounted for or had been turned in for disposal.

At all three facilities, clinical staff frequently moved nonexpendable equipment without notifying supply chain staff. As a result, supply chain staff did not update equipment location records.

Nonexpendable equipment inventory managers at all three facilities identified this as a primary reason for discrepancies between system records and actual equipment locations. Similarly, custodial officers told the OIG team that these pieces of equipment often lack a permanent location and are used by several employees across different areas. To address this challenge, supply chain staff use various strategies, such as helping custodial officers find the equipment. The Orlando facility also uses Real Time Location System devices to help track mobile items.

Inaccurate inventory records of nonexpendable equipment put these medical facilities at increased risk of equipment loss, misplacement, or unauthorized use. Inaccurate inventory records compromise staff's ability to locate and manage assets effectively, which can delay equipment availability for clinical services and hinder maintenance and repair schedules, resulting in operational inefficiencies.

According to the OIG's survey results, 180 medical providers at these three facilities reported using nonexpendable equipment to deliver patient care. Among these, 37 providers (21 percent) reported instances in the past year when equipment was unavailable due to reasons such as insufficient quantity, inoperability, or the need to search for equipment. Additionally, 19 providers noted that the unavailability of nonexpendable equipment affected patients' appointments. Collectively, these challenges may increase the risk that equipment needed for patient care may not always be available.

Barcode Labeling on Nonexpendable Equipment

The team estimated that 3,000 of 17,600 items (17 percent) across the three facilities did not have the required barcode labels, which are necessary to conduct annual inventory scans and maintain accurate tracking. VA Handbook 7002 states that equipment inventories should be conducted using barcode technology compatible with the automated inventory management system. Items without barcode labels included a surgical robot (valued at about $2 million), a robotic arm system (valued at about $1.2 million), a delivery cart, a precision saw, and communication devices.

All three medical facilities lacked controls to ensure supply chain staff properly received, tagged, and recorded nonexpendable equipment. A supervisory inventory management specialist stated that in some cases, equipment is delivered directly to service areas without undergoing the required receiving and tagging processes. These items bypass the supply chain process, which delays or prevents the application of barcode labels and their entry into the inventory system. Facility staff also reported that barcode labels are sometimes not applied to equipment items that need frequent sanitation for patient care and items that are too small for a label to fit properly.

Nonexpendable equipment that is not properly tagged with barcodes cannot be scanned during the required annual inventory. This prevents facilities from accurately accounting for the equipment and its condition, as required by VA Handbook 7002 for asset management and

financial reporting. When logistics staff discover equipment that has not been tagged, they initiate the tagging process so equipment can be scanned for inventory.

The OIG's fifth recommendation is to ensure equipment items are properly tagged, establish protocols to notify supply chain staff when equipment is moved, and validate and update equipment location during clinical moves.

Reports of Survey for Missing Equipment

At all three facilities, reports of survey were not completed in a timely manner to address equipment losses. VA Handbook 7002 mandates that employees immediately report such incidents to their supervisors, who then inform the VA police. The report of survey should be submitted to the accountable officer within 72 hours. This handbook further states that the entire report of survey process should be completed within 60 days of an incident, unless there is a risk of financial liability or an ongoing investigation.

The OIG team reviewed 16 pieces of equipment documented across nine reports of survey that were either selected for testing or identified as missing during site visits. The equipment included sampled items that were listed as lost or stolen in the inventory system or were not located during the team's site visit review. The team found that the process for initiating and completing the report of survey was not consistently enforced or monitored. As a result, losses were not promptly reported or investigated, weakening overall asset accountability.

The team found that the overall process was not completed in a timely manner for at least five of the nine reviewed reports of survey. Five reports of survey lacked sufficient information to determine whether the submission was compliant because it was unclear when the item was identified as missing. According to the Miami facility supply chief, these delays stemmed from custodial officers neglecting to initiate the process promptly, often spending more time searching for lost items instead. A custodial officer at the Gainesville facility said once the inventory deadline passes, supply chain staff urge custodial officers to initiate a report of survey for any missing equipment, but staff continue to search for the items, as shown in example 2.

Example 2

After conducting an annual inventory in March 2024, Gainesville facility staff determined that 158 items, valued at about $152,000, were missing. A report of survey was signed by the custodial officer in October 2024 for all items; however, the process stalled until the OIG team asked for the status of the report of survey in March 2025. According to the police report, staff did not thoroughly search for the items during the inventory review. The report of survey indicated that 96 of the 158 items had been found or turned in and 62 had not. The report was finalized in September 2025.

Without accurate and timely reports of survey, facilities are at increased risk of financial loss and inventory discrepancies, potentially affecting their ability to maintain accurate financial reporting and asset management. Inaccurate inventory records hinder VA's capacity to safeguard assets and ensure accountability, and heighten the risk of misplacement, loss, or theft of government property.

To safeguard facilities' equipment, the OIG's sixth recommendation is to require facilities to enforce completing reports of survey on time according to VHA policy and to implement mechanisms to monitor the initiation, approval, and closure of these reports.

Medical Facilities' Response to VISN Quality Control Reviews

The VISN chief logistics officer fulfilled their oversight responsibilities in accordance with VHA Directive 1761 by identifying deficiencies at each facility and monitoring the facilities' progress toward implementing corrective action plans. Despite the VISN's active monitoring and follow-up, recurring inventory management issues at the three facilities suggest a need to further strengthen implementation efforts and internal controls at the facility level.

The VISN 8 chief logistics officer, or their designee, conducted annual quality control reviews of supply chain operations at every facility in the VISN in FY 2024, as required by VHA Directive 1761. These reviews identified 179 combined deficiencies across VISN 8 facilities, with more than 100 of those deficiencies attributed to the Miami, Orlando, and Gainesville facilities. The deficiencies included inaccurate inventory records, improper labeling, a lack of barcode application on nonexpendable equipment, and facilities not completing reports of survey within 60 days as required by VA Directive 7002. Each facility was required to develop corrective action plans for identified deficiencies. To monitor the progress and implementation of these plans, VISN staff used a site visit tracker, which documented issues and tracked resolution status and closeouts. According to the VISN 8 chief logistics officer, the tracker also sends automated email notifications to the VISN's leadership team when a facility's supply chief takes an action or misses a deadline, helping reinforce accountability and increase visibility into unresolved issues.

Facility supply chiefs consistently described VISN 8's oversight as proactive, helpful, and responsive. For example, the Miami supply chief said the VISN chief logistics officer holds calls every two weeks to discuss supply chain performance. These efforts show that the VISN chief logistics officer fulfilled his assigned oversight responsibilities and actively supported medical facilities in strengthening supply chain operations. However, despite the VISN chief logistics officer's engagement, the recurring deficiencies in supply chain operations at the Miami, Orlando, and Gainesville facilities indicate that these facilities did not always take corrective actions to resolve the issues the VISN identified. Although the VISN chief logistics officer does not have direct authority to enforce corrective actions, the VISN shares identified deficiencies with facility leadership, including officials who oversee supply chain management. It is

important that VISN and facility directors work together to ensure facility supply chain staff develop and implement action plans to address deficiencies found during the VISN's quality control reviews.

The OIG identified some issues during the audit that had also been noted in previous quality control reviews, indicating that the facilities had not fully addressed these deficiencies. For example, consecutive quality control reviews (in FYs 2023 and 2024) found all three facilities noncompliant with annual equipment inventory requirements, and the FY 2024 review further identified noncompliance with barcode labeling. These repeat findings imply a continuous breakdown in the control environment around asset tagging and accountability.

These issues were not isolated. In FY 2023, the VISN 8 chief logistics officer identified 154 noncompliant findings across the VISN's quality control reviews, of which 88 (57 percent) were attributed to the Miami, Orlando, and Gainesville facilities. These repeated control breakdowns suggest that while corrective actions may have been documented, they were not always sustained at the facility level, further highlighting ongoing weaknesses in these facilities' internal controls for supply chain management. The Miami facility interim director reported that the facility had no controls in place for verifying the effectiveness of corrective actions and cited staffing shortages as a challenge. The Gainesville director said the facility relies on quality control reviews to determine whether corrective actions were effective and noted staffing limitations and the use of an antiquated inventory system as barriers. The Orlando facility associate director explained that the facility monitors the effectiveness of corrective actions by reviewing multiple daily reports.

While VHA Directive 1761 explains that the VISN is responsible for monitoring and tracking facility compliance with supply chain requirements, VISN staff do not have direct authority to enforce corrective actions or implement structural changes at the facilities. This limits the VISN's ability to ensure timely and effective resolution of deficiencies, particularly when facilities do not prioritize or fully execute action plans. The VISN 8 chief logistics officer noted that he does not have a direct line of authority over facility supply chiefs and instead must rely on "influential authority" to ensure they follow through on their responsibilities. According to VHA Directive 1761, medical facility directors have direct authority of facility supply chiefs. The current oversight structure may reduce the overall effectiveness of the VISN's efforts, despite consistent engagement and follow-through. As VHA undertakes its organizational restructuring, leadership should consider the findings in this report to help ensure future oversight structures address the identified gaps in authority and accountability.

The OIG's final recommendation is to ensure facilities implement corrective actions to effectively address deficiencies identified by VISN 8 during the quality control reviews.

Conclusion

Supply chain staff at the three facilities the audit team visited did not consistently manage expendable supplies or nonexpendable equipment in accordance with VA Handbook 7002 and VHA Directive 1761. All three facilities had inaccurate inventory records in the inventory management system, outdated stock levels, incorrect unit conversion factors, and missing or incorrect ABC classification labels. The OIG team determined that items with physical counts higher than the quantities recorded in the system and those held above normal stock levels could yield an estimated $1.2 million and $2.9 million, respectively, in better use of funds.[14] In addition, several supply storage areas at two of the facilities lacked basic security controls, increasing the risk of unauthorized access. For nonexpendable equipment, supply chain staff did not accurately maintain location data in AEMS/MERS or Maximo or consistently apply barcode labels. Although the VISN 8 chief logistics officer effectively identified and escalated supply chain deficiencies, he lacked authority to ensure facility compliance. And, because facility supply chiefs do not report to the VISN chief logistics officer, oversight efforts are limited, reducing the overall effectiveness of supply chain management across the VISN. It is important that the VISN director ensures that facility supply chain staff implement action plans to address deficiencies found during the VISN's quality control reviews.

Recommendations 1–7

The OIG made the following recommendations to the VISN 8 network director:[15]

1. Require medical facility directors in Veterans Integrated Service Network 8 to ensure supply chain staff periodically review unit conversion factors in the Generic Inventory Package to ensure accurate system values and quantities are recorded and then correct any discrepancies.
2. Require medical facility directors in Veterans Integrated Service Network 8 to develop and implement procedures to maintain stock within the required thresholds as outlined in Veterans Health Administration Directive 1761.
3. Require medical facility directors in Veterans Integrated Service Network 8 to ensure supply chain staff review and update ABC classification labels on expendable supplies in accordance with Veterans Health Administration guidance and establish a process to routinely verify that labeling aligns with the official ABC classification report.

[14] See appendix D for information regarding monetary benefits in accordance with Inspector General Act Amendments.

[15] The recommendations addressed to VISN 8 network director are directed to anyone in an acting status or performing the delegable duties of the position.

4. Ensure medical facility directors in Veterans Integrated Service Network 8 develop a process to ensure facility staff safeguard expendable supplies in accordance with Veterans Administration Handbook 0730.
5. Ensure medical facility directors in Veterans Integrated Service Network 8 develop and implement local procedures that require clinical service areas to notify supply chain staff when equipment is relocated and establish protocols to validate and update equipment location during clinical moves or room changes and ensure equipment items are properly tagged.
6. Require medical facility directors in Veterans Integrated Service Network 8 to enforce timely completion of reports of survey in accordance with Veterans Health Administration policy and implement oversight mechanisms to monitor the timely initiation, approval, and closure of reports.
7. Ensure facilities implement corrective actions to effectively address deficiencies identified during the Veterans Integrated Service Network's quality control reviews.

VA Management Comments

In May 2026, the acting VISN 8 network director concurred with recommendations 1 through 4, 6, and 7 and concurred in principle with recommendation 5. The acting director also submitted corrective action plans to address each recommendation.

For recommendations 1 through 4, the VISN plans to provide conversion-factor training for supply chain staff and correct conversion factor discrepancies; strengthen stock-threshold compliance through training, quarterly inventories, and annual quality control reviews; implement standardized ABC-classification procedures and provide required classification training; and develop processes to safeguard expendable supplies, communicate the new process to all applicable staff, and assess compliance with quality control reviews.

For recommendation 6, the VISN is enforcing timely completion of reports of survey by implementing a dashboard to track reports, ensuring that custodial officials and investigation board members complete training, and conducting quality control reviews. For recommendation 7, the VISN plans to address all outstanding quality-control deficiencies within 90 days of the OIG's report publication, and any deficiencies that cannot be addressed in that time frame will require an extension from the network director.

Regarding recommendation 5, the acting director concurred in principle and plans to evaluate the potential use of tagging and tracking technology to enhance accountability for mobile equipment and conduct periodic audits and quality control reviews.

OIG Response

The VISN's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will close the recommendations when VISN 8 provides sufficient evidence that the action plans have been completed. The full text of the VISN 8 acting director's comments and target completion dates are presented in appendix E.

Appendix A: Scope and Methodology

Scope

The VA Office of Inspector General (OIG) team conducted its work from March 2025 through April 2026, focusing on expendable supplies and nonexpendable equipment at the Veterans Integrated Service Network (VISN) 8 VA medical facilities in Miami, Orlando, and Gainesville, Florida. These three facilities were judgmentally selected based on total expenditures for supplies and equipment and prior quality control reviews with repeat noncompliant findings. The audit included expendable supply operations during the second quarter of fiscal year (FY) 2025, as well as nonexpendable equipment purchased from October 1, 2019, through March 5, 2025. In March 2025, the team conducted site visits at each facility.

Methodology

The team interviewed the VISN 8 chief logistics officer and supply chain management leaders from six of seven VISN 8 facilities to assess oversight of each facility's supply chain management program. They also interviewed clinical and supply staff responsible for the management, accountability, and physical security of supplies and equipment at the Miami, Orlando, and Gainesville facilities. The team identified and reviewed applicable laws, regulations, and policies related to the Veterans Health Administration's (VHA) supply chain management. The team also reviewed FY 2023 and FY 2024 quality control reviews and other relevant documentation from the Miami, Orlando, and Gainesville facilities.

During site visits to the Miami, Orlando, and Gainesville facilities, the team reviewed a statistical sample of expendable supplies to test the accuracy of the inventory data in the Generic Inventory Package (GIP) and also tested the accuracy of the nonexpendable equipment inventory data in the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS) and Maximo systems. The team physically observed the facilities' storage areas, as well as controls at the facilities' warehouses and medical distribution areas.

Survey Methodology

The team conducted a web survey of 461 providers at the Miami, Orlando, and Gainesville facilities from April 8, 2025, through May 9, 2025. The survey's objective was to determine whether healthcare providers experienced any impact on patient care due to shortage or expiration of expendable medical and surgical supplies and missing or inoperable nonexpendable medical equipment.

The survey was distributed to 468 statistically sampled healthcare providers stratified by specialty clinics in each facility. Seven providers were excluded due to incomplete contact information, out-of-office status during the survey period, misclassification as nonproviders, or

undeliverable email. Of the remaining 461 providers, 291 completed the survey, resulting in a response rate of over 63 percent. Twenty-five (25) of the providers who completed the survey said they do not provide direct patient care. The team's analysis is based on 266 survey responses from healthcare providers who provide direct patient care or clinical services in support of patient care, as shown in table A.1.

Table A.1. Survey Stratification Summary by Facility

Stratum	Gainesville n (N)	Miami n (N)	Orlando n (N)	Total n (N)
Women's Health, Dentistry, Nephrology, Urology, Rehabilitation	12 (74)	12 (141)	12 (42)	36 (257)
Allergy, Ophthalmology	12 (108)	12 (97)	12 (60)	36 (265)
Surgical Specialties	12 (91)	12 (87)	12 (194)	36 (372)
Specialized Medicine, Diagnostics Fields	18 (288)	18 (210)	18 (440)	54 (938)
Primary Care, General Medicine	42 (1,112)	42 (984)	18 (437)	102 (2,533)
Mental Health, Neurology	24 (592)	24 (309)	24 (676)	72 (1,577)
Emergency Medicine	12 (134)	12 (105)	18 (359)	42 (598)
Critical and Palliative Care	12 (137)	12 (70)	24 (645)	48 (852)
Other	12 (112)	12 (110)	18 (260)	42 (482)

Source: VA OIG statistician's stratified survey population. Distribution data were obtained from the Miami, Orlando, and Gainesville medical facilities.

Abbreviations: n, sample size; N, population size.

The survey was restricted to a predetermined set of email addresses, and the review team implemented measures to disable multiple submissions. The team also sent follow-up reminders to providers who did not respond to the survey. The results of the survey are based on self-reported information, which the team could not validate without performing site visits or monitoring all individuals during the survey process.

Internal Controls

The team assessed internal controls to determine whether they were significant to the audit objective. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communication, and

monitoring.[16] In addition, the team reviewed the principles of internal controls associated with the objective. The team identified four components and six principles as significant to the objective.[17] The team identified internal control deficiencies during this audit and proposed recommendations to address those listed in table A.2.

Table A.2. VA OIG Analysis of Internal Control Components and Principles Identified as Significant

Component	Principle	Deficiency identified by this audit
Control environment	3. Establish structure, responsibility, and authority organizational structure	VISN 8 leadership does not have established formal authority for the VISN chief logistics management to escalate unresolved corrective actions for the facility leadership to review.
	5. Enforce accountability	Medical facility leaders did not hold supply chain management staff accountable for properly managing and securing the expendable and nonexpendable items.
Risk assessment	7. Identify, analyze, and respond to risks	Medical facility leaders did not access the accuracy of expendable and non-expendable inventory records and ensure timely oversight to address risks.
Control activities	12. Implement control activities	Medical facility leaders did not ensure VA supplies and equipment were accurately recorded in the inventory management systems.
Monitoring	16. Perform monitoring activities	Medical facility leaders did not enforce consistent monitoring to ensure accurate accountability for supplies and equipment in the inventory systems.
	17. Evaluate issues and remediate deficiencies	Medical facility leaders did not enforce accurate and timely completion of reports of survey.

Source: VA OIG analysis of internal control components and principles listed in the Government Accountability Office's Standards for Internal Control in the Federal Government.

Data Reliability

The team assessed the reliability of inventory data extracted from GIP for expendable supplies and from Maximo and AEMS/MERS for nonexpendable equipment. The team tested key data

[16] Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

[17] Because the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that could have existed at the time of this audit.

fields for completeness, accuracy, and reasonableness; reviewed system documentation; and compared recorded data to physical inventory observations. Based on the results of these procedures, the team determined that the data were sufficiently reliable for the purpose of this audit.

Interim Communications with VHA

The OIG team conducted the following interim briefings with VISN 8 leaders, facility leaders, and facility supply chiefs to discuss the audit's preliminary results:

- In September 2025, the OIG team met with the VISN 8 chief logistics officer and facility supply chiefs.
- In October 2025, the OIG team met with the Orlando, Gainesville, and Miami facility leaders.
- During the week of December 15, 2025, the OIG team met with the VISN 8 network director and the deputy network director.
- During the week of January 12, 2026, the OIG team met with VHA's chief officer for support operations.

The team met with each facility director from all three reviewed facilities separately in October 2025, and during these meetings, they told the OIG team that they had implemented several recent initiatives to improve inventory and equipment accountability.

At Orlando, the director reported that supply chain management staff have decreased the number of items that have been in inventory for more than 90 days and reorganized their storage to improve compliance. He also said quarterly inventory registry reviews now help set appropriate normal stock levels and standard on-hand items. According to the director, supply chain management staff also tightened custodial official responsibilities using internal nonexpendable inventory dashboards and report of survey processes; the director said this measure improved compliance and improved accountability. He also said the Lake Nona campus is now using a Real Time Location System and has tagged 1,000 pieces of mobile medical equipment, with plans to expand tagging for all high-dollar equipment and operationally beneficial items.

The interim director for the Miami facility said they have made significant progress in improving accountability and staff training. Leaders have encouraged better communication with clinical counterparts to support these improvements.

At the Gainesville facility, the director reported that supply chain management staff conducted wall-to-wall inventories in October 2025, scanning 15,844 equipment items. These inventories will occur twice a year to improve accountability. She also told the OIG team that a systems redesign project was completed on October 1, 2025, which implemented the Electronic Turn-In Portal to track all equipment turn-ins in a centralized electronic system accessible by supply

chain staff, custodial officials, and their designees. She also said the new portal will improve equipment accountability and ensure all equipment turned in is electronically tracked through final disposition.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards.[18] Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

[18] Government Accountability Office, *Government Auditing Standards 2024 Revision*, GAO-24-106786, February 2024.

Appendix B: Statistical Sampling Methodology

Approach

To accomplish the audit objective, the team reviewed a statistical sample of expendable supplies recorded in the Generic Inventory Package (GIP) at Veterans Integrated Service Network (VISN) 8 medical facilities in Miami, Orlando, and Gainesville, Florida. The team used statistical sampling to estimate the extent of discrepancies between recorded inventory and actual quantities on hand and the number of unaccounted-for equipment items. The team also reviewed a stratified sample of nonexpendable equipment recorded in the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS) and Maximo.

Population

The team obtained the universe of total expendable supplies and quantities on hand as of March 11, 2025. The team excluded certain categories, such as supplies in community-based outpatient clinics or those with zero quantities in normal stock levels and quantities on hand. After these exclusions, the remaining universe included 4,255 items, valued at $5,547,419.18.

The team also obtained a universe of nonexpendable equipment items with a purchase date from October 1, 2019, through March 5, 2025. From the universe, the team then excluded disposition records, equipment assigned to the Office of Information and Technology, building service equipment, records with a total asset value of less than $300, records listed as “lost or stolen,” and station numbers and locations associated with community-based outpatient clinics, veteran centers, and other off-site locations. Following those exclusions, the universe consisted of 20,355 nonexpendable equipment items valued at $198,085,461.91.

Based on the review of a probability sample (to be described further below) from the nonexpendable equipment sampling frame, the team estimated that the target population consisted of about 17,600 items. The difference between the review population size and the estimated target population size is due to the sampled records that did not meet project scope requirements (for example, locations outside the medical center) as shown in table B.1.

Table B.1. Estimated Out-of-Scope and In-Scope Nonexpendable Equipment Items, with a 90 Percent Confidence Interval

Request	Estimate	Margin of error	Lower limit	Upper limit	Sample size	Rounded estimate
Out of scope (percentage)	2,731 (13.4)	835 (4.1)	1,896 (9.3)	3,565 (17.5)	19	2,700
In scope (percentage)	17,624 (86.6)	835 (4.1)	16,790 (82.5)	18,459 (90.7)	141	17,600
Total (percentage)	**20,355 (100)**	**—**	**—**	**—**	**160**	**20,300**

Source: VA OIG statistician's analysis. Data were obtained from the Corporate Data Warehouse.

Note: The numbers in this table are rounded.

Expendable Supplies Sampling Design

To assess the accuracy of inventory records for expendable supplies, the team selected a stratified sample of 98 supply items from data extracted from GIP. The sample was divided into 15 strata based on their value ranges (see table B.2 on the next page). The sample included expendable supplies stored and distributed by the C-Distribution or the medical and surgical primary inventory point. For each sampled item, the team physically observed the on-hand inventory to verify the recorded quantity, labeling, and storage locations and compared the observed results to the corresponding GIP records to identify discrepancies. While the team did not suspend operations during physical inventory counts, as some facilities do during their internal inventories, the team mitigated the associated risk of inaccurate counts by capturing and reviewing the transaction register report at the beginning and end of each day.[19] For any sampled items with activity on the day of the count, the team verified transaction posting times and compared them to the time the item was physically counted. This process allowed the team to account for any inventory movement and avoid double counting or missing items that moved in or out of inventory during the physical counts. In April 2025, the team shared all discrepancies with a point of contact at each facility who had responsibility over the expendables inventory, allowing them to review and respond with supporting documentation.

[19] GIP User Training Guide, December 2015; The transaction register report provides detailed transactions and activity for a specified item in a selected month, as well as the display of opening and closing balances.

Table B.2. Stratified Inventory Summary by Medical Facility in Florida

Location	Station	Stratum	Value range	Number of items	Total value	Number of sampled items
Miami	546	1	$0 to less than $300	303	$31,871.56	2
	546	2	$300 to less than $1,000	184	$107,299.99	2
	546	3	$1,000 to less than $5,000	214	$501,127.74	7
	546	4	$5,000 to less than $10,000	37	$257,726.49	4
	546	5	$10,000 or more	49	$1,265,694.99	18
Gainesville	573	6	$0 to less than $300	800	$95,653.86	2
	573	7	$300 to less than $1,000	385	$211,666.93	4
	573	8	$1,000 to less than $5,000	245	$522,483.59	10
	573	9	$5,000 to less than $10,000	51	$354,154.32	7
	573	10	$10,000 or more	23	$511,021.11	10
Orlando	675	11	$0 to less than $300	1,103	$127,822.21	3
	675	12	$300 to less than $1,000	510	$288,809.49	6
	675	13	$1,000 to less than $5,000	281	$571,754.40	10
	675	14	$5,000 to less than $10,000	45	$308,728.03	6
	675	15	$10,000 or more	25	$391,604.47	7
Total	**—**	**—**	**—**	**4,255**	**$5,547,419.18**	**98**

Source: VA OIG statistician's stratified population. Data were obtained from the Corporate Data Warehouse.

Note: Items valued at the lower bound of each range (for example, $300, $1,000, $5,000, and $10,000) are included in that value range.

Nonexpendable Equipment Sampling Design

To assess the accountability of nonexpendable equipment, the team selected a stratified sample of 160 equipment items from data extracted from AEMS/MERS and Maximo on March 5, 2025. The sample was divided into 12 strata based on the station and asset value ranges (see table B.3 on the next page), and of the 160 samples selected, 141 were deemed in scope for testing. The team physically observed each sampled equipment item to verify its existence, location, and key

identifying fields such as serial number, electronic equipment record number, and room number. The team shared all discrepancies with the nonexpendable supervisory inventory management specialists and the supply chiefs for visibility, allowing them to review and respond with supporting documentation.

Table B.3. Stratified Equipment Sample Summary by Medical Facility in Florida

Location	Station	Stratum	Value range	Number of items	Total value	Number of sampled items
Miami	546	1	$300 to less than $1,000	1,466	$864,746.45	2
	546	2	$1,000 to less than $5,000	2,835	$6,475,367.01	5
	546	3	$5,000 to less than $10,000	1,018	$7,298,034.41	7
	546	4	$10,000 or more	814	$48,539,331.56	35
Gainesville	573	5	$300 to less than $1,000	1,738	$1,042,242.81	2
	573	6	$1,000 to less than $5,000	2,000	$5,179,745.27	4
	573	7	$5,000 to less than $10,000	970	$7,358,942.69	5
	573	8	$10,000 or more	1,311	$54,096,300.37	37
Orlando	675	9	$300 to less than $1,000	2,745	$1,417,255.58	2
	675	10	$1,000 to less than $5,000	3,460	$7,957,326.35	12
	675	11	$5,000 to less than $10,000	945	$7,107,519.09	5
	675	12	$10,000 or more	1,053	$50,748,650.32	44
Total				**20,355**	**$198,085,461.91**	**160**

Source: VA OIG statistician's stratified population. Data were obtained from the Corporate Data Warehouse.

Note: Items valued at the lower bound of each range (for example, $300, $1,000, $5,000, and $10,000) are included in that value range.

Weights

Samples were weighted to represent the population from which they were drawn, and the weights were used in the estimate calculations. For example, the team calculated the error rate estimates by first summing the sampling weights for all sample records that contained the given

error, then dividing that value by the sum of the weights for all sample records. The OIG statistician employed statistical analysis software to calculate estimates, margins of error, and confidence intervals.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this audit with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value about 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate estimates, margins of error, and confidence intervals that account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistic concerns of the sample review. While precision improves with larger samples, the rate of improvement decreases significantly as more records are added to the sample review. Figure B.1. shows the effect of progressively larger sample sizes on the margin of error.

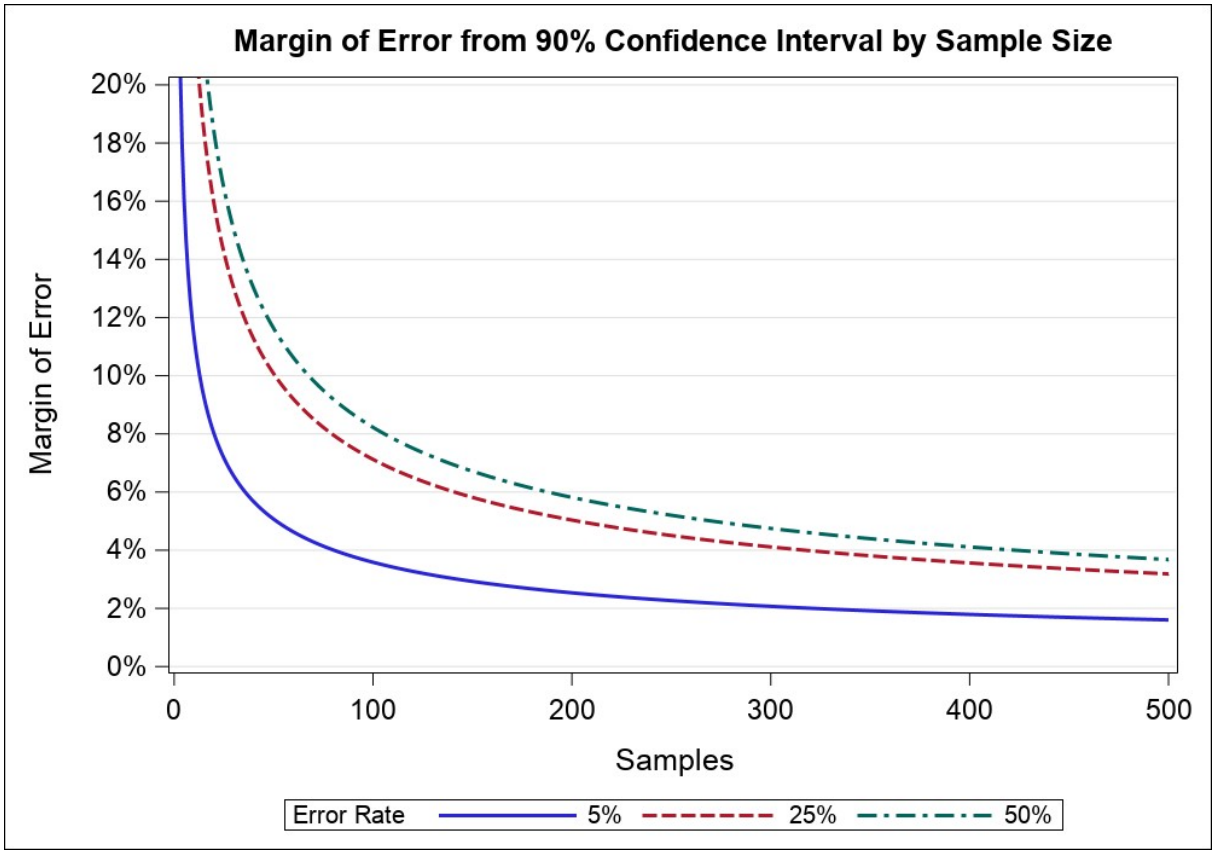

Figure B.1. *Effect of sample size on margin of error.*

Source: VA OIG statistician's analysis.

Projections

Table B.4 presents the 16 categories of expendable supply items along with the OIG's corresponding estimates.

Table B.4. Statistical Projections Summary for Expendable Supply Items, with a 90 Percent Confidence Interval

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count (sample size)	Rounded estimate
1. Count of items in which the physical count did not match the recorded quantity on hand (percentage)	3,309 (77.8)	867 (20.4)	2,442 (57.4)	4,176 (98.1)	85 (98)	3,300 (78)
2. Value of items in which the physical count did not match the recorded quantity on hand	$4,899,992	$536,805	$4,363,188	$5,436,797	85 (98)	$4,900,000
3. Count of items in which the physical count was less than the recorded quantity (percentage)	1,924 (58.1)	773 (22.6)	1,151 (35.5)	2,697 (80.8)	61 (85)	1,900 (58)
4. Value of items in which the physical count was less than the recorded quantity	-$2,016,751	$470,472	-$2,487,223	-$1,546,279	61 (85)	-$2,000,000
5. Count* of items in which the physical count was more than the recorded quantity (percentage)	1,385 (41.9)	715 (17.6)	670 (24.3)	N/A	24 (85)	670 (24)

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count (sample size)	Rounded estimate
6. Value* of items in which the physical count was more than the recorded quantity	$2,122,003	$951,398	$1,170,605	N/A	24 (98)	$1,200,000
7. Count* of conversion factor errors (percentage)	292 (6.9)	163 (3.8)	129 (3.0)	N/A	23 (98)	130 (3)
8. Value of conversion factor errors	$1,063,046	$347,933	$715,113	$1,410,979	23 (98)	$1,100,000
9. Count* of items in which the physical count was less than the system reorder point (percentage*)	1,144 (26.9)	592 (13.9)	552 (13.0)	N/A	20 (98)	550 (13)
10. Value of items in which the physical count was less than the system reorder point	$1,218,419	$455,959	$762,459	$1,674,378	20 (98)	$1,200,000
11. Count of items in which the physical count was more than the system normal stock level (percentage)	2,048 (48.1)	1,016 (23.9)	1,032 (24.3)	3,064 (72.0)	57 (98)	2,000 (48)
12. Value of items in which the physical count was more than the system normal stock level	$2,942,897	$1,211,913	$1,730,984	$4,154,811	57 (98)	$2,900,000

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count (sample size)	Rounded estimate
13. Count* of items with label that did not match the ABC Classification Report (percentage*)	1,482 (34.8)	616 (14.5)	866 (20.3)	N/A	40 (98)	870 (20)
14. Value of items with label that did not match the ABC Classification Report	$2,278,780	$522,527	$1,756,253	$2,801,307	40 (98)	$2,300,000
15. Count* of items without an ABC classification label (percentage*)	491 (11.5)	259 (6.1)	232 (5.4)	N/A	20 (98)	230 (5)
16. Value of items without an ABC classification label	$1,190,121	$436,755	$753,366	$1,626,876	20 (98)	$1,200,000
17. Total value* (sum of discrepancies) of items in which the physical count was higher than the system quantity and physical count exceeded normal stock levels	$3,077,369	$1,212,660	$1,864,709	$4,290,030	93 (98)	$3,100,000

Source: VA OIG statistician's analysis.

** Denotes one-sided lower-limit estimates.*

Note: The numbers in this table are rounded.

Table B.5 lists the three categories of nonexpendable equipment items and the OIG's associated estimates.

Table B.5. Statistical Projections Summary for Nonexpendable Equipment, with a 90 Percent Confidence Interval

Estimate name	Estimate number	Margin of error	Lower limit	Upper limit	Sample count (sample size)	Rounded estimate
1. Count of items in which the location did not match the system (percentage)	8,516 (48.3)	2,986 (16.9)	5,529 (31.4)	11,502 (65.3)	62 (141)	8,500 (48)
2. Count* of missing items (percentage*)	2,333 (13.2)	1,216 (6.9)	1,117 (6.3)	N/A	12 (141)	1,100 (6)
3. Value of missing items	$12,727,214	$6,026,964	$6,700,250	$18,754,178	12 (141)	$12,700,000
4. Count of items with no barcode label (percentage)	2,974 (16.9)	241 (1.4)	2,733 (15.5)	3,215 (18.2)	8 (141)	3,000 (17)

Source: VA OIG statistician's analysis.

** Denotes one-sided lower-limit estimates.*

Note: The numbers in this table are rounded.

Appendix C: Sample Results by Facility

The figures below summarize the samples tested for expendable supplies and nonexpendable equipment items at the Miami, Orlando, and Gainesville medical facilities in Veterans Integrated Service Network (VISN) 8. The figures present the number of items tested at each facility, along with the corresponding results by testing category. Figure C.1 shows discrepancies by facility, noting instances in which supply chain management did not adequately manage expendable inventory.

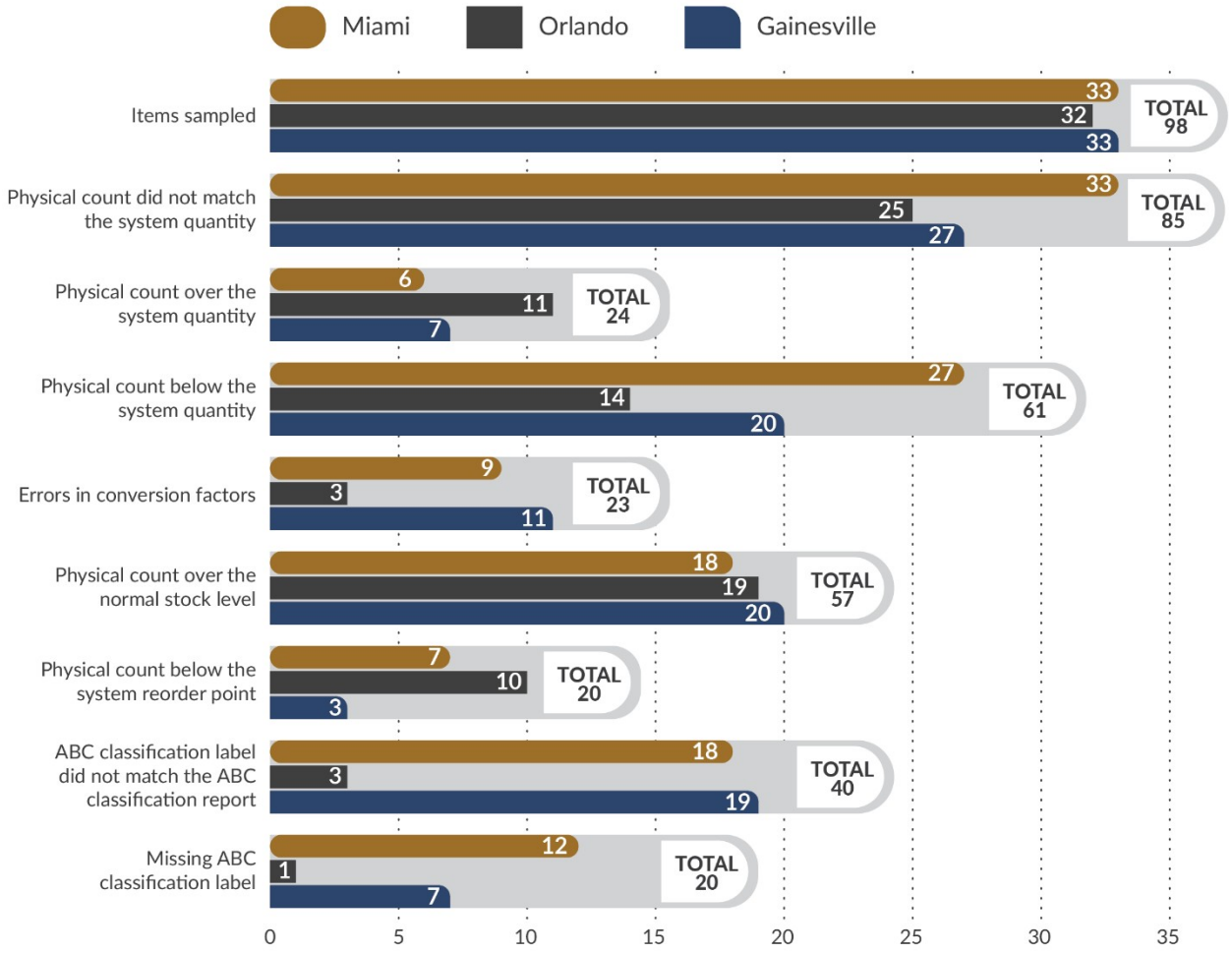

Figure C.1. *Categories of expendable supply deficiencies by facility.*

Source: VA Office of Inspector General (OIG) statistician's stratified population and VA OIG team analysis results. Some data were obtained from VA's Corporate Data Warehouse, while others were collected through the team's on-site observation.

The OIG team also tested the accuracy of the nonexpendable equipment locations recorded in the systems. Figure C.2 on the next page presents discrepancies by facility.

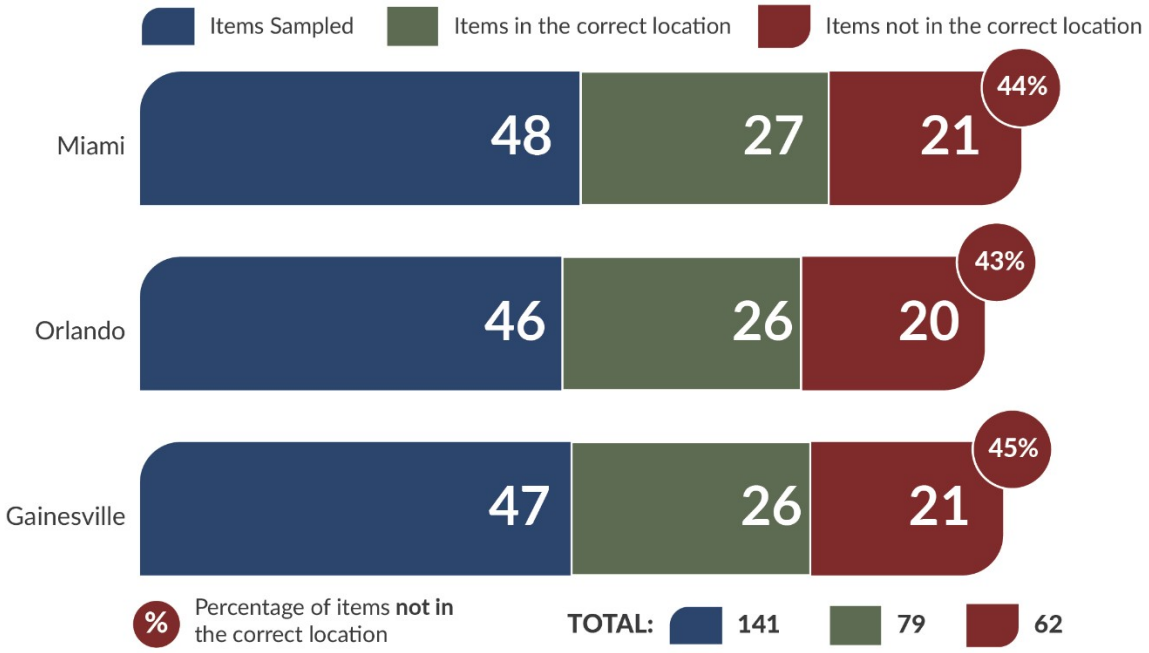

Figure C.2. *Sampled nonexpendable equipment found in the wrong location.*

Source: VA OIG statistician's stratified population and VA OIG team analysis results. Some data were obtained from VA's Corporate Data Warehouse, while others were collected through the team's on-site observation.

Appendix D: Monetary Benefits in Accordance with Inspector General Act Amendments

Recommendation	Explanation of Benefits	Better Use of Funds	Questioned Costs[20]
2	Physical count was higher than system quantity	$1,170,605*	$0
2	Physical count exceeded normal stock levels	$2,942,897	$0
	Total	**$3,077,369‡**	**$0**

***** *Denotes one-sided lower-limit estimates.*

‡ *The total value of $3.1 million is less than the sum of the $1.2 million and $2.9 million values. This difference exists because some physical counts exceeded both the system quantity and normal stock levels. The $3.1 million total does not double count these units. Additionally, the $1.2 million value conservatively reflects a statistical lower bound due to poor estimate precision. The $2.9 million and the $3.1 million value are standard statistical estimates.*

[20] The OIG questions costs when VA action or inaction (such as spending or neglect to fully compensate eligible beneficiaries) is determined by the OIG to violate a provision of law, regulation, contract, grant, cooperative agreement, or other agreement; when costs are not supported by adequate documentation; or when they are expended for purposes that are unnecessary or unreasonable under governing authorities. Within questioned costs, the OIG must, as required by section 405 of the IG Act, report unsupported costs. Unsupported costs are those determined by the OIG to lack adequate documentation at the time of the audit.

Appendix E: VA Management Comments

Department of Veterans Affairs Memorandum

Date: April 16, 2026

From: Acting Director, Department of Veterans Affairs (VA) Sunshine Healthcare Network (10N08)

Subj: VA Office of Inspector General (OIG) Report, Audit of VISN 8 Supply Chain Management (VIEWS 14593643)

To: Director, Office of Audits and Evaluations (52A03)
Chief Integrity and Compliance Officer (10OIC)

Thank you for the opportunity to review the draft report. I reviewed the action plan provided by the facility and concur with the response.

The OIG removed point of contact information prior to publication.

(Original signed by)

Verana Richardson

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA) Action Plan

OIG Draft Report – Audit of VISN 8 Supply Chain Management

(2025-00885-AE-0044)

Recommendation 1: Require medical facility directors in Veterans Integrated Service Network 8 to ensure supply chain staff periodically review unit conversion factors in the Generic Inventory Package to ensure accurate system values and quantities are recorded and then correct any discrepancies.

VHA Comments: Concur. By January 2027, each Veterans Integrated Service Network (VISN) 8 Health Care System (HCS) will provide Generic Inventory Package Conversion Factor Training to all Supply Chain Management (SCM) Expendable Inventory Management Staff, achieving at least a 90% training completion rate. Each HCS will validate completion and submit confirmation to the VISN 8 Chief Logistics Officer (CLO). Primary Inventory Point Conversion Factors will be monitored using the Primary Conversion Factor Report to identify and correct discrepancies. These reports will be incorporated into the metrics reviewed during the VISN 8 Chiefs monthly calls and the bi-monthly Logistics Procurement Committee (LPC) meetings. Success will be measured by reaching a minimum of 95% of total items with no identified discrepancies for 6 consecutive months.

Status: In-Progress Target Completion Date: January 2027

Recommendation 2: Require medical facility directors in Veterans Integrated Service Network 8 to develop and implement procedures to maintain stock within the required thresholds as outlined in Veterans Health Administration Directive 1761.

VHA Comments: Concur. By January 2027, each VISN 8 HCS will provide overstock and understock training to all SCM Expendable Inventory Management Staff, achieving at least a 90% completion rate and reporting validation to the VISN 8 CLO. Facilities will maintain inactive inventory at or below 10% by monitoring the Expendable Primary Inactive Report and will use internal reports to identify understocked items that may impact patient care. In accordance with VHA Directive 1761, facilities will conduct quarterly inventories based on ABC Classification, and facility SCM staff will ensure these inventories are completed and documented appropriately. VISN Quality Control Reviews will be conducted annually as required by VHA Directive 1761. These inventory reports will be incorporated into metrics reviewed during VISN 8 Chief Supply Chain Officer (CSCO) monthly calls and bimonthly LPC meetings. To ensure alignment with VHA Directive 1761, facilities will establish and maintain documented workflows for how stock thresholds are monitored, escalated, and corrected, Success will be measured by meeting training completion targets, maintaining inactive inventory thresholds, adhering to required quarterly inventories and annual Quality Control Reviews, monitoring understock risks, and demonstrating compliance through audit results.

Status: In-Progress Target Completion Date: January 2027

Recommendation 3: Require medical facility directors in Veterans Integrated Service Network 8 to ensure supply chain staff review and update ABC classification labels on expendable supplies in accordance with Veterans Health Administration guidance and establish a process to routinely verify that labeling aligns with the official ABC classification report.

VHA Comments: Concur. By January 2027, each VISN 8 HCS will develop and implement a local Standard Operating Procedures (SOP) for the ABC classification process and provide required training to all impacted SCM Expendable Inventory Staff, achieving at least a 90% completion rate. Training

completion will be validated and reported to the VISN 8 CLO. The VISN 8 CLO will monitor SOP compliance and conduct sample auditing while conducting VISN Quality Control Reviews. VISN Quality Control Reviews are to be conducted annually per VHA Directive 1761. Facilities will submit station-specific workflows showing how they implement and audit procedures in accordance with VHA Directive 1761 regarding the use of the ABC classification report. Success will be measured by SOP completion, training completion rates, and demonstrated compliance through spot checks. The VISN 8 CLO will report bi-monthly through the VISN 8 governance structure.

Status: In-Progress Target Completion Date: January 2027

Recommendation 4: Ensure medical facility directors in Veterans Integrated Service Network 8 develop a process to ensure facility staff safeguard expendable supplies in accordance with Veterans Administration Handbook 0730.

VHA Comments: Concur. By January 2027, medical facility directors in VISN 8 will develop and implement a standardized process to ensure facility staff safeguard expendable supplies in accordance with VA Handbook 0730. Each facility will document and communicate the process to all applicable staff, and evidence of implementation will be submitted to the VISN 8 CLO. Compliance will be assessed during Quality Control Reviews. VISN Quality Control Reviews will be conducted annually per VHA Directive 1761. Facilities will conduct periodic or random audits of secured storage areas and report trends through facility and VISN governance structures. VISN oversight will ensure consistent application of security controls and mitigation of unauthorized access risks. Success will be measured by documented process development, evidence of staff communication, and demonstrated adherence during reviews. The VISN 8 CLO will report bi-monthly through the VISN 8 governance structure. Compliance of the audits will also be tracked bi-monthly for 6 consecutive months with a goal of 90% compliance.

Status: In-Progress Target Completion Date: January 2027

Recommendation 5: Ensure medical facility directors in Veterans Integrated Service Network 8 develop and implement local procedures that require clinical service areas to notify supply chain staff when equipment is relocated and establish protocols to validate and update equipment location during clinical moves or room changes and ensure equipment items are properly tagged.

VHA Comments: Concur in Principle. By January 2027, each VISN 8 HCS, in collaboration with the VISN 8 CLO will evaluate and explore the potential implementation of advanced tagging and tracking technologies such as Air Tag-like devices or real-time locating systems (RTLS) to enhance accountability for mobile equipment. Facilities will ensure updated equipment locations are accurately maintained, and random audits will be conducted by facility SCM supervisory staff and the VISN 8 CLO during Quality Control Reviews to validate accuracy. VISN Quality Control Reviews will be conducted annually per VHA Directive 1761. Success will be measured by documented evaluation efforts, identified technology opportunities, and audit results confirming accurate equipment tracking. Audits for equipment location and proper tagging will be tracked monthly for 6 consecutive months with a goal of 90% compliance.

Status: In-Progress Target Completion Date: January 2027

Recommendation 6: Require medical facility directors in Veterans Integrated Service Network 8 to enforce timely completion of reports of survey in accordance with Veterans Health Administration policy and implement oversight mechanisms to monitor the timely initiation, approval, and closure of reports.

VHA Comments: Concur. By January 2027, medical facility directors in VISN 8 will enforce timely initiation, approval, and closure of Reports of Survey (ROS) in accordance with VHA policy. Each facility will implement oversight mechanisms, including an internal dashboard that tracks ROS timelines, aging, and compliance. All Custodial Officials and Report of Survey Investigation Board Members will complete and submit Report of Survey (ROS) training certificates to the VISN CLO. The Report of Survey Register and dashboards will be reviewed during VISN 8 CSCO monthly calls and bimonthly LPC meetings. Facilities will provide evidence of compliance with the VISN 8 CLO, with spot checks and audits conducted during Quality Control Reviews. VISN Quality Control Reviews will be conducted annually per VHA Directive 1761. Incidents of non-compliance will require the facility to develop and implement an action plan to the VISN 8 CLO. Success will be measured by on-time ROS completion rates, dashboard accuracy, and audit results for six consecutive months with a goal of 90% compliance.

Status: In-Progress Target Completion Date: January 2027

Recommendation 7: Ensure facilities implement corrective actions to effectively address deficiencies identified during the Veterans Integrated Service Network's quality control reviews.

VHA Comments: Concur. VISN 8 HCS will resolve all outstanding Quality Control Review corrective actions from previous fiscal years within 90 days of this report's release. All FY 2026 Quality Control Reviews deficiencies identified for noncompliance will be corrected within 90 days of the review date or submitted report. If any deficiencies remain after 90 days, approval for an extension from the VISN 8 CLO and VISN Network Director will be necessary. These unresolved issues will also be reported to the Office of Supply Chain (OSC) until they are completely addressed. Success will be measured by timely closure of corrective actions, adherence to the 90day requirement, and documentation of CLO-approved extensions and OSC reporting. The VISN 8 CLO will report bi-monthly through the VISN 8 governance structure.

Status: In-Progress Target Completion Date: July 2026

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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