US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Review of Supply Chain Management at the VA Augusta Health Care System in Georgia

Review | **26-02023-176** | **September 2, 2026**

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Executive Summary

In March 2026, the VA Secretary, a Veterans Integrated Service Network leader, and a leader at the VA Augusta Health Care System in Georgia voiced concerns about supply chain issues at the facility. As part of ongoing oversight work to combat fraud, waste, and abuse, the VA Office of Inspector General (OIG) conducted this review to determine whether facility leaders effectively oversaw supply chain management operations and complied with applicable Veterans Health Administration (VHA) policies. The review focused on operations from March through June 2026 specific to four areas with known recurring weaknesses: supply chain leadership, expendable supplies inventory (disposable items typically used in patient care), nonexpendable equipment inventory (durable equipment with a service life of at least two years), and medical distribution and warehouse controls.

Overall, the VA Augusta Health Care System did not consistently meet VHA's requirements for managing expendable supplies and nonexpendable equipment. The OIG identified oversight deficiencies that increased the risk of loss of supplies, unaccounted-for equipment, and expired products. These issues mirrored previous OIG report findings in multiple facilities. In May 2026, the OIG team briefed Veterans Integrated Service Network and medical facility leaders, who shared plans to improve inventory and equipment accountability. The team's findings underscore the need for comprehensive oversight and controls over supply chain management operations to support accountability and stewardship of taxpayer dollars.

The OIG made seven recommendations to improve supply chain management at the VA Augusta Health Care System. In August 2026, the acting executive director for the VA Health Service Area 2.4 and the VA Augusta Health Care System interim director concurred with all seven recommendations. Based on additional evidence provided with the concurrence, the OIG closed recommendations 1, 2, and 3.

What the Review Found

The OIG team found that inventory inaccuracies, weak monitoring, and lapses in physical security increased the risks of equipment loss and items being out of stock, ordered in excess, or expiring—which, in turn, affected clinical operations. Facility staff reported four operating room closures from October 2025 through February 2026—including one lasting 27 days—due to incomplete supply carts and kits, expired supplies, and unreliable stocking of secondary inventory locations that forced urgent calls to primary inventory areas during surgeries. According to an operating room leader, this contributed to surgical backlogs and cancellations.

In expendable supply operations, the OIG team found discrepancies between physical counts and Generic Inventory Package records in sampled operating rooms and medical and surgical

inventory areas. Contributing factors included limited barcode scanning and handwritten logs, all of which undermined inventory accuracy and timely replenishment.

The facility did not ensure nonexpendable equipment items were properly recorded and accounted for. Of 35 pieces of equipment the review team sampled, neither the team nor facility staff could find five items with a total value of about $25,000, and the facility had not documented those losses. Contributing factors were weak enforcement of inventory policies, delays in officials completing annual inventories and documentation, unclear procedures, and unreliable systems.

Warehouse conditions were unsafe and noncompliant with VA requirements. Across three warehouses, the team observed improperly stored compressed gas cylinders, and supplies stored in a disorganized manner. The OIG observed 50 pallets of supplies marked expired, excess, obsolete, damaged, awaiting disposal, or awaiting resale. Facility reports showed about $613,000 in expired supplies among 22 pallets, while the team identified 28 more pallets of items the facility did not intend to use, suggesting the magnitude of waste was higher. These conditions increased the risk that essential supplies needed for patient care could become damaged, unavailable, or unsuitable for safe use.

Finally, the VA Augusta Health Care System awarded a $3.2 million contract for a weight-based inventory management system that was only partially installed and was not used as intended, so the planned operational benefits were not fully realized. According to the contracting officer's representative, the incomplete system was disabled in 2023 by the chief supply chain officer at the time; the OIG found some equipment for the system abandoned in a warehouse. VA awarded a second contract for about $223,000 in December 2025 for the contractor to audit and complete installation by May 31, 2026. However, as of June 2026, the system was still not fully installed. In July 2026, the facility reported that it continued to take action to address deficiencies identified in this report.

Next Steps

The OIG will continue to monitor VHA's corrective actions and will close the remaining recommendations once VHA provides sufficient evidence that it has addressed the risks identified in this report.

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Contents

Abbreviations

FY	fiscal year
GIP	Generic Inventory Package
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

In March 2026, a Veterans Integrated Service Network (VISN) leader and a leader from the VA Augusta Health Care System in Georgia contacted the VA Office of Inspector General (OIG) to inform the OIG of supply chain issues identified at their facility including

- a large amount of expired and damaged medical supplies and
- an inability to account for millions of dollars of various equipment, including surgical robotic devices.

The VA Secretary visited the facility in March 2026, and according to the acting facility director, had concerns about the facility's culture, accountability, and supply chain management. As part of ongoing oversight work to combat fraud, waste, and abuse, the OIG conducted this review to assess supply chain management and determine whether facility leaders effectively oversaw it to ensure compliance with Veterans Health Administration (VHA) policies. The OIG team visited the facility twice in March 2026 and once in May 2026.

Specifically, the team evaluated management of expendable supplies and nonexpendable equipment. In this context, expendable supplies are disposable items used in patient care, such as syringes, while nonexpendable equipment is durable and has a service life of at least two years, such as magnetic resonance imaging machines.

Recent executive orders on cost efficiency emphasize the importance of ensuring transparency and prudent use of taxpayer dollars.[1] This report enhances visibility of VA's supply chain management and makes recommendations to advance prudent use of government resources consistent with the OIG's statutory obligation under the Inspector General Act of 1978, as amended, to promote economy and efficiency and deter fraud and waste.[2]

At the time of this report, VHA divided 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. 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.[3] The OIG's findings and recommendations can help improve VISN oversight during this restructuring

[1] Exec. Order No. 14222, 90 Fed. Reg. 11095 (March 3, 2025); Exec. No. Order 14271, 90 Fed. Reg. 16433 (April 18, 2025).

[2] Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424.

[3] In December 2025, VA announced plans to reorganize the management structure of VHA. On May 1, 2026, the under secretary for health announced the consolidation of the VISNs from 18 networks to five. On July 15, 2026, the acting under secretary for health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's review. For more information on this initiative, visit https://digital.va.gov/rise/.

by addressing supply chain deficiencies that contribute to mismanagement and waste of taxpayer dollars, and that may cause disruptions to patient care.

Oversight of Supply Chain Management at VA Medical Facilities

VHA Directive 1761, *Supply Chain Management Operations*, sets policy related to the VA Secretary's authority under 38 U.S.C. §§ 8121 and 8125 to procure healthcare items.[4] In managing nonexpendable equipment, VHA facilities must comply with VA Directive 7002, *Logistics Management Policy*, which incorporates regulatory requirements under Public Law 107-217 (2002) that govern federal management of property.[5]

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. The directive requires VISN chief logistics officers to assess supply chain management programs at each medical facility through an annual quality control review.[6] Quality control reviews cover expendable and nonexpendable inventory management, medical distribution, warehouse management, and supply chain management leadership. Facilities must develop action plans for any identified deficiencies and complete corrective actions within 90 business days. VISN chief logistics officers must ensure deficiencies are corrected by the end of each fiscal year, according to VA's quality control review instructions for supply chain management.[7]

At the medical facility level, a chief supply chain officer (supply chief) is responsible for establishing a supply chain management program that aligns with VHA policy by using approved inventory systems, accounting for inventory, and completing year-end certifications. According to VA Handbook 7002, which sets forth the agency's logistics management procedures, the supply chief also serves as the accountable officer and is responsible for expendable supplies and nonexpendable equipment from acquisition through disposition.[8] The handbook explains 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 ensuring property is appropriately used and maintained.[9]

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

[5] VA Directive 7002, *Logistics Management Policy*, January 8, 2020.

[6] VHA Supply Chain Management Quality Control Review Instructions, September 1, 2024.

[7] VHA Supply Chain Management Quality Control Review Instructions.

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

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

Management of Expendable Clinical Supplies

VHA Directive 1761 defines expendable clinical supplies as disposable items (such as gloves, syringes, and catheters) that should be inventoried each quarter, twice a year, or once a year depending on each item's annual usage spending. Inventory items are categorized based on their annual usage spending, which reflects the dollar value of supplies used during the year. Inventory items with the highest annual usage spending (the top 80 percent) must be counted each quarter. Items with the next highest annual usage spending (the next 10 percent) are counted in the first and third quarters, and items representing the remaining 10 percent (lowest usage spending) are inventoried in the second quarter.

Supplies are stored at both primary and secondary inventory points.

- The primary inventory point is a storeroom that houses all expendable supplies for an inventory account, which staff use to determine what items have been used and to order replacements.
- A secondary inventory point, such as a supply closet in an emergency department, is a distribution point that is typically replenished using supplies from the primary inventory point.

Facility staff use barcode data to track expendable inventory and monitor the use of supplies. VHA Directive 1761 requires barcode labels on all expendable supplies and storeroom shelves. Physical counts are not required for primary inventory points where supplies are distributed directly to patients if inventory is taken monthly with a scanner or other electronic means. Inventory at secondary points should be scanned and reconciled every month, according to VHA Directive 1761.

VHA staff use Generic Inventory Package (GIP) software to manage expendable supplies. To control inventory, medical facility staff must establish and maintain the following 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 emergencies.

Facility staff must base these stock levels on usage data, ordering lead times, and available storage space and review inventory thresholds quarterly to ensure accurate inventory control.[10]

Management of Nonexpendable Equipment

Nonexpendable equipment is durable and for continuous use, generally has a service life of two or more years, and costs $300 or more. VHA Directive 1761 requires that all nonexpendable equipment must be accounted for in an approved automated inventory system, such as Maximo. According to VA Directive 7002, all nonexpendable items are tracked through an equipment inventory listing for each line of service, 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 are accountable for certifying the results electronically in the inventory system, ensuring accurate and current records. Custodial officers also manage equipment returns and dispositions, process inventory updates such as updating equipment locations, and coordinate reports of survey—which are used to investigate and notify VA about the loss, damage, or destruction of government supplies and property.

VA Augusta Health Care System

The VA Augusta Health Care System in Georgia in VISN 7 includes the Charlie Norwood VA Medical Center (also known as the downtown location), the Augusta VA Medical Center-Uptown, and three medical clinics (figure 1). As of April 2026, the facility reported about $109.5 million in nonexpendable equipment inventory—not including information technology equipment—and about $4.4 million in expendable supply inventory.

[10] GIP User Training Guide, December 2015; VHA Directive 1761.

Figure 1. *Location of facilities in the VA Augusta Health Care System applicable to the review.*

Sources: VA OIG analysis of VHA Support Service Center Unique Patient Trend report and the VA Augusta Health Care System locations web page.

Results and Recommendations

Finding: VA Augusta Health Care System Leaders and Staff Did Not Effectively Manage Expendable Supplies and Nonexpendable Equipment

The VA Augusta Health Care System had significant breakdowns in internal controls related to supply chain management, including inaccurate inventory records, weak monitoring, poor labeling, and security lapses. These issues led to shortages, overordering, expired supplies, equipment loss, and delayed patient care. Notably, the operating room at the VA Augusta Health Care System closed four times between October 2025 and February 2026 due to insufficient stock, and medical procedures had to be rescheduled, according to facility leaders and staff.

During two site visits in March 2026, the OIG team found that three of the facility's warehouses were disorganized. The warehouses had disorganized, unlabeled storage; compressed gas cylinders stored unsafely at two locations; and at least 50 pallets of expired or otherwise unused items. The OIG team could not find about $25,000 in nonexpendable equipment. VA also paid $3.2 million for a supply chain management system that was never fully implemented.

Since 2023, VISN quality control reviews have identified deficiencies in the Augusta Health Care System's supply chain management, some of which overlapped with the OIG's findings. Despite the repeated findings, the deficiencies persisted because of weak internal controls, leadership turnover, lack of accountability, and noncompliant practices—such as incomplete inventory tracking, blind ordering, and improper storage. These long-standing issues risk patient safety, stewardship of taxpayer dollars, and operational reliability and have eroded clinicians' trust in supply operations.

Of note, facility and supply chain leaders said the Augusta facility has experienced persistent staffing instability and rapid turnover of supply chain leaders, with critical roles frequently vacant or filled by acting staff. As of March 2026, the OIG team determined that 125 positions were authorized for the facility's supply chain management service, with only 60 positions filled.

Supply staff told the OIG team that because of staffing vacancies, individual staff members had to fill multiple roles, which delayed routine tasks necessary for ordering supplies, managing inventory, and restocking. These delays increased the risk of items being out of stock or staff ordering in excess; they contributed to breakdowns in accountability in what should be a disciplined process. Staff described a slow hiring process and inadequate training during onboarding—which the OIG team determined undermined morale, contributed to burnout, increased turnover rates, and hindered corrective actions.

What the OIG Did

The OIG team visited the VA Augusta Health Care System twice in March 2026 and once in May 2026. The team reviewed relevant policies and procedures; interviewed VISN, facility, and supply chain leaders and staff; and evaluated inventory practices for expendable supplies and nonexpendable equipment. The team evaluated a judgmental sample of 100 expendable supply items and compared inventory records to physical counts. For nonexpendable equipment, the team judgmentally selected 35 items to determine whether the recorded equipment location matched each item's actual physical location. The team also physically observed expendable supplies and nonexpendable equipment in the healthcare system's warehouses and storage areas. See appendix A for more on the review's scope and methodology.

The team informed VISN 7 leaders, the facility's interim director, and the acting supply chief about the audit's preliminary findings in May 2026. The leaders were receptive to the OIG's findings and said they would continue to enhance their corrective actions to address the OIG's recommendations.

Expendable Supplies

The OIG team evaluated expendable supply management to test the accuracy of quantities recorded in GIP (the software used to manage expendable supplies) and to test compliance with VHA Directive 1761, the policy for supply chain management operations. The OIG team found that GIP records did not match on-hand supplies at the facility for 89 of the 100 items judgmentally selected for review:

- Twenty-nine items, valued at about $196,172, had more supply on hand than reported in GIP. These differences ranged from one to 292 units and included items such as surgical staplers and catheters. These errors could result in the premature purchase of more supplies, resulting in overordering and increasing the risk of waste and abuse of taxpayer dollars.
- Sixty items, valued at about $356,152, had fewer quantities on hand than reported in GIP. These differences ranged from one to 2,301 units and included items such as oxygen sensors and humidifiers. These errors could result in supply shortages and potential delays in patient care.

In addition to these quantity variances, the team identified noncompliance with established stock-level parameters in GIP: inventory thresholds intended to maintain appropriate minimum and maximum quantities of supplies. Of the 100 items reviewed, 34 items had on-hand quantities that exceeded VHA's required normal stock levels with a combined value of about $368,946 above those thresholds. These excess quantities were consistent with overstocking conditions that increased the risk of supplies expiring or becoming obsolete, resulting in unnecessary costs and potential risk to patient safety. Additionally, of the 100 items reviewed, 42 were stocked

below the system reorder point, and 26 fell below the established emergency stock level, increasing the risk that supplies needed for clinical care of veteran patients would not be available.

These inventory discrepancies occurred because supply chain staff did not consistently follow established inventory management procedures and facility leaders did not ensure compliance with inventory management requirements. In addition to the VHA Directive 1761 requirement that medical facilities routinely monitor reports for inventory accuracy, internal VHA guidance states that, as part of inventory replenishment activities, inventory managers are expected to perform a daily walk-through of the primary inventory point storage area.[11]

However, a VISN leader said that inventory managers frequently ordered supplies without verifying that inventory records accurately reflected on-hand quantities. During the OIG team's March 2026 site visits, the facility acting supply chief said supply chain staff did not scan barcodes and that, although some staff may have received informal on-the-job training, the facility did not have a formally documented onboarding or refresher training program for supply chain staff until he created one in March 2026. The acting supply chief also said that staff used handwritten logs instead of the required electronic processes.

After analyzing the VISN's quality control review results for fiscal years (FYs) 2023 through 2025, the OIG team found the facility did not comply with expendable inventory management requirements in each of those fiscal years. These challenges persisted because facility supply chain leaders did not establish adequate controls, monitoring processes, or documented training programs to ensure compliance with inventory management requirements.

Poor data quality may constrain effective decision-making related to procurement, stock replenishment, and resource allocation. Without reliable GIP inventory data, facility leaders cannot make informed decisions for operational planning and supply chain management. Furthermore, inaccurate expendable supply inventory records limit the VISN's ability to effectively monitor and manage supply chain operations at the facility.

Meanwhile, these supply chain management challenges related to expendable supplies prompted facility leaders to close the facility's operating room four times from October 2025 through February 2026. One of the closures lasted 27 days, from January 21 through February 16, 2026. An operating room staff member and a VISN leader reported that closures and medical procedure disruptions were driven by incomplete supply carts and kits, expired supplies, and unreliable stocking of the secondary inventory room, which forced urgent calls to the primary inventory room during surgeries.

[11] "New Item Request and Replenishment Process," (web page), VHA Procurement and Logistics Office, accessed June 5, 2026. (This web page is not publicly accessible.)

During the January 2026 operating room closure, staff were instructed to reschedule medical procedures and notify veterans of cancellations. Staff further noted unreliable inventory data, such as reported levels not reflecting actual stock and on-hand counts varying across locations. This required staff to visually verify supply availability in storage bins.

An operating room staff member reported high turnover rates among supply chain staff and said that new supply room employees appeared to lack the training and sense of urgency needed to support clinical care. In March 2026, acting facility leaders told the OIG team that supply chain staff were not held accountable by previous supply chain leaders for complying with standard inventory requirements, such as scanning supplies and using items on a first-in/first-out basis.

During the March 2026 site visits, the OIG team found expired supplies in the operating room's primary supply area and provided them to facility staff for disposal. Although VISN and facility leaders later reported that they had removed expired items, the OIG team's follow-up visit in May 2026 again identified and brought about the removal of expired supplies from the operating room's primary and secondary inventory rooms.

A VISN leader told the OIG team that communication between supply chain and surgical leaders was poor and often was limited to crisis situations. According to an operating room leader, these issues resulted in surgical backlogs; rescheduled, canceled, or delayed medical procedures; and growing distrust among clinicians regarding the reliability of supply operations.

Nonexpendable Equipment

The facility did not ensure all nonexpendable equipment was properly recorded and accounted for in the automated equipment inventory system, as required by VA Handbook 7002 (the logistics management procedures), and facility staff described persistent challenges with tracking, accountability, and inventory accuracy. Facility supply staff also said the process of tagging and barcoding equipment and updating records was inconsistent. Specifically, a supply staff member said service line staff rarely reported when they moved or disposed of equipment, and inventory listings or reports of survey were often incomplete or delayed. VA Directive 7002 (the logistics management policy) requires facilities to immediately submit reports of survey to explain the circumstances surrounding the loss, damage, or destruction of government property. Any employee who discovers a loss or damage to government property must immediately orally report the incident to their supervisor, who will notify the VA police (if necessary) and supply staff.

To assess records accuracy, the OIG team evaluated a judgmental sample of 35 nonexpendable items.

- Twenty-three items had not been inventoried over the prior 13 months even though VA Directive 7002 requires annual inventories. As of April 2026, the facility had not inventoried those 23 items, on average, in 44 months.

- For five of the 35 items, neither the OIG team nor facility staff could locate the items; facility staff also could not provide report-of-survey documentation. The five items totaled about $25,000 in value.

During interviews with the OIG, facility staff reported inconsistent enforcement of policies, delays in custodial officials signing reports of survey or annual inventories, reliance on peers instead of training, unclear standard operating procedures, and unreliable inventory systems. In FYs 2024 and 2025, some facility staff did not complete their annual inventories. A facility staff member noted that a custodial official did not agree with some of the items on their inventory listings and were unwilling to accept responsibility for the inventory listing as recorded.

When items are not found during an annual inventory, facility staff should complete a report of survey, in accordance with VA Directive 7002. However, the facility provided the OIG team with several partially completed reports of survey that listed equipment that had not been inventoried in several years. According to a facility staff member, some custodial officials delayed signing the report-of-survey form because they were trying to find an item. Nevertheless, not properly inventorying equipment or completing reports of survey undermines both operational efficiency and a facility's ability to provide timely, high-quality care to veterans.

In May 2026, the OIG team interviewed the third acting supply chief the facility has had since this review began in March 2026. The third acting supply chief started in April 2026, following the team's initial site visits. According to that official, the facility conducted a wall-to-wall inventory in response to the OIG's work but could not account for over 1,760 nonexpendable items valued at almost $10.5 million. A facility leader said staff were still trying to find these items and they planned to complete reports of survey for any that remained unaccounted for. Ensuring nonexpendable equipment is properly inventoried will enable the facility to locate and use equipment as needed, protect against fraud and waste, and properly plan for maintenance and replacement costs.

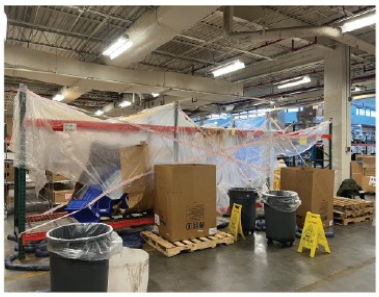
Warehouse Storage Conditions

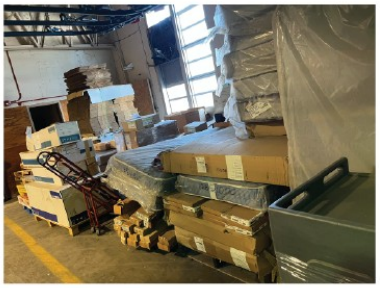
During site visits, the OIG team observed several warehouse storage areas that required improvements to environmental controls and organization to safeguard the integrity and availability of medical supplies. VA Handbook 7128 (which details the agency's storage and distribution procedures) and VHA Directive 1761 establish requirements for managing clean and organized storage areas and for managing inventory in a manner that supports accountability and protects supplies from contamination.[12] Figure 2 shows examples of warehouse locations that stored items to support the facility's supply chain operations.

[12] VA Handbook 7128, *Storage and Distribution Procedures*, March 15, 1996.

Warehouse Location 1	Warehouse Location 2	Warehouse Location 3
• Broken door lock secured with masking tape • Open box of unpackaged surgical supplies stored near loading dock and dumpster • Pallets of expired, excess, obsolete, or damaged supplies • No barcode labels on rack locations	• Several holes in the roof and water–damaged supplies • Trash cans collecting rain water • Pallets of expired, excess, obsolete, or damaged supplies	• No temperature control • Nonexpendable equipment covered in dust and water–damaged supplies • Pallets of uninstalled equipment with no disposition plan



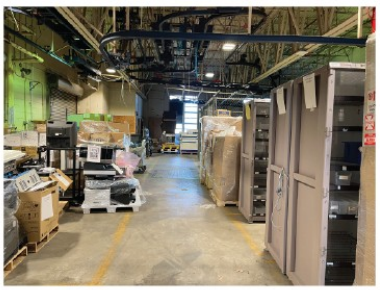
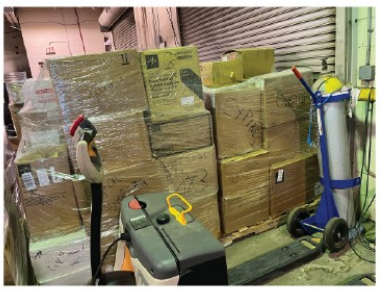




Figure 2. *Warehouse locations that stored items to support the facility's supply chain operations.*
Source: VA OIG observations at the VA Augusta Health Care System in March 2026.

Across the three warehouses, the OIG team saw at least 50 pallets of supplies marked expired, excess, obsolete, damaged, awaiting disposal, or awaiting resale through the General Services Administration. The facility reported about $613,000 in expired supplies among 22 pallets; the OIG team identified 28 more pallets of items the facility did not intend to use, indicating a higher magnitude of waste. Additionally, the team observed nonexpendable equipment staged in a warehouse that facility staff reported was not temperature controlled and previously had broken windows and mold. Documentation indicated the supplies and equipment were awaiting disposal. These conditions and storage practices increased the risk of taxpayer-funded supplies and equipment expiring or deteriorating before it could be used for veterans' patient care. These conditions also increased the risk that essential supplies needed for patient care could become damaged, unavailable, or unsuitable for safe use.

According to a VISN leader and facility leaders, several factors contributed to the deterioration of the warehouses and wasted supplies, including leadership turnover and inconsistent direction, ordered items that were never retrieved, end-of-year bulk purchasing without regard to usage or capacity, informal email requests used in place of required VA forms, poor implementation, inconsistent scanning and stock rotation, inadequate training and onboarding, and delayed facility repairs. The warehouse deterioration and issues with storage increased risks of supply contamination, waste, and loss; obscured visibility of usable inventory; and disrupted supply chain operations.

Physical Security Controls

VA Handbook 0730 (VA's security and law enforcement procedures) and VA Directive 7002 (the logistics management policy) require facilities to plan for effective physical security that prevents theft and loss of vulnerable supplies and equipment and to ensure staff are personally accountable for government property under their use, control, or custody.[13] Augusta facility staff reported inconsistent access controls over storage areas and said supplies were stored across multiple locations—including bulk storage, closets, rooms without temperature control, and unofficial storage spaces.

During site visits, the OIG team found that some supply storage locations lacked adequate physical security. For example, storage areas were left unlocked and were accessible to unauthorized personnel. Additionally, the team observed compressed gas cylinders that were not consistently stored in locations that met security and safety expectations. According to the interim medical facility director, the area where the compressed gas cylinders were stored did not meet requirements in VA Handbook 0730/4. The interim facility director agreed with the OIG team that storing the cylinders in these locations created a safety risk. After the team notified the interim facility director, he said that the facility had removed the cylinders from one of the

[13] VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.

locations and that the engineering team had engaged with contractors to bring the second location into compliance.

Facility leaders attributed these security lapses to breakdowns in previous leadership and resource allocation. The OIG team determined that leaders did not consistently enforce compliance with required security practices. Without physical security controls, the facility is at a heightened risk of theft, diversion of supplies and equipment, or unauthorized use of government property, including high-value items.

Contract Management

In 2021, VA awarded a contract of $3.2 million to implement a PAR Excellence weight-based inventory management system across the VA Augusta Health Care System. However, the system was only partially installed and was not used as intended, so the planned operational benefits were not fully realized.

The PAR Excellence website describes its equipment as a point-of-use inventory system that uses calibrated weight-sensing bins and scales to continuously measure on-hand quantities; changes in weight prompt a signal to automatically replenish supplies.[14] The Augusta facility intended to purchase turnkey delivery and installation of an integrated hardware and software solution, including bins, scales, and software that interfaced with GIP for automated restocking and real-time data integration across designated clinical areas. The planned locations for the inventory system included the operating room and dental and imaging services at the Charlie Norwood VA Medical Center and several community-based outpatient clinics.

The contractor delivered and installed equipment in some departments of the facility. For example, bins and scales were delivered and installed in some secondary supply locations, and the system was partially configured and periodically maintained. However, several planned installations never occurred—including in the operating room and in dental and imaging departments—and PAR Excellence equipment was abandoned in a warehouse. As shown in figure 3, in one warehouse, the OIG team counted more than 10 PAR Excellence storage cabinets and several pallets of equipment that remained unopened or were damaged.

[14] "Inventory Automation" (website), PAR Excellence, accessed May 11, 2026, https://parexcellence.com/inventory-managment/inventory-automation.

Figure 3. *PAR Excellence cabinets (left) and boxes of PAR Excellence equipment (right) stored in a warehouse at the VA Augusta Health Care System.*
Source: VA OIG observations on March 18, 2026.

The contracting officer's representative said the supply chief at the time directed the PAR Excellence system to be shut off in 2023 and later restricted the contractor's access to the facility, which hindered full installation and integration. The contracting officer's representative said the system was taken offline at that point at the former supply chief's direction—despite warnings from supply chain staff that shutting down the automated system would destabilize inventory accuracy and waste VA's investment.

Although the system was not fully operational, the facility processed and paid invoices under the initial contract. Federal Acquisition Regulation 32.905 (2026) says all invoice payments must be supported by government documentation that includes a description of services, date of services performed, and the date the designated government official accepted the services. The contracting officer's representative explained that he certified the final invoice because a facility supply chain leader and the PAR Excellence project manager directed him to do so. He told the team he did not notify the contracting officer to pause payments, require the work to be redone, or modify the contract even though the system had not been fully installed. The contracting officer no longer works for VA, and the team found no evidence showing the contracting officer had enforced acceptance requirements according to Federal Acquisition Regulation 46.502 (2026).

In December 2025, VA awarded a second contract to PAR Excellence for over $223,000 to audit the project, install remaining equipment, and complete work by May 31, 2026. The contracting officer's representative said this second award is intended to address tasks left from the first contract.

Oversight Practices and Recurring Deficiencies

Previous OIG reports have identified security and supply chain deficiencies similar to those found at the Augusta facility. One OIG report made national recommendations about addressing physical security vulnerabilities at VHA facilities, and other reports recommended improving supply chain management at the facility and VISN level to strengthen oversight.[15]

As reported previously by the OIG, VISNs do not have the authority to enforce corrective action plans even when VISN quality control reviews repeatedly identify deficiencies. At the VA Augusta Health Care System, leadership turnover, inadequate accountability, and insufficient follow-through on corrective actions allowed noncompliant practices to become entrenched—contributing to unreliable inventory data, wasted resources, and disruptions to patient care, including multiple operating room closures.

Response to VISN Quality Control Reviews

VISN quality control reviews have identified recurring noncompliance with requirements related to the focus of this OIG review: supply chain leadership, expendable supply inventory, nonexpendable equipment inventory, and supply distribution and warehouse conditions. Specifically, the VISN reviews identified 30 deficiencies in FY 2023, 28 in FY 2024, and 24 in FY 2025. Across the three fiscal years, up to 41 percent of the findings were repeated from the previous year.

Facility staff struggled to complete action plans to address these deficiencies. In FYs 2023 and 2025, facility staff did not complete any of the action plans; in FY 2024, staff completed only 15 of 27 corrective actions (about 60 percent). A VISN leader described repeat findings year after year and said that, in some cases, they used photographs of the same deficiency to document unresolved issues for multiple quality control reviews. Facility leaders attributed incomplete follow-through to leadership turnover, unclear accountability, not prioritizing action items, a lack of training and communication, and confusion over roles and responsibilities. Even when the VISN provided support and resources, the facility's internal processes did not support sustained compliance or improvement.

As a result, noncompliant practices became ingrained in supply chain operations. Persistent deficiencies—such as unmanaged excess inventory, unreliable inventory data, and poor accountability—led to ongoing waste, inefficiency, and risk of supply shortages. Most

[15] VA OIG, *Security and Incident Preparedness at VA Medical Facilities*, Report No. 22-03770-49, February 22, 2023; 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.

importantly, unresolved deficiencies contributed to repeated disruptions in patient care, including multiple operating room shutdowns and delays in critical services.

Leadership Changes and Planned Actions to Address Issues

The OIG team identified that the facility has had significant turnover in both executive leadership and supply chain management over several years. According to a VISN leader, the former supply chief was reassigned in January 2026, and the role has been temporarily filled by acting staff from other medical centers as of July 2026. An interim facility director arrived in February 2026 and according to the interim facility director, subsequently received a mandate from the VA Secretary and VISN 7 director to address the facility's culture and accountability. That same month, the interim facility director developed an action plan to strengthen supply chain operations and reinforce accountability. In March 2026, according to the interim facility director, VHA replaced many of the facility's other leaders.

The action plan included targeted goals for improving communication, developing supply chain leaders, correcting inventory inaccuracies, establishing effective governance structures, ensuring compliance with facility policies, resolving the issues with the PAR Excellence contract, implementing structured daily huddles, hiring supply chain staff, and building a more skilled and accountable workforce. In May 2026, VISN and facility leaders shared with the OIG team a new action plan—including actions they identified as completed—designed to improve the facility's supply chain management. However, during a follow-up visit to the facility that month, the OIG team determined that the supply chain management deficiencies identified in March had persisted.

If implemented effectively, the action plan could significantly benefit both the facility and the veterans it serves. Strengthening inventory accuracy and ensuring full compliance with VHA Directive 1761 should reduce operating room delays, prevent supply shortages, and stabilize day-to-day clinical operations. The action plan reflects leaders' engagement and ownership and emphasizes accelerated hiring, better communication, and a renewed culture of accountability across departments. While the facility's action plan is a positive start, the OIG made seven recommendations to further support improvements to the facility's supply chain management system.

In July 2026, the facility reported to the OIG team that the acting supply chief was continuing to identify and confirm the location of the missing nonexpendable inventory. The facility also reported that it extended the period of performance for the PAR Excellence contract with no additional cost. The OIG will continue to evaluate actions taken to address report deficiencies and recommendations.

Conclusion

The OIG found that long-standing deficiencies in supply chain management, inventory controls, warehouse conditions, and leadership oversight created significant risks to patient safety, financial stewardship, and operational reliability at the facility.

Chronic inaccuracies in expendable and nonexpendable inventory data, compounded by years of inadequate monitoring and training, undermined the facility's ability to maintain essential supplies and equipment. Repeated operating room closures and canceled surgeries demonstrated the direct clinical impact of these challenges, which eroded trust between clinical staff and supply chain operations staff. Widespread warehouse disorganization and disrepair, improper storage, significant quantities of expired or unused supplies, and lack of security controls reflected systemic breakdowns in accountability in what should be a disciplined supply chain process.

Although the PAR Excellence contract was intended to modernize inventory management, the system was never fully installed, resulting in wasted taxpayer money and resources and lost opportunities for improvement. Persistent staffing shortages and leadership turnover further contributed to a cycle of poor performance, unaddressed deficiencies, and inefficient or unsafe practices. The facility's ineffective response to VISN quality control reviews showed that oversight findings were not being addressed by sustained improvements.

The facility's March 2026 action plan represents a critical step toward restoring compliance, strengthening supply chain functions, and safeguarding the quality of care provided to veterans, but more effective improvement is needed.

Recommendations 1–7

The OIG made the following recommendations to the under secretary for health to ensure the VA Augusta Health Care System facility director takes the following actions:[16]

1. Develop and implement procedures to maintain stock within the required thresholds as outlined in Veterans Health Administration Directive 1761.
2. Ensure all relevant supply chain staff receive appropriate and recurring training and require supervisors to perform ongoing monitoring—including periodic inventory reviews and root-cause analyses—to strengthen controls over VA supplies.
3. Develop and implement, in collaboration with the Veterans Integrated Service Network, local procedures that require custodial officers to notify supply chain staff

[16] The recommendations addressed to the under secretary for health are directed to anyone in an acting status or performing the delegable duties of the position.

when equipment is relocated, and establish protocols to validate and update equipment location and ensure equipment items are properly tagged.

4. Ensure expendable supplies labeled expired are, in fact, expired and appropriate documentation is completed before turning the supplies in.
5. Address the physical security issues discussed in this report and provide recurring training on proper physical security controls and procedures to individuals with authorized access to the primary inventory point and warehouses.
6. Evaluate contractor performance under the contracts awarded for inventory management systems in the Augusta VA Health Care System and take appropriate action to ensure performance in accordance with the contract and to recover funds.
7. Ensure supply chain management staff effectively address deficiencies identified during Veterans Integrated Service Network quality control reviews.

VA Management Comments

In August 2026, the acting executive director for the VA Health Service Area 2.4 and the VA Augusta Health Care System interim director, with clearance from the under secretary for health, concurred with all seven recommendations. The interim director submitted responsive corrective action plans to address each recommendation. These actions include developing and implementing local policies and training for supply chain management staff, conducting monthly reviews of expired items, plans for construction improvements to existing warehouses, planned oversight of contract management, and plans for remediation of open VISN findings. The interim director also provided supporting documentation of corrective actions already taken and asked the OIG to close recommendation 1. For recommendation 1, VHA provided evidence that a local policy had been implemented to maintain stock within the required thresholds. For recommendation 2, VHA provided evidence of completing necessary training to ensure supply chain staff strengthen controls over VHA supplies. For recommendation 3, VHA provided evidence that the facility developed and implemented procedures to ensure equipment is properly located and identified. The full text of the comments from the acting executive director for VISN Health Service Area and the VA Augusta Health Care System interim director can be found in appendixes B and C, respectively.

OIG Response

The OIG closed recommendations 1, 2, and 3 based on the evidence VHA provided. The OIG will monitor VHA's corrective actions and will close recommendations 4 through 7 when VHA provides sufficient evidence that it has improved supply chain operations and addressed the risks identified in this report.

Appendix A: Scope and Methodology

Scope

The VA Office of Inspector General (OIG) team conducted its work from March through June 2026, focusing on expendable supplies, nonexpendable equipment, supply chain leadership, and medical distribution and warehouse controls at the VA Augusta Health Care System in Georgia. The OIG initiated this review of the Augusta VA Health Care System in response to allegations concerning ineffective purchasing and management of expendable supplies and insufficient accountability for nonexpendable equipment.

Methodology

To understand the Veterans Health Administration's supply chain management requirements, the team reviewed applicable laws, regulations, policies, and procedures. The team interviewed the Veterans Integrated Service Network (VISN) 7 director and chief logistics officer, Augusta facility executive and supply chain management leaders, and clinical and supply staff from the Augusta facility who are responsible for the management and accountability of the facility's expendable supplies and nonexpendable equipment. The team also reviewed fiscal year 2023, 2024, and 2025 quality control reviews and other relevant documentation.

The team evaluated expendable supplies and nonexpendable equipment during two site visits in March 2026. During those visits, the team reviewed a judgmental sample of 100 expendable items (50 from the operating room primary inventory area and 50 from the medical and surgical primary inventory area) and compared inventory records in the Generic Inventory Package to physical counts. The team also tested the accuracy of the nonexpendable equipment inventory data by judgmentally selecting 35 items to determine whether the recorded equipment location in Maximo (an approved automated inventory system that VA uses) matched each item's actual physical location. The team physically observed warehouses and storage areas, which held expendable supplies and nonexpendable equipment. The team also conducted a follow-up site visit in May 2026 to assess and validate corrective actions taken in response to identified deficiencies.

Internal Controls

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

monitoring.[17] In addition, the team reviewed the principles of internal controls as associated with the objective and identified four components and six principles as significant.[18] The team identified internal control deficiencies during this review and proposed recommendations to address those listed in table A.1.

Table A.1. VA OIG Analysis of Internal Control Components and Principles Identified as Significant

Component	Principle	Deficiency identified by this review
Control environment	3. Establish structure, responsibility, and authority organizational structure.	Routine turnover in key leadership positions at the facility reduced continuity and process discipline.
	5. Enforce accountability.	Leaders did not address staff's poor performance. Additionally, staff did not always complete their annual inventories on time.
Risk assessment	7. Identify, analyze, and respond to risks.	Inventory areas lacked adequate security for inventory points and a warehouse.
Control activities	12. Implement control activities.	Staff did not use barcode scanning and did not always verify on-hand quantities before ordering expendable supplies.
Monitoring	16. Perform monitoring activities.	Staff processed invoices for a contract that had incomplete work.
	17. Evaluate issues and remediate deficiencies.	The facility had repeated findings in quality control reviews for multiple fiscal years and did not complete most of their action plans for prior-year deficiencies.

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 the Generic Inventory Package for expendable supplies and from Maximo for nonexpendable equipment. The team tested key data 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 the data were sufficiently reliable for the purpose of this review.

[17] Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-25-107721, May 2025.

[18] Because the review 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 review.

Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.[19]

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

Appendix B: VA Management Comments, Acting Executive Director, VA Health Service Area 2.4

Department of Veterans Affairs Memorandum

Date: August 7, 2026

From: Acting Executive Director, Department of Veterans Affairs (VA) Health Service Area 2.4

Subj: VA OIG Report, Review of Supply Chain Management at the VA Augusta Health Care System in Georgia (VIEWS# 15005117)

To: Under Secretary for Health (10)
Assistant Inspector General for Audits and Evaluations (52)
Executive Director, Veterans Health Administration Office of Integrity and Compliance (10OIC)

1. We appreciate the opportunity to review and comment on the Office of Inspector General draft report, Review of Supply Chain Management at the VA Augusta Health Care System in Georgia. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I reviewed the action plan provided by the facility and concur with the response.

2. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

(Original signed by)

The OIG removed point of contact information prior to publication.

(Original signed by)

Kevin P. Amick MBA, MHRM (SES)

The text of VA's management comments is reprinted verbatim as received from the department. For accessibility, the original format of this appendix has been modified to comply with section 508 of the Rehabilitation Act of 1973, as amended.

Appendix C: VA Management Comments, Interim Director, VA Augusta Health Care System

Department of Veterans Affairs Memorandum

Date: August 10, 2026

From: Interim Director, Department of Veterans Affairs (VA) Augusta Health Care System (509)

Subj: VA OIG Report, Review of Supply Chain Management at the VA Augusta Health Care System in Georgia (VIEWS# 15005117)

To: Acting Executive Director, VA Health Service Area 2.4

We appreciate the opportunity to review and comment on the Office of Inspector General draft report. I have reviewed the documentation and concur with the submitted responses.

The OIG removed point of contact information prior to publication.

(Original signed by)

James Doelling

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report – Review of Supply Chain Management at the VA Augusta Health Care System in Georgia (2026-02023-AE-0046)

Recommendation 1: Develop and implement procedures to maintain stock within the required thresholds as outlined in Veterans Health Administration Directive 1761.

VHA Comments: Concur. VA Augusta Health Care System (HCS) has developed and implemented Standard Operating Procedure (SOP) 7201.509, Process for Electronic Monitoring of Supply Usage, effective July 7, 2026, which establishes the procedures and controls used to maintain stock within the thresholds required by VHA Directive 1761, Supply Chain Management Operations. This SOP is the facility's compliance mechanism for this recommendation and is attached as supporting documentation.

Specifically, SOP 7201.509 requires: Stock level thresholds (Section 2.b): Every primary inventory item must have a Normal Stock Level, Emergency Stock Level, and Reorder Point Level established, with these fields never left blank. Secondary inventory items must have a Normal Stock Level and Reorder Point Level established. Inventory Managers and functional area employees jointly review each inventory point at least quarterly to confirm correct items and stock levels are maintained, per Appendix D, paragraph 2.a.(3) of VHA Directive 1761.Ongoing monitoring (Section 2.a): Supply Chain Management (SCM) Inventory Management staff generate and review the Stock Status Report biweekly, the Due-In Report and Emergency Stock Report weekly, and the Usage Demand Item Report, Inactive Items report, and Long Supply report monthly, using the Supply Chain Common Operating Picture (SCCOP) and Supply Chain Data Integrity Office (SCDIO) tools referenced in the original response. Supervisory oversight and accountability (Section 2.f): The SCM Supervisor, Inventory Management, reviews staff report activity monthly, confirming reports are generated, reviewed, and acted upon, documents this review, and escalates any discrepancies to the Chief Supply Chain Officer (CSCO).

Physical inventory verification (Section 2.d): Physical inventory counts are conducted on a schedule tied to ABC classification, with a required minimum 95% accuracy rate. If accuracy falls below threshold, a corrective action plan is developed and submitted for Veterans Integrated Service Network (VISN) Chief Logistics Officer (CLO) approval within 1 month, with monthly recounts continuing until an acceptable accuracy rate is achieved.

These procedures, taken together, constitute the facility's implemented process for maintaining stock within required thresholds. VA Augusta HCS requests closure of this recommendation based on the implementation of SOP 7201.509 and will continue to monitor compliance through the monthly supervisory reviews described above.

Status: Complete **Completion Date:** July 7, 2026

Recommendation 2: Ensure all relevant supply chain staff receive appropriate and recurring training and require supervisors to perform ongoing monitoring—including periodic inventory reviews and root-cause analyses—to strengthen controls over VA supplies.

VHA Comments: Concur. VA Augusta HCS SCM Service has implemented the SCM Master Training Plan, Version 1.0 (effective April 20, 2026), which establishes recurring training requirements for all SCM staff, and SOP 7201.509, Process for Electronic Monitoring of Supply Usage, which establishes supervisory monitoring controls. Both are attached as supporting documentation. As of July 20, 2026,

supervisors verified 41 current SCM staff have completed the training requirements applicable to their functional role, including New Hire Orientation, required Talent Management System (TMS) modules, Local Training, and National Training, where applicable based on tenure and grade. This baseline completion was verified via TMS training reports reviewed by Section Supervisors and consolidated by the Administrative Officer. Ongoing compliance with recurring training requirements will be sustained through the monthly and annual mechanisms described below.

The SCM Master Training Plan requires New Hire Orientation, TMS training, Local Training, and National Training through the VA Acquisition Academy (VAAA), assigned by Supply Chain Professional Level (I-III) based on grade. Section Supervisors ensure employees complete annually required TMS modules by established due dates, review TMS monthly training reports, and issue written notices for approaching or missed deadlines. Local training is conducted at least monthly, with each session lasting no less than 30 minutes. Content is aligned with established Standard Operating Procedures and competency requirements. Attendance is recorded through sign-in sheets, and when skills demonstration is required, supervisors complete written competency assessments. All competency documentation is maintained in the employee's six-part personnel folder.

The Logistics Management Specialist (LMS) certifies the relevance and adequacy of all local training conducted.

Per the Master Training Plan, the Administrative Officer consolidates SCM training activity into a report distributed to facility executive leadership and reported quarterly to VISN, consistent with VHA Directive 1761 quarterly training activity reporting requirements. The Facility CSCO evaluates the training plan's implementation after the first quarter of each fiscal year, and a quarterly review of training activities is conducted to identify improvement opportunities. National Training completions include a mandatory 30-day follow-up assessment to confirm principles learned are being applied on the job.

Supervisory monitoring is addressed in SOP 7201.509, Section 2.f: the SCM Supervisor, Inventory Management, reviews staff report activity monthly to confirm reports are generated, reviewed, and acted upon, documents this review, and escalates any discrepancies to the CSCO. Root-cause analysis is incorporated into the physical inventory accuracy process (SOP 7201.509, Section 2.d.3): where a physical inventory count falls below the required 95% accuracy threshold, a corrective action plan addressing the root cause must be developed and submitted for VISN CLO approval within 1 month, with monthly recounts continuing until an acceptable accuracy rate is restored.

VA Augusta HCS has implemented the training and oversight structure described above and confirmed baseline staff training completion as of July 20, 2026.

Status: Complete **Completion Date:** July 20, 2026

Recommendation 3: Develop and implement, in collaboration with the Veterans Integrated Service Network, local procedures that require custodial officers to notify supply chain staff when equipment is relocated and establish protocols to validate and update equipment location and ensure equipment items are properly tagged.

VHA Comments: Concur. SOP 7012.509, Report of Survey, was established May 11, 2026, and requires Custodial Officers to notify SCM staff when equipment is relocated. This notification requirement is reinforced through annual Custodial Officer training.

Equipment location validation is performed through two mechanisms: (1) the annual EIL physical inventory, which captures the last-scanned location for each item and updates the Maximo asset management system accordingly, and (2) ad-hoc scans conducted whenever a location is commissioned

or decommissioned through the Facility Planner, ensuring location data remains accurate between annual cycles. SCDIO barcode and location lists are cross-referenced against Maximo to confirm equipment tagging remains accurate and current.

Oversight of this process is provided by the CSCO, who reviews EIL completion and Maximo update accuracy quarterly and reports results to facility leadership.

VA Augusta HCS will monitor compliance until 90% of equipment locations are validated as accurate for 6 consecutive months, as confirmed by the SCCOP, Non-IT Accountability report.

Status: In Progress Target **Completion Date:** May 2026

Recommendation 4: Ensure expendable supplies labeled expired are, in fact, expired and appropriate documentation is completed before turning the supplies in.

VHA Comments: Concur. VA Augusta HCS has established the following standards to ensure expired-item determinations are accurate and properly documented. When items are identified as expired, they are pulled from inventory and reviewed by SCM staff to confirm the expiration date before removal. Single expired items are discarded and removed from inventory upon the next inventory scan. Items valued at $5,000 or more require a 2237 turn-in document and a completed Report of Survey (ROS) per policy.

These verification standards are pre-existing and have been in place prior to this finding. What is new, in direct response to this recommendation, is a monthly oversight and reporting mechanism, which did not previously exist as a formal, documented check on adherence to these standards. This new mechanism is being formalized under SOP Secondary Inventory Point Set-up and Maintenance, which is currently in development and has not yet been finalized.

Once finalized, this SOP will require the SCM Supervisor, Inventory Management, to conduct a monthly review of expired-item turn-ins and associated documentation (2237 forms, ROS packages, adjustment vouchers) to confirm completeness and accuracy, with results reported to the CSCO monthly and discrepancies escalated for corrective action.

For ROS-related adjustment vouchers, processing continues to follow VA Handbook 7002, Logistics Management Procedures (January 8, 2020): vouchers of $5,000 or more require a Board of Survey, and vouchers related to clerical or administrative error are reviewed by the VA medical facility CSCO and retained with inventory point physical count audit records. Positive adjustments in primary inventory points are completed via an expendable adjustment voucher in the Generic Inventory Package (GIP).

Once SOP Secondary Inventory Point Set-up and Maintenance is finalized and the monthly review process is active, VA Augusta HCS will monitor compliance until 90% accuracy in expired-item documentation is maintained for 6 consecutive months.

Status: In-Progress **Completion Date:** January 2027

Recommendation 5: Address the physical security issues discussed in this report and provide recurring training on proper physical security controls and procedures to individuals with authorized access to the primary inventory point and warehouses.

VHA Comments: Concur. VA Augusta HCS is addressing this recommendation through two parallel efforts: physical infrastructure improvements and recurring personnel training.

The physical security infrastructure issues identified in the OIG review were incorporated into the construction plans for Buildings 95 and 111 following completion of the roof work, ensuring correction of previously noted noncompliance with required security and climate control standards. For Building 95, the design award is targeted for the first quarter of fiscal year 2027, with the construction award anticipated in

the second quarter of fiscal year 2028. For Building 111, the design award remains pending, with a projected completion date of July 2027.

All individuals with authorized access to the primary inventory point and warehouses will receive recurring training on physical security controls and procedures, including access control protocols, key/badge management, visitor logging, and incident reporting. Physical security has been added as an annual training topic under the SCM Master Training Plan's Attachment C, Annual Local Training Schedule, and will be delivered once per year as part of the Local Training requirement, a minimum 30-minute session, documented via sign-in sheet, and certified for adequacy by the LMS. Completion will be tracked and reported quarterly to VISN alongside other SCM training activity, consistent with VHA Directive 1761 reporting requirements. In the interim, prior to completion of the building 95/111 construction projects, supplemental locks and physical barriers, along with badge access for elevators and key access for doors, remain in place to mitigate risk.

VA Augusta HCS will monitor training compliance until 90% of authorized personnel have completed initial and recurring training, maintained for six consecutive reporting periods, in addition to tracking construction milestones through completion.

Status: In-Progress **Target Completion Date:** July 30, 2029

Recommendation 6: Evaluate contractor performance under the contracts awarded for inventory management systems in the Augusta VA Health Care System and take appropriate action to ensure performance in accordance with the contract and to recover funds.

VHA Comments: Concur. A contract modification was executed to extend the period of performance until December 2026. SCM leadership is working with Par Excellence to remediate noncompliance and fully implement the program at VA Augusta HCS.

The VA Augusta Health Care System continues to advance implementation of the inventory management system in collaboration with the contractor. To date, approximately twenty-three primary and secondary inventory locations have completed full inventory scans. Item counts from each location are being monitored and shared with the contractor to support ongoing deployment activities.

As scanning progresses, previously identified inaccuracies within the Generic Inventory Package have been corrected, including the removal of items confirmed as no longer present in the scanned rooms. To further support implementation, 234 equipment bins have been ordered, and coordination with the vendor is ongoing to confirm delivery. Several clinical and operational areas are temporarily unable to proceed with scanning due to recent flooding. Scanning activities in these areas will resume once conditions allow. Additional implementation requirements remain underway, including verification of laptop availability for logistics personnel, production of updated labels for newly scanned locations, expansion of GIP/VistA edit access beyond the current single point of contact, and uploading an updated inventory file to strengthen audit transparency.

A Par Excellence site visit occurred the week of July 13, 2026. GIP inventory data exports for the 10 locations reviewed during that visit confirm the review took place. The formal outcome and findings of the visit have not yet been released. VA Augusta HCS will provide a further update to this recommendation once the contractor's formal results are available, including whether the visit identified additional corrective actions, confirmed operational status for the reviewed areas, or affected the December 2026 implementation timeline.

VA Augusta HCS will continue to monitor contractor performance against the modified period of performance and will pursue appropriate contractual remedies, including fund recovery where warranted, if performance deficiencies are confirmed.

Status: In-Progress **Target Completion Date:** December 2026

Recommendation 7: Ensure supply chain management staff effectively address deficiencies identified during Veterans Integrated Service Network quality control reviews.

VHA Comments: Concur. VA Augusta HCS SCM staff have been proactively working through the fiscal year (FY) 2026 Quality Control Review (QCR) list in draft form, in advance of the official VISN QCR findings being issued, in addition to continuing corrective action on open items from the finalized FY 2025 QCR. This early engagement allows the facility to begin remediation on likely findings rather than waiting for official issuance to start work.

Based on the current draft, corrective action planning is underway across several categories, with particular attention to items carrying High risk ratings and/or flagged as repeat findings from FY 2025.These priority areas include inventory certification/reconciliation, GIP usage for expendable inventory management, mail center and inventory access controls, clean/sterile storage compliance required by VHA Directive 1761 Appendix F, nonexpendable property accountability, Board of Survey procedures, and bringing warehouse security practices into compliance with VA Handbook 0730/1, Security and Law Enforcement Officer Handbook.

VA Augusta HCS will finalize its corrective action plan and target completion dates for each open item once the official FY 2026 QCR is issued by the VISN, since draft ratings and item numbers are subject to change prior to formal release. In the interim, SCM leadership is tracking draft item status and prioritizing remediation of items rated High risk or flagged as repeat findings, given the likelihood these will carry forward into the official report largely unchanged.

Status: In-Progress **Target Completion Date:** January 2027

The text of VA's management comments is reprinted verbatim as received from the department. 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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