



US DEPARTMENT OF VETERANS AFFAIRS **OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Pittsburgh Healthcare System in Pennsylvania

Healthcare Facility
Inspection

26-00047-288

October 6, 2026



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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA Pittsburgh Healthcare System (the facility) from March 24 through 26, 2026. The facility is rated as *highest complexity* and in fiscal year 2025, provided direct care to about 93,000 patients.¹ The inspection team examined aspects of care delivery and patient safety within the facility using five domains.²

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG team found dust on patient care surfaces and supply shelves, portable equipment overdue for maintenance, and unsecured power strips and stretched electrical cords; also, some employees could not explain proper procedures for pharmaceutical waste disposal. The OIG made four recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG made no recommendations.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.³ The OIG made no recommendations.
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of

¹ VHA classifies facilities based on their complexity level. Highest-complexity facilities have "high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY2026 Through April," VHA Support Service Center, last updated April 28, 2026, <https://reports.vssc.med.va.gov/ReportViewer>. (This website is not publicly accessible.)

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

³ VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

homelessness or have recently been incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Director takes appropriate action for employees to keep patient care areas clean as required by Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program* and clean storerooms as required by Veterans Health Administration Directive 1761, *Supply Chain Management Operations*.⁴
2. The Director takes appropriate action for employees to inspect and test all medical equipment as required by The Joint Commission standard PE [Physical Environment] 04.01.01.⁵
3. The Director takes appropriate action so pharmaceutical waste containers are provided and accessible, and trains employees on container use as required by Veterans Health Administration Directive 1850.06(1), *Waste Management Program*.⁶
4. The Director takes appropriate action so employees secure power strips as required by National Fire Protection Association's *Health Care Facilities Code, NFPA 99* and electrical cords are connected to prevent pulling or straining as required by *National Electrical Code, NFPA 70*.⁷

VA Comments and OIG Response

The Health Service Area Director and facility Director concurred with the recommendations and provided acceptable action plans (see the responses in the report body and appendixes C and D for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.



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⁴ VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023; VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

⁵ The Joint Commission, *Standards Manual*, E-dition, PE 04.01.01, March 1, 2026.

⁶ VHA Directive 1850.06(1), *Waste Management Program*, July 22, 2022, amended June 5, 2024.

⁷ National Fire Protection Association, *Health Care Facilities Code, NFPA 99*, 2024; National Fire Protection Association, *National Electrical Code, NFPA 70*, 2026.

Abbreviations

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

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Introduction

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.⁸ VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

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



Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.⁹



Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.¹⁰



Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.¹¹



Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.



Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.¹²

⁸ "About Us," VA, last updated June 2, 2026, <https://department.va.gov/vha/about-us>.

⁹ Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," *BMJ Open* 7, no. 11 (2017): 1–11, <https://doi.org/10.1136/bmjopen-2017-017708>.

¹⁰ VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

¹¹ VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

¹² VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.



Figure 1. Pittsburgh VA Medical Center (left) and H. John Heinz III Department of Veterans Affairs Center (right).

Source: “VA Pittsburgh Health Care,” VA, last updated December 15, 2025, <https://www.va.gov/pittsburgh-health-care>.

The VA Pittsburgh Healthcare System (the facility) consists of the Pittsburgh VA Medical Center (Pittsburgh), the H. John Heinz III Department of Veterans Affairs Medical Center (Heinz), and several outpatient clinics serving veterans in Pennsylvania and Ohio.¹³ The facility also houses four VA research centers that support research and clinical collaboration across VA and partners with educational organizations including the University of Pittsburgh. Of note, the facility offers kidney and liver transplant services. The facility is rated as *highest complexity* and in fiscal year (FY) 2025 provided direct care to about 93,000 patients.¹⁴ The facility’s medical care budget was approximately \$1.2 billion in FY 2025.

The OIG team inspected the facility from March 24 through 26, 2026. The executive leaders referred to throughout this report include the Interim Executive Director (Director), Deputy Executive Director (Deputy Director), Acting Chief of Staff, Deputy Chief of Staff, Associate Director for Patient Care Services/Nurse Executive, Acting Deputy Nurse Executive, Acting Associate Director, and Assistant Director.

¹³ The clinics are located in Greensburg, Monroeville, Rochester, Uniontown, and Washington, Pennsylvania, and St. Clairsville, Ohio. “VA Pittsburgh Health Care, Locations,” VA, accessed April 13, 2026, <https://www.va.gov/pittsburgh-health-care/locations>.

¹⁴ VHA classifies facilities based on their complexity level. Highest-complexity facilities have “high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs.” VHA Office of Productivity, Efficiency and Staffing (OPES), “VHA Facility Complexity Model Fact Sheet.” “Trip Pack - Operational Statistics Table FY2026 Through April,” VHA Support Service Center, last updated April 28, 2026, <https://reports.vssc.med.va.gov/ReportViewer>. (This website is not publicly accessible.)



CULTURE

The OIG team examined the facility’s culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization’s daily operations), and both employees’ and veterans’ experiences.¹⁵ The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).¹⁶ The team also interviewed executive and facility leaders and employees and considered data from patient advocates.¹⁷

System Shocks

Executive leaders reported that a system shock was the Office of Personnel Management’s (OPM) classification oversight review, a process initiated in fall 2011 to review position descriptions to confirm they meet OPM’s standards.¹⁸ VA issued a human resources memorandum in June 2012 that suspended changes to grades (the ranking system used to determine the level of difficulty, responsibility, and required credentials of the position) and pay scales (resultant from OPM’s reclassification review) pending discussions with OPM. In 2023, OPM reinitiated the review with the first group of position descriptions completed in May 2024.

The Deputy Director reported the reviews classified many administrative positions to lower grades, affected about 75–100 employees across multiple administrative services, and some employees resigned. The Deputy Director provided documentation listing some affected positions, such as industrial hygienists (employees who assess the environment for hazards and work to reduce those in the workplace), purchasing agents, and environmental management staff. The Associate Director, Patient Care Services/Nurse Executive shared that because some administrative staff manage equipment orders and contracts, losing experienced employees in these roles can delay patient care. Additionally, one executive leader said the review process affected their ability to recruit candidates in the transportation service, and another executive

¹⁵ Valerie M. Vaughn et al., “Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies,” *BMJ Quality and Safety* 28 (2019): 74–84, <https://doi.org/10.1136/bmjqs-2017-007573>.

¹⁶ “Veteran Trust in VA,” VA, last updated June 4, 2026, <https://www.va.gov/initiatives/veteran-trust-in-va>.

¹⁷ Patient advocates are employees who receive feedback from veterans and help resolve their concerns. “Patient Advocate,” VA, last updated May 9, 2022, <https://www.va.gov/patientadvocate>. For more information on the OIG’s data collection methods, see appendix A.

¹⁸ “About Us,” Office of Personnel Management, accessed April 8, 2026, <https://www.opm.gov/about-us>; “Classification Review Project,” VA, accessed April 17, 2026, <https://dvagov.sharepoint.com/sites/Classification-Review-Project>. (This site is not publicly accessible.)

leader added that because their transportation workforce has been reduced by approximately 25 percent, the capability to provide transportation services to veterans was limited.

Executive leaders stated that the impact of the position downgrades and pay reductions also restricted career progression and diminished the facility’s ability to recruit and sustain an innovative work environment. As reviews of non-clinical position descriptions continue, executive leaders expressed concerns that this process will further reduce employee promotion opportunities, diminish internal talent pipelines, and heighten strain on succession planning (a process that prepares employees to assume key roles during leadership transitions). The Deputy Director said some of the position descriptions under review serve as pathways to executive leader roles and that as current leaders and staff retire, the facility will have fewer qualified internal candidates. In addition, executive leaders identified recruitment challenges and stated that downgraded positions are unlikely to attract qualified external applicants due to uncompetitive wages relative to community pay.

Executive leaders implemented temporary measures to limit further operational disruptions. The Interim Director stated leaders assigned employees on a temporary basis to maintain operations until they could fill vacated positions. Executive leaders said Veterans Integrated Service Network (VISN) leaders approved retention bonuses to slow additional turnover but emphasized that the bonuses provide only short-term relief.¹⁹

Employee Experiences

Because VA did not conduct an All Employee Survey in FY 2025, the OIG team evaluated executive leaders’ efforts to assess employee engagement and satisfaction.²⁰ Executive leaders said they use several methods to communicate with employees, including daily meetings, weekly emails from the Director, visits to employee work locations, and open office hours. The Deputy Director said they receive employee feedback during visits to work areas and added that executive leaders meet weekly to discuss concerns, identify themes, develop actions, and share updates with employees at town halls.

¹⁹ Veterans Integrated Service Networks (VISNs) are “regional care systems working together to better meet local healthcare needs and provide greater access to care.” “Veterans Integrated Service Networks,” VA, last updated July 24, 2026, <https://department.va.gov/visns>. In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. 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 inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit <https://digital.va.gov/rise>.

²⁰ Drew Friedman, “After Months of Postponing, OPM Opts to Fully Cancel 2025 FEVS [Federal Employee Viewpoint Survey],” *Federal News Network*, August 15, 2025; The All Employee Survey is an annual, voluntary survey of VA workforce experiences. “AES Survey History, Understanding Workplace Experiences in VA,” VHA National Center for Organization Development.

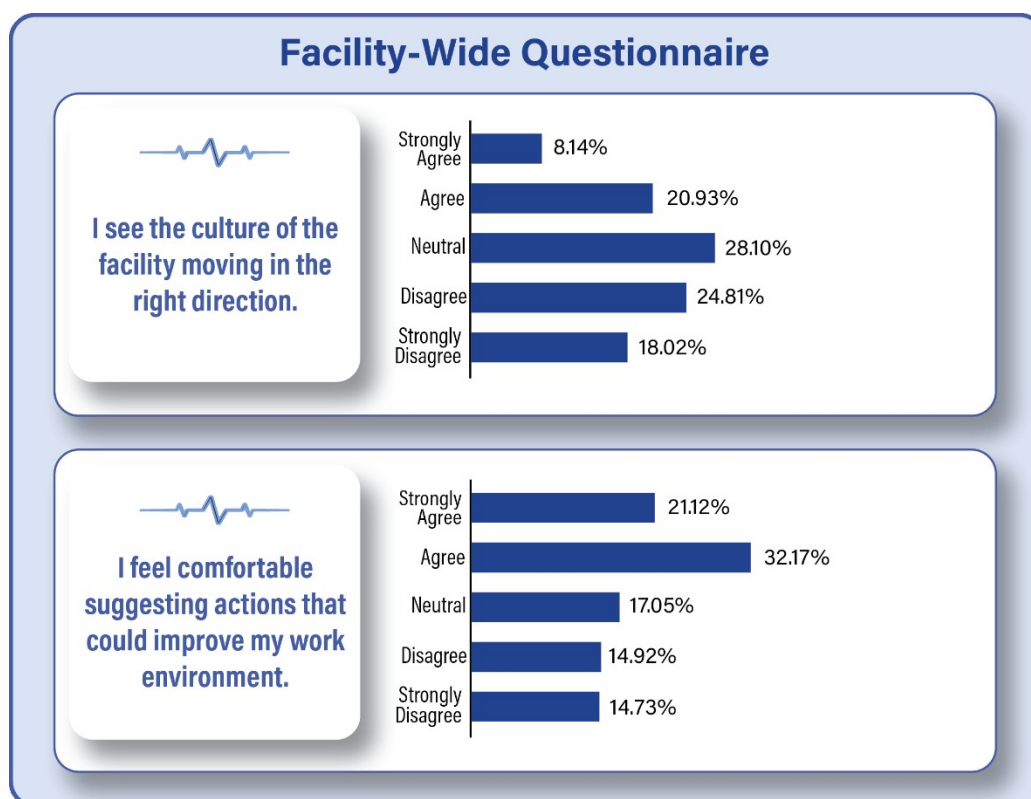


Figure 2. Employee perceptions of facility culture.

Source: OIG analysis of selected questionnaire responses.

Employee responses to an OIG questionnaire indicated that stress and burnout were the main factors that make them consider leaving the facility.²¹ High levels of stress and burnout may impair employees' capacity to maintain safe, timely, and high-quality care for veterans. Executive leaders said employees were frustrated with the executive actions that required a return to in-person work and removed the option to telework and said this requirement caused some employees to leave the facility, which increased workload.²² One executive leader reported that the prevalence of telework options among community healthcare organizations hindered the facility's ability to attract and recruit quality candidates, including administrative personnel who provide operational support.

Executive leaders described several actions to address employee stress and burnout. Executive leaders said they enhanced their Whole Health Program, a model that promotes veteran and employee well-being.²³ The Acting Deputy Nurse Executive added that nursing leaders also

²¹ The facility had approximately 4,100 employees at the time of the questionnaire, with a response rate around 8 percent.

²² "Return to In-Person Work," 90 Fed. Reg. 8251 (Jan. 28, 2025).

²³ VHA Directive 1445, *Whole Health System*, October 13, 2023.

issue surveys to new nursing staff at 30-, 60-, and 90-day intervals and then annually to collect feedback to assess opportunities for retention and identify potential workplace issues.

Veteran Experiences

Executive leaders said they receive veteran concerns from multiple sources: the patient safety reporting process; weekly meetings with patient advocates; and communication from police, nursing, and other services. The Interim Director stated patient advocates address veteran concerns with service leaders during daily meetings and track the concerns through resolution. Nursing leaders stated they obtain inpatient feedback through a daily bedside television prompt that solicits veteran comments, and when a complaint is submitted, the nurse manager responds within two hours to address and resolve the concern.

Patient advocate responses to the OIG questionnaire indicated that veterans most often reported telephone access issues, including long wait times and delays in returned calls from clinic and transportation staff. The Interim Director acknowledged that the centralized call centers limit veterans' ability to speak directly with their care teams, which contributes to veterans' dissatisfaction. During town hall events, the Interim Director explained that leaders encourage veterans to use VA's secure messaging system as an alternative to directly communicate with their care teams. The Deputy Director said their VISN uses a centralized call center for primary care and the nurse help line, while specialty care calls are managed at the facility level. This structure allows veterans to speak directly with specialty care staff and has improved satisfaction. Executive leaders said they also monitor call-volume and response-time data.

Some patient advocates identified veterans' concerns with transportation services. The Assistant Director attributed these concerns to a reduced workforce related to the classification reviews. The executive leader further explained that the facility operates one of the largest transportation programs in VHA and that the lack of an approved position description has constrained recruitment efforts. Consequently, the facility has experienced fewer transport drivers, which has negatively affected veteran satisfaction. The Assistant Director said leaders made changes to better support veterans, including assigning transportation employees to discharge areas at both medical centers and schedule changes to extend hours of coverage.

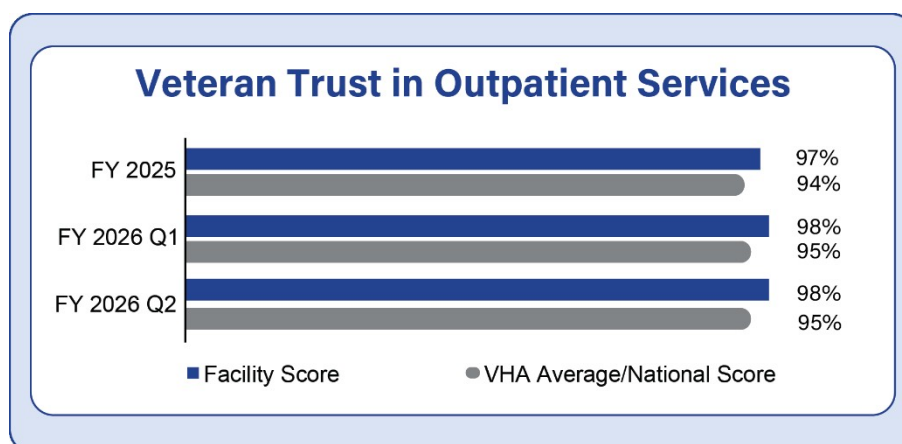


Figure 3. Veteran trust in outpatient services.

Source: VSignals data.

The facility's VSignals results for FY 2025 and the first two quarters in FY 2026 reflect positive experiences, and facility scores consistently exceeded the national average, indicating veterans trust the care they receive, as shown in figure 3. The Deputy Director attributed this to veteran participation in the Veteran Engagement Council (a facility committee comprised of employees and veterans), attendance at town halls, and frequent communication with providers, nurses, and other facility staff.



ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.²⁴ The OIG team assessed how the facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.²⁵

²⁴ "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, <https://www.va.gov/WholeHealth/Healing-Spaces>.

²⁵ VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, 2025; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

General Inspections

At the Heinz location, the OIG team observed cracked sidewalks and noted that one crosswalk did not have a detectable warning surface. VA's *PG 18-10 Site Design Manual* requires detectable warning surfaces to alert visually impaired pedestrians of potential hazards at points where a walkway transitions onto a vehicle roadway.²⁶ The Acting Associate Director explained that employees repair sidewalks after the winter months and noted that staff would address the lack of detectable warning surfaces to the crosswalk, so the OIG did not make a recommendation.

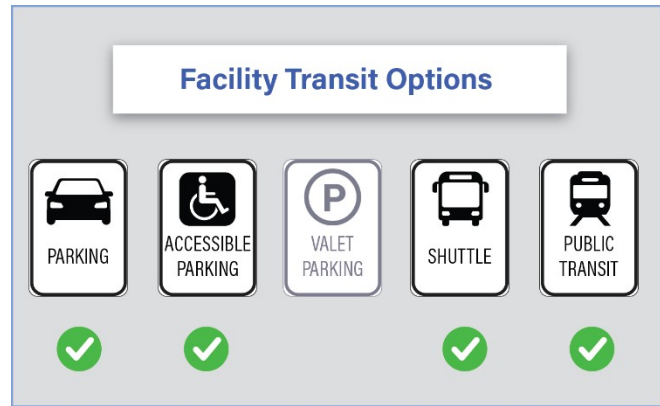


Figure 4. Transit options for arriving at the facility. Source: OIG review of facility parking lot maps, shuttle schedule, staff response to document request, and a questionnaire response.

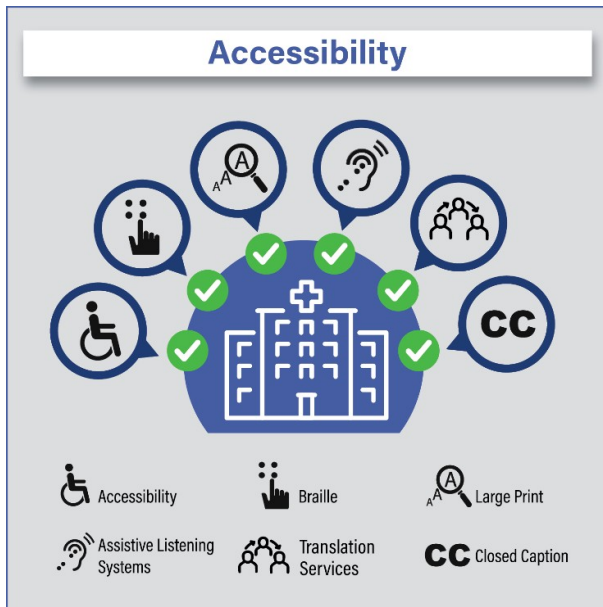


Figure 5. Accessibility tools available to veterans with impairments. Source: OIG team observations and a questionnaire response.

The OIG team found the main entrances at both locations generally clean and identified multiple features to aid veterans with sensory or physical impairments (see figure 5). The main lobby at the Heinz location features a ceramic village and model railroad that a VHA recreational therapist created to honor veterans and provide replicas of local scenes (see appendix B, figure B.1). Additionally, at this location the facility has a simulated patient home called My Home. The Deputy Director said rehabilitation staff and volunteers created the project so veterans can practice daily activities in a homelike environment under staff supervision before discharge. The home includes an entrance with stairs, a kitchen, living room, bedroom, bathroom, and garage with a car. It also includes carpet and solid flooring to help veterans practice walking on different surfaces.

The Deputy Director said this setting is a valuable resource that helps veterans prepare for common challenges before they return home.

²⁶ VA, *PG-18-10, Site Design Manual*, February 1, 2013, revised March 1, 2024.

During the inspection, the OIG team found dust on the bed frames beneath mattresses, on the base of examination tables, and on supply storeroom shelves. VHA Directive 1608(1), *Comprehensive Environment of Care Program*, requires facilities to keep the environment clean. Additionally, VHA Directive 1761, *Supply Chain Management Operations*, requires staff to create, follow, and enforce a daily cleaning schedule for storerooms and weekly for supply storeroom shelves.²⁷ A clean environment reduces infection risks and supports quality care.

The chief of environmental management service identified staff competency opportunities and stated service leaders plan to retrain employees. The chief also said the facility lost three of four foremen (supervisors) during the deferred resignation program—a presidential executive order managed by OPM that allowed government employees to resign and keep their pay and benefits through September 2025.²⁸ The chief added that moving forward, each medical center will have one foreman.

Recommendation 1

The Director takes appropriate action for employees to keep patient care areas clean as required by Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program* and clean storerooms as required by Veterans Health Administration Directive 1761, *Supply Chain Management Operations*.

☒ Concur

☐ Nonconcur

Target date for completion: May 28, 2027

Director Comments

The Executive Director at the VA Pittsburgh Healthcare System, through the Deputy Director, Chief Logistics Officer, and Chief, Environmental Services (EVS), conducted a review of current cleaning practices of patient care areas and clean storerooms. In April 2026, the Chief Logistics Officer reviewed the established procedures for cleaning and monitoring of clean storerooms with Logistics supervisors and staff. Logistics staff perform weekly cleaning of storeroom bins and drawers. Logistics supervisors conduct and document monthly inspections of all clean storerooms, including verification of bin and drawer cleanliness. Compliance has consistently remained above 95% since April 2026. In May 2026, EVS supervisors instituted real-time quality assurance audits to verify the cleanliness of patient care areas and to ensure daily inspection of clean storerooms. Real-time coaching and feedback is provided to

²⁷ VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

²⁸ “Original Email to Employees,” Office of Personnel Management, last updated January 28, 2025, <https://www.opm.gov/about-us/fork/original-email-to-employees>.

employees with immediate corrections completed as issues are identified. The audit tool was created and is being used to promote staff development, identify further training needs, and reinforce best practices. Each supervisor is expected to complete two audit checklists per workday. A 90% compliance benchmark was established. While the 90% benchmark has not been met, steady progress is evident: May reached 64%, June 72%, and July 80% compliance rate. EVS departmental leadership continues to provide education and reinforce performance expectations. While the facility will monitor and report compliance monthly to the Safety/Environment of Care (EOC) Committee until 90% compliance is maintained for six consecutive months, the auditing process has been incorporated into the Logistics and EVS department's ongoing quality assurance and performance improvement programs.

The OIG team found that staff had not monitored daily temperature and humidity readings in a supply room for more than one year because the monitor was turned off during a construction project but was not turned back on. VHA Directive 1761 requires daily monitoring of temperature and humidity in supply rooms. When staff do not monitor temperature and humidity as required, supplies can become damaged or unsafe to use, which may lead to risk of infection or ineffective treatment for patients. After the OIG identified the deficiency, staff reported turning the monitor back on. Because staff corrected the deficiency during the site visit and the Acting Associate Director provided documentation showing all supply rooms were monitored or had work orders in place for repair, the OIG did not make a recommendation.

At the Heinz location, the OIG found portable infusion pumps and portable suction devices overdue for scheduled preventive maintenance. The Joint Commission standard PE [Physical Environment] 04.01.01 requires staff to inspect, test, and maintain medical equipment.²⁹ Maintenance lapses increase the risk of device malfunction and clinical harm (e.g., incorrect dosing or loss of airway suction).

The chief of biomedical engineering explained that staff could not locate all the portable equipment due for scheduled maintenance in January 2026. The chief of logistics added that the suction machines were inadvertently removed from the tracking inventory when staff flagged the equipment for replacement, so biomedical engineering would not have been notified to look for them.

²⁹ The Joint Commission, *Standards Manual*, E-dition, PE 04.01.01, March 1, 2026.

Recommendation 2

The Director takes appropriate action for employees to inspect and test all medical equipment as required by The Joint Commission standard PE [Physical Environment] 04.01.01.

☒ Concur

☐ Nonconcur

Target date for completion: May 28, 2027

Director Comments

The Executive Director at the VA Pittsburgh Healthcare System, through the Deputy Director, the Associate Director, Chief Biomedical Engineering, and Chief Logistics Officer conducted a review of current practices for inspecting and testing medical equipment as well as the equipment turn in process. The Chief Logistics Officer reported equipment requests were previously entered into Veterans Health Information Systems and Technology Architecture (VISTA), which automatically created turn ins for replacement items and removed them from Biomedical Engineering's preventive maintenance schedule while they remained in use. This process has been discontinued. All legacy turn ins have been cleared, and VISTA equipment request menus are no longer used. Turn-ins are now initiated in real time by the service line, which enters the work order and notifies Personal Property Management (PPM). PPM then retrieves the equipment within five days and transfers it to the Logistics equipment inventory listing for final disposition. Communication is then made to Healthcare Technology Management (HTM), biomedical engineering of the equipment turn-in so it can be appropriately decommissioned. HTM biomedical engineering monitors compliance with preventative maintenance completion rates for all medical devices. While the facility will monitor and report compliance monthly to the Safety/ EOC Committee, until 90% compliance is maintained for six consecutive months, the auditing process will remain incorporated into the HTM biomedical engineering department's ongoing quality assurance and performance improvement program.

In several areas, staff could not explain the correct process to dispose of pharmaceutical waste, which VHA Directive 1850.06(1), *Waste Management Program* defines as leftover, unused, or expired hazardous or nonhazardous medication that may pose a risk to people and the environment.³⁰ The OIG team also observed waste containers were either missing or difficult to access due to being blocked by other items. Additionally, the directive requires facilities to establish and maintain a comprehensive waste management program that includes providing the

³⁰ VHA Directive 1850.06(1), *Waste Management Program*, July 22, 2022, amended June 5, 2024.

correct containers and ensuring staff know where they are located and how to use them.³¹ When staff cannot access containers or misunderstand the process, the risk of improper disposal increases and can harm patients, staff, and the environment.

Recommendation 3

The Director takes appropriate action so pharmaceutical waste containers are provided and accessible, and trains employees on container use as required by Veterans Health Administration Directive 1850.06(1), *Waste Management Program*.

☒ Concur

☐ Nonconcur

Target date for completion: May 28, 2027

Director Comments

The Executive Director at the VA Pittsburgh Healthcare System, through the Associate Director, the Associate Director Patient Care Services, and the Safety and Occupational Health Manager, conducted a review of current practices related to and employee education associated with pharmaceutical waste. The review identified that current reference materials did not meet the intent. The Environmental Protection Specialist has revised the reference poster for pharmaceutical waste in an easy-to-follow format with the new reference materials currently in production. Once available, the new reference materials will be placed in all areas where medications are prepared and/or disposed. All Nursing staff complete annual training that includes information on the proper disposal of pharmaceutical waste. Current compliance for Fiscal Year 26 for the Talent Management System (TMS) training Hazardous Drug Handling (4550571) is 97%.

Validation of availability and accessibility of pharmaceutical waste containers has been incorporated into the Safety Environment of Care Checklist. While the facility will monitor and report compliance monthly until 90% compliance is maintained for six consecutive months, the auditing process has been incorporated into the Safety department's ongoing quality assurance and performance improvement program.

The OIG team found areas where power strips were left unsecured on floors and observed one area that had stretched electrical cords. The National Fire Protection Association's *Health Care Facilities Code*, NFPA 99 requires power strips to be secured and *National Electrical Code*,

³¹ VHA Directive 1850.06(1).

NFPA 70 identifies that cords must be connected in a way that prevents any pulling or strain.³² Unsecured power strips and stretched electrical cords increase the risk of equipment failure, electrical shock, and fire and also create tripping hazards. The OIG team also noted The Joint Commission survey with a similar finding.³³ The acting safety manager said staff must complete a yearly education course, which reviews the proper use of extension cords and power strips. The acting chief engineer added that the environment of care team checks electrical hazards during scheduled inspections and removes any cords that do not meet safety requirements. Because the OIG team found these issues reoccurred, the OIG made a recommendation.

Recommendation 4

The Director takes appropriate action so employees secure power strips as required by National Fire Protection Association's *Health Care Facilities Code*, *NFPA 99* and electrical cords are connected to prevent pulling or straining as required by *National Electrical Code*, *NFPA 70*.

☒ Concur

☐ Nonconcur

Target date for completion: May 28, 2027

Director Comments

The Executive Director at the VA Pittsburgh Healthcare System, through the Associate Director, the Chief Facilities Management Service, and the Safety and Occupational Health Manager, conducted a review of current practice related to use of power strips and electrical cords. All VA Pittsburgh staff are required to take TMS training course General Safety and Security (4642889) which includes education on proper use of power strips and electrical cords. Current compliance for Fiscal Year 26 for the TMS training is 94%. The Safety Environment of Care checklist has been updated to include validating any power strips in use are secured in patient care areas and ensuring proper electrical cord management, i.e. cords are connected to prevent pulling or straining. While the facility will monitor and report compliance monthly to the Safety/EOC Committee until 90% compliance is maintained for six consecutive months, the auditing process has been incorporated into the Safety department's ongoing quality assurance and performance improvement program.

³² National Fire Protection Association, *Health Care Facilities Code*, NFPA 99, 2024; National Fire Protection Association, *National Electrical Code*, NFPA 70, 2026.

³³ The Joint Commission performed a hospital, behavioral health care and human services, and home care accreditation inspection March 28, 2023, through March 31, 2023. The Joint Commission, *Final Accreditation Report VA Pittsburgh Healthcare System*, June 2, 2023.



PATIENT SAFETY

OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results, the sustainability of changes made by leaders in response to previous oversight recommendations, and improvement projects.

Communication of Urgent but Noncritical Test Results

The facility had a policy and service-level workflows that outline how they communicate test results, including urgent but noncritical test results, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.³⁴ A quality specialist explained that staff use external peer review program data to assess the timeliness of communicating test results and send the data to executive leaders each quarter.³⁵ Additionally, the quality specialist said if data are trending in the wrong direction, they will investigate the cause and alert providers and executive leaders.

Action Plans and Process Improvements

When the OIG team inspected the facility in March 2026, it was noted that the previous OIG comprehensive healthcare inspection, conducted in April 2023, did not result in any recommendations.³⁶ In FY 2025, staff completed a root cause analysis (a process used to assess potential and actual patient harm) related to test results, and patient safety staff said they continue to monitor improvement outcomes.³⁷ The patient safety coordinator explained that they monitor action plans for root cause analyses through the use of an electronic tracker that sends reminders to the employees responsible for the action. Additionally, patient safety staff report overdue action items to the Executive Leadership Board.

The acting director of quality and patient safety explained that facility staff use a computer-guided simulation laboratory as a training tool for process improvement and staff education.³⁸ The Deputy Director said topics also include infection prevention and inspection readiness. The

³⁴ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

³⁵ VHA established the External Peer Review Program's communicating test results measure as a way for facility leaders to review compliance and take corrective action when needed. VHA Directive 1088(1).

³⁶ VA OIG, [Comprehensive Healthcare Inspection of the VA Pittsburgh Healthcare System in Pennsylvania](#), Report No. 23-00095-107, March 19, 2024.

³⁷ "Root Cause Analysis (RCA)," VA National Center for Patient Safety, accessed May 21, 2026, <https://dvagov.sharepoint.com/sites/Root-Cause-Analysis>. (This website is not publicly accessible.)

³⁸ Munazza Saleem and Zuhera Khan "Healthcare Simulation: An Effective Way of Learning in Health Care," *Pakistan Journal of Medical Sciences* 39, no. 4 (July-August 2023): 1185–90, <https://doi.org/10.12669/pjms.39.4.7145>.

acting director of quality and patient safety described using simulation exercises to train staff on how to conduct root cause analyses. The Acting Chief of Staff added the simulation laboratory includes a replica of an operating room suite and patient care room, which allows staff to train on familiar equipment.



INTEGRATED VETERAN CARE

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.³⁹ The OIG evaluated the facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

The patient centered management module coordinator reported the facility provides primary care services through 64 teams. The associate chief nurse reported vacancies for licensed practical nurses and medical support assistants. The vice president of primary care (more commonly referred to as the chief of primary care) stated that two float providers (staff not assigned to a specific team) are available to cover leave and absences. The associate chief nurse added that primary care service does not have nursing float staff, and when employees are off, another clinic nurse must cover two teams. Primary care leaders did not provide additional plans for nursing coverage when staff are absent. Assigning one nurse to two teams can increase workload, potentially leading to burnout and fatigue.

The OIG team determined the facility primary care panels (the number of patients assigned to a care team) averaged just under 97 percent of expected capacity. VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, states primary care panel capacity is based on variables such as staffing, number of rooms, and provider types.⁴⁰ The vice president of primary care increased panel utilization from below 90 percent to its current level by balancing provider panel sizes and revising appointment options to support either face-to-face or video appointments, since video only appointments were underused. This change increased scheduling flexibility and maximized utilization of provider schedules.

³⁹ "Community Care," VA, accessed June 29, 2026, <https://department.va.gov/vha/community-care>; VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

⁴⁰ VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

The OIG team found that for May 2026, average new patient wait times were just under 13 days, and established patient wait times averaged 5 days. The administrative officer for primary care reported that, at the time of the inspection in March 2026, wait times were 15 days for new patients and about 5 days for established patients. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the wait time is greater than 20 days.⁴¹

Community Care Staffing and Access to Care

During the March 2026 inspection, the community care nurse manager said they had requested replacements for five vacated positions. The ambulatory care operations director/group practice manager stated the request for these positions was sent to executive leaders but had not been approved at the time of OIG inspection. The nurse manager stated clinical and administrative employees work overtime to complete their duties and to help meet departmental demands. The ambulatory care operations director/group practice manager added that the executive leaders are aware of the challenges faced by the community care team and continue to approve employee overtime.

From January through November 2025, the OIG team found that employees took an average of eight days to schedule a community care appointment, just above the VHA's Office of Integrated Veteran Care, *Consult Timeliness Standard Operating Procedure* requirement of seven days.⁴² Community care leaders said they implemented a process improvement project about 18 months before the inspection visit that positively affected scheduling. Previously, community care leaders assigned consults to staff based on the type of specialty care needed and overall number of consults. Under the new process, employees are assigned consults using a weighted scale based on complexity, such as the patient's diagnosis, type of specialty care needed, and the anticipated length of the consult. As a result, some employees may have fewer assigned consults because their consults are more time consuming. Additionally, in attempt to schedule veterans within the required time frame, community care leaders provide employees with prioritized consult lists based on dates consults are entered into the electronic health record. Overall, the facility provided data to indicate the new process reduced the average time required to schedule a community care appointment from nearly 10 days in January 2025 to approximately 8 days by February 2026. The OIG did not make a recommendation as facility leaders had implemented actions that improved timeliness.

⁴¹ 38 C.F.R. § 17.4040 (2025).

⁴² VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 2025.



VETERAN-CENTERED SAFETY NET

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

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.⁴³

VHA uses performance measures to determine the success of each medical facility’s program. HCHV1 measures the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).⁴⁴ HCHV2 measures the percentage of veterans who are discharged from contracted emergency residential services or low-demand safe haven beds due to a “violation of program rules...failure to comply with program requirements...or [who] left the program without consulting staff (referred to as negative exits).”⁴⁵

Performance and Improvement Highlights

- Program staff shared they engage veterans through an on-site walk-in clinic, facility consults, street outreach (engagement of unsheltered veterans in places not meant for habitation), and community partner referrals.⁴⁶

⁴³ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴⁴ VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens, a veteran can typically stay between 4 and 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

⁴⁵ VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

⁴⁶ VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

- The facility did not meet the exit to permanent housing (HCHV1) target for FY 2025, missing the measure by less than 1 percent. However, performance data through the first quarter of FY 2026 showed that program staff were meeting the established targets.⁴⁷ The homeless program coordinator reported that leadership turnover in residential services and the need to train new employees at the contracted residential services site contributed to the missed permanent housing target. In response, the coordinator said employees started discharge planning at admission and provided training to contract residential services staff. The homeless program coordinator added that these actions strengthen veteran engagement and improve housing placement targets. The facility met the negative exit (HCHV2) target for FY 2025 and sustained this performance through the first quarter of FY 2026.
- Program leaders explained this program employs a nurse practitioner who assesses veterans' medical and psychological needs, completes physical exams for those who enter transitional housing, and conducts in-home evaluations to ensure aging veterans remain safe in their HUD-VASH apartments. The program coordinator added that at the beginning of FY 2026, the program's nurse practitioner implemented a new opioid overdose education and suicide prevention program that provides instruction on usage of Narcan (a medication, also known as naloxone, used to reverse an opioid overdose) and education on recognizing symptoms of a mental health crisis.⁴⁸

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including “serious mental illness, physical health diagnoses, and substance use disorders.”⁴⁹ The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.⁵⁰

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by

⁴⁷ FY 2026 quarter 1 dates are October 1, 2025, through December 31, 2025.

⁴⁸ “Naloxone Drug Facts,” National Institute on Drug Abuse, last updated January 2022, <https://nida.nih.gov/drugfacts/naloxone>.

⁴⁹ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁵⁰ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).⁵¹

Performance and Improvement Highlights

- Program staff reported they oversee 449 housing vouchers across three public housing authorities and ensure the most vulnerable veterans have priority for housing vouchers through the coordinated entry process (standardized assessment and referral process for housing and services).⁵²
- The facility met the voucher use (HMLS3) target for FY 2025, which the program lead attributed to a fully staffed team of experienced case managers and increased landlord engagement. The facility missed the voucher utilization target by 2.5 percent in the first quarter of FY 2026.⁵³
- The facility met the employment (VASH3) target for FY 2025 and continued to meet the target through the first quarter of FY 2026. The program lead reported that strong collaboration with local VA employment programs, along with vocational staff who understand the unique employment challenges faced by homeless veterans, contributed to consistently meeting the targets.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.⁵⁴ Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).⁵⁵

⁵¹ VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility’s program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

⁵² “Coordinated Entry,” HUD Exchange, accessed April 10, 2026, <https://www.hudexchange.info/coordinated-entry>.

⁵³ At the time of the inspection, the VHA website used to monitor performance measures was unavailable, therefore the OIG was unable to assess why program staff did not meet FY 2026 quarter 1 targets.

⁵⁴ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁵⁵ VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

Performance and Improvement Highlights

- Program staff reported engaging veterans involved in the justice system through in-person, telephone, and video outreach at 12 local county jails. Outreach specialists also provide case management to veterans enrolled in eight local veteran treatment courts.
- The facility met the enrollment (VJP1) target for FY 2025 and maintained this performance through the first quarter of FY 2026. The program lead attributed staff's success in meeting the measure to increased outreach through virtual opportunities and collaboration with jail and court staff.

Conclusion

To assist leaders in evaluating the quality of care at the VA Pittsburgh Healthcare System, the OIG conducted an inspection across five domains. The OIG made four recommendations related to cleaning, medical equipment inspections, pharmaceutical waste, and electrical cords. The OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

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

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.⁵⁶ The OIG administered voluntary questionnaires to all employees through the facility’s email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility from March 24 through 26, 2026. During site visits, the team referred any concerns that were beyond the scope of the inspections to the OIG’s hotline management personnel for further review.

The inspection team’s analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency’s standards.⁵⁷ During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust*.⁵⁸

Possible limitations on the information collection methods include questionnaire and interview participants’ self-selection bias and response bias.⁵⁹ The OIG acknowledges potential bias because the facility liaison selected staff who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

⁵⁶ Accreditation reports covered the time frame of March 28, 2023, through January 9, 2026—the most recent available at the time of the inspection.

⁵⁷ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

⁵⁸ Director for the Office of Management and Budget, “Accelerating Federal Use of AI through Innovation, Governance, and Public Trust,” memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

⁵⁹ Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants “give inaccurate answers for a variety of reasons.” Dirk M. Elston, “Participation Bias, Self-Selection Bias, and Response Bias,” *Journal of American Academy of Dermatology* (2021): 1-2, <https://doi.org/10.1016/j.jaad.2021.06.025>.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.⁶⁰ The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

⁶⁰ Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Appendix B: Additional Facility Photograph



Figure B.1. Ceramic village and model railroad made to honor veterans and provide replicas of local scenes.
Source: Photo taken by OIG inspector.

Appendix C: Health Service Area Director Comments

Department of Veterans Affairs Memorandum

Date: September 18, 2026

From: Interim Director, Health Service Area 1.3

Subj: Healthcare Facility Inspection of the VA Pittsburgh Healthcare System in Pennsylvania

To: Director, Office of Healthcare Inspections (54HF03)
Chief Integrity and Compliance Officer (10OIC)

1. I have reviewed and concur with the findings and recommendations in the Office of Inspector General's (OIG's) draft report entitled – Healthcare Facility Inspection of the VA Pittsburgh Healthcare System in Pennsylvania.
2. I have reviewed the corrective action plans provided by the Medical Center Director, VA Pittsburgh Healthcare System. I concur that recommendations one, two, three, and four will remain open and in progress.
3. Should you require any additional information, continued monitoring and oversight for Pittsburgh is by the Regional Quality Management office for HSA 1.3.

(Original signed by:)

Daniel L. Dücker, MSS, M.Ed.

Interim Health Service Area Director, Veterans Health Administration

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 4, 2026

From: Interim Executive Director, VA Pittsburgh Healthcare System (646)

Subj: Healthcare Facility Inspection of the VA Pittsburgh Healthcare System in Pennsylvania

To: Network Director, VA North Atlantic Health Network (10N1)
Executive Director, Health Service Area 1.3

1. VA Pittsburgh Healthcare System (VAPHS) reviewed the report overview of the Office of Inspector General (OIG) Healthcare Facility Inspection (HFI) that occurred during the week of March 24, 2026.
2. VAPHS concurs with the four recommendations associated with the report.

(Original signed by:)

Derek Coughenour, PT, DPT, MPM, CLD, VHA-CM

OIG Contact and Staff Acknowledgments

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