



## HIGHLIGHTS April 2010

### **CONGRESSIONAL TESTIMONY**

#### **Assistant Inspector General for Audits and Evaluations Testifies on VA's Fiduciary Program**

Assistant Inspector General for Audits and Evaluations Belinda Finn testified before the Subcommittee on Disability Assistance and Memorial Affairs, Committee on Veterans' Affairs, U.S. House of Representatives, on Office of Inspector General (OIG) audit findings related to VA's Fiduciary Program. The audit showed that many of the program weaknesses that OIG identified in 2006 persist today. Specifically, the Veterans Benefits Administration (VBA) still needs to improve its management infrastructure in the areas of information systems, staffing models, and management oversight to support the program. Ms. Finn was accompanied by Timothy Crowe, Director of the OIG's Audit Operations Division in Bay Pines, FL.

### **OIG REPORTS**

#### **Risk Management Plan Would Improve Accountability, Transparency in Recovery Act-Funded State Home Construction Projects**

OIG performed an audit of the Veterans Health Administration's (VHA's) expenditure of American Recovery and Reinvestment Act of 2009 (Recovery Act) funds provided to the State Home Construction Grant Program (SHCGP). The Recovery Act provided \$150 million to SHCGP and VHA is required to obligate these funds by September 30, 2010. As of December 31, 2009, VHA had obligated about 94 percent. OIG determined that SHCGP managers need to improve accountability and transparency by developing a risk management plan that identifies all potential risks and implements adequate strategies to mitigate these risks. [\[Click for Report.\]](#)

#### **Endoscope Reprocessing Issues Substantiated at St. Louis VA Medical Center**

OIG conducted an inspection in response to allegations of ongoing endoscope reprocessing issues and breakdowns in communication with regard to adverse events and outcomes at the St. Louis VA Medical Center (VAMC) in St. Louis, MO. OIG substantiated the allegations and identified several items related to reusable medical equipment reprocessing and staff safety that need improvement to meet VHA policy requirements. [\[Click for Report.\]](#)

### **Emergency Departments, Urgent Care Clinics Meet VHA Standards for Uniform Delivery of Healthcare**

OIG performed a healthcare inspection of 46 VHA emergency departments (EDs) and urgent care clinics (UCCs). The review found that VHA facilities' EDs and UCCs generally met VHA guidelines; however, ED/UCC operations could be strengthened in the areas of documentation, competency evaluations, and privileging requirements. OIG recommended that VHA reinforce compliance with transfer and discharge documentation requirements, and ensure compliance with VHA competency evaluations and privileging requirements. [\[Click for Report.\]](#)

### **Review Confirms Inaccurate Documentation, Diagnosis at Dallas HCS**

OIG reviewed the validity of allegations on quality of care issues in Geriatrics and Extended Care Service at the VA North Texas Health Care System (HCS) in Dallas, TX. OIG substantiated that a diagnosis of a coronary artery bypass graft was inaccurately documented in a patient's history and physical, and that a physician recommended removal of a patient's cognitive impairment diagnosis based on a brief cognitive exam. However, neither of these occurrences adversely affected patient care. OIG made no recommendations. [\[Click for Report.\]](#)

### **Reviews Conducted of Twelve Community Based Outpatient Clinics**

OIG performed reviews of six Community Based Outpatient Clinics (CBOCs) to assess if they provide Veterans with consistent, safe, high quality health care. The reviews covered five areas: quality of care measures, credentialing and privileging, environment of care and emergency management, patient satisfaction, and CBOC contracts. Reviews included Payson and Sun City, AZ, in Veterans Integrated Service Network (VISN) 18; Sidney, NE, and Fort Collins, CO, in VISN 19; and Eureka and Ukiah, CA, in VISN 21. OIG noted several opportunities for improvement and made 13 recommendations. [\[Click for Report.\]](#)

In a second set of CBOC reviews, OIG examined six facilities including Boca Raton, Coral Springs, Key West, and Vero Beach, FL, in VISN 8; and Denton and Fort Worth, TX, in VISN 17. OIG made 19 recommendations for improvement. [\[Click for Report.\]](#)

### **Waco VA Regional Office Needs To Improve Rating Accuracy, Controls**

OIG's Benefits Inspection Division conducted a review of disability compensation claims processing and Veterans Service Center operations at the Waco, TX, VA Regional Office (VARO). Of the 120 claims reviewed by OIG, 36 percent of rating decisions were incorrectly processed by VARO staff. Management needs to improve the accuracy of disability claims processing for temporary 100 percent disability evaluations, post-traumatic stress disorder (PTSD), and traumatic brain injury. In addition, management needs to improve controls over processing fiduciary claims, establishing correct dates of claims, establishing Notices of Disagreements for appealed claims timely, completing Systematic Analysis of Operations accurately and timely, safeguarding of Veterans' personally identifiable information, and handling mail appropriately. [\[Click for Report.\]](#)

### **Allegations Against Gainesville, Florida, VAMC Not Substantiated**

OIG performed a review of the Malcom Randall VAMC in Gainesville, FL, to determine the validity of allegations relating to excessive wait times for radiology biopsies and cardiac catheterizations; lack of sedation and inadequate recovery time for radiology biopsies; and radiology biopsies performed by staff uncertified in Basic Life Support and Advanced Cardiac Life Support. OIG did not substantiate the allegations and made no recommendations. [\[Click for Report.\]](#)

### **CRIMINAL INVESTIGATIONS**

#### **Former CEO Sentenced for Fraud Involving Improvements for Nursing Home Facilities**

The former Chief Executive Officer (CEO) of a nursing home chain that received Federal funds was sentenced to 366 days' incarceration, 3 years' probation, a \$6,000 fine, and ordered to forfeit \$500,000 to the Government after pleading guilty to fraud charges. A multiagency investigation determined that the defendant conspired to create false invoices to obtain loans from lenders. The loans were intended for the improvement of the nursing home facilities; instead, the funds were used to pay for the CEO's personal expenses, including the purchase of a number of apartment complexes. Three other defendants were previously convicted in this case and are currently awaiting sentencing.

#### **Veteran Arrested for Making Threats at Martinsburg, West Virginia, VAMC**

A Veteran was arrested after threatening to shoot others and himself at the Martinsburg, WV, VAMC. The Veteran stated that he was frustrated with the quality of his medical care.

#### **Veteran Arrested for Assault of VA Physician at Palo Alto, California, VAMC**

A Veteran at the Palo Alto, CA, VAMC was arrested for assaulting a VA physician. An OIG and VA Police investigation determined that the physician was attacked from behind and struck in the head by the defendant. The physician was hospitalized with a fractured clavicle, lacerations, and post-concussive syndrome.

#### **Veteran Arrested for Possession of Firearms at Palo Alto, California, VAMC**

A Veteran was arrested for possession of firearms on Federal property. An OIG and VA Police investigation determined that the defendant, a recent Iraq war Veteran suffering from PTSD, made statements to a Palo Alto, CA, VAMC physician that he wanted to harm and/or kill others. A search of the defendant's bag by VA Police revealed a loaded .22 caliber pistol, an unloaded .357 magnum revolver, and ammunition for the .357 magnum. The defendant was subsequently interviewed and arrested by OIG.

#### **Atlanta VAMC Physician Indicted for False Statements, Assault**

An Atlanta, GA, VAMC physician was indicted for false statements, abusive sexual contact, and assault after an OIG investigation revealed that a female patient was examined at the VAMC without another staff member in the room and was sexually assaulted by the physician. The investigation also revealed that a VAMC nurse was

asked by the defendant to provide false statements to reflect that the nurse was present in the room during the examination.

### **Veteran Sentenced for Theft of Government Funds**

A Veteran was sentenced to 366 days' incarceration and ordered to pay restitution of \$11,098 to VA after pleading guilty to theft of Government funds and false claims about receiving military decorations. An OIG and U.S. Coast Guard Investigative Service investigation revealed that the defendant falsified a DD-214 when transferring from the Navy to the Coast Guard in 1979. During his service with the Coast Guard, the defendant continued to falsify his DD-214 and service record. The defendant retired from the Coast Guard after 11 years, during which time he represented himself as a Navy Seal who received multiple Silver Stars, Bronze Stars, Purple Hearts, and other medals for valor. The defendant applied for and received PTSD benefits from VA based on multiple false combat stressors.

### **Boston HCS Employee Charged with Theft of Drugs**

A Boston, MA, VA HCS employee was charged in a criminal information with acquisition of a controlled substance by deception or subterfuge. An OIG, VA Police, and local police investigation revealed that the defendant, a VA courier who transported prescription narcotics between various VA facilities, stole controlled substances, particularly oxycodone and Percocet, from prescription bottles packaged for Veterans.

### **Son of Deceased Beneficiary Arrested for Theft**

The son of a deceased VA beneficiary was arrested after being indicted for theft of Government funds. In 2001, the defendant, who was a loan officer at a bank, assisted the Veteran in opening a joint bank account at the defendant's bank. In March 2004, the beneficiary died in a foreign country and the son was notified of the death by the U.S. Department of State. The defendant concealed the death from VA and then subsequently used VA benefits for his personal benefit. The investigation revealed that the defendant used his position at the bank to facilitate the scheme to defraud VA. The loss to VA is approximately \$95,000.

### **Veteran Indicted for Fraud Exceeding \$500,000 in Government Benefits**

A Veteran was indicted for VA benefits fraud, Social Security fraud, education benefits fraud, and tax evasion. A multiagency investigation revealed that the Veteran and his wife conspired to falsify their own and others' tax returns while hiding their income from VA, the Social Security Administration, and the Department of Education in the process. The loss to VA is over \$200,000, with the total loss to the Government exceeding \$500,000.

### **Portland VAMC Nurse Charged with Theft of Drugs**

A Portland, OR, VAMC nurse was charged with felony computer crime and identity theft. An OIG and VA Police investigation revealed that the defendant used his position to gain access to the identities of patients no longer under his care and then used the identities to access a VA narcotic dispensing machine, falsely recording that the

narcotics were for these patients. The defendant then used the narcotics, to include fentanyl and midazolam, while on duty and providing health care services to Veterans.

### **Nashville VAMC Employee Indicted for Time and Attendance Fraud**

A Nashville, TN, VAMC employee was indicted for activities related to time and attendance fraud and making false statements to Federal agents. An OIG investigation revealed that the defendant was teaching classes at a local university during his scheduled tour of duty at VA. The defendant held full-time employment positions at both the VAMC and the university during a 6-month period in 2006. The loss to VA is approximately \$32,000.

### **Lyons, New Jersey, VAMC Employee, Associate Plead Guilty to Health Care Fraud**

A Lyons, NJ, VAMC employee and an associate in the employee's private practice pled guilty to health care fraud. An OIG, Federal Bureau of Investigation (FBI), and state regulatory agency investigation revealed that the VA employee and the associate devised a scheme to misrepresent the associate's qualifications and bill Government and private insurers at inflated prices for services not rendered. The employee also identified the VAMC's facsimile number as the business' facsimile number on the practice's web site.

### **Brockton, Massachusetts, VAMC Employee Arrested for Drug Possession**

A Brockton, MA, VAMC environmental management service employee and a co-defendant were arrested for possession of controlled substances with intent to distribute. The arrests resulted from a 7-month OIG, Drug Enforcement Administration, and VA Police investigation involving undercover purchases. The VA employee was interviewed and confessed to selling prescription pills to individuals in and around the VAMC. The second defendant sold oxycodone to an undercover agent on two separate occasions during the operation.

### **Former Martinsburg, West Virginia, Employee Sentenced for Drug Distribution**

A former Martinsburg, WV, VAMC food service employee was sentenced to 70 months' incarceration and 60 months' probation after pleading guilty to possession with intent to distribute cocaine base. During an OIG, FBI, and VA Police investigation, the defendant sold crack cocaine to a confidential informant on three occasions. During an unrelated investigation coordinated by a local drug task force, the defendant sold crack cocaine and heroin to another confidential informant on two occasions. In addition, during a traffic stop, state troopers found 238 grams of crack cocaine in the defendant's vehicle.

### **Veteran Sentenced for Using Child Pornography at Palo Alto Nursing Home**

A Veteran was sentenced to 5 years' incarceration after pleading guilty to sexual exploitation of minors. The defendant, a former inpatient at a VA nursing home, had two previous child pornography convictions. During an OIG and VA Police investigation, the defendant admitted to using a computer at the VA nursing home to access the internet and download sexually explicit images of minors. An analysis by the

OIG Computer Crimes and Forensics Lab found over two hundred child pornography images on electronic media associated with the defendant.

*(original signed by:)*  
GEORGE J. OPFER  
Inspector General