



Department of Veterans Affairs

Office of Inspector General

April 2011 Highlights

CONGRESSIONAL TESTIMONY

Assistant Inspector General for Audits and Evaluations Testifies on VA's Contract Management

Belinda Finn, Assistant Inspector General (AIG) for Audits and Evaluations, testified before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, on VA's contract management. Ms. Finn discussed the deficiencies of VA's acquisition processes and infrastructure as well as the impact these deficiencies have on VA operations. She stated that VA needs to exercise greater organizational discipline over its primary management oversight tool, the electronic Contract Management System (eCMS), to ensure the transparency needed to manage a multi-billion dollar acquisition program. Ms. Finn also recommended that VA continue its efforts to integrate eCMS into existing and future financial systems. Ms. Finn was accompanied by Cherie Palmer, Director, Chicago Office of Audits and Evaluations. [\[Click here to access testimony.\]](#)

AIG for Healthcare Inspections Testifies on Review of Infection Controls at the Dayton, Ohio, VA Medical Center

John D. Daigh, Jr., M.D., AIG for Healthcare Inspections, testified at a field hearing of the Committee on Veterans' Affairs, United States Senate, on the Office of Inspector General's (OIG's) oversight review of VA's handling of the infection control breaches at the Dayton, OH, VA Medical Center (VAMC) Dental Clinic. Dr. Daigh discussed the reviews conducted by VA after learning of the allegations of improper infection control procedures at the Dental Clinic. He concluded that established infection control practices and policies were not properly or consistently adhered to, that there was evidence Dental Clinic staff and management were aware of these unacceptable practices, and that definitive action was not taken until a VA Central Office review body was at the Dayton VAMC conducting a routine inspection. Dr. Daigh was accompanied by George Wesley, M.D., Director, Medical Consultation and Medical Review Division, and Kathleen Shimoda, BNS, Healthcare Inspector, Los Angeles Office of Healthcare Inspections. [\[Click here to access testimony.\]](#)

OIG REPORTS

Management Slow to Address Poor Infection Control Practices, Staffing Issues at Dayton Dental Clinic

As stated above, OIG reviewed infection control issues at the Dayton, OH, VAMC, at the request of the Chairmen and Ranking Members of the Senate Committee on Veterans' Affairs and the House Committee on Veterans' Affairs. The inspection found evidence of a lack of adherence to proper infection control policies and determined that a VAMC dentist did not comply with infection control and related procedures. Dental Service management was aware of these infractions, yet did not act sufficiently on this evidence. Additionally, OIG found Dental Service staffing levels to be suboptimal, which may have increased the likelihood that deviations from approved infection control

practices would occur. Moreover, interpersonal relations among Dental Service staff were strained and negatively impacted the Dental Service. OIG recommended that the Veterans Integrated Service Network Director review the findings related to the Dayton Dental Service and take appropriate action, in addition to ensuring the Dental Service is required to comply with the relevant infection control policies. [\[Click here to access report.\]](#)

Audit Questions Use of \$273 Million in Rural Health Care Program

OIG audited the Veterans Health Administration's (VHA's) Office of Rural Health (ORH) to determine if it effectively planned and managed \$533 million allocated during fiscal years 2009 and 2010 to improve access and quality of care for Veterans residing in rural areas. The audit concluded that ORH lacks reasonable assurance that its expenditure of \$273.3 million in funding received actually improved access and quality of care for Veterans residing in rural areas. This occurred because of program weaknesses such as a lack of financial controls, the absence of policies and procedures to ensure staff followed management directives, inadequate communication with key stakeholders, an ineffective project monitoring system, the absence of procedures to monitor performance measures, and an inadequate process to assess rural health needs. OIG recommended that VHA take steps to strengthen the management of rural health care funding in order to improve accountability of funds entrusted to ORH and measure the impact of their program on the health care of rural Veterans and their families. [\[Click here to access report.\]](#)

Allegations Regarding Medical Follow-Up for Urology Care Not Substantiated Against Chattanooga, Tennessee, Community Based Outpatient Clinic

OIG conducted a healthcare inspection of the Chattanooga, TN, Community Based Outpatient Clinic (CBOC) in response to a Hotline allegation regarding medical follow-up for elevated prostate-specific antigen (PSA) levels of a patient. The patient experienced periods of elevated PSA levels since 2004, and an August 2010 prostate biopsy revealed cancer. Contrary to the allegations that CBOC staff did not follow up on the elevated PSA levels, OIG found that the patient's CBOC providers routinely measured PSA levels and communicated results to the patient. The patient chose to receive primary care and urology care from community providers. Medical documentation reflected that the patient either reported a recent normal prostate examination by a community provider or refused a CBOC prostate examination. Although CBOC staff requested that the patient provide documentation of visits with community providers, none were provided. OIG did not substantiate the allegation and made no recommendations. [\[Click here to access report.\]](#)

Rescue Medication Policy in Need of Updating at VA Eastern Kansas Health Care System, Topeka, Kansas

OIG reviewed the validity of allegations that local policy regarding rescue medications was inappropriate and unsafe for the Specialized Inpatient Stress Disorders Unit (SIPU) patient population at the VA Eastern Kansas Health Care System, Topeka, KS. The inspection substantiated that facility policy did not allow patients to carry rescue medications with them when they left the unit. Although SIPU staff identified this

problem and implemented a change in practice that allowed patients to carry rescue medications with them when they leave the facility, the facility policy did not reflect the new process. In accordance with OIG's recommendation, the facility developed a policy that includes procedures for administering rescue medications in the SIPU; therefore, OIG considers the recommendation implemented. [\[Click here to access report.\]](#)

Benefits Inspection Division Visits Salt Lake City, Utah, VA Regional Office

OIG conducted an onsite inspection at the Salt Lake City, UT, VA Regional Office (VARO) to review disability compensation claims processing and Veterans Service Center operations. OIG found that VARO staff generally followed Veterans Benefits Administration (VBA) policy for processing Post-Traumatic Stress Disorder (PTSD) and herbicide exposure-related disability claims, in addition to ensuring timely completion of Systematic Analyses of Operations and correcting errors identified by VBA's Systematic Technical Accuracy Review program. However, VARO management lacked effective controls and accuracy in processing temporary 100 percent disability evaluations and traumatic brain injury claims. Additionally, VARO management lacked control of outstanding action items related to disability claims processing. Although VARO staff were not timely in recording Notices of Disagreement for appealed claims, they were better than the national average for processing the appeals. Further, processes for establishing correct dates of claim in the electronic record and managing mail in the Triage Team were also not fully effective. OIG made seven recommendations to improve operations. [\[Click here to access report.\]](#)

CRIMINAL INVESTIGATIONS

CEO Convicted of Fraudulently Obtaining Over \$16 Million in Contracts Set Aside for Veterans

The Chief Executive Officer (CEO) of a construction management and general contracting company, who received VA and Department of the Army construction contracts set aside for Service-Disabled Veteran-Owned Small Businesses (SDVOSB) and Veteran-Owned Small Businesses (VOSB), was convicted of committing major frauds against the United States, witness tampering, false statements, and mail fraud. An OIG, Small Business Administration OIG, and Department of the Army Criminal Investigation Division (CID) investigation revealed that the defendant falsely certified that his company qualified as an SDVOSB and VOSB in order to obtain over \$16 million in contracts fraudulently. During the investigation, the defendant made false statements to a Federal agent claiming that another person who had served in the military was the majority owner of his company.

Former Accountant Sentenced for Embezzling over \$1 Million from Non-Profit VA Research and Education Corporation

A former employee of the Louisiana Veterans Research and Education Corporation (LVREC) was sentenced to 33 months' incarceration, 3 years' probation, and ordered to pay \$1,009,605 in restitution after pleading guilty to embezzlement of Federal program funds and mail fraud. The defendant also consented to an asset forfeiture decree and surrendered approximately \$650,000 in cash, vehicles, and real estate to the Government. An OIG, Defense Criminal Investigative Service, and Department of the

Army CID investigation revealed that for over 4 years the defendant, who was a bookkeeper and accountant with LVREC, embezzled approximately \$1,013,700 through Department of Defense grants given to the VA Gulf Coast Health Care System. The LVREC is a domestic non-profit organization employing VA research specialists and contractors responsible for neurological research studies on Veterans before and after deployment to war zones. The defendant issued payroll checks in the names of employees of the corporation, forged their signatures on the endorsement line, and then cosigned the checks in order to deposit the funds to her own accounts. To conceal the scheme, she also falsified the annual accountings of the corporate assets.

Former Pharmaceutical CEO Sentenced for Off-Label Marketing

The former CEO of a pharmaceutical company, previously convicted at trial of wire fraud, was sentenced to 6 months' home detention, 3 years' probation, 200 hours' community service, and a \$20,000 fine. A multi-agency investigation revealed that under the direction of the defendant, who is also a medical doctor, the company marketed and sold a drug as a treatment for idiopathic pulmonary fibrosis (IPF), despite the fact that it was not approved by the Food and Drug Administration. This investigation further revealed that the defendant and other senior officials were aware that a clinical trial involving the use of this drug to treat patients with IPF failed. However, when the trial results were publicized, the defendant caused the issuance and distribution of a false and misleading press release to portray that the trial established that patients lived longer using this drug. The company previously agreed to pay the Government nearly \$37 million to resolve criminal charges and civil liability in connection with its illegal marketing and sales. VA's portion of this civil settlement was approximately \$3.2 million.

Son of Deceased VA Beneficiary Sentenced for Theft

The son of a deceased beneficiary was sentenced to 48 months' incarceration, 3 years' probation, and ordered to pay restitution of \$79,265. An OIG investigation revealed that the defendant failed to report his father's March 1999 death and collected the benefits for over 8 years. The defendant secretly transported the deceased Veteran's remains to another state and buried them in an unmarked grave in a national forest. OIG assisted State and local authorities in the recovery of the Veteran's remains.

Veteran Pleads Guilty to Making Threats to Salt Lake City, Utah, VA Facility

A Veteran pled guilty to threatening intimidation by telephone and was sentenced to 46 days' incarceration and 36 months' probation. An OIG, Federal Protective Service, and local law enforcement investigation determined that the defendant called the VA Fiduciary Hub in Salt Lake City, UT, and stated that he was coming to the facility because he was "not afraid to die and take 30 or 40 people with [him]."

Veteran Arrested for Threatening to Murder a Seattle, Washington, VAMC Patient Advocate

A Veteran was arrested for threatening to murder a Seattle, WA, VAMC patient advocate. An OIG and VA Police investigation determined that the defendant left a threat on the employee's voice mail. The investigation also revealed that the defendant

had a long criminal history including arrests for threats, assaults, and a conviction for assault on a Veteran at a VAMC.

Veteran Sentenced for Threats to White River Junction, Vermont, VAMC

A Veteran was sentenced to 10 months' incarceration and 36 months' supervised release after pleading guilty to making threats. An OIG and VA Police investigation revealed that the defendant left threatening voicemail messages at the White River Junction, VT, VAMC stating that he would blow up the place and use an AK-47 and MAC-10 to "go out in a blaze of glory." During an interview, the defendant admitted to making the phone calls and provided a written statement that said, "If you take away my disability, I will go on a killing spree." In 2009, the Veteran intimidated another VAMC by threatening to make an ammonium nitrate bomb.

Phoenix, Arizona, Nursing Home Owner Arrested for Vulnerable Adult Abuse

A Phoenix, AZ, nursing home owner was indicted and subsequently arrested for vulnerable adult abuse and forgery. An OIG and local law enforcement investigation determined that the defendant, who is also a nurse at the Phoenix, AZ, VAMC, provided inadequate care and treatment to Veterans placed under her care by VA at three assisted living facilities she owned and operated. The State of Arizona shut down her facilities and condemned the buildings. The Veterans were returned to the VAMC or placed in other facilities. The defendant forged Cardiopulmonary Resuscitation (CPR) certifications for her unqualified staff by forging the name of a VAMC CPR trainer.

Former Federal Fiduciary Charged with Misappropriation by a Fiduciary

A former Federal Fiduciary pled guilty to misappropriation by a fiduciary. The defendant, who had been a Department of Labor employee, is charged with stealing VA funds for approximately 18 months from three incompetent Veterans while she was their VA legal custodian. The loss to the Veterans is approximately \$62,000.

Former Fiduciary Enters Plea Agreement

A former VA fiduciary entered into a plea agreement and admitted to sufficient facts for larceny relating to the theft of a disabled Veteran's funds. The defendant was sentenced to 1 year of probation and ordered to make restitution of \$25,000 to the Veteran within 90 days. An OIG investigation revealed that the defendant, who served as the Veteran's VA fiduciary from June 2005 through May 2008, embezzled funds from the Veteran for personal use and took steps to deceive VA, to include creating and submitting fraudulent bank statements.

Postal Service Employee Arrested for Theft of VA Narcotics

A U.S. Postal Service (USPS) employee was arrested after being indicted for theft of mail. An OIG and USPS OIG investigation revealed that the defendant diverted approximately 25 parcels of VA controlled narcotics to his own use.

Former Prescott, Arizona, VAMC Registered Nurse Indicted for Obtaining Controlled Substances by Deception

A former Prescott, AZ, VAMC registered nurse was indicted for obtaining controlled substances by deception. An OIG investigation revealed that the defendant was removing hydromorphone and morphine at a rate of five times the average of any other full-time nurse. The defendant admitted that between August 2009 and January 2010 she stole drugs and injected herself while on duty.

Veteran Pleads Guilty to Theft Charges in Connection with PTSD Claim

A Veteran pled guilty to theft charges after an OIG investigation revealed that he provided fraudulent information to a VARO and a VAMC in support of his claim for VA disability compensation benefits. Between 2003 and 2006, the defendant submitted documents and photos and later made statements to VA that he allegedly participated in combat activities while serving in the Persian Gulf War. The false claims included hand-to-hand combat in the trenches, killing enemy combatants, seeing fellow soldiers die, seeing dead bodies inside burned-out tanks, and being under chemical attack. Based on these false statements, the VAMC diagnosed the Veteran with PTSD relating to his purported military service, and the VARO subsequently awarded the Veteran disability compensation. Since the conclusion of the investigation, VA terminated the disability compensation. The loss to VA is approximately \$173,000.

Widow Sentenced for Fraudulently Receiving VA Benefits

The widow of a Veteran was sentenced to 4 months' home confinement, 8 months' community service, 3 years' probation, and ordered to pay restitution of \$4,345. An OIG investigation determined the defendant fraudulently received VA Dependency and Indemnity Compensation benefits from March 1997 to December 2009 by failing to report her remarriage to VA. The loss to VA is \$148,943.

Daughter of Deceased Beneficiary Pleads Guilty to Theft of Government Funds

The daughter of a deceased VA beneficiary pled guilty to theft of Government funds after an OIG investigation revealed that between March 2001 and October 2009 the defendant failed to report the beneficiary's February 2001 death to VA and subsequently stole VA funds that were direct deposited to a joint account. The loss to VA is \$129,836.

Former Muskogee, Oklahoma, VARO Employee and Nephew Sentenced for Fraudulent Claims

A former Muskogee, OK, VARO claims examiner was sentenced to 366 days' incarceration and 36 months' supervised release, and his nephew was sentenced to 36 months' probation for conspiring to defraud VA by submitting fraudulent claims for VA education benefits. The judge also ordered that total restitution of \$40,098 be paid jointly by both defendants. The loss to VA is approximately \$45,000.

Defendant Sentenced for Identity Theft

A defendant was sentenced to 16 months' incarceration and ordered to pay restitution to VA after pleading no contest to felony identity theft. An OIG investigation determined

that the defendant, who was not a Veteran, stole the identity of his cousin and obtained over \$98,274 in VA medical services.

Former Gainesville, Florida, Credit Union Teller Sentenced for Stealing VA Canteen Service Deposits

A former teller for a Federal credit union located on the Gainesville, FL, VAMC campus was sentenced to over 1 year of incarceration, 10 years' probation, and ordered to pay restitution of \$34,064 after pleading guilty to grand theft for embezzling funds from the credit union, to include \$20,197 in deposits from VA Canteen Services. The teller confessed to stealing VA deposits and manipulating the credit union computer systems to hide the loss.

Jackson, Mississippi, VAMC Employee Arrested for Theft of VA Property

A Jackson, MS, VAMC employee was arrested for the theft of VA property after an OIG investigation revealed that a group of VA employees conspired to steal VAMC property. The stolen items included several flat panel televisions, multiple vacuums, a commercial floor buffer, and a large amount of industrial cleaning supplies. Many of the stolen items have been recovered. Additional charges are pending against other suspects.

Veteran Pleads Guilty to Committing Travel Benefits Fraud Against Gainesville, Florida, VAMC

A Veteran pled guilty to theft of Government funds after an OIG investigation determined that the Veteran filed 227 fraudulent travel claims at the Gainesville, FL, VAMC. The defendant claimed that he was traveling 300 miles roundtrip when in reality he was living 33 miles away. The loss to VA is approximately \$28,650.

*(original signed by Richard J. Griffin,
Deputy Inspector General for:)*

GEORGE J. OPFER
Inspector General