



Department of Veterans Affairs

Office of Inspector General

October 2012 Highlights

OIG REPORTS

Veterans Benefits Administration Needs To Improve Oversight, Policies, and Risk Management for Foreclosed Property Appraisals

The Office of Inspector General (OIG) evaluated the effectiveness of the Veterans Benefits Administration's (VBA's) Loan Guaranty Program (Program) which paid just over \$1.4 billion to acquire about 14,000 foreclosed real estate properties. OIG found improvement of liquidation appraisal oversight was needed at the Cleveland and Phoenix Regional Loan Centers. Comparable properties and sales price adjustments were not consistently reviewed to establish appraised value. Policies and procedures did not include sufficient criteria for loan center staff to evaluate every appraisal. The Program did not use an automated appraisal review tool and VA may not have paid fair and reasonable prices when acquiring properties. OIG recommended policies and procedures be revised, use of an automated appraisal review tool, implementation of a comprehensive risk management program, and revisions to the Program managers' performance plans. [\[Click here to access report.\]](#)

Poor Planning and Project Management Lead to \$5.1 Million in Unused Software Encryption Licenses

OIG substantiated the allegation the Office of Information and Technology (OIT) had not installed and activated all of the 300,000 encryption software licenses purchased in 2006 at a cost of about \$3.7 million. OIG also found OIT purchased an additional 100,000 licenses in 2011. As of July 2012, OIT had installed and activated only about 65,000 (16 percent) of the total 400,000 licenses procured. This was due to OIT's poor planning and inadequate management in not allowing time to test the software; ensuring sufficient staff were allocated to the project; adequately monitoring the project; and assuring the remaining licenses were compatible in the current computer environment. As a result, 84 percent of the total 400,000 licenses procured, totaling about \$5.1 million in questioned costs, remain unused as of the end of fiscal year 2012.

[\[Click here to access report.\]](#)

Allegations of Patient Care Delays Substantiated at the VA North Texas Health Care System, Dallas, Texas

OIG conducted an inspection to determine the validity of allegations regarding patient care delays at the VA North Texas Health Care System (HCS), Dallas, TX. A complainant alleged that a dialysis patient waited more than 4 months for permanent vascular access and that ambulatory monitoring for a cardiac patient was delayed 3 months. OIG substantiated that these and other patients experienced excessive wait times. For five recent referrals for vascular access, the time from referral to completion of a procedure was 89–138 days. For 213 patients scheduled for ambulatory cardiac monitoring, the average wait time was 68 days. OIG also found that clinicians did not review referral requests, consultation reports were not linked to requests in the electronic health record as required, and that appointment dates requested by patients

for vascular and cardiac procedures were incorrectly recorded by scheduling staff. OIG recommended that the Facility Director ensure that patients receive timely vascular and cardiac care, that providers document review of consults in the electronic health record and link results to consult requests, and that staff comply with Veterans Health Administration (VHA) policy for scheduling outpatient appointments. [\[Click here to access report.\]](#)

VA Data Exchanged With Research Partners and University Affiliates at Risk of Unauthorized Access

OIG conducted this audit to determine the effectiveness of VA's management of its systems interconnections and data exchanges with external research and university affiliates. OIG found VA has not effectively managed its network interconnections and data exchanges with its external research partners. VA could not readily account for various systems linkages and sharing arrangements. VA also could not provide an accurate inventory of research data exchanged, where data was hosted, or the sensitivity levels of the data. OIG also identified unsecured electronic and hardcopy research data at VAMCs and in co-located research facilities. VA's data governance approach has been ineffective to ensure that research data exchanged is adequately controlled and protected throughout the data life cycle. OIG recommended OIT and VHA implement a centralized data governance model and ensure formal agreements are established requiring research partners to implement controls commensurate with VA standards for securing and protecting sensitive data. [\[Click here to access report.\]](#)

VA Needs Strategic Plan To Guide Effective Future IT Workforce Development

OIG conducted this audit to determine the effectiveness of OIT's strategic human capital management program. OIG found OIT has not instituted a human capital strategy for its workforce of approximately 7,300 employees and has been managing its human resources in an ad hoc manner. OIT experienced vacancies and excessive turnover in key leadership positions; has not developed succession plans; lacked the human resources needed to move forward with a strategic approach to managing its personnel in line with Federal guidelines; has not fully implemented competency models; and has not identified competency gaps. Additionally, OIT has not assessed its use of contractors to supplement staff nor has OIT established a mechanism to evaluate the success of its human capital initiatives. OIG recommendations include assigning adequate leadership and staff to guide the program, developing a leadership succession plan, and completing a competency gap analysis.

[\[Click here to access report.\]](#)

IG Follow-Up Review Notes Improvements in Quality of Care and Veterans Integrated Service Network Oversight at Grand Junction, Colorado, Facility

OIG conducted a follow-up review of a report published May 14, 2012, *Oversight Review of Quality of Care and Other Issues at the Grand Junction VA Medical Center (VAMC), Grand Junction, Colorado*. The purpose was to determine whether adverse conditions have been resolved and whether OIG's recommendations were implemented. OIG conducted a site visit to the Grand Junction facility during the week of August 6–9, 2012, interviewed key staff members, and evaluated current processes

and documentation. OIG found appropriate oversight by Veterans Integrated Service Network (VISN) 19. The facility was providing surgical care in accordance with its standard complexity designation and had implemented plans to address deficiencies in peri-operative care. The facility had also taken appropriate action to address the inconsistent availability of surgeons for consultations, deficiencies in quality management procedures, and incomplete medical record documentation. OIG made no recommendations. [\[Click here to access report.\]](#)

Improvements Needed in Scheduling Consults and Patient Contact at the Louis Stokes VAMC, Cleveland, Ohio

The VA OIG OHI conducted an inspection to determine the validity of allegations regarding a patient's care at the Louis Stokes VAMC (the facility). A complainant alleged that biopsy technique and delay in treatment contributed to enlargement of a cutaneous squamous cell carcinoma (CSCC) lesion, affecting the patient's prognosis and necessitating extensive surgical treatment and follow-up. OIG did not substantiate that the biopsy technique used to obtain a tissue sample for diagnosis contributed to a CSCC lesion enlargement. OIG substantiated that a delay in scheduling the patient's Dermatology Clinic appointment occurred but did not substantiate that the delay affected the patient's prognosis. OIG found that the following facility policies and procedures did not ensure adherence to VHA requirements: (1) outlining procedures for contacting patients to schedule an appointment, (2) scheduling consults within the timeframe established by VHA, and (3) defining timeliness of response from Dermatology Service regarding consult requests. OIG recommended that the Facility Director strengthen local policies to include all VHA required elements regarding procedures for contacting patients to schedule appointments. Additionally, OIG recommended that the Facility Director strengthen processes for clinic scheduling and consult tracking and monitor timeliness of outpatient scheduling for adherence with VHA timeliness requirements. [\[Click here to access report.\]](#)

Allegations of Improper Reusable Medical Equipment Practices Substantiated at the VA Northern California Healthcare System, Sacramento, California

OIG reviewed allegations of improper reusable medical equipment practices at the VA Northern California Healthcare System (system), Sacramento, CA. OIG found that the system generally complied with the manufacturer's instructions (MI) regarding sterilization parameters for selected Olympus and Padgett Dermatomy devices. However, sterilization processes for the Phaco Alcon and Midwest dental handpieces were inconsistent with the MI. OIG concluded that the system's standard operating procedures and sterilization logs were generally inconsistent with the MI. OIG substantiated the allegations related to bioburden testing, delayed reprocessing, endoscope reprocessing documentation, and staff competencies. OIG identified improvement opportunities regarding proper use and care of suction canisters and other accessories. The VISN and System Directors agreed with the findings and recommendation and provided acceptable action plans. [\[Click here to access report.\]](#)

Allegations of Mismanagement of Government Funds and Quality of Care Issues Not Substantiated at the Oscar G. Johnson VAMC, Iron Mountain, Michigan

At the request of Congressman Bill Johnson, Chairman of the Subcommittee on Oversight and Investigations for the House Veterans' Affairs Committee, the OIG conducted an inspection to assess the merits of allegations regarding the mismanagement of Government funds and quality of care issues at the Oscar G. Johnson VAMC in Iron Mountain, MI. OIG reviewed allegations regarding the compensation rates and overtime patterns of nurse administrators and inappropriate patient transfers. Additionally, OIG evaluated the following quality of care allegations: (1) no peer review for physicians and nurses, (2) insufficient number of primary care physicians affected patient care, (3) Intensive Care Unit (ICU) nurses were not appropriately trained, and (4) ICU physicians and nurses did not participate in the ICU Management Committee meetings. OIG did not substantiate any of the allegations, and we made no recommendations. [\[Click here to access report.\]](#)

Allegations of Inappropriate Respiratory and Clinical Care Evaluated at the VA Northern Indiana HCS, Fort Wayne, Indiana

OIG conducted an inspection to determine the validity of anonymous complainants' allegations regarding inappropriate respiratory and clinical care at the VA Northern Indiana HCS, Fort Wayne, IN. OIG determined that the clinical care provided was appropriate. OIG substantiated the allegation that respiratory care policies were absent or ignored, and found that oxygen therapy was being initiated without a provider order. OIG substantiated that an identified physician had a higher readmission rate than other facility physicians, and also found that the Peer Review Committee did not ensure specific actions are taken in response to deficiencies identified. OIG did not substantiate the allegations that another physician admitted patients with a diagnosis of pneumonia without obtaining appropriate diagnostics tests, patients were overmedicated due to short staffing, staff were leaving due to inferior patient care, and when patients became Do Not Resuscitate they were considered do not treat. OIG could not determine if arterial blood gases (ABGs) are performed when not indicated because there was no written criteria for ordering ABGs. OIG recommended that the facility Acting Director ensure that facility respiratory care policies are updated, including specific guidance and expectations for ordering oxygen therapy; that peer review processes comply with VHA policy; and that an assessment of ABG usage is completed. [\[Click here to access report.\]](#)

CRIMINAL INVESTIGATIONS**Non-Veteran Indicted for Service-Disabled Veteran-Owned Small Business Fraud**

A non-Veteran owner of a Service-Disabled Veteran-Owned Small Business (SDVOSB) was indicted for conspiracy to defraud the United States and wire fraud. A VA OIG, Small Business Administration (SBA) OIG, General Services Administration (GSA) OIG, and Army Criminal Investigations Division (CID) investigation revealed that from late 2005 to November 2010 the defendant fraudulently represented that a company he owned was an SDVOSB in order to qualify for and obtain Government contracts from VA, GSA, the U.S. Army, and the U.S. Navy. The defendant utilized disabled Veterans to serve nominally as president and majority owners of the SDVOSB. However, the

defendant actually operated the company from 2006. As a result of this scheme, the SDVOSB received over \$100 million in payments from VA.

VA Contractor Pleads Guilty in SDVOSB Fraud

A VA contractor was arrested and subsequently pled guilty to conspiracy to commit wire fraud. A VA OIG, GSA OIG, SBA OIG, Department of Labor OIG, and U.S. Army CID investigation revealed that the defendant submitted statements to VA, SBA, and other Government agencies falsely representing that he, a minority and service-disabled Veteran, owned and managed the daily operations of the business in order to get Federal government contract awards that were set aside for or preferentially awarded to disadvantaged minority and service-disabled Veteran-owned and operated small businesses. A co-conspirator was previously convicted for his involvement in the scheme.

Veteran Charged with SDVOSB Fraud

A Veteran was charged in a criminal information with making false statements by fraudulently representing that his company was an SDVOSB. An OIG investigation revealed that the defendant submitted claims to VBA for service-connected disability in 1969 and 2009 and that the claims were denied. The defendant certified his company as an SDVOSB despite the fact that he was not a service-connected disabled Veteran. VA awarded approximately \$5,849,000 in VA SDVOSB set-aside contracts to the company between August 2009 and March 2011 and approximately \$3,571,000 of the contract awards were funded with American Reinvestment and Recovery Act funds.

Former Richmond, Virginia, VAMC Housekeeping Aide Pleads Guilty in Death of Another Person

A former Richmond, VA, VAMC housekeeping aide pled guilty to use of a firearm in relation to a crime of violence causing the death of another. An OIG and Federal Bureau of Investigation (FBI) investigation, assisted by VA Police Service and Virginia State Police, determined that the defendant, after engaging in a brief verbal confrontation with two individuals in the medical center parking lot, shot one of them in the shoulder. Upon seeing the victim fall to the ground, the defendant followed the other individual a short distance. The defendant returned to the victim and shot him a second time. The victim subsequently died as a result of his injuries.

Veteran Sentenced for Theft of Government Funds

A Veteran was sentenced to 60 months' incarceration, 36 months' supervised release, and ordered to pay restitution of \$893,739 after pleading guilty to the theft of Government funds. The defendant, who was treated by VA for numerous ailments, claimed to be wheelchair bound and required the need of an aide. The defendant gave various fabricated accounts to neighbors, the media, and VA staff on how his injury occurred, including being a U.S. Navy SEAL wounded during Operation Desert Storm, being injured during hand-to-hand combat training, falling down steps, and being shot by friendly fire while at Ft. Bragg. The investigation also revealed that while the defendant reported to VA that he was not ambulatory, he completed the North Carolina Basic Law Enforcement Training program and later held jobs as a police officer and a

child protective services officer.

Veteran Charged With Making False Statements

A Veteran was charged in a criminal information with willfully making materially false statements relating to his VA benefits. The defendant, who was receiving VA compensation benefits, including aid and attendance, reported to VA that he had no use of his upper or lower extremities and had received prosthetic aides to help him ambulate, which the OIG investigation proved he never used except when attending medical examinations. The defendant fraudulently received approximately \$510,000 from VA based on his false statements and has agreed to enter a guilty plea to the charges.

Fiduciary Pleads Guilty to Theft of Veteran's Benefits

A VA appointed fiduciary pled guilty to the misapplication of fiduciary property of the elderly. An OIG investigation revealed that the defendant misappropriated \$23,930 in VA benefits intended for the Veteran. The defendant's failure to pay for the Veteran's medical expenses also resulted in the Veteran being refused admission to a nursing home and denial of medical care.

Granddaughter of Deceased Beneficiary Sentenced for Theft of VA Funds

The granddaughter of a deceased beneficiary was sentenced to 33 months' incarceration, 36 months' supervised release, and ordered to pay \$222,641 in restitution after pleading guilty to theft of Government funds, wire fraud, and Social Security fraud. A VA OIG, Office of Personnel Management (OPM) OIG, Housing and Urban Development (HUD) OIG, U.S. Secret Service, and Social Security Administration OIG investigation revealed that the defendant stole VA benefits and OPM retirement payments after her grandmother's death in April 1986. Also, the defendant failed to notify Social Security and a public housing authority of her illicit income in order to receive additional benefits.

Subject Sentenced for Making False Statements

A defendant was sentenced to 27 months' incarceration, 5 years' supervised release, and ordered to pay \$544,602 in restitution (\$48,754 to VA) after pleading guilty to false statements relating to a credit application. A VA OIG and HUD OIG investigation revealed that the defendant purported to buy over 50 properties from distressed homeowners "subject to" the underlying mortgage. The defendant then "sold" the homes to individuals with poor credit, little or no assets, and weak work histories. To obtain down payments, the defendant filed Federal income tax returns for buyers to receive first time homebuyer refunds and later demanded kickbacks from the buyers.

Veteran Pleads Guilty to Conspiracy and False Statements

A Veteran pled guilty to conspiracy to defraud the Government and false statements. An OIG investigation revealed that the defendant and his live-in girlfriend structured their business in the girlfriend's name to hide the Veteran's income from VA and that they operated the business for over 8 years while the defendant received monthly VA pension benefits and co-pay exempt VA health care. The defendant was also charged

with delivery of a controlled substance after discovering that he was selling his VA prescribed Morphine tablets. The loss to VA is \$177,108.

Daughter of a Deceased VA Beneficiary Indicted for Theft of Government Funds

The daughter of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation determined the defendant withdrew the VA benefits from a joint bank account after her mother's death in May 2007. The loss to VA is \$63,300.

Veteran Sentenced for Making False Statements

A Veteran was sentenced to 60 months' probation, 90 days' home detention, 100 hours' community service, a \$2,000 fine, and ordered to pay \$51,237 in restitution after pleading guilty to making false statements. A VA OIG and Department of Transportation OIG investigation revealed that while the defendant was receiving VA Chronic Obstructive Pulmonary Disease (COPD) benefits he was reporting to the Federal Aviation Administration (FAA) that he was not diagnosed with a lung disease. During several VA medical exams, the defendant failed to fully cooperate during his Pulmonary Function Tests in order to continue to fraudulently receive VA COPD benefits. The defendant subsequently cooperated fully during an FAA Pulmonary Function Test to provide proof that he did not have COPD. The defendant's VA COPD benefits were terminated.

Son of Deceased Beneficiary Charged with Theft of Government Property

The son of a deceased beneficiary was charged with theft of Government property. An OIG and FBI investigation revealed that the defendant stole VA benefits that were direct-deposited after his father's death in March 2006. The defendant used the stolen funds for personal use to include nightclubs, entertainment, and daily expenses while living in his father's house. The loss to VA is \$202,662.

Veteran Indicted for Identity Theft

A Veteran was indicted for fraudulently obtaining a U.S. passport and possessing firearms as a convicted felon. An OIG investigation revealed that the defendant, who resided in Vermont, assumed a North Carolina Veteran's identity for the past 7 years and used the false identity to obtain a U.S. passport, purchase firearms, vote, obtain employment, and obtain VA funded medical care through the VA fee basis program. Additional charges, to include the theft from VA, are anticipated. The defendant continues to be detained.

Defendant Sentenced for Burglary at the Cleveland, Ohio, VAMC

A defendant was sentenced to 7 years' incarceration after pleading guilty to burglary. An OIG and VA Police Service investigation revealed that the defendant, who had a long history of violent criminal activity, committed the burglary in the room of a paraplegic Veteran at the Cleveland, OH, VAMC Spinal Cord Injury Unit. The burglary occurred during the night while the Veteran was sleeping in the room.

Veteran Charged with Assaulting Northampton, Massachusetts, VAMC Employee

A Veteran inpatient at the Northampton, MA, VAMC was charged with assaulting a VA employee. An OIG and VA Police Service investigation revealed that the defendant punched the employee in the head several times and bit him on the neck. The employee required medical treatment that included blood testing and also missed time from work.

Veteran Found Guilty of Making Threats

A Veteran was found guilty at trial of making threats in interstate communication. An OIG and local police investigation revealed that the defendant called the VA National Call Center in Phoenix, AZ, and informed the call taker that he was going to the Atlanta, GA, VA Regional Office to shoot the first 3,000 people he saw if he did not receive a permanent rating decision within 5 business days.

Former Martinsburg, West Virginia, VAMC Registered Nurse Indicted for Drug Theft

A former Martinsburg, WV, VAMC registered nurse was indicted for acquiring and obtaining controlled substances by misrepresentation, fraud, forgery, deception, and subterfuge. An OIG and VA Police Service investigation revealed that on approximately 78 occasions the defendant retrieved controlled medication from the facility's automated Pyxis medication dispensers using the names of VA patients whose electronic medical records indicated that they did not receive the medication.

U.S. Postal Service Carrier Arrested for Drug Possession

A U.S. Postal Service (USPS) carrier was arrested for drug possession charges after she confessed to stealing numerous packages of controlled VA medications. A VA OIG, USPS OIG, and local law enforcement investigation revealed that for approximately 1 year the defendant stole packages intended for five different Veterans in a rural section of North Carolina. A search of the defendant's residence resulted in the discovery of VA parcel packaging, pill bottles, and controlled medication.

Veteran Sentenced for Possession of Child Pornography at Phoenix, Arizona, VAMC

A Veteran was sentenced to 57 months' incarceration and lifetime probation after pleading guilty to possession of child pornography. An OIG investigation revealed that the defendant was viewing child pornography on his personal laptop computer in his hospital room at the Phoenix, AZ, VAMC. A search warrant and subsequent forensic examination of the defendant's laptop and related memory card devices identified approximately 110 digital images and 77 digital videos depicting child pornography.

Physical Therapist Pleads Guilty to Obstruction of a Health Care Audit

A physical therapist providing fee basis service to VA and other Government beneficiaries pled guilty to a criminal information charging him with obstruction of a health care audit. A VA OIG, Health and Human Services OIG, and FBI investigation revealed that the defendant deliberately obstructed a Medicare/Medicaid audit in order

to hide the fact that he was billing for services not provided by licensed physical therapists and that he was not documenting treatment provided to his patients.

Former Cleveland, Ohio, VAMC Supervisor Sentenced for Trafficking in Counterfeit Goods

A former Cleveland, OH, VAMC supervisor, who was removed from VA employment pursuant to this investigation, was sentenced to 6 months' home detention, 3 years' probation, and ordered to pay \$3,020 in restitution to Gucci after pleading guilty to trafficking in counterfeit goods and infringement of copyrighted works. An OIG and VA Police Service investigation revealed that the defendant solicited his employees to purchase counterfeit DVDs and copies of brand name purses on VA property during official duty hours. The defendant admitted to the criminal activity in a sworn statement and a search of his vehicle resulted in the seizure of counterfeit items totaling \$16,061.

Veteran Pleads Guilty to Travel Benefit Fraud

A Veteran pled guilty to a criminal information charging him with filing false claims to VA for travel benefits. An OIG investigation disclosed that from June 2009 to February 2012, the defendant submitted 156 false travel claims reporting that he was driving to the Togus, ME, VAMC from locations that were over 300 miles round-trip, when in actuality he resided only 3 miles away. The loss to VA is approximately \$17,000.



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