



Department of Veterans Affairs

Office of Inspector General

March 2013 Highlights

CONGRESSIONAL TESTIMONY

Assistant Inspector General Tells House Panel That Indecision Measuring Physician Productivity Is Hampering Maximum Utilization of Resources

Linda A. Halliday, Assistant Inspector General for Audits and Evaluations, testified before the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives, that the Veterans Health Administration (VHA) did not have an effective staffing methodology to ensure appropriate staffing levels for physician specialty care services. Moreover, VHA could not agree on how to develop a methodology although required to do so by Public Law 107-135, *Department of Veterans Affairs Health Care Programs Enhancement Act of 2001*. This indecision resulted in insufficient guidance to VA medical facilities as well as potentially insufficient services to Veterans. Ms. Halliday was accompanied by Mr. Larry Reinkemeyer, Director of the Office of Inspector General (OIG), Kansas City Office of Audits and Evaluations. [\[Click here to access testimony.\]](#)

OIG REPORTS

Review Questions VA's Methodology for Completing Report on \$2.2 Billion in Improper Payments in Fiscal Year 2012

OIG conducted this annual review to determine whether VA complied with the *Improper Payments Elimination and Recovery Act of 2010* (IPERA) for fiscal year (FY) 2012. VA reported about \$2.2 billion in improper payments in its FY 2012 Performance and Accountability Report (PAR). In doing so, OIG found VA did not comply with four of seven IPERA requirements in FY 2012. For example, VHA did not report a gross improper payment rate less than 10 percent or meet a reduction target for one program, and the Veterans Benefits Administration (VBA) did not use statistically valid methodologies to calculate improper payment estimates for some programs or report recapture amounts. VA did meet the requirements to publish a PAR, perform risk assessments, and provide information on its corrective action plans. OIG recommended that action be taken to reduce improper payments and develop achievable reduction targets for the Non-VA Care Fee program, as well as to implement an estimation methodology to achieve statistical precision for all VHA programs. Further, a statistically valid estimation methodology needs to be implemented for the Compensation, Pension, and Vocational Rehabilitation and Employment programs. The required recapture information for all reported VBA programs needs to be provided as required. Lastly, OIG recommended the Executive in Charge for the Office of Management and Chief Financial Officer complete planned actions to improve compliance with IPERA. OIG's recommendations were agreed with and appropriate action plans were provided. [\[Click here to access report.\]](#)

IG Finds Emergency Visit at Biloxi VAMC Did Not Meet Standards, Telephone Access at Mobile Clinic Also Faulted

At the request of Congressman Jo Bonner, OIG conducted an inspection to assess allegations concerning a patient's quality of care and problems with services at the VA Gulf Coast Veterans Health Care System (HCS), in Biloxi, MS. OIG substantiated that the patient's overall medical evaluation during one of four Emergency Room visits did not meet VHA standards. OIG substantiated that the telephone service at the Mobile Community Based Outpatient Clinic (CBOC) is problematic, and that payment for a non-VA hospital stay was originally denied. OIG did not substantiate allegations that the patient's chronic back pain was not addressed at the CBOC or that the patient did not receive timely delivery of durable medical equipment. OIG could neither confirm nor refute that the CBOC provider received any telephone calls from the patient's family during the months of January, February, or March 2012. OIG recommended that leadership ensure that a quality of care review is conducted with specific attention to the deficiencies identified in this report, and strengthen processes to address patient complaints regarding the problematic telephone system at the CBOC. The Veterans Integrated Service Network (VISN) and Facility Directors concurred with OIG's recommendations and provided an acceptable action plan.

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

VHA Needs to Strengthen Oversight and Improve Eligibility Review To Avoid Renewing Ineligible Nursing Home Contracts

OIG evaluated VHA's community nursing home program to determine if nursing homes met eligibility requirements. VHA's Office of Finance reported nursing home program expenditures totaled \$614 million in FY 2012 and were estimated to grow to \$767 million in FY 2013. OIG found weaknesses and untimely VA health care facility eligibility reviews of 30 nursing homes resulted in the renewal of 5 ineligible nursing homes' contracts. This occurred because VA officials did not effectively monitor the nursing home program and did not provide guidance needed to ensure the proper completion of eligibility reviews. Further, VA review teams did not always obtain and evaluate required operational information about the nursing homes when they performed their initial and subsequent annual reviews. Over the next 5 years, VHA will place about 33,500 patients at a cost of about \$296.5 million in ineligible nursing homes if VHA does not strengthen program oversight and improve its eligibility reviews. This amount is not a "cost savings," as Veterans need these vital services, but future payments should be provided to eligible nursing homes that provide the quality of care Veterans deserve. OIG recommended the Under Secretary for Health update community nursing home policies, conduct a national review to ensure Veterans are not currently in ineligible nursing homes, and strengthen nursing home program oversight and monitoring. [\[Click here to access report.\]](#)

Review Finds Some VA Medical Centers and Clinics Transmitted Sensitive Data Over Unencrypted Network

OIG evaluated the merits of an allegation that VA was transmitting sensitive data, including personally identifiable information (PII) and internal network routing information, over unencrypted telecommunications carrier networks. OIG substantiated

the allegation. Office of Information and Technology (OIT) personnel disclosed VA typically transferred unencrypted sensitive data, such as electronic health records and internal Internet protocol addresses, among certain VA medical centers (VAMCs) and outpatient clinics using an unencrypted telecommunications carrier network. OIT management acknowledged this practice, accepting the security risk of potentially losing or misusing the sensitive information exchanged via a waiver. However, the use of a system security waiver was not appropriate. Without controls to encrypt the sensitive VA data transmitted, Veterans' PII may be vulnerable to interception and misuse by malicious users as it traverses unencrypted telecommunications carrier networks. Further, malicious users could obtain VA router information to identify and disrupt mission-critical systems. [\[Click here to access report.\]](#)

Review of Cataract Surgery Care Shows Effective Outcomes and Compliance with VHA Policies

OIG assessed: (1) whether cataract surgery care complied with VHA policies related to informed consent, time-outs, operative report timeliness, and resident supervision; (2) whether cataract surgery patients had improved visual acuity after surgery; (3) selected comorbid conditions and postoperative complications within 30 days of surgery; and (4) whether quality management processes were in place to review care and improve outcomes. OIG found compliance with the documentation of informed consents and resident supervision, timeliness of operative reports, and verification of the patient's correct identity and procedural site during the time-out process. OIG found that patients without diabetes, glaucoma, or macular degeneration had better visual acuity after cataract surgery than patients who had one or more of these three comorbidities. However, VHA should continue to monitor and ensure consistent documentation of intraocular lens implant (IOL) verification in the electronic health records (EHRs) for cataract surgeries. OIG noted the completion of the Ophthalmic Surgery Outcomes Database (OSOD) pilot project and suggested that ophthalmology leaders analyze OSOD results and disseminate associated quality improvement methods, if any, to VA cataract surgery facilities. OIG recommended that the Under Secretary for Health monitor and ensure consistent verification and documentation of preoperative IOL implant verification in the EHR for all cataract surgeries and ensure analysis of OSOD data and dissemination of associated quality improvement processes to VA cataract surgery facilities. [\[Click here to access report.\]](#)

VHA Lacks Consistent Guidance to Identify and Manage Disruptive Patients, Delays Also Found in Flagging Patient Records

OIG conducted a review to assess how VAMCs manage patients who display disruptive and violent behaviors. OIG found that VHA facilities vary significantly in how they identify and manage disruptive patient behavior, especially in regards to defining disruptive behavior, documenting incidents and interventions, and employing interventions to prevent and/or minimize the risk of further incidents. OIG also found significant delays in facilities' assignments of Category I Patient Record Flags (PRFs), which are intended to alert VHA employees to patient behavior that may pose an immediate threat to other patients, facility employees, and visitors. OIG recommended that the Under Secretary for Health ensure that VHA program officials provide guidance

on what constitutes disruptive behavior and establish common terminology for VHA facilities, develop guidelines for what information facilities should document about disruptive incidents and where this information should be documented, and provide guidance to VHA facilities on collecting and analyzing data on disruptive incidents. OIG also recommended that the Under Secretary for Health consider implementing a national reporting system or data collection template for disruptive patient incidents and ensure that VHA facilities implement procedures to improve the timeliness of assigning Category I PRFs to alert VHA employees to patients who may pose an immediate threat. The Under Secretary for Health agreed with the findings and recommendations and provided acceptable improvement plans. [\[Click here to access report.\]](#)

Inspection Results for Nashville, Tennessee, VA Regional Office

OIG evaluated the Nashville, TN, VA Regional Office (VARO) to see how well it accomplishes its mission. OIG found VARO staff, overall, did not accurately process 24 (41 percent) of 59 disability claims reviewed. OIG sampled claims for certain types of medical disabilities that OIG considered to be at higher risk of processing errors, so these results do not represent the overall accuracy of disability claims processing at this VARO. Specifically, 47 percent of the 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate. Generally, these errors occurred because VARO staff did not schedule medical reexaminations or take actions to reduce benefits as appropriate. Further, staff incorrectly processed 34 percent of 29 traumatic brain injury claims (TBI). Most errors occurred when peers rather than Quality Review Team staff conducted second-level reviews of TBI claims. Management generally ensured Systematic Analyses of Operations were complete and timely. However, staff did not always properly address Gulf War Veterans' entitlement to mental health care. Staff also did not provide outreach to homeless Veterans in their entire area of jurisdiction or always accurately identify their claims. The VARO Director concurred with OIG's recommendations. Management's planned actions are responsive and OIG will follow up as required. [\[Click here to access report.\]](#)

IG Finds Excessive Emergency Room Length of Stay a Chronic Problem at Columbia, South Carolina, VAMC

OIG conducted an evaluation in response to allegations of an excessive length of stay (LOS) and lack of treatment for elevated blood pressure in the Emergency Department (ED) at the William Jennings Bryan Dorn VAMC in Columbia, SC. During OIG's inspection, an anonymous complainant further alleged that acuity levels for various conditions were triaged lower than indicated by ED guidelines. OIG substantiated the patient's excessive LOS in the ED, and determined it to be a chronic problem at the facility. Emergency Department Integration Software (EDIS) was not utilized to provide data to assist in improving flow management, and ED providers considered EDIS data entry a low priority. OIG did not substantiate that the facility failed to address a patient's elevated blood pressure in the ED or that urgent or critical conditions were triaged at non-urgent levels. OIG recommended that the Facility Director identify a reporting structure for EDIS data and ensure that mandated quarterly reports containing and utilizing EDIS data are provided, ensure that planned actions to address patient flow are implemented and patient flow outcomes are monitored, and ensure that ED providers

and other clinical and administrative staff receive training on the use of EDIS delay reasons and that accuracy is monitored. [\[Click here to access report.\]](#)

IG Finds Conflict of Interest in VA Doctor's Attempts To Influence Committee Reviewing Spouse's Research Proposal

OIG reviewed allegations that a Merit Review Scientific Review Group (SRG) member (Dr. X) violated ethical standards of conduct by approaching other SRG members to seek support for his wife's (Dr. Y's) research proposal. OIG substantiated that Dr. X had a clear conflict of interest in this case, yet he repeatedly attempted to influence other SRG members to score Dr. Y's proposal favorably. Dr. X had a pattern of similar actions in the past. While OIG did not evaluate whether Dr. Y's proposal was inappropriately funded as a result of Dr. X's efforts, Dr. X's actions could have affected the Merit Review proceedings and subsequent funding decisions. As such, a review of Dr. Y's ongoing grant award may be indicated. Further, Dr. X retains a 3-year approval (expiration date in 2014) to submit research proposals to VA Merit Review for possible funding. Because of his pattern of improper conduct, his eligibility for Federal research funding should be reconsidered. The Office of Research and Development (ORD) has revised its guidance on reporting ethical breaches like those discussed in this report; however, SRG members may still be dissuaded from reporting ethical breaches due to concerns about retaliation. OIG recommended that ORD conduct an Administrative Board of Investigation into this matter and evaluate existing policies and controls related to Merit Review SRG processes. The Under Secretary for Health concurred with OIG's recommendations and provided an acceptable action plan. OIG will follow up on the planned actions until they are completed. [\[Click here to access report.\]](#)

Clinic Inspection Results for San Francisco VAMC, San Francisco, California

OIG reviewed the San Francisco VAMC's six CBOCs during the week of January 21, 2013. The purpose of the review was to assess whether the CBOCs provide Veterans with consistent and safe high-quality health care. The review covered the clinical care components of women's health cervical cancer screening and tetanus and pneumococcal vaccinations. OIG also randomly selected the Clearlake, CA, CBOC for a site visit and evaluated credentialing and privileging, environment of care, and emergency management processes. OIG noted opportunities for improvement and made a total of five recommendations to the VISN and facility managers.

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

Clinic Inspection Results for Palo Alto HCS, Palo Alto, California

OIG reviewed the VA Palo Alto HCS's seven CBOCs during the week of January 28, 2013. The purpose of the review was to assess whether the CBOCs provide Veterans with consistent and safe high-quality health care. The review covered the clinical care components of women's health cervical cancer screening and tetanus and pneumococcal vaccinations. OIG also randomly selected the Monterey CBOC in Seaside, CA, and the Stockton CBOC in French Camp, CA, for site visits and evaluated credentialing and privileging, environment of care, and emergency management processes. OIG noted opportunities for improvement and made a total of four recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

CRIMINAL INVESTIGATIONS

Nine Veterans Indicted for VA Compensation Fraud

A retired Maryland Department of Veterans Affairs State employee and eight other Veterans, to include a retired Baltimore VARO employee, were indicted for wire fraud and *Hobbs Act* violations. From 2003 to 2011, while working at the Maryland Department of Veterans Affairs, the State employee created fraudulent doctor notes and amendment forms, commonly referred to as DD-215s, as part of claims for service-connected disability. An OIG investigation revealed that the State employee solicited and received cash payments from the Veterans in exchange for assistance with their claims. The doctor's notes claimed the Veterans had been diagnosed with diabetes and were insulin dependent. The fraudulent DD-215s were used as proof of service in Vietnam. The State employee also filed a fraudulent DD-215 form to increase his own rating for post-traumatic stress disorder. Seventeen Veterans received compensation benefits using the fraudulent forms. The loss to VA is \$1,151,219. The State employee also assisted the Veterans in receiving \$255,555 in property tax waivers from the State that they were not entitled to receive.

New York Men Face 10 Years in Prison if Convicted for Pretending To Be Disabled Veterans To Receive Set Aside VA Contracts

Two contractors were arrested for committing major fraud against the United States. An OIG and Federal Bureau of Investigation (FBI) investigation revealed that the two defendants, who owned and operated a separate non Service-Disabled Veteran-Owned Small Business (SDVOSB) construction company, used the service disabled Veteran status of a relative to bid on and be awarded Government contracts through a second company. Because of the scheme, the defendants were awarded contracts valued at over \$13 million.

Veteran Indicted for SDVOSB Fraud

A Veteran was indicted for wire fraud and aggravated identity theft after a VA OIG and Small Business Administration OIG investigation revealed that, in order to obtain VA contracts for architectural and engineering services, he fraudulently claimed to be the owner of a SDVOSB. The defendant had been discharged from the Navy with a pre-existing condition, after which he filed for and was denied VA benefits. When his company was scheduled for an onsite review to verify his company as an SDVOSB, the defendant again filed for and was denied VA benefits. Because of his fraudulent actions, the company was paid over \$1.4 million, approximately \$156,500 of which was funded with *American Recovery and Reinvestment Act of 2009* funds.

Former Fiduciary Pleads Guilty to Theft

A former fiduciary pled guilty to theft of public funds. An OIG investigation revealed that the defendant embezzled funds from the accounts of various Veterans. The defendant withheld the Veterans' funds from deposits or wrote checks to himself from the Veterans' accounts. The loss in VA funds is \$236,204.

New Hampshire Fiduciary Sentenced to Prison and Fined \$55K for Embezzling Funds from Disabled Veterans

The former estate manager of a nonprofit corporation, who was also a VA fiduciary, was sentenced to 13 months' incarceration, 3 years' supervised release, and ordered to pay approximately \$55,000 in restitution. A VA OIG, Social Security Administration (SSA) OIG, and local law enforcement investigation revealed that the defendant embezzled funds from 23 victims, including 3 disabled Veterans, by creating a payee code that issued checks to the defendant and by purchasing gift cards at retail stores. After discovering discrepancies in the victims' accounts, the nonprofit corporation took prompt action to terminate the employee, notify authorities, and reimburse the victims.

Former VA Fiduciary Sentenced for Theft

A former VA fiduciary was sentenced to 1 year of incarceration, 9 years' probation, and ordered to pay \$26,083 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant embezzled benefits from a VA beneficiary and used the funds for his personal use.

Veteran Caretakers Arrested for Theft of Government Funds

Three former Veteran caretakers were indicted and subsequently arrested for conspiracy and theft of Government funds. An OIG and U.S. Postal Inspection Service investigation revealed that the defendants applied and received VA pension benefits without the knowledge of a Veteran while he resided in their personal care home. From August 2003 to October 2010, the defendants used a post office box to receive and negotiate all of the Veteran's VA benefit checks. The approximate loss to VA is \$123,000.

Phoenix, Arizona, VAMC Nurse Indicted for Elder Abuse

A Phoenix, AZ, VAMC nurse was indicted for vulnerable adult abuse, fraudulent schemes, forgery, theft, identity theft, and negligent homicide. An OIG and local law enforcement investigation determined that the defendant provided inadequate care and treatment to VA-placed Veterans at three assisted living facilities she owned and operated. The State of Arizona subsequently closed the facilities and condemned the buildings. The Veterans were returned to the VAMC or placed in other facilities approved by VA. The defendant also forged cardiopulmonary resuscitation (CPR) certifications for her staff by forging the name of a retired VAMC CPR trainer.

Topeka, Kansas, VAMC Neurologist Pleads No Contest to Sexual Battery

A Topeka, KS, VAMC neurologist pled no contest to aggravated sexual battery and sexual battery. An OIG, VA Police Service, and local police investigation revealed that the defendant administered full pelvic examinations without a chaperone and without any medical necessity for such procedures. Five victims were identified in a 1-year period.

Former West Los Angeles, California, VAMC Employee Convicted of Possession of Child Pornography

A former West Los Angeles, CA, VAMC employee was found guilty at trial of possession of child pornography and was sentenced to 9 years' incarceration, followed by a lifetime of supervised release. The defendant previously pled guilty to the sexual abuse of his daughter in his apartment, which was located at the Hines, IL, VAMC.

Former Cleveland, Ohio, VAMC Purchasing Agent and Equipment Provider Sentenced for Health Care Fraud

A former Cleveland, OH, VAMC purchasing agent was sentenced to 10 days' incarceration, 6 months' home confinement, 3 years' probation, and ordered to pay \$110,581 in restitution after pleading guilty to conspiracy to commit health care fraud. Additionally, the owner of a durable medical equipment provider was sentenced to 3 months' incarceration, 6 months' home confinement, 2 years' supervised release, and ordered to pay \$110,581 in restitution. An OIG investigation revealed that the former VA employee used her position to provide competitors' bid information to the medical equipment provider and inflate payments for services. In some instances, the medical equipment was not installed, either because the Veteran refused delivery or died waiting for a ramp or ceiling lift to be delivered. The company charged as if the equipment had been installed and then kept the unused equipment for a subsequent Veteran.

Veteran Sentenced for Health Care Fraud

A Veteran was sentenced to 366 days' incarceration, 36 months' probation, and ordered to pay VA \$7,042 in restitution and "Vacations for Veterans" \$2,093 in restitution. An OIG investigation revealed that the defendant submitted an altered DD-214 in order to fraudulently receive VA health care benefits from three different VAMCs. The defendant also submitted fraudulent documents to a VARO in an attempt to obtain unauthorized claims for various physical conditions. Further investigation revealed that the defendant received a donated vacation to Hawaii from a Veteran's charity by submitting fraudulent documents and by representing himself as a Purple Heart recipient with terminal cancer.

Former VA CBOC Registered Nurse Arrested for Drug Violations

A former VA CBOC registered nurse was arrested after being indicted for unlawfully distributing oxycodone, obtaining oxycodone through fraud, forgery and subterfuge, and conspiring. An OIG, VA Police Service, and local police investigation revealed that on eight occasions between May and September 2010, the defendant stole prescription forms from a nurse practitioner at the VA clinic and forged the nurse practitioner's name on prescriptions for oxycodone. The prescriptions were subsequently filled by the defendant or others at a local pharmacy.

Former Temple, Texas, VAMC Mailroom Employee Indicted for Drug Theft

A former Temple, TX, VAMC mailroom employee was indicted for possession of stolen mail (prescription drugs) and theft of Government property. An OIG and VA Police Service investigation determined that the defendant removed the narcotics prior to transferring the packages to the U.S. Postal Service.

West Palm Beach, Florida, Respiratory Therapist Sentenced for Drug Violation

A VA respiratory therapist was sentenced to 12 years' incarceration, with a 6-year mandatory minimum, and a \$157,860 fine after pleading guilty to trafficking in oxycodone. The plea stemmed from a 7-month multiagency drug diversion task force investigation. Operation Tango Vax focused on combating the sale and distribution of illicit and controlled prescription pharmaceuticals at the West Palm Beach, FL, VAMC and the surrounding community by VA employees, Veterans, and their associates. The investigation determined that the majority of all criminal activity occurred at the VAMC and resulted in the seizure of over 3,000 oxycodone pills, 2 vehicles, and \$180,920 in cash.

Four Defendants Sentenced for Prescription Fraud

Four defendants pled guilty and were sentenced up to 24 months' probation, \$600 in fines, and 240 hours' community service for altering and using fraudulent VA oxycodone prescriptions. An OIG investigation revealed that one of the defendants, a Veteran, forged the signature and the Drug Enforcement Administration number of a VA CBOC contract nurse. The Veteran then conspired with the other defendants to create prescriptions using spurious names and addresses and then submitting them to various retail drug stores.

Non-Veteran Arrested for Loan Fraud

A non-Veteran was indicted and arrested for conspiracy, mail fraud, wire fraud, and bank fraud. An OIG and FBI investigation determined that the defendant provided down payments to multiple buyers during real estate closings in the form of gift funds that were reported to the lenders as originating from a family member of the buyer. The funds were fraudulently reported on the Uniform Residential Loan Application to increase the buyers' credit score and allowed them to qualify for mortgages. Thirteen loans were identified in the scheme, including a VA guaranteed home loan. The potential loss to VA should this guaranteed VA home loan default is about \$152,203.

Veteran Charged with VA Home Loan Fraud

A Veteran was charged with theft for fraudulently obtaining a \$58,000 VA Home Loan Guaranty. An OIG investigation determined that the defendant falsely certified to VA that he would occupy the home as his primary residence. The defendant provided a fraudulent lease agreement to VA and the lender regarding his primary residence in order to qualify for the home loan. In 2011, the defendant refinanced the home and again falsely certified that he had previously occupied the home as his primary residence. The defendant subsequently admitted that he never intended to occupy the home as his primary residence, and in fact, purchased the home for his son.

Veteran Pleads Guilty to VA Compensation Fraud

A Veteran pled guilty to aggravated misappropriation, misrepresentation, fraud, and possession and transfer of false documents and was sentenced to time served, ordered to pay \$652,652 in restitution, and to serve probation until he repays the full restitution amount, including a provision that the defendant is to spend 1 day in jail for each

instance of non-payment to VA. An OIG Benefits Inspection and subsequent investigation revealed that the defendant fraudulently received both VA compensation and pension benefits based upon multiple fraudulent enlistments in the U.S. Army and a fraudulent Social Security card. This case is the OIG's first prosecution and conviction in the Commonwealth of Puerto Rico after securing legal standing from Puerto Rico's Attorney General. The OIG became the first Federal Law Enforcement Agency to be authorized to present criminal cases directly to the Commonwealth Attorney for prosecution.

Veteran Sentenced for Travel Benefit Fraud Against Seattle, Washington, VAMC

A Veteran was sentenced to 24 months' incarceration for false claims and conspiracy to defraud VA. The defendant was one of nine Veterans and two VA travel clerks who participated in a conspiracy to defraud VA by submitting hundreds of inflated and fictitious travel benefit vouchers to the Seattle, WA, VAMC. Kickbacks were paid by the Veterans to the VA travel clerks who processed the vouchers. This defendant also participated in the collection of kickback payments from other Veterans involved in the scheme. The estimated loss is in excess of \$160,000.

Veteran Charged with Defrauding the VA Grant and Per Diem Program

A Veteran, purporting to be an advocate for homeless Veterans, was charged in a criminal information with theft of public funds and making false statements. An OIG investigation revealed that the defendant founded a company with a stated purpose of providing training, transportation, and housing for homeless Veterans in the Nashville, TN, area. The defendant provided false information in her applications submitted to the VA Grant and Per Diem Program; subsequently obtained the grants; and then diverted the majority of the VA funds to her own personal use, to include vacation trips to gambling establishments. The defendant improperly obtained \$360,600 as part of the grant fraud scheme.

Former Bay Pines, Florida, VAMC Employee Sentenced for Theft

A former Bay Pines, FL, VAMC employee was sentenced to time served, 36 months' probation, ordered to participate in a mental health and substance abuse program, reside at a Residential Reentry Center for a period of 6 months, and to pay VA \$32,844 in restitution. The defendant had previously pled guilty to theft of Government funds and use and trafficking of unauthorized access devices affecting interstate commerce. An OIG investigation determined that the defendant stole a General Services Administration fuel card and purchased and sold fuel using the card.

Former Home Health Aide Indicted for Identity Theft

The former home health aide of a disabled Veteran was indicted for identity theft, exploitation of the elderly and disabled, theft by taking, and theft by deception. An OIG investigation revealed that the defendant stole the Veteran's personal and financial information while acting as a caregiver. Using the Veteran's information, the defendant subsequently contacted VA and redirected the Veteran's VA compensation benefits. To further the scheme, the defendant applied for and received several prepaid debit

cards in the Veteran's name and used the prepaid debit cards for his personal use. The loss to VA is approximately \$17,900.

Former Richmond, Virginia, VAMC Social Worker Indicted for Mail Fraud and False Statements

A former Richmond, VA, VAMC social worker was indicted for mail fraud and false statements. A VA OIG and Department of Labor OIG investigation revealed that the defendant, beginning in June 2011, submitted approximately 380 fraudulent travel vouchers claiming reimbursements for taxi rides for physician and rehabilitation appointments. The false travel vouchers were related to two different injury compensation claims filed while the defendant was employed at the West Los Angeles, CA, VAMC. The loss to VA is approximately \$44,000.

Son of Deceased Beneficiary Pleads Guilty to Theft of Government Funds

The son of a deceased VA beneficiary pled guilty to a criminal information charging him with theft of Government funds. The defendant admitted to disguising his voice in an attempt to sound like his mother when he was contacted by phone by a Veterans Service Representative regarding an address change he fraudulently submitted to VA. The defendant also admitted to stealing the VA benefits that were direct deposited to his mother's account after her death in November 2003. The loss to VA is \$107,848.

Daughter of Deceased Beneficiary Sentenced for Theft

The daughter of a deceased VA and SSA beneficiary was sentenced to 366 days' incarceration, 2 years' supervised release, and ordered to pay \$177,694 in restitution after pleading guilty to conspiracy, theft, and false statements. A VA OIG and SSA OIG investigation revealed that the defendant provided false statements to VA and SSA after her mother's death in July 2002 and then continued to receive, forge, and negotiate her deceased mother's benefit checks. The loss to VA is \$119,642.

Wife of Deceased Veteran Arrested for Failure to Report Remarriage

The wife of a deceased Veteran was indicted and subsequently arrested for falsifying VA documentation. An OIG investigation determined that the defendant failed to report her remarriage in 1978 to VA in order to continue to receive benefits she was no longer entitled to receive. The loss to VA is approximately \$308,000.

Fugitive Orlando, Florida, VAMC Employee Arrested

An Orlando, FL, VAMC employee wanted for felony distribution of cocaine was arrested by local law enforcement with the assistance of OIG and VA Police Service.



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

GEORGE J. OPFER
Inspector General