



Department of Veterans Affairs

Office of Inspector General

May 2013 Highlights

CONGRESIONAL TESTIMONY

OIG Offers Views on Draft Bill That Would Require VA to Report Managers Slow To Implement IG Recommendations

The Office of Inspector General (OIG) provided a statement for the record for a hearing before the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives, on OIG's follow-up process and views on a draft bill that would require the VA Secretary to identify managers who do not implement OIG recommendations in a timely manner. OIG's statement explained the process for tracking recommendations and reporting on recommendations that are not implemented within 1 year. OIG also offered technical corrections to a draft bill by the Health Subcommittee Chairman. [\[Click here to access testimony.\]](#)

OIG REPORTS

OIG Review Finds Six Factors Contributed to Misuse of Insulin Pens at Buffalo, New York, Facility

OIG conducted an inspection to evaluate the circumstances surrounding the reported inappropriate use of insulin pens at the VA Western NY Healthcare System (HCS), Buffalo, NY. OIG conducted the inspection at the requests of the Chairmen and Ranking Members of the House Committee on Veterans' Affairs and the Senate Committee on Veterans' Affairs, Senator Charles Schumer, and Congressmen Brian Higgins and Chris Collins. This report addresses questions raised by Members of Congress regarding the specific circumstances at the HCS. OIG will issue a separate report addressing broader questions pertaining to insulin pen use at other facilities, as well as Veterans Health Administration (VHA) oversight and follow-up. OIG recommended that the Under Secretary for Health (USH) finalize VHA's Clinical Operations Guideline for "Implementation of a Large Scale Disclosure Decision" and that the Veterans Integrated Service Network (VISN) Director review the facts that led to the misuse of insulin pens and take appropriate administrative action. OIG also recommended that the Facility Director implement a process to ensure the HCS's Medication Use, Nursing Practice, and Commodity Standards Committees and other relevant leadership evaluate the risks and benefits before introducing new medical products or supplies; strengthen nurse education practices when introducing new medical products or supplies; and ensure that all nurses are made aware of how to find and use the HCS's nursing practice procedures. The USH concurred with OIG's findings and recommendations and provided an acceptable action plan.

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

Delays Noted in Providing Patients with Biopsy Results at Salisbury, North Carolina, Facility

OIG conducted an inspection in response to a complaint concerning delays in reporting biopsy test results to patients and possible delays in treatment at the W.G. (Bill) Hefner VA Medical Center (VAMC), Salisbury, NC. OIG substantiated the allegation that the

facility was not timely in notifying patients of biopsy test results. However, OIG did not substantiate that resulting treatments were delayed. In addition, OIG identified that notification procedures for new malignancies found during outpatient test biopsies were not included in the facility's critical biopsy policy. OIG recommended that procedures be implemented to ensure that patients receive timely notification of biopsy test results, notifications be documented in patients' electronic health records, performance improvement procedures be adjusted to include periodic monitoring of test result communication to patients, and the facility's written policy for critical test results be revised to include outpatient biopsy test results. Management agreed with the findings and recommendations and provided an acceptable improvement plan.

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

IG Makes Three Recommendations to Improve the Safe Provision of Moderate Sedation

OIG completed an evaluation of moderate sedation in VHA facilities. The purpose of the evaluation was to determine whether VHA facilities used safe processes for the provision of moderate sedation that complied with selected requirements. OIG conducted this review at 44 facilities during Combined Assessment Program reviews performed from October 1, 2011, through September 30, 2012, and identified three areas where VHA facilities needed to improve compliance. OIG recommended that clinicians consistently document all required elements of comprehensive pre-procedure assessments; that when there is a provider change, clinicians consistently document that the patient was informed of and agreed to the change; and that clinicians consistently discharge moderate sedation patients appropriately and safely.

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

Quality of Surgical Technique of Specialty Service Surgeon Assessed at a VA HCS

OIG conducted an inspection in response to allegations that a VA HCS specialty service surgeon had licenses suspended in two states and had several near misses, with some related to wrong site surgeries, and that the Chief of Surgery declined to review two alleged sentinel event cases or take action on reported staff concerns. OIG did not substantiate that the surgeon had suspended medical licenses in two states or had several wrong site surgery "near misses." OIG identified and had concerns with one case regarding the quality of surgical technique. While the Chief of Surgery declined to review two alleged "near miss" cases as sentinel events, OIG concurred that the cases did not meet the definition of a sentinel event. The Chief of Surgery had taken multiple actions to address staff's concerns regarding the surgeon's surgical techniques. The system did not delineate the surgeon's privileges, the privileges were not facility or provider specific, and an initial focused professional practice evaluation (FPPE) was not completed as required. OIG recommended that the System Director ensure the two alleged "near misses" are referred to quality management staff to determine if action should have been taken, consult with Regional Counsel regarding possible clinical disclosure to the patient for whom quality of surgical technique concerns were identified, ensure that initial FPPEs are completed on all newly hired providers, and that privileges

are facility and provider specific. The VISN and Facility Directors concurred with OIG's recommendations and provided acceptable action plans.

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

Inspection Results for Clinics in Multiple VAMCs

OIG reviewed the Northport VAMC's six Community Based Outpatient Clinics (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 Patchogue, NY, 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 nine recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG also conducted several CBOC reviews covering the same health care topics at the following locations:

OIG reviewed the Manchester VAMC's four CBOCs during the week of March 11, 2013. OIG noted opportunities for improvement and made a total of one recommendation to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the VA New Jersey HCS's 11 CBOCs during the week of January 21, 2013. OIG noted opportunities for improvement and made a total of nine recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Cheyenne VAMC's three CBOCs during the week of March 25, 2013. OIG noted opportunities for improvement and made a total of four recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Edith Nourse Rogers Memorial Veterans Hospital's four CBOCs during the week of March 11, 2013. OIG noted opportunities for improvement and made a total of five recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the VA Maine HCS's seven CBOCs during the week of March 11, 2013. OIG noted opportunities for improvement and made a total of five recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Sioux Falls VA HCS's five CBOCs during the week of April 1, 2013. OIG noted opportunities for improvement and made a total of five recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Oklahoma City VAMC's eight CBOCs during the week of March 4, 2013. OIG noted opportunities for improvement and made a total of 10 recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the North Florida/South Georgia Veterans Health System's 10 CBOCs during the week of March 25, 2013. OIG noted opportunities for improvement and made a total of five recommendations to the VISN and facility managers.

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

CRIMINAL INVESTIGATIONS

Retired Baltimore, Maryland, VA Regional Office Employee and Other Veterans Plead Guilty to Wire Fraud

A retired Baltimore, MD, VA Regional Office employee and five other Veterans pled guilty to wire fraud. From 2003 to 2011, while working at the Maryland Department of Veterans Affairs, an employee created fraudulent doctor notes and amendment forms, commonly referred to as DD-215s, as part of claims for service-connected disabilities. 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 (PTSD). Seventeen Veterans received compensation benefits using the fraudulent forms. The loss to VA is \$1,151,219. The State employee also assisted some of the Veterans in receiving \$255,555 in property tax waivers from the State that they were not entitled to receive. Plea hearings for the remaining three defendants are pending.

Former Lyons, New Jersey, VAMC Patient Pleads Guilty to Concealing the Death of Veteran

A former Lyons, NJ, VAMC patient pled guilty to misprision of the felony of distribution of heroin. An OIG investigation revealed that the defendant and a second defendant, who has also been charged, used heroin in the victim's room at the medical center. While using the drug, the Veteran collapsed and the defendant and the other patient departed the room and failed to notify staff. The deceased victim's body was discovered the next morning, and the body's positioning initially led OIG to investigate his death as an apparent accidental suicide. Subsequent information developed through a confidential source revealed that the second defendant actually administered the heroin to the victim. After the victim died, the second defendant propped up the body to make it appear as though the Veteran had taken the heroin and overdosed on his own.

Topeka, Kansas, VAMC Neurologist Sentenced for Sexual Battery

A Topeka, KS, VAMC neurologist was sentenced to 32 months' incarceration for aggravated sexual battery and 12 months' incarceration (concurrent) for sexual battery. The defendant was granted a suspended imposition of sentence and received 36 months' probation. An OIG, VA Police Service, and local police investigation revealed that the defendant administered full pelvic examinations, without a chaperone, to five patients without any medical necessity for such procedures.

Veteran Arrested for Defrauding Other Veterans

A Veteran was arrested for mail fraud after an OIG and Internal Revenue Service Criminal Investigation Division investigation determined that he fraudulently took payments from 16 Veterans with the promise of getting the Veterans VA compensation benefits at a 100 percent rating. The payments were allegedly used to pay an attorney to do research and file the claims with VA. The defendant stole over \$400,000 from these Veterans and never filed a single claim on their behalf.

Former Roseburg, Oregon, Pharmacy Technician Charged with Theft of Government Property

A former Roseburg, OR, pharmacy technician was charged with theft of Government property. An OIG investigation revealed that the defendant received stolen narcotics from another pharmacy technician who was previously prosecuted. That technician diverted the narcotics from the pharmacy through an elaborate scheme of manipulating inventory control safeguards and creating false entries indicating that the narcotics were dispensed to automated dispensing machines throughout the facility. The technician then removed the narcotics from the pharmacy and shared a portion of the drugs with the defendant. The loss to VA was approximately \$26,000.

Long Beach, California, VAMC Health Care Technician Arrested for Theft and False Statements

A Long Beach, CA, VAMC health care technician was indicted and arrested for theft and false statements. An OIG investigation confirmed the results of an administrative investigation concerning time card fraud by the defendant, who was terminated from employment. The defendant submitted fraudulent attendance and overtime information to her timekeeper and was paid for 1,695 hours of overtime pay. The loss to VA is \$55,502.

Former Martinsburg, West Virginia, Registered Nurse Sentenced for Drug Diversion

A former Martinsburg, WV, registered nurse was sentenced to 14 days' incarceration after previously pleading guilty to acquiring and obtaining a controlled substance by fraud. 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 they did not receive the drugs.

Former VA Contract Employee Sentenced for Possession of Child Pornography

A former VA contract employee was sentenced to 78 months' incarceration after pleading guilty to possession of child pornography and receipt of child pornography. An OIG investigation determined that the defendant accessed internet websites containing images of child pornography and then saved the images to his VA-issued computers while working at two VA clinics in New Mexico.

Former VA Fiduciary Pleads Guilty to Immigration Charge

A former VA fiduciary pled guilty to harboring a foreign national. A female co-defendant also pled guilty to a similar immigration charge. An OIG investigation revealed that the VA fiduciary became romantically involved with the co-defendant and helped arrange a fraudulent marriage between the co-defendant and an incompetent Veteran. The VA fiduciary and co-defendant subsequently embezzled funds from the Veteran to help fund immigration fees and living expenses. The fiduciary has agreed to make full restitution.

Former Caretakers Plead Guilty to Conspiracy and Theft of Government Funds

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

Veteran Pleads Guilty after Assuming Veteran's Identity

A Veteran pled guilty to possession of child pornography, failure to register as a sex offender, health care fraud, and possession of firearms as a convicted felon. An OIG investigation revealed that for 7 years the defendant, who resided in Vermont, assumed a North Carolina Veteran's identity and used the false identity to obtain a U.S. Passport, purchase firearms, vote, obtain employment, and obtain VA medical care through the VA fee basis program. A computer analysis conducted by OIG's Computer Forensics Laboratory also linked the defendant to child pornography. The defendant continues to be detained, and sentencing is scheduled for September 2013.

Veteran Arrested for Theft of Government Funds

A Veteran was arrested for theft of Government funds relating to his fraudulent award of VA compensation benefits for PTSD. An OIG investigation revealed that the defendant was awarded compensation at the 100 percent rate based on false stressors he fabricated to support his claim. Some of these false stressors included his claimed participation in a dead body detail during Operation Desert Storm, his involvement in an incident where a fellow soldier's vehicle was fired upon causing the vehicle to crash, and being subjected to constant incoming rounds. The loss to VA is approximately \$185,000. Also, the defendant was previously convicted in 1996 of defrauding VA's home loan guarantee program.

Veteran Sentenced for Theft of Government Funds

A Veteran was sentenced to 25 months' incarceration and ordered to pay \$4,824 in restitution after pleading guilty to theft of Government funds. An OIG investigation determined that for approximately 3 years the defendant assumed the identity of a deceased Veteran in order to obtain medical treatment at four different VAMCs. In addition to obtaining medical care, the defendant also applied for and received pension benefits under the assumed identity. When interviewed, the defendant stated that he

assumed the identity of the deceased Veteran because he knew he had an outstanding warrant and would not be able to obtain medical care from VA under his own name. The loss to VA is in excess of \$182,000.

Former Miami, Florida, VAMC Chief of Canteen Service Arrested for Organized Fraud and Grand Theft

A former Miami, FL, VAMC chief of canteen service was arrested for organized fraud and grand theft. An OIG investigation revealed that the defendant stole VA property, cash, a laptop, a Blackberry, misused his Government issued travel card, and negotiated several bad checks. The loss to VA is \$22,450.

Veteran Sentenced for Using Stolen Identities to Defraud VA

A Veteran was sentenced to 3 months' incarceration, 3 months' home detention, 3 years' supervised release, and ordered to pay \$18,000 in restitution. An OIG investigation determined that the defendant assumed the identities of six other Veterans in order to fraudulently receive advanced education payments under the GI Bill. While on active duty, the defendant obtained a personnel roster that contained personally identifiable information of other service members. After the defendant's discharge, she assumed the identities of the six Veterans in order to request advance education payments online. The defendant had the checks mailed to her residence and created false powers of attorney in order to negotiate the checks. The loss to VA is \$18,000.

Non-Veteran Sentenced for Identity Theft

A non-Veteran was sentenced to 152 days' incarceration and ordered to pay VA \$19,072 in restitution after pleading guilty to fraud charges. An OIG, VA Police Service, and local police investigation revealed that the defendant stole a Veteran's identity and for 3 months fraudulently received VA medical care.

Daughter of Deceased Beneficiary Indicted for Theft of Government Funds

The daughter of a deceased beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant failed to report her mother's death to VA and then stole VA benefits that were direct deposited after the beneficiary's death in May 2005. The loss to VA is \$103,557.

Veteran Sentenced for Theft of VA Travel Benefits

A Veteran was sentenced to 60 months' probation, 100 hours' community service, and ordered to pay restitution of \$57,535 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant submitted fraudulent travel benefit vouchers to the Bay Pines, FL, VAMC since 1998. The defendant claimed that he resided in Sebring, FL, and traveled 224 miles roundtrip, when in actuality he lived in St. Petersburg, FL, and only traveled approximately 18 miles roundtrip to the medical center.

Veteran Sentenced for Travel Benefit Fraud

A Veteran was sentenced to 15 months' incarceration and ordered to pay restitution of \$3,796 after pleading guilty to grand theft. An OIG investigation revealed that the

defendant filed 101 fraudulent travel vouchers at the Bay Pines, FL, VAMC claiming that he traveled 55 miles roundtrip from Sarasota, FL, when in actuality he resided in St. Petersburg, FL, and only traveled approximately 18 miles per trip.

Veteran Indicted for False Claims and False Statements

A Veteran was indicted for false claims and false statements. An OIG investigation, initiated as a result of a referral from a VBA employee, revealed that the defendant submitted fraudulent military documents to VA in order to receive VA compensation benefits for PTSD. The defendant claimed to be an Air Force Ranger, to have been under fire and engaged in hand-to-hand combat in Vietnam, to have 7 confirmed kills, and to have saved a comrade by carrying him for 6 miles to safety. The investigation revealed that the defendant was a carpenter in the military with no foreign service. These false statements were discovered early in the investigation and prevented the awarding of any VA compensation benefits.

Veteran Indicted for False Travel Claims

A Veteran was indicted for false claims after an OIG investigation revealed that he submitted 146 false travel claims to the Albuquerque, NM, VAMC. The investigation revealed that the defendant was certifying that he was traveling approximately 400 miles roundtrip when in actuality he was residing in Housing and Urban Development-Veterans Affairs Supportive Housing in Albuquerque, NM. The loss to VA is approximately \$24,000.

Health Care Worker Pleads Guilty to Theft

A healthcare worker at a VA contracted facility pled guilty to theft and was sentenced to 30 days' incarceration, ordered to have no contact with the Veteran for 10 years, to pay restitution of \$9,303, and not to have any employment (paid or volunteer) with vulnerable adults for 10 years. An OIG and local police investigation revealed that the defendant stole VA compensation funds from an elderly Veteran's bank account.

Texas Valley Coastal Bend HCS VA Nurse Educator Indicted for Forgery

A VA nurse educator at the Texas Valley Coastal Bend HCS was indicted for forgery, tampering with Government records, and misdemeanor perjury. An OIG investigation revealed that the defendant falsified training records by forging the signatures of several VA employees on fraudulent course rosters and posting the data to the VA Talent Management System in an attempt to obstruct a VHA audit of the Resuscitation Education Initiative Program. The defendant also lied to OIG special agents during the course of the investigation resulting in the misdemeanor perjury charge.

Former Rochester, New York, VA Employee Arrested for Workers' Compensation Fraud

A former Rochester, NY, CBOC employee was arrested for making false statements to obtain Federal employee compensation. An OIG and Department of Labor (DOL) OIG investigation revealed that the defendant, who claimed an on-duty back injury and that she could only work for VA a limited number of hours each day, failed to disclose to DOL or VA that she was working at a liquor store that she owned and operated. The

defendant was observed on numerous occasions working at her store after her limited shift at VA.

Veteran Pleads Guilty to Theft and Making False Statements

A Veteran pled guilty to theft of Government funds and making false statements after an OIG, Postal Service OIG, and DOL OIG investigation revealed that he was committing Workers' Compensation fraud against the Postal Service and disability fraud against VA by claiming he could not work due to his medical issues. The investigation further determined that the defendant was coaching little league sports, going on vacations, breeding and selling dogs for profit, and lifting heavy objects. The loss to VA is \$51,269 and the loss to the Postal Service is in excess of \$288,000.

Veteran Pleads Guilty to Threats and False Impersonation

A Veteran pled guilty to interstate threats against VA employees and false impersonation of an officer or employee of the United States. An OIG, Defense Criminal Investigative Service, and Immigration and Customs Enforcement investigation revealed that the defendant submitted a fraudulent DD-214 to VA that misrepresented his true level of functioning. The defendant also impersonated military personnel, participated in civilian contracted military exercises, taught martial arts, and brought and sold military grade lasers overseas while fraudulently collecting VA compensation benefits. When the Veteran learned he was about to have his benefits reduced, he threatened to kill VA employees. The loss to VA is \$120,093.

Asheville, North Carolina, VAMC Supply Technician Arrested for Misuse of a Government Purchase Card

An Asheville, NC, VAMC supply technician was arrested for misuse of a Government purchase card. An OIG investigation revealed that the employee made 17 unauthorized purchases over 5 days, beginning the day the card was issued. The current loss to VA is \$4,293.

Fugitive Felon Arrested with Assistance of OIG and VA Police Service

OIG and VA Police Service assisted the local police with the arrest of a Veteran at the Asheville, NC, VAMC. The fugitive was wanted for discharging a firearm into an occupied residence and assault with a deadly weapon with intent to kill.

Fugitive Loma Linda, California, VAMC Employee Arrested with Assistance of OIG

OIG assisted a local sheriff's office with the arrest of a Loma Linda, CA, VAMC housekeeping supervisor wanted for a dangerous drug violation. During a search of the subject incident to the arrest, agents found hidden inside the employee's sock a plastic bag containing a white substance and a glass pipe. A field test of the white substance tested positive for methamphetamines. The employee was transported by the local sheriff's office, and a new charge was filed for possession of controlled substances. The employee has an extensive drug history and is pending judicial and administrative procedures.

A handwritten signature in black ink, appearing to read "Richard J. Griffin". The signature is written in a cursive style with a prominent initial "R".

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

GEORGE J. OPFER
Inspector General