



Department of Veterans Affairs

Office of Inspector General

August 2013 Highlights

CONGRESSIONAL TESTIMONY

OIG Promises Vigorous Follow Up on Atlanta, Georgia, VA Medical Center Mental Health Services at Senate Veterans' Affairs Committee Field Hearing

Dr. Michael L. Shepherd, Senior Physician, Office of Healthcare Inspections (OHI), testified at a field hearing of the Committee on Veterans' Affairs, United States Senate, in Atlanta, GA, on two April 2013 Office of Inspector General (OIG) reports on the mental health care at the Atlanta, GA, VA Medical Center (VAMC). His testimony outlined the findings of those reports which includes deficiencies in the administration of the acute mental health inpatient unit and deficiencies in administration, tracking, and monitoring of contract mental health services and the clinical impact. Dr. Shepherd assured the Committee that OIG will continue to review actions by the Atlanta VAMC to implement our recommendations. Dr. Shepherd was accompanied by Mr. Murray Leigh, Director of the Healthcare Financial Analysis Division, OHI.

OIG REPORTS

Review Finds Legionella Prevention Compliance Varies Across VA System, OIG Makes Four Recommendations for Improvement

OIG's OHI conducted a review to assess how VHA medical facilities manage prevention of Legionnaires' Disease at the request of the VA Secretary, Senator Robert P. Casey, Jr., Congressman Tim Murphy, and the Chairmen and Ranking Members of the House Committee on Veterans' Affairs and the Senate Committee on Veterans' Affairs. VHA Directive 2008-010, *Prevention of Legionella Disease*, outlines specific measures that VA facilities should follow to monitor and reduce Legionella in the water distribution system. OIG found that compliance with the directive was variable. VHA is currently in the process of revising Directive 2008-010. OIG recommended that the USH address the reported compliance issues when revising the directive and provide a plan that simplifies and monitors its implementation. VHA Directive 2008-010's risk stratification criteria are based at the facility level and focus on transplant facilities. OIG recommended that the USH consider re-evaluation of the current stratification of facilities that focuses on transplant status. OIG also recommended that the USH institute a national-level water safety committee that will provide expert and technical assistance for collaborative decision-making at the local level in the control and prevention of waterborne disease. The USH concurred with the findings and recommendations and provided an acceptable action plan.

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

National Review Finds No Widespread Systemic Reuse of Insulin Pens on Multiple Patients

OIG's OHI conducted an inspection to evaluate how VHA followed up on the inappropriate use of insulin pens at the VA Western New York HCS, Buffalo, NY, and to determine what controls VHA has in place to minimize the risk of other incidents involving insulin pens and similar devices. OIG conducted the inspection at the request

of the Ranking Member, Senate Committee on Veterans' Affairs. Although two other VHA facilities reported isolated incidents of nurses using insulin pens on multiple patients, OIG found no evidence of widespread, systemic reuse of insulin pens on multiple patients. Further, OIG found that VHA has processes in place to identify important patient safety alerts and disseminate this information to facility managers, and numerous policies and procedures in place to address infection prevention. OIG recommended that the USH implement procedures to ensure that future VHA internal assessments resulting from adverse events include clear guidance to facilities on minimal required steps and supporting documentation; require facilities to develop processes for assessing the risks and benefits of adopting new medical products or devices that may require significant changes in nursing procedures; and ensure that facility nursing education departments are sufficiently staffed to provide comprehensive and ongoing nursing education, especially when adopting new medical products or devices that may significantly change nursing procedures. The USH concurred with our findings and recommendations and provided an acceptable action plan.

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

Suspension of Inpatient Care at Fort Wayne Facility Shows Need for VHA Policy When Major Clinical Services Are Paused

OIG conducted an inspection at the request of Senator Joe Donnelly and Congressman Marlin Stutzman regarding the suspension (pause) of all inpatient admissions at the Fort Wayne campus (facility) of the VA Northern Indiana Healthcare System (HCS) in October 2012. OIG was asked to review overall quality of care and management at the facility, define what issues led to suspension of inpatient care, and determine what measures need to be taken to return the facility to normal operations. As of May 2013, inpatient operations had not resumed at full capacity but were being phased in. OIG determined that the facility, VISN 11, and VHA could have improved communication to stakeholders regarding the pause. In view of recurring qualitative issues relating to patient care, lack of long-term stability in upper and mid-level leadership positions, and workload, VISN 11 may need to consider the scope of services the facility is capable of reliably providing, namely, the appropriate designation for Intensive Care Unit (ICU) level care in the near term and whether an ICU is viable in the long term. OIG recommended that VHA develop policy and guidance for facilities when major clinical services are paused, that the VISN Director ensure the assigned ICU level of care is commensurate with facility capabilities, that the facility Director ensure that recruitment efforts continue for vacant leadership positions, that nurse competencies are consistently completed and validated, and that the nurse staffing methodology is fully implemented. The USH, VISN, and facility Directors concurred with the inspection results. OIG will follow up on the planned actions until they are completed.

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

OIG Recommends Chaperone Policy Education for Primary Care Clinic Staff at VA Puget Sound HCS, Seattle, Washington

At the request of Senator Patty Murray, OIG's OHI conducted an evaluation in response to allegations brought forth by a patient related to a dermatology examination the patient received at the Seattle Division of the VA Puget Sound HCS, Seattle, WA. OIG did not

substantiate that the examination was unnecessary as alleged. However, OIG found the provider did not ensure a chaperone was present during the examination as required. OIG did not substantiate allegations that the provider nudged and pushed the patient, did not wash her hands, or had ragged and unkempt fingernails. OIG substantiated that the provider did not wear gloves during the examination as alleged but determined the use of gloves was not indicated and that this was appropriate practice. OIG substantiated that the window in the examination room was not covered but determined the window was not covered to aid the provider's diagnostic exam and it was unlikely the patient's privacy was breached. OIG found that system staff did not fully respond to the patient's concerns and did not report the patient's allegations in accordance with Federal regulation and VHA policy. OIG recommended the System Director ensure the Women Veterans Program Manager provides chaperone policy education to all primary care clinics. OIG also recommended the System Director ensure all staff are informed about the VHA requirement to report allegations of patient abuse and educated on the processes for reporting the alleged abuse.

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

Veterans Benefits Administration Needs To Do Better Job Verifying Payments on Foreclosure Maintenance, Closer Oversight Could Reduce Safety Risks

OIG conducted this audit to determine if the Veterans Benefits Administration (VBA) Loan Guaranty Service (LGY) approved payments for allowable expenses submitted by VA's foreclosed property management contractor. In addition, the audit determined whether LGY ensured properties met safety, preservation, and maintenance requirements. LGY made payments for 528 of 890 individual expense items not supported by vendor invoices. This occurred because LGY did not ensure the contractor complied with the contractual requirement to provide the documentation necessary to demonstrate the appropriateness and legitimacy of expenses claimed for reimbursement. As a result, OIG found LGY made approximately \$64,400 in payments from October 2010 through March 2012, for expense reimbursements submitted by the contractor without adequate supporting documentation. In addition, LGY did not timely notify the contractor of property maintenance exceptions that posed safety hazards or risk of immediate deterioration, or consistently ensure correction of these issues. This occurred because LGY policies did not require LGY staff to report maintenance exceptions and ensure correction. OIG recommended the Under Secretary for Benefits (USB) ensure VBA's contractor provides vendor invoices to substantiate claimed expenses prior to reimbursement by LGY and determine whether it is cost effective to initiate recovery of improper payments. Additionally, OIG recommended the USB develop policies that ensure LGY staff report maintenance exceptions when identified and ensure contractor correction. The USB concurred with Recommendations 1 and 3 but did not concur with Recommendation 2. OIG revised Recommendation 2 to recognize that LGY can decide if recouping these improper payments from the prior property management contractor is cost effective. However, OIG reiterated that VBA paid some expenses that were not supported by sufficient evidence. Without adequate documentation to support expenses claimed, LGY cannot ensure prudent use of taxpayer funds in compensating the contractor for managing VA-owned foreclosed properties. [\[Click here to access report.\]](#)

Veterans Health Administration Can Increase Rebates and Save \$120 Million by Maximizing Use of Purchase Cards for Micro-Purchases

OIG conducted this audit to evaluate whether opportunities exist for VA medical facilities to increase purchasing efficiency and cost effectiveness by increasing purchase card use for micro-purchases. During fiscal year 2012, the Veterans Health Administration (VHA) spent about \$3 billion on micro-purchases of \$3,000 or less for supplies and services. VA's Purchase Card Program allows VHA to streamline the procurement process and earn rebates from purchase card use. Although VHA has increased purchase card use over the past 5 years, opportunities still exist for VHA to achieve significant procurement savings. OIG estimated VHA could decrease procurement-processing costs by about \$20 million and receive additional rebates of about \$4 million annually by maximizing purchase card use for micro-purchases. VHA did not identify micro-purchases and establish yearly goals for using purchase cards. Additionally, VHA did not implement mechanisms to ensure purchase card use or establish policies and procedures requiring the Veterans Integrated Service Networks (VISNs) to perform oversight of non-purchase card micro-purchases. As a result, VHA could miss opportunities to achieve procurement savings ranging from approximately \$102 to \$133 million over the next 5 years, with an estimate of \$120 million. OIG recommended the Under Secretary for Health (USH) work with the VA Office of Management to establish policies and procedures to regularly identify and evaluate micro-purchases, and establish annual and long-term strategic goals to increase the percentage of VA medical facility purchase card micro-purchases. Additionally, OIG recommended the USH collaborate with the VA Office of Management to implement procedures to ensure purchasers and approvers adequately consider purchase card use for micro-purchases, including requiring VISNs to perform oversight of non-purchase card micro-purchases. The USH concurred with our findings and recommendations and has a plan for corrective action. [\[Click here to access report.\]](#)

OIG Makes Four Recommendations to Improve Contracted Counseling Services at Vet Centers

OIG completed an evaluation of Vet Center contracted counseling services. The purpose of the evaluation was to: (1) determine if VA required contractors to complete specific components of client documentation in accordance with Readjustment Counseling Service (RCS) policy, (2) determine if managers provided appropriate oversight for the contracted clinicians' required client documentation, (3) assess the management and oversight of contracted care based on compliance with the contract, and (4) determine if invoicing practices complied with RCS contract requirements. OIG conducted onsite and remote reviews for a random sample of 30 Vet Centers during the weeks of June 11 and 18, 2012, and reviewed psychosocial assessments and initial treatment plans for clients who received contracted counseling services during the study period from April 1, 2011, through March 31, 2012. OIG identified six areas where Vet Centers needed improvement. OIG recommended that team leaders (1) receive, review, and approve psychosocial assessments and counseling plans prior to authorizing contracted counseling services; (2) conduct and document client assessments after 1 year of eligibility for contracted client services; (3) conduct annual

onsite quality reviews for contractors who participate in the Contract for Fee Program; and (4) authorize contracted counseling services in accordance with RCS and VHA policy. OIG also recommended that RCS use a standard template that includes terms and conditions that are consistent with those in the RCS policy and maintain and monitors counseling service contracts in accordance with RCS and VHA policy. [\[Click here to access report.\]](#)

Inspection Results for Clinics in Multiple VAMCs

OIG reviewed the Louis A. Johnson VAMC's four Community Based Outpatient Clinics (CBOCs) during the week of March 18, 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 Gassaway-Braxton County CBOC, Sutton, WV, 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 three 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 VA Pittsburgh HCS's five CBOCs during the week of March 18, 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 Carl Vinson VAMC's three CBOCs during the week of June 3, 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 Charlie Norwood VAMC's two CBOCs during the week of June 10, 2013. OIG noted opportunities for improvement and made a total of seven recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

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

OIG reviewed the VA Connecticut HCS's six CBOCs during the week of June 24, 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 VA Central California HCS's three CBOCs during the week of June 17, 2013. OIG noted opportunities for improvement and made a total of two recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

OIG reviewed the Philadelphia VAMC's three CBOCs during the week of April 1, 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 Chillicothe VAMC's five CBOCs during the week of March 18, 2013. OIG noted opportunities for improvement and made a total of five recommendations to the VISN and facility managers. [\[Click here to access report.\]](#)

Results for Benefits Inspection for VA Regional Office Milwaukee, Wisconsin

OIG evaluated the Milwaukee, WI, VA Regional Office (VARO) to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 8 of 49 disability claims reviewed. OIG sampled claims considered to be at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Claims processing lacked consistent compliance with VBA procedures and resulted in paying inaccurate and unnecessary financial benefits. Specifically, 6 of 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate. Errors in processing the temporary evaluations generally occurred because VARO staff did not enter suspense diaries into the electronic record or take timely action to reduce benefits as appropriate. Additionally, staff incorrectly processed 2 of 19 traumatic brain injury (TBI) claims. VARO managers ensured Systematic Analyses of Operations (SAOs) were complete and timely. However, staff did not always accurately address Gulf War Veterans' entitlement to mental health treatment. VARO staff provided adequate outreach to homeless Veterans in the VARO's area of jurisdiction; however, OIG could not fully assess the effectiveness of these outreach activities because VBA needs performance metrics for its homeless Veterans outreach program. OIG recommended the VARO Director should implement a plan to ensure staff review for accuracy the 294 temporary 100 percent disability evaluations OIG provided at the end of this inspection. The Director concurred with our recommendation. Management's planned actions are responsive and OIG will follow up as required. [\[Click here to access report.\]](#)

Results for Inspection of VARO Albuquerque, New Mexico

OIG evaluated the Albuquerque, NM, VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 23 (40 percent) of 58 disability claims reviewed. OIG sampled claims considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Specifically, 13 of 30 temporary 100 percent disability evaluations OIG reviewed were inaccurate. These errors generally occurred because VARO staff did not establish controls to request future medical reexaminations. Further, VARO staff incorrectly processed 10 of 28 TBI claims. These errors occurred primarily because staff misinterpreted VBA policy for rating a TBI with a coexisting mental condition and used insufficient VA medical examination reports to evaluate TBI claims. Three of the 11 SAOs were either untimely or not completed due to a lack of management oversight. VARO staff did not always properly grant Gulf War Veterans' entitlement to mental health treatment, but provided adequate outreach to homeless Veterans. Due to a lack of performance measures, OIG could not fully assess the

effectiveness of the VARO's homeless Veterans outreach efforts. OIG recommended the VARO Director develop and implement a plan to review all temporary 100 percent disability evaluations remaining from our inspection universe of related claims and take appropriate action. The Director should provide refresher training on processing TBI claims and monitor its effectiveness. The Director should also develop and implement a plan to ensure staff return insufficient medical reports to examiners to obtain the evidence needed to support TBI claims. The Director concurred with our recommendations, although VARO staff did not agree with 5 of the 23 claims processing errors identified. [\[Click here to access report.\]](#)

Results of Inspection of VARO Newark, New Jersey

OIG evaluated the Newark, NJ, VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 21 of 46 disability claims reviewed. OIG sampled claims considered at higher risk of processing errors, thus these results do not represent the overall accuracy of disability claims processing at this VARO. Specifically, 17 of 30 temporary 100 percent disability evaluations were inaccurate. These errors primarily occurred because VARO staff did not take actions to reduce these temporary evaluations as appropriate. Additionally, 4 of 16 TBI claims were incorrectly processed because management did not ensure effective second-signature review of these claims. In general, VARO managers ensured SAOs were complete and timely and staff addressed Gulf War Veterans' entitlement to mental health treatment as required. VARO staff did not provide adequate outreach to homeless Veterans in the VARO's area of jurisdiction. Due to a lack of performance measures, OIG could not fully assess the effectiveness of the VARO's homeless Veterans outreach efforts. OIG recommended the VARO Director implement a plan to ensure staff follow up to reduce temporary 100 percent disability evaluations as appropriate. The Director should ensure staff review for accuracy the 149 temporary 100 percent disability evaluations OIG did not sample during our inspection. Management should develop and implement a plan to ensure second-signature review of TBI claims. Further, management should ensure staff conduct outreach to homeless Veterans in the VARO's area of jurisdiction as required. The VARO Director concurred with our recommendations. [\[Click here to access report.\]](#)

CRIMINAL INVESTIGATIONS

Veteran Indicted for Murder of Another Veteran

A Veteran was indicted for first degree murder and conspiracy to commit first degree murder. A VA OIG, Social Security Administration OIG, Tennessee Bureau of Investigation, and a district attorney investigation revealed that the defendant and his current spouse conspired to murder her previous husband, a combat Veteran and VA beneficiary, by forcing him to overdose on prescription drugs. The defendant and spouse then staged a crime scene to make it appear that the victim committed suicide. The victim's former spouse then fraudulently applied for Dependency and Indemnity Compensation (DIC) benefits, claiming his drug overdose was related to his service connected post-traumatic stress disorder (PTSD). The defendant has agreed to fully cooperate with the upcoming prosecution against his wife in exchange for a reduced sentence. The loss to VA is over \$100,000.

Former Health Care Worker Pleads Guilty to Drug Possession and Tampering

A former health care worker, who provided contract services to VA in 2008, pled guilty to acquiring or obtaining possession of a controlled substance by fraud and tampering with consumer products with reckless disregard. A multi-agency investigation revealed that the defendant stole syringes of fentanyl that were prepared and intended for patients scheduled to undergo a medical procedure and replaced them with syringes that he had previously stolen and filled with saline. The defendant used the stolen syringes to inject himself, causing the syringes to become tainted with his blood that was infected with Hepatitis C. As a result of the defendant's conduct, over 40 patients became infected with Hepatitis C, to include three Veterans. Two of the Veterans became infected during procedures at a private hospital and one during a procedure at a VAMC. As part of the plea agreement, the defendant agreed to a sentence of between 30 and 40 years of incarceration.

Bristol, Virginia, Outpatient Clinic Practical Nurse Pleads Guilty to Drug Theft

A Bristol, VA, Outpatient Clinic licensed practical nurse pled guilty to acquiring and obtaining a controlled substance by misrepresentation, fraud, forgery, deception, and subterfuge. An OIG and VA Police Service investigation revealed that the defendant stole controlled substances from VA patients during scheduled medication counts.

Former Martinsburg, West Virginia, VAMC Nurse Pleads Guilty to Drug Theft

A former Martinsburg, WV, VAMC registered nurse pled guilty to acquiring and obtaining a controlled substance by fraud, deception, and subterfuge. An OIG and VA Police Service investigation determined that on approximately 23 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.

Veteran Indicted for Assault of Waco, Texas, VAMC Psychiatrist

A Veteran was indicted for the assault of a VA psychiatrist at the Waco, TX, VAMC. An OIG and VA Police Service investigation revealed that the defendant choked the doctor while being admitted as a psychiatric inpatient.

Former Fiduciary Arrested for Misappropriation

A former fiduciary was arrested after being indicted for misappropriation by a fiduciary. An OIG investigation revealed that from October 2004 to September 2010 the defendant embezzled approximately \$251,534 by submitting fraudulent accountings and fictitious certificate of deposit forms to VA. In the accountings, the defendant claimed that \$244,857 of the Veteran's assets were in savings and certificate of deposit accounts, when, in actuality, there was less than \$100 in the accounts. The defendant admitted to fabricating the financial records to prevent VA from terminating her as the Veteran's fiduciary.

Veterans Sentenced for VA Compensation Fraud

A Veteran was sentenced to 12 months' home detention, 36 months' supervised release, 100 hours' community service, and ordered to pay \$70,912 in restitution after pleading guilty to wire fraud. A second Veteran was sentenced to 12 months' home detention, 36 months' supervised release, and ordered to pay \$73,737 in restitution after pleading guilty to wire fraud. A third Veteran was sentenced to 8 months' home detention, 36 months' supervised release, and ordered to pay \$56,304 in restitution after pleading 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 that 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 PTSD. A total of 17 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.

Seattle, Washington, VAMC Travel Clerks and Veterans Sentenced for Travel Benefit Fraud

A Seattle, WA, VAMC travel clerk was sentenced to 42 months' incarceration and 3 years' supervised release. A second travel clerk in the same office was sentenced to 37 months' incarceration and 3 years' supervised release. Both defendants were also ordered to pay a total of \$181,114 in restitution after pleading guilty to conspiracy to defraud the U.S. Government and bribery. Two Veterans, who cooperated during the investigation, were sentenced to 3 years' supervised release and ordered to pay restitution of \$23,089 and \$19,992, respectively. A third Veteran was sentenced to 4 months' incarceration, 3 years' supervised release, and ordered to pay restitution of \$21,260. An OIG investigation revealed a scheme in which the travel clerks recruited Veterans to submit inflated and fictitious travel benefit vouchers. The clerks then received kickback payments from the Veterans. The loss to VA is in excess of \$188,000.

Veteran Indicted for VA Travel Benefit Fraud

A Veteran was indicted for false, fictitious, or fraudulent claims and fraudulent acceptance of payment after an OIG investigation revealed that he submitted 259 fraudulent travel claims utilizing 11 different addresses. The defendant and an unindicted co-conspirator also stole appointment slips from a fee basis provider and utilized the stolen documents for travel benefits. The loss to VA is \$18,961.

Veteran Sentenced for VA Travel Benefit Fraud

A Veteran was sentenced to 30 days' incarceration, 36 months' probation, and ordered to pay \$8,882 in restitution after pleading guilty to organized scheme to defraud. An OIG investigation revealed that the defendant submitted fraudulent travel voucher

claims with fictitious addresses to the Miami, FL, and West Palm Beach, FL, medical centers in order to obtain \$8,882 in travel reimbursement payments.

Former Calverton National Cemetery, New York, Mechanic Pleads Guilty to Theft of Workers' Compensation

A former Calverton National Cemetery, NY, mechanic pled guilty to a criminal information charging him with theft of Government funds. An OIG investigation revealed that the defendant, who filed a workers' compensation claim for an on-the-job injury in 2006, was working as a mechanic at an auto body shop. The earnings from this employment, which were not reported to the Department of Labor, Office of Workers' Compensation Program, were in excess of \$10,000 for a period of 5 months. During this period, the defendant claimed he was unable to return to work for VA in any capacity. The defendant, who was receiving \$3,200 per month in workers' compensation benefits, is no longer receiving any benefits.

Former Memphis, Tennessee, VAMC Employee Sentenced for Theft

A former Memphis, TN, VAMC employee was sentenced to 2 years' probation and ordered to pay \$6,792 in restitution after pleading guilty to theft of property over \$1,000. An OIG and VA Police Service investigation determined that the defendant used a Government issued credit card to purchase items for personal use.

Asheville, North Carolina, VAMC Employee Indicted for Obtaining Property Under False Pretenses

An Asheville, NC, VAMC employee was indicted for obtaining property under false pretenses. An OIG investigation determined that the defendant used a Government issued credit card to purchase items for personal use. This was the second time in 2 years that the defendant misused a Government credit card. The loss to VA is \$4,293.

Veteran Arrested for VA Pension Benefits Fraud

A Veteran was arrested for theft of Government funds and false statements. An OIG investigation disclosed that the defendant fraudulently obtained a VA pension by falsifying his initial application and attempting to hide his assets from VA. The loss to VA is approximately \$75,250.

Veteran Sentenced for VA and Workers' Compensation Fraud

A Veteran, who was a former civilian U.S. Navy employee, was sentenced to 24 months' incarceration and ordered to pay \$357,977 in restitution. At sentencing, the defendant paid full restitution to VA. The defendant fraudulently received VA individual unemployability benefits and workers' compensation benefits while actively managing a landscaping business. The loss to VA was \$143,195.

Veteran Sentenced for VA Compensation Benefits Fraud

A Veteran was sentenced to 2 years' incarceration, 36 months' probation, and ordered to pay VA \$654,081 in restitution. An OIG investigation revealed that the Veteran and his wife falsified the Veteran's service-connected disability to include dementia

symptoms. The Veteran and his wife continued to fraudulently report the symptoms to VA for over 20 years in order to obtain VA compensation benefits, VA educational benefits, and Civilian Health and Medical Program of VA medical benefits for the family.

Granddaughter of Deceased VA Beneficiary Sentenced for Theft of VA Benefits

The granddaughter of a deceased VA beneficiary was sentenced to 3 months' incarceration, 12 months' probation, and ordered to pay VA restitution of \$50,073 after pleading guilty to theft of Government funds. An OIG investigation determined that the defendant stole VA DIC benefits that were direct deposited after her grandmother's death in April 2009. The defendant admitted to using the stolen funds for her own expenses. The loss to VA is \$51,227.

Daughter of a Deceased Veteran Sentenced for Theft of VA Benefits

The daughter of a deceased Veteran was sentenced to 6 months' home confinement, 2 years' probation, and ordered to pay VA \$50,674 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits direct deposited into her father's bank account after his death in December 2009.



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