



# Department of Veterans Affairs

## Office of Inspector General

### June 2014 Highlights

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#### CONGRESSIONAL TESTIMONY

##### **Acting Inspector General Testifies Before House Committee on Interim Report on Delays at the Phoenix Health Care System**

Richard J. Griffin, Acting Inspector General, testified before the Committee on Veterans' Affairs, United States House of Representatives, on the Office of Inspector General's (OIG's) [Interim Report – Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System](#). He discussed the interim report as well as the work OIG has remaining in the review and repeated OIG's commitment to working with Department of Justice officials in this review. He stressed the importance of holding leadership accountable for inappropriate scheduling practices and remarked that it will "no longer be a game" once someone loses his or her job or faces criminal charges. Mr. Griffin was accompanied by Ms. Linda Halliday, Assistant Inspector General for Audits and Evaluations. [Click here to access testimony.](#)

#### OIG REPORTS

##### **Veterans Benefits Administration Could Recover \$623 Million in Improper Payments by Offsetting Benefits for Reservists and Guard Members Earning Drill Pay**

OIG conducted this audit to determine whether the Veterans Benefits Administration (VBA) timely processed VA benefit offsets when drill pay was earned concurrently. Federal regulations prohibit reservists and National Guard members from concurrently receiving VA compensation or pension benefits and military reserve pay, referred to in this report as "drill pay," earned while training on weekends and during full-time training events. The audit focused on VA benefits offsets for beneficiaries who concurrently received drill pay during fiscal years (FYs) 2011 and 2012. This data represented the most current audit data available at the time OIG began the audit in August 2013. OIG determined VBA did not timely process VA benefits offsets when drill pay was earned concurrently. VBA did not timely offset 601 (86 percent) of 700 cases OIG reviewed for FYs 2011 and 2012. Of the 601 offsets not timely processed, 553 (79 percent) were not processed and the remaining 48 were not processed within VBA's timeliness standard. According to VBA, higher priorities, such as processing compensation claims, took precedence over processing offsets. VBA also lacked an adequate tracking mechanism, a current cost-benefit analysis, and Systematic Analysis of Operations (SAO) reviews of the drill pay offset process. VBA's unprocessed rate for FYs 2011 and 2012 is not significantly different from the 90 percent unprocessed rate reported in OIG's 1997 audit. Therefore, it is likely VBA has not processed hundreds of millions of dollars in offsets since OIG's previous report. OIG projected VBA has not offset payments of approximately \$48.9 million for FY 2011 and \$95.7 million for FY 2012. If VBA improves controls over drill pay offset processing, OIG projected VBA could recover approximately \$478.5 million from FY 2013 through FY 2017 of additional payments. In total, VBA could recover approximately \$623.1 million in improper payments. OIG recommended the Under Secretary for Benefits (USB) implement measures to ensure drill pay offsets are timely processed, process all offsets for

FYs 2011 and 2012, more effectively track and monitor offsets, update the cost-benefit analysis, and include drill pay offset processing in SAOs. The USB concurred with OIG's recommendations and submitted a corrective action plan.

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

### **Greater Attention To Scheduling Exams for Veterans with Temporary 100 Percent Ratings Could Avoid \$222 Million in Improper Payments**

OIG's objective of this audit was to determine whether VBA took sufficient action to implement recommendation 7 from the 2011 report, *Audit of 100 Percent Disability Evaluations*, which advised a review of all temporary 100 percent disability evaluations and ensure each evaluation has a future exam date entered in the veterans' electronic records. In January 2011, OIG reported that VBA was not correctly evaluating and monitoring 100 percent disability evaluations. OIG projected that VA Regional Office (VARO) staff did not correctly process 100 percent disability evaluations for about 27,500 (15 percent) of 181,000 veterans. The 27,500 disability evaluations included over 9,900 veterans with temporary 100 percent disability evaluations without a future exam date entered in their electronic record. OIG reported that without improved management of these claims, VBA could overpay veterans a projected \$1.1 billion in the next 5 years. VBA reviewed all temporary 100 percent disability evaluations but did not take sufficient action to ensure each evaluation had a future exam date. As of January 2014, VBA identified over 8,300 temporary 100 percent disability evaluations for VAROs to review, of which 7,400 (88 percent) had not been reviewed. OIG estimated 3,100 (42 percent) of these veterans received almost \$85 million in improper benefit payments since January 2012 because these claims lacked adequate medical evidence. OIG remains concerned about VBA's financial stewardship of these claims and projects VBA, without action, could continue making unsupported payments to veterans totaling about \$371 million over the next 5 years. OIG identified a \$456 million (\$85 million plus \$371 million) total impact to the Government. OIG reduced this projection to \$222.6 million because the 2011 projection and report included all benefits before December 31, 2015. OIG determined that almost 1,500 claims folders with temporary 100 percent disability evaluations were located at the VA Records Management Center. Previously, VBA told OIG they implemented the recommendation to transfer claims folders with temporary 100 percent disability evaluations back to the VARO of jurisdiction. OIG recommended the USB ensure VARO staff take appropriate action on temporary 100 percent evaluations within 180 days and transfer from the Records Management Center all claims folders with temporary 100 percent evaluations to the VARO of jurisdiction. The USB concurred with OIG's recommendations.

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

### **Follow-Up Review Shows Overall Improvement in Atlanta, Georgia, VA Medical Center's Oversight of Inpatient & Contracted Mental Healthcare**

OIG conducted an inspection at the request of Senator Johnny Isakson to follow up on two prior reports at the Atlanta VA Medical Center (VAMC), Decatur, GA. OIG evaluated management of care on the VAMC's mental health (MH) inpatient unit, and assessed administration, management, and coordination of the VAMC's contract MH program through which patients receive outpatient MH services at community service boards (CSBs). OIG noted overall improvements in oversight of the inpatient MH unit

and contract MH care program. OIG found that the facility made changes in leadership that enhanced interdisciplinary collaboration and added supervisory processes previously absent from these programs. OIG found that the Under Secretary for Health had issued a memorandum to the field and published a Handbook to provide guidelines and requirements for inpatient MH units. The facility developed and implemented policies and procedures to address hazardous items on the unit, patient off-unit escorts, urine drug screenings, and patient visitation. The facility also established processes to strengthen documentation of patient monitoring and on-unit observation, interdisciplinary communication, leadership oversight, and rigor of the root cause analysis process. OIG found improvements to the facility's administration and coordination of contract MH care with CSBs, billing, and oversight. However, challenges persist in the absence of a centralized repository for CSB patient data, tracking of patients beyond first appointments, and in the transfer of patient information between the facility and the CSBs. OIG recommended that the Facility Director ensure that a standardized and facility-wide repository be developed and implemented to monitor patients referred to CSBs, patients are tracked for follow-up beyond the first contract MH appointment, and that communication is strengthened to better coordinate patient care. [\[Click here to access report.\]](#)

#### **Poor Management of High Risk Patient's Medications Contributed to Accidental Drug Overdose at Tuscaloosa, Alabama, VAMC**

OIG conducted an evaluation in response to allegations that providers at the Tuscaloosa VAMC mismanaged opioid therapy for a high-risk patient and that facility managers did not take appropriate actions after the patient's death. OIG substantiated that facility providers collectively prescribed oxycodone, methadone, and benzodiazepines to a high-risk patient who died of an accidental multi-drug overdose. Three factors contributed to this outcome: (1) the patient's primary care provider (PCP) did not consistently complete key elements of the pain assessment, initiate an opioid pain care agreement, ensure adequate patient monitoring and follow-up after prescribing methadone, or document patient education regarding the specific dangers of methadone; (2) the facility did not ensure access to an interdisciplinary pain management team or Pain Clinic to provide needed services to this patient; and (3) the PCP, MH provider, and Suicide Prevention Coordinator did not ensure communication and coordination of care for this high-risk patient. OIG did not substantiate that the facility covered up the patient's subsequent visit to the facility or delayed the autopsy report. However, the facility did not comply with selected aspects of VHA Directives on clinical reviews and patient safety processes. OIG made seven recommendations. [\[Click here to access report.\]](#)

#### **Expired Inspection Labels Need Attention but Pose No Immediate Hazard to Patients at Northern Arizona VA Health Care System, Prescott, Arizona**

OIG conducted an inspection in response to a complainant's allegations concerning medical equipment with expired preventive maintenance inspections (PMIs). The confidential complainant alleged that equipment with expired PMIs posed an immediate hazard to the safety of patients at the Northern Arizona VA Health Care System (HCS), Prescott, AZ. OIG did not substantiate the allegation that medical equipment with expired PMIs posed an immediate hazard to the safety of patients. OIG found no

evidence of medical equipment failures or malfunctions that contributed to the death, serious injury, or serious illness of any individual. OIG did not substantiate the allegations that all of the respiratory therapy (RT) equipment had expired PMIs, with some exceeding expiration dates by several years, and that several pieces of RT equipment had inspection stickers indicating “routine inspection not applicable.” OIG did not substantiate the allegation that the expectation was for RT equipment to remain in use with expired PMIs. OIG substantiated the allegation that other departments had medical equipment with expired PMIs. OIG found medical equipment with expired or missing safety inspection labels and missing equipment entry numbers. OIG substantiated the allegation that the Biomedical Engineering (BME) Department is “short staffed.” OIG found that the system was allocated four full-time equivalent BME technician positions but did not fill the vacancies of two technicians who terminated their employment. OIG recommended that the System Director initiate actions to address medical equipment with expired PMIs and assess staffing in the BME Department and take appropriate actions to meet the workload requirements.

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

### **OIG Recommends Improvements to Opioid Medication Prescription Processes at VA Western New York HCS, Buffalo, New York**

OIG conducted an inspection at the VA Western New York HCS in Buffalo, NY, in response to allegations that staff prematurely referred critically ill intensive care unit (ICU) patients to the Hospice/Palliative Care Program for hospice care and that providers inappropriately prescribed opioid medications to sedated patients receiving hospice care. Because the HCS predominantly provides hospice care in the community living center (CLC), OIG expanded the review to include CLC patients as well as those who received hospice care in the ICU. OIG did not substantiate the allegations that staff prematurely referred ICU patients to palliative care or that sedated ICU patients received opioid medications that were inappropriate. However, OIG found that because providers in the CLC used narrative text orders for dose increase instructions, pharmacy and on-call physicians were, at times, unaware of opioid medication dose increases made by the CLC nursing staff. In addition, narrative text orders related to opioid infusions placed responsibility for dose increases solely with nursing and lacked recognition of drug pharmacokinetics. Portions of required nursing documentation of patient pain assessments and reassessments were lacking and scanning of paper opioid infusion records was inconsistent in both the CLC and ICU. OIG recommended that the System Director strengthen processes in the CLC to prevent the use of narrative text orders for opioid patient controlled or nurse controlled analgesia and that opioid titration orders include titration parameters. OIG also recommended that the System Director strengthen processes to ensure that nursing pain documentation adheres to Veterans Health Administration (VHA), Veterans Integrated Service Network, and local policies and copies of paper records are available in electronic health records.

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

### **OIG Makes 10 Recommendations for Improvement After Review of 58 Facilities' Controlled Substance Inspection Program**

The purpose of the review was to determine whether VHA facilities complied with requirements related to controlled substances (CS) security and inspections and to

follow up on the OIG report *Healthcare Inspection – Review of Selected Pharmacy Operations in Veterans Health Administration Facilities* (Report No. 07-03524-40, December 3, 2009). OIG performed this review in conjunction with 58 Combined Assessment Program reviews of VHA medical facilities conducted from October 1, 2012, through September 30, 2013. OIG identified opportunities for improvement in conducting annual physical security surveys and correcting identified deficiencies; completing quarterly trend reports and providing them to facility Directors; conducting monthly CS inspections of non-pharmacy areas; completing non-pharmacy inspection activities; performing emergency drug cache quarterly physical counts and monthly verification of seals; validating completion of required drug destruction activities, validating accountability of prescription pads stored in the pharmacy, and verifying outpatient pharmacy written prescriptions for schedule II drugs; and providing annual CS inspector training. VHA can strengthen policy by defining acceptable reasons for missed CS area inspections and providing guidance on CS Coordinator performance of monthly inspections. OIG made 10 recommendations.

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

### **Healthcare Inspection Results for Quality of Care and Staffing Concerns, Salem VAMC, Salem, Virginia**

OIG conducted an inspection in response to quality of care and staffing concerns at the Salem VAMC, Salem, VA. OIG substantiated that post-operative complications for orthopedic and podiatry surgery cases increased in FY 2013. The VAMC has implemented corrective actions and is monitoring for effectiveness. OIG did not substantiate that bowel perforations occurred during surgery requiring ostomies; that a number of outpatients having lung biopsies required chest tube placements and admissions; that patients were being told that they had a spot on their lung and months later were told they had Stage IV lung cancer; or that a dying patient was inappropriately transferred from the emergency department to a medical/surgical unit. OIG also did not substantiate that the administrative officer of the day was admitting patients to units that could not properly care for them resulting in those patients being transferred within minutes of arrival. However, OIG did identify inefficiencies in the admission process and inter-unit transfer patterns. OIG substantiated the subject unit had been staffed for 20 patients. In 2013, the unit's bed capacity increased from 20 to 24 patients. Staffing initially remained the same while the facility monitored the average daily census to determine the unit's resource needs. Additional nursing staff has been hired. OIG did not substantiate that the unit routinely received up to 15 admissions during an 8-hour shift. OIG recommended that the Facility Director continue to monitor and address increases in post-operative infection rates and take appropriate corrective actions when indicated and evaluate the admission process in the emergency department, monitor inter-unit transfer patterns, and take corrective actions as needed.

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

### **Healthcare Inspection Results for Resident Supervision in the Operating Room, Ralph H. Johnson VAMC, Charleston, South Carolina**

OIG conducted a review in response to a complainant's allegation that inexperienced and first-year residents in the Anesthesiology Service at the Ralph H. Johnson VAMC were improperly supervised while in the operating room. OIG conducted an

unannounced site visit at the facility and immediately inspected the operating room. OIG did not substantiate the allegation that anesthesiology residents were inadequately supervised while in the operating room. OIG concluded that supervisory practices and expectations were clearly understood and adhered to by facility attending physicians, residents, and operating room staff. OIG made no recommendations.

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

### **Results for Benefits Inspection of VARO New York, New York**

OIG evaluated the New York VARO to see how well it accomplishes its mission. OIG found that VARO staff did not accurately process 27 (30 percent) of 90 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, generally because VARO staff delayed ordering medical reexaminations on average for 9 months after receiving reminder notifications. VARO staff incorrectly processed 8 of 30 TBI claims. Most of the errors occurred because staff misinterpreted VBA policy for rating a TBI with a coexisting mental condition. Staff also incorrectly processed 6 of 30 claims related to SMC and ancillary benefits. Generally, these errors occurred because VARO staff did not follow VBA policy to forward these complex claims to a specialized team for evaluation. VARO managers ensured SAOs were complete and timely. However, staff inaccurately processed and delayed completion of 14 of 30 rating reduction claims OIG reviewed because management did not prioritize this work. OIG recommended the VARO Director develop and implement a plan to ensure timely and appropriate action on reminder notifications for medical reexaminations and on the 320 temporary 100 percent disability evaluations remaining from our inspection universe. OIG also recommended the VARO Director develop and implement a plan to ensure accurate second signature reviews of TBI claims, routing of higher level SMC claims to a specialized team for processing as required, and prioritization of benefits reduction actions in order to minimize improper payments to veterans. The VARO Director concurred with all recommendations.

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

### **Benefits Inspection Results for Reno VARO, Reno, Nevada**

OIG evaluated the Reno VARO to see how well it accomplishes its mission. OIG found the VARO staff did not accurately process 36 (51 percent) of 71 disability claims reviewed. OIG sampled claims considered at higher risk of processing errors, thus these results do not represent this VARO's overall accuracy in processing disability claims. Specifically, 22 of 29 temporary 100 percent disability evaluations were inaccurate, generally because staff did not timely act on reminder notifications for medical reexaminations. VARO staff incorrectly processed 4 of 14 traumatic brain injury (TBI) claims, primarily by using insufficient medical examination reports. VARO staff also incorrectly processed 10 of 28 special monthly compensation (SMC) and ancillary benefit claims due to lack of training. Nine of 11 SAOs were untimely; 7 of the 9 were also incomplete. Management did not timely complete the SAOs scheduled for FY 2014 due to lack of oversight. Further, VARO staff delayed completion of 15 of 30 benefits reduction cases because management did not prioritize this work. OIG recommended the VARO Director implement a plan to ensure timely and appropriate

action on reminder notifications for medical reexaminations and review and take appropriate action on the 275 temporary 100 percent disability evaluations remaining from our inspection universe. OIG also recommended the VARO Director ensure required staff receives training on identifying insufficient TBI examinations and properly processing SMC and ancillary benefit claims, provide oversight and training on SAOs, and develop a plan to prioritize action on benefit reduction cases. The VARO Director concurred with all recommendations. [\[Click here to access report.\]](#)

### **Community Based Outpatient Clinic Reviews**

In June 2014, the Office of Healthcare Inspections published six Community Based Outpatient Clinic (CBOC) reviews containing OIG's findings at select CBOCs and primary care clinics that fall under the oversight of the parent facilities listed below. The purpose of the CBOC reviews was to evaluate four operational activities:

(1) environment of care, (2) alcohol use disorder, (3) medication management, and (4) designated women's health provider proficiency.

[Huntington VAMC, Huntington, West Virginia](#)

[South Texas Veterans HCS, San Antonio, Texas](#)

[VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon](#)

[Wilmington VAMC, Wilmington, Delaware](#)

[VA Eastern Kansas HCS, Topeka, Kansas](#)

[Hampton VAMC, Hampton, Virginia](#)

### **CRIMINAL INVESTIGATIONS**

#### **Construction Company Owner Sentenced for Service-Disabled Veteran-Owned Small Business Fraud**

The owner of a New Mexico construction company was sentenced to 57 months' incarceration and ordered to forfeit \$1.1 million. The owner's son-in-law was sentenced to 37 months' incarceration and ordered to forfeit \$250,000. Both defendants previously pled guilty to conspiracy and to committing a major fraud against the United States. An OIG investigation determined that the owner of the company paid his stepbrother approximately \$50,000 to use his service-disabled veteran status in order to qualify for and obtain \$10.9 million in VA Service-Disabled Veteran-Owned Small Business (SDVOSB) contracts. The owner's stepbrother previously pled guilty to conspiracy, major fraud, and wire fraud.

#### **Program Manager Indicted for Conspiracy To Defraud the Government**

A defendant was indicted for conspiracy to defraud the Government with respect to claims and false, fictitious, and fraudulent claims. A VA OIG, Defense Criminal Investigative Service, Small Business Administration OIG, Department of Labor OIG, and Federal Bureau of Investigation (FBI) investigation revealed that the defendant, who was a program manager for a small, disadvantaged 8(a) company, was involved in the alteration of two subcontractors' proposals. One of the altered proposals was submitted by a SDVOSB company to the Clarksburg, WV, VAMC. The loss to VA is \$73,793. The other proposal was submitted by another 8(a) company to a Navy facility. The loss to the Navy is \$297,022.

**VA Construction Contractor Pleads Guilty to Bribery, Conspiracy, and Tax Fraud**

A VA construction contractor pled guilty to bribery, conspiracy to defraud the U.S. Government, and tax fraud. An OIG, FBI, and Internal Revenue Service Criminal Investigation (IRS CI) investigation revealed that between 2007 and 2012 the defendant paid over \$671,975 in bribes to a former supervisory engineer at the East Orange, NJ, VAMC in connection with VA contracts. Additionally, the investigation disclosed the defendant and the VA engineer, who was also criminally charged, conspired to set up three companies (one being a fraudulent SDVOSB company) to obtain VA contracts. The VA engineer then directed more than \$6 million worth of VA construction projects to those companies with more than \$3 million being paid to the falsely claimed SDVOSB.

**Veteran Indicted for SDVOSB Fraud**

A veteran was indicted for wire fraud after obtaining payment through a fraudulently obtained SDVOSB contract. The veteran, along with other unindicted co-conspirators, obtained a contract from VA to transport veterans who use wheelchairs and claimed that a service-disabled veteran owned 51 percent of the business. It was further alleged that his company met all criteria to obtain the set aside contract. As a result, the subjects were paid in excess of \$3.2 million. Civil forfeiture provisions were also included as part of the indictment. Also, the purported service-disabled veteran is the subject of further investigation as he had been declared blind and was observed operating a motor vehicle. As a result of the alleged disability, the veteran was paid approximately \$600,000 in VA benefits.

**Former Service Company Employee Sentenced for Theft of VA Equipment**

A former field service engineer for a private company was sentenced to 1 day of time served, 2 years' supervised release with 1 year of home detention, and ordered to pay restitution of \$197,770. An OIG and Food and Drug Administration (FDA) investigation determined that the defendant stole four endoscopy and colonoscopy scopes, valued at \$114,210, from the Fort Wayne, IN, VAMC. The defendant subsequently admitted to the theft of additional scopes, bringing the total value of stolen VA medical equipment to \$220,000.

**Veteran Arrested for Assault on Wilmington, Delaware, VAMC Police Officers**

A veteran was arrested for assault on a Federal officer. An OIG, VA Police Service, and FBI investigation revealed that Wilmington, DE, VAMC police officers, responding to a complaint of a man with a gun, confronted the suspect on VA property and ordered him to drop his weapon. The suspect failed to comply and raised his weapon in an apparent threatening manner. VA Police fired twice and struck the suspect in the hand. The suspect was taken into custody, treated for his injuries, and transported to a local psychiatric facility for evaluation.

**Veteran Arrested for Assaulting Miami, Florida, VAMC Physician**

A veteran was arrested for assaulting a VA physician at the Miami, FL, VAMC. An OIG investigation revealed that the defendant, upset about having to wait to see his physician, shouted obscenities and injured the physician by hitting him with a door.

**Veteran Sentenced for Making Threats to Seattle, Washington, VAMC Police Officers**

A veteran was sentenced to 20 months' incarceration and 3 years' probation after pleading guilty to threatening to murder a Government employee. An OIG and VA Police Service investigation determined that the defendant threatened to kill Seattle, WA, VAMC police officers while they were engaged in the performance of their official duties.

**Veteran Arrested for Stalking VA Employee**

A veteran was arrested for stalking after OIG, VA Police Service, and a local District Attorney's Office investigation revealed that he was regularly sending letters and leaving sexually explicit telephone messages for a VA social worker, formerly assigned to the defendant's care. The defendant had been warned several times by both VA police officers and OIG agents not to have any contact with the victim. The defendant disregarded the warnings and attempted to meet with the victim near her residence. In conjunction with the arrest, a temporary order of protection was issued.

**Long Beach, California, VAMC Employees Arrested for Fraud and Receiving Stolen Property**

A pharmacist, three pharmacy technicians, and a distribution supervisor at the Long Beach, CA, VAMC were arrested for committing computer access fraud and receiving stolen property. An OIG investigation revealed that the defendants diverted non-controlled VA medications or received stolen VA medications. Since 2011, over 16,000 tablets of prescription medications were diverted.

**Former Dayton, Ohio, VAMC Physician Pleads Guilty to Drug Violation**

A former Dayton, OH, VAMC physician pled guilty to aiding and abetting another in the possession of a controlled substance absent a valid prescription. An OIG, State medical board, and Drug Enforcement Administration (DEA) Tactical Diversion Squad investigation revealed that the defendant, who was the supervisor of the VAMC's pain management clinic, wrote VA prescriptions for oxycodone to a veteran and his non-veteran spouse which were then filled at outside pharmacies. The extra oxycodone was intended for the veteran with whom the defendant admitted to having a sexual relationship. As part of her plea, the defendant agreed to permanently surrender her medical license and DEA number after having previously been removed from her position at the VAMC.

**Former Philadelphia, Pennsylvania, VA Contract Employee Sentenced for Fraud**

A former contracted certified nursing assistant working at the Philadelphia, PA, VAMC was sentenced to 5 months' incarceration, 36 months' supervised release, and ordered to pay restitution of \$75,819. An OIG investigation revealed that the defendant submitted false time sheets to her employer, fraudulently claiming that she was working an average of 100 hours per week and causing VA to overpay her \$75,819 in unearned wages. The defendant submitted over \$108,000 in false time sheet hours.

**Northport, New York, VAMC Information Technology Specialist Arrested for Illicit Salary Supplementation**

A Northport, NY, VAMC information technology specialist was arrested for illicit salary supplementation. An OIG investigation revealed that the defendant unlawfully accepted over \$40,000 in gifts, to include expense paid vacations, dinners, golf outings, and concert tickets, from sales representatives working for a telecommunications firm contracted by the VAMC. The gifts were paid to the defendant because of a longstanding relationship he developed with the contractor and not for any specific act.

**Gainesville, Florida, VAMC Medical Support Assistant Arrested for Impersonation Fraud**

A Gainesville, FL, VAMC medical support assistant was arrested for impersonation fraud. An OIG, IRS CI, and local police investigation revealed that the defendant unlawfully obtained veterans' personally identifiable information (PII) with the intent of filing false tax refunds.

**Orlando, Florida, VAMC Work-Study Employee Sentenced for Theft of Government Property**

An Orlando, FL, VAMC work-study employee was sentenced to 12 months' probation after pleading guilty to theft of Government property. An OIG and VA Police Service investigation revealed that the defendant stole Continuous Positive Airway Pressure equipment from the VAMC and then sold and shipped the equipment from the VA mailing facility. The loss to VA is \$29,902.

**Former VA Fiduciary Pleads Guilty to Misappropriation**

A former VA fiduciary pled guilty to misappropriation by a fiduciary and theft of Government funds. VA OIG, Social Security Administration (SSA) OIG, and a State financial crimes task force investigation substantiated that the fiduciary embezzled \$206,368 in VA funds from multiple veterans and collected another \$62,781 in fees from VA that she was not entitled to receive. The fiduciary also embezzled \$23,092 in SSA benefits. The total loss is \$292,242.

**VA-Appointed Fiduciary Sentenced for Theft**

A VA-appointed fiduciary was sentenced to 5 years' probation and ordered to pay restitution of \$45,060 after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds intended for his disabled brother.

**Non-Veteran Sentenced for Identity Theft at the Cleveland, Ohio, VAMC**

A non-veteran was sentenced to 18 months' incarceration after pleading guilty to identity theft. An OIG investigation revealed that the defendant assumed the identity of a veteran and then from September 2010 to March 2013 fraudulently used the veteran's PII to obtain medical care at the Cleveland, OH, VAMC. The loss to VA is \$13,800.

**Veteran Sentenced for Identity Theft and Fraud**

A veteran was sentenced to 48 months' incarceration, 60 months' probation, and ordered to pay \$86,273 in restitution after pleading guilty to aggravated identity theft,

wire fraud, and bank fraud. VA OIG, SSA OIG, Department of the Treasury OIG, and State social and health services investigation revealed that the defendant stole and utilized the PII of two veterans to establish fraudulent VA e-Benefits accounts and re-route service compensation payments to prepaid debit cards. The veteran also utilized Direct Express to set up fraudulent accounts through prepaid debit card-issuing banks in order to launder VA and SSA payments. The defendant obtained PII for over 100 individuals from various sources and caused a combined fraud loss of over \$86,000 to VA, SSA, private individuals, and corporations.

### **Non-Veteran Pleads Guilty to Identity Theft and Conspiracy**

A non-veteran pled guilty to identity theft and conspiracy to obtain property by false pretenses. The defendant failed to appear for sentencing, and the presiding judge issued orders for arrest and set a \$1,000,000 secured bond. An OIG and local law enforcement investigation revealed that the defendant used 26 victims' identities, to include 13 veterans, to fraudulently open more than 150 cable accounts and then sold those accounts to other people.

### **Veteran Sentenced for VA Compensation and Education Benefits Fraud**

A veteran was sentenced to 18 months' incarceration, 36 months' supervised release, and ordered to pay \$89,277 in restitution after pleading guilty to conspiracy to defraud VA. An OIG investigation revealed that the defendant received VA disability compensation and education benefits for injuries not sustained while in the U.S. Marine Corps.

### **Veteran Indicted for "Stolen Valor"**

A veteran was indicted for embezzlement, theft, conversion of Government funds, and obtaining a controlled substance by fraud. An OIG investigation revealed that the defendant submitted altered DD-214s, a fraudulent Purple Heart certificate, and a forged "buddy statement" to VA in support of his claim for post-traumatic stress disorder (PTSD). To date, the defendant has received over \$500,000 in VA compensation benefits.

### **Veteran Sentenced for Theft and False Statements**

A veteran was sentenced to 60 months' probation and ordered to pay VA \$53,270 in restitution after pleading guilty to theft of Government funds and false statements. An OIG investigation revealed that in an effort to support his claims for compensation benefits the defendant feigned a greater degree of hearing loss to VA physicians, made false statements to VA mental health providers, and altered a DD-214 to fraudulently reflect service in Vietnam and to having received a Bronze Star and a Purple Heart.

### **Daughter of Deceased Widow Beneficiary Pleads Guilty to Theft of Government Funds**

The daughter of a deceased widow beneficiary pled guilty to theft of Government funds. An OIG investigation disclosed that the defendant fraudulently stole VA benefits that were direct deposited after her mother's death in March 1993. The loss to VA is \$271,402.

**Son of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds**

The son of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited into a joint account after his mother's death in May 2007. The loss to VA is \$83,472.

**Veteran Pleads Guilty to Theft of VA Pension Benefits**

A veteran pled guilty to theft of Government funds after an OIG investigation revealed he fraudulently obtained VA pension benefits while operating a construction company. The loss to VA is \$33,470.

**Former Home Health Aide Charged With Theft**

A former home health aide, employed by a company contracted by VA to provide home health care services to a blind veteran, was charged with theft of \$7,300 from the veteran's account using multiple wire transfers. An OIG and local police investigation disclosed that the defendant gained access to the veteran's account and hid this fact from her employer because she knew it was against company policy. The defendant confessed that she embezzled the money without the veteran's knowledge.

**Veterans and Non-Veteran Arrested for Drug Distribution**

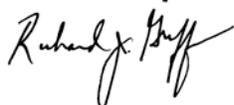
One veteran and one non-veteran were arrested for obtaining controlled substances by fraud, possessing controlled substances, and selling controlled substances to an undercover officer. A second veteran, who is a registered sex offender, was arrested for possessing, transporting, and selling controlled substances to an undercover officer. If convicted, this would be the veteran's third felony conviction, which may result in a life sentence. This veteran's bail was set at \$1,050,000. An OIG and VA Police Service investigation revealed that the defendants were selling controlled prescription pharmaceuticals and illegal narcotics at the Long Beach, CA, VAMC.

**Veteran Sentenced for Drug Distribution at the Lyons, New Jersey, VAMC**

A veteran was sentenced to 6 months' home confinement and 5 years' probation after pleading guilty to possession of a controlled substance. An OIG investigation determined that the defendant, who resided in transitional housing for homeless veterans, sold heroin on numerous occasions to veterans receiving treatment at the Lyons, NJ, VAMC where the transitional facility is co-located. This case was a result of a long-term drug investigation, Operation Red, White, and Blue, which resulted in several defendants being arrested for drug distribution.

**Fugitive Felon Arrested With Assistance of OIG**

An Atlanta, GA, VARO employee was arrested by the local police with the assistance of OIG and VA Police Service. The employee was wanted for aggravated sodomy, aggravated assault, battery (family violence), cruelty to children, and aggravated assault-family violence.



Richard J. Griffin  
Acting Inspector General