



Department of Veterans Affairs

Office of Inspector General

December 2015 Highlights

OIG REPORTS

Allegations of Lapses in Medical Record Documentation Substantiated at Perry Point, Maryland, VA Medical Center Residential Rehabilitation Program

The Office of Inspector General (OIG) conducted an inspection in response to complaints regarding documentation and follow-up of clinical events at the Mental Health (MH) Residential Rehabilitation Treatment Program (RRTP) located at Perry Point VA Medical Center (VAMC). The program is part of the Maryland VA Health Care System (HCS), headquartered in Baltimore, MD. OIG did not substantiate the allegation that facility staff did not follow sufficient practices to manage significant clinical events. OIG substantiated the allegation that some staff did not consistently document significant clinical events in patients' electronic health records (EHR). OIG did not substantiate the allegation that subject policy-makers knew of documentation lapses but took no action to correct them. Prior to OIG's inspection, and for unrelated reasons, the current MH Clinical Center Director identified concerns and took steps to revise and improve MH RRTP documentation processes. OIG found that the MH RRTP medical provider staffing of 1.2 providers was not compliant with the Veterans Health Administration's required minimum core staffing guidelines of 2.3 providers and that staff did not consistently comply with all safe medication management documentation elements. On September 24, 2014, the Chief of Staff approved the hiring of one additional physician and two mid-level practitioners to cover MH programs. OIG recommended that the System Director ensure that MH RRTP medical providers document information pertinent to medical decision-making related to clinical events in the EHR, managers review and address medical provider staffing needs, and staff document in the EHR all required elements of safe medication management for MH RRTP patients. [[Click here to access report.](#)]

Lapses in Training and Patient Identification Noted in Review of In-House Laboratory Testing at VAMC, Cleveland, Ohio

OIG conducted an inspection in response to complaints about lapses in policy compliance and quality oversight for the point of care testing program by Pathology and Laboratory Management Service at the Louis Stokes Cleveland VAMC (facility), Cleveland, OH. A complainant alleged that some facility staff members improperly shared point of care operator identification barcodes with those who had not been issued identification barcodes or whose identification barcodes had lapsed due to lack of training. The complainant also alleged that some patient point of care laboratory values could not be linked to the correct patient's EHR because operators entered incorrect patient identifiers; that management failed to track misuse of operator identifications and incorrect patient identifiers, including unresolved errors; and that testing operators were not trained in accordance with facility policy. OIG substantiated the allegations that some staff shared test operator identifications and improperly entered patient identifiers. OIG did not substantiate the allegation that management failed to track misuse of operator identifiers and incorrect patient identifiers including

unresolved errors. The facility had a process established to track missing or incorrect patient identifiers; however, OIG found that managers did not consistently track errors to resolution. OIG substantiated that staff not trained in accordance with facility policy and procedure were performing tests, and OIG found weaknesses in the training and competency assessment process, which may have been a contributing factor. OIG made four recommendations. [\[Click here to access report.\]](#)

OIG Finds Improper Beneficiary Travel Payments at Three Facilities

VA has the authority to assist eligible beneficiaries in offsetting the cost associated with traveling for certain medical care or services. From December 2014 through April 2015, OIG received three separate allegations of Beneficiary Travel Program (BTP) processing irregularities at the Hudson Valley HCS, located in Montrose, New York; Hampton VAMC, Hampton, VA; and Lexington VAMC, Lexington, KY. OIG either partially or fully substantiated all three allegations. BTP staff at the 3 medical facilities did not consistently approve mileage reimbursement vouchers appropriately and made 1 or more processing errors for 31 of 149 (21 percent) vouchers OIG reviewed for claims during calendar year 2014. As a result, OIG projected these medical facilities improperly approved reimbursements totaling approximately \$37,400 for beneficiaries who claimed travel during 2014. Although individual approved travel reimbursements averaged less than \$26 per trip for the facilities within the scope of this review, if program weaknesses identified occur across VA's facilities nationwide, they have the potential to be significant. Generally, errors occurred because the medical facilities did not fully use all Chief Business Office BTP enhancements and had not developed or implemented formal, routine quality reviews of approved mileage reimbursement vouchers. OIG recommended the Under Secretary for Health ensure facilities improve controls over beneficiary travel mileage processing and determine whether the improper payments identified by the review warrant establishing bills of collections or reimbursing beneficiaries, where applicable. The Under Secretary for Health concurred with the findings and recommendations and provided an appropriate action plan.

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

Results of Benefits Inspection of VA Regional Office, Hartford, Connecticut

Overall, OIG benefits inspectors determined Hartford VA Regional Office (VARO) claims processing staff incorrectly processed 5 of the 33 disability claims (15 percent) selected for review. As a result, 58 improper payments were made to 5 veterans totaling \$49,237. OIG benefits inspectors sample disability claims considered at increased risk of processing errors so inspection results do not represent the accuracy of all disability claims processed at the Hartford VARO. The OIG report indicated VARO staff incorrectly processed 4 of 25 claims related to temporary 100 percent disability evaluations but accurately processed all 5 disability claims related to traumatic brain injuries (TBI)—a significant improvement from the 2011 benefits inspection. During the 2011 review, 18 of the 30 temporary 100 disability evaluations and 7 of the 10 TBI cases OIG sampled contained processing errors. The OIG report also indicated one of the three Special Monthly Compensation and ancillary benefits claims VARO staff processed between July 2014 and June 2015 contained an error. Additionally, VARO staff followed policy and accurately established claims in an electronic system of

records using correct dates of claims for the 30 claims sampled. However, delayed processing actions in 14 of the 30 benefits reduction cases resulted in approximately \$71,709 in improper benefit payments. The improper payments resulted from delays in taking actions to reduce the benefits because VARO management did not place emphasis on timely processing benefits reductions. The Director of the Hartford VARO concurred with all recommendations and OIG plans to follow up to ensure the planned corrective actions were implemented. [\[Click here to access report.\]](#)

Unapproved Wait List, Intra-Departmental Discord Identified in Review of Allegations Concerning Eye Care at Eastern Kansas HCS

OIG conducted an inspection to assess the validity of allegations concerning eye care at the Topeka, KS, and Leavenworth, KS, divisions of the Eastern Kansas HCS. OIG substantiated the allegation that staff used an unapproved wait list for patients awaiting cataract surgery and determined that system leadership did not ensure the staff were adequately trained to use the required surgical scheduling software package. OIG did not substantiate that the unapproved wait list was created to falsify cataract surgery wait times. However, at the time of OIG's onsite review, system leadership had instructed staff to reduce the cataract surgery wait time to no more than 90 days and, to achieve this, had been authorizing Non-VA Care more frequently. OIG substantiated that providers did not consistently enter eye care requests for new Leavenworth VAMC and Topeka VAMC Eye Clinic patients using the consult referral process as required. However, OIG could not substantiate that providers did not follow the required consult process in an attempt to falsify wait times. OIG did not substantiate that cataract surgeries were completed unnecessarily for two identified patients nor that patients were harmed while awaiting surgery. OIG substantiated that ophthalmologists' productivity was below expected thresholds. OIG determined that improved productivity may reduce cataract surgery wait times. OIG found intra-departmental discord and poor communication at the Topeka VAMC and Leavenworth VAMC Eye Clinics and learned that both Eye Clinics had not had a chief for 6 years. OIG recommended that the System Director ensure Eye Clinic Leavenworth VAMC staff use only an approved cataract surgery wait list, that providers use the Computerized Patient Records System for eye care consults, and that system leadership explore and implement measures to improve communication and operations. [\[Click here to access report.\]](#)

Combined Assessment Program Reviews

In December 2015, OIG published three Combined Assessment Program (CAP) reviews and two summary reports containing OIG findings for the facilities listed below. The purpose of the CAP reviews was to evaluate selected health care facility operations. Topics reviewed may vary due to differences in services provided at each facility, the need to follow up on previous CAP findings, or the rotation of CAP review topics over time. The reviews covered the following 12 activities:

- (1) Quality Management
- (2) Environment of Care
- (3) Medication Management
- (4) Coordination of Care

- (5) Computed Tomography Radiation Monitoring
- (6) Advanced Directives
- (7) Surgical Complexity
- (8) Emergency Airway Management
- (9) Quality, Safety and Value
- (10) Magnetic Resonance Imaging Safety
- (11) Suicide Prevention Program
- (12) Acute Ischemic Stroke Care

[Oklahoma City VA HCS, Oklahoma City, Oklahoma](#)
[Royal C. Johnson Veterans Memorial Medical Center, Sioux Falls, South Dakota](#)
[Salem VAMC, Salem, Virginia](#)
[CAP Summary – Evaluation of Magnetic Resonance Imaging Safety in Veterans Health Administration Facilities](#)
[CAP Summary – Evaluation of Acute Ischemic Stroke Care in Veterans Health Administration Facilities](#)

Community Based Outpatient Clinic Reviews

In December 2015, OIG published five 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 seven operational activities:

- (1) Environment of Care
- (2) Alcohol Use Disorder Care
- (3) Human Immunodeficiency Virus Screening
- (4) Outpatient Documentation
- (5) Outpatient Lab Results Management
- (6) Home Telehealth Enrollment
- (7) Post-Traumatic Stress Disorder

[Charles George VAMC, Asheville, North Carolina](#)
[Oklahoma City VA HCS, Oklahoma City, Oklahoma](#)
[Royal C. Johnson Veterans Memorial Medical Center, Sioux Falls, South Dakota](#)
[Salem VAMC, Salem, Virginia](#)
[Louis A. Johnson VAMC, Clarksburg, West Virginia](#)

CRIMINAL INVESTIGATIONS

Civil Settlement Reached with Spiracur, Inc.

The United States Attorney's Office for the Western District of Washington in Seattle has reached a \$3,000,000 civil settlement agreement with Spiracur, Inc., the manufacturer of a wound care product. An OIG investigation revealed the company paid gratuities and bribes to VA clinicians at multiple locations throughout the United States. The company sold approximately \$18,100,000 of the product to VA between January 2011 and September 2015. Sales employees utilized schemes such as paying \$15,000 in "preceptorships" to a full-time VA physician to allow new Spiracur employees

to observe the VA employee treat veteran's wounds while the VA physician was on-duty. In addition, the company paid several VA clinicians "honorariums" to give lectures about wound treatment to other VA clinicians. These lectures usually were held at expensive restaurants during off-duty hours. The company paid two other VA clinicians to give presentations at Spiracur national sales meetings regarding how to identify sales opportunities at VA.

Miami, Florida, VAMC Nurse Pleads Guilty to Obstruction and Altering Computer Records

A Miami, FL, VAMC nurse pled guilty to obstruction and altering computer records. An OIG investigation revealed that the defendant provided substandard care and manipulated patient information that caused the patient in the Surgical Intensive Care Unit to be discharged to a less acute care unit, where the patient later died. The defendant confessed to altering the patient's record to reflect that the vital signs were stable, when in fact they were not. The investigation further revealed that the defendant made additional alterations to the patient's record after his death to conceal the patient's true condition and that he failed to provide medications prescribed by the treating physicians.

Former VA Contractor Sentenced for Paying Gratuity

A former VA contractor was sentenced to 8 months' home detention, 3 years' probation, and a \$20,000 fine after pleading guilty to paying a gratuity. An OIG and Federal Bureau of Investigations (FBI) investigation revealed that the contractor paid gratuities to a Sacramento, CA, VAMC contracting officer (CO) between July 2009 and March 2011. The contractor provided the CO with cash payments, Disneyland® tickets, and hotel accommodations worth approximately \$43,400. Additionally, the investigation also revealed that the former contractor provided a VA contracting officer's representative with cash, a new Ford F-150 truck, and two Disneyland® vacation packages. In exchange for the payments, the former contractor received 27 VA contracts and task orders worth approximately \$7,411,000. Both VA employees previously pled guilty and are awaiting sentencing.

Local Business Owner Pleads Guilty to Conspiracy To Commit Wire Fraud

A local business owner pled guilty to conspiracy to commit wire fraud. An OIG investigation revealed that the defendant filed multiple fraudulent name entities with a county clerk's office, which the filed entities purported to be property management companies. The defendant then conspired with a former Goodwill Industries program manager to steal VA Supportive Services for Veteran Families grant funds by claiming to house homeless veterans in the defendant's non-existent properties. The loss to VA is \$237,793.

Veteran Indicted for Kidnapping, Felony Menacing, and Introducing a Weapon into a Federal Facility

A veteran was initially arrested for assaulting and impeding a Federal employee. An OIG and VA Police Service investigation revealed that the defendant produced a handgun during his medical appointment and held a Denver, CO, VAMC nurse

hostage. The defendant later released the nurse and was disarmed by the VA police. The assault charge was dismissed and the defendant was subsequently indicted for kidnapping, felony menacing, and introducing a weapon into a Federal facility.

Non-Veteran Pleads Guilty to Theft of Government Funds and Aggravated Identity Theft

A non-veteran pled guilty to theft of Government funds and aggravated identity theft. An OIG investigation revealed that the defendant, using the name of an actual veteran, diverted monthly VA compensation benefits by use of a fraudulently established eBenefits account. The defendant also applied for and was granted health care benefits in 2011 by using the veteran's identity. The defendant has been in custody since his arrest because he is considered a flight risk. The loss to VA is approximately \$42,000.

Veteran Sentenced for Assaulting East Orange, New Jersey, VAMC Social Worker

A veteran with an extensive history of violence was sentenced to 46 months' incarceration and 3 years' probation after pleading guilty to assaulting an East Orange, NJ, VAMC social worker. An OIG investigation revealed that the defendant attacked the social worker by striking her with a cane and fracturing her elbow. As the victim tried to escape, the defendant stalked and taunted her by asking if she wanted more. The broken elbow required extensive physical therapy, and the victim suffered emotional trauma and an absence from her duties.

Former Rhode Island State Cemetery Employee Sentenced for Theft of VA Provided Gravestones

A former Rhode Island State cemetery employee was sentenced to 1 year of probation and 200 hours' community service after pleading guilty to stealing granite gravestones VA provided to the Rhode Island Veterans Memorial Cemetery. An OIG and Rhode Island State Police investigation revealed that for several years the defendant removed worn or broken grave markers from the cemetery and brought them to his residence. A search of the defendant's property revealed that approximately 150 VA-provided grave markers were being used as flooring for a shed and two make-shift garages.

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

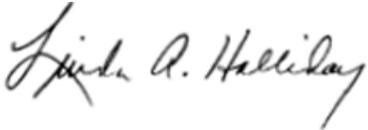
The daughter of a deceased VA beneficiary was arrested after being indicted for theft of Government funds. An OIG investigation revealed that after the beneficiary's death in January 2013 the defendant transferred VA funds from her mother's bank account to her own account. The stolen VA funds were then used for personal expenses. The loss to VA is \$27,632.

Veteran Arrested for Possession with Intent To Distribute a Controlled Substance

A veteran was arrested for possession with intent to distribute a controlled substance. An OIG, VA Police Service, and local law enforcement investigation revealed that the defendant, who was previously enrolled in an in-patient substance abuse treatment program, was selling crack cocaine at the Canandaigua, NY, VAMC. The defendant was arrested at the Charleston, SC, VAMC after it was discovered that he had relocated and was working as a housekeeping employee.

Subject Sentenced for Drug Conspiracy

A defendant was sentenced to 160 months' incarceration, 3 years' supervised release, and ordered to enter into an alcohol and substance abuse program after pleading guilty to drug conspiracy. An OIG and Drug Enforcement Agency investigation revealed that a former Muskogee, OK, VAMC employee, with the assistance of another VA employee and two non-VA employees, stole VA prescription pads from the medical center and used those pads to illegally obtain prescription drugs. The two former VA employees and one additional defendant are awaiting sentencing.



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