



Department of Veterans Affairs

Office of Inspector General

May 2016 Highlights

CONGRESSIONAL TESTIMONY

Inspector General Testifies at Congressional Field Hearing on Past Inspections of Tomah, Wisconsin, VA Medical Center and Opioid Prescribing Practices

Mr. Michael J. Missal, Inspector General, testified at a field hearing held in Tomah, WI, by the Committee on Homeland Security and Governmental Affairs (HSGAC), United States Senate, on May 31, 2016. Mr. Missal, who was sworn in as the VA Inspector General on May 2, 2016, discussed the Office of Inspector General's (OIG) past inspections at the Tomah VA Medical Center (VAMC), in Tomah, WI, and OIG's work in the areas of pain management and opioid prescribing practices. He also discussed actions he has taken since becoming the Inspector General, to include meeting with the HSGAC staff on two occasions to ensure they have the necessary information about OIG's work as it pertains to the Tomah VAMC. Mr. Missal's testimony outlined a timeline of events related to the OIG's Tomah VAMC administrative closure and the reasons why OIG staff believed at the time that an administrative closure was appropriate. He discussed two additional OIG inspections completed in 2015 regarding allegations at the Tomah VAMC as well as two 2016 OIG inspection reports addressing various aspects of VA opioid prescribing practices. OIG's recent work on opioid prescribing practices identified many of the same issues previously reported in OIG's May 2014 national review of VA outpatient opioids and monitoring of patients on opioid therapy—that VA providers were in general non-compliance with *VA/Department of Defense Clinical Practice Guidelines for the Management of Opioid Therapy for Chronic Pain*. Mr. Missal emphasized that the issues associated with the use of opioids to treat chronic pain and other conditions are a serious concern not just at the Tomah VAMC, but throughout the nation. Clinicians vary widely in their chronic opioid therapy prescribing practices within VA and the nation, and there is little agreement regarding the appropriate use of opioids for treating pain, especially chronic non-cancer pain. He was accompanied by John D. Daigh, Jr., MD, CPA, Assistant Inspector General for Healthcare Inspections. [\[Click here to access testimony.\]](#)

ADMINISTRATIVE INVESTIGATIONS

Alleged Prohibited Personnel Practice, Board of Veterans Appeals, Washington, DC

OIG Administrative Investigations Division did not substantiate an allegation that Ms. Laura H. Eskenazi, Board of Veterans Appeals (BVA) Executive in Charge and Vice Chairman, engaged in a prohibited personnel practice or directed members of a screening panel to increase an applicant pool to include a particular employee or that a favored employee would be promoted to a Veterans Law Judge (VLJ) position. This VLJ recruitment action was a highly sensitive and important matter, since the appointments required the approval of the President of the United States, and it was necessary, due to a shortage of VLJs. During the course of the investigation, OIG found that members of the screening panel compromised this recruitment action when

they disclosed applicant information as well as a request to expand the applicant pool to non-panel members. This caused rumors to spread throughout BVA that falsely accused Ms. Eskenazi of trying to influence the recruitment process. There was no guidance given to the panel members prohibiting such disclosures, but a subsequent requirement put into place as a result of this compromise provides specific guidance and requires future panel members to sign confidentiality agreements for these recruitment efforts. OIG also discovered BVA employees misusing their official VA time and resources to send unprofessional and inappropriate email messages. OIG referred this matter to VA to investigate and to consult with the Offices of General Counsel and Human Resources Management to take any appropriate action.

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

OIG REPORTS

Quality of Care Concerns in the Management of a Hepatitis C Patient, Grand Junction Veterans Health Care System, Grand Junction, Colorado

OIG conducted a review to assess quality of care concerns in the management of a Hepatitis C patient at the Grand Junction Veterans Health Care System (HCS), Grand Junction, CO. OIG substantiated the allegation that follow-up care was inadequate and led to further hospitalization. The Hepatitis C care provider often did not provide the care or assess the patient thoroughly when seen. The circumstances of discontinuity of care and the lack of a thorough analysis of the patient's condition may have contributed to his progressive decline and slower recovery. Although not part of the original allegations, OIG also found that contingency plans were not in place to account for reduced availability of the Hepatitis C care provider as he started to decrease his hours. OIG did not substantiate that a non-qualified physician provided Hepatitis C treatment. Neither VA policy nor general practice regarding physicians' credentialing and privileging, ongoing professional practice evaluations, and documentation of education hours require that clinicians have specific evidence of competency to manage Hepatitis C patients. OIG did not substantiate that the patient should have been admitted earlier to the hospital based on laboratory results. OIG found that the patient had an elevated ammonia level that was acknowledged timely and appropriately treated with medication. OIG made one recommendation. [\[Click here to access report.\]](#)

Alleged Improper Management of Dermatology Requests, Fayetteville VAMC, Fayetteville, North Carolina

OIG reviewed allegations that dermatology appointments and consults were improperly cancelled or discontinued in 2011–2012 at the direction of the Director and Chief of Staff at the Fayetteville VAMC (facility), Fayetteville, NC. OIG substantiated that 1,993 dermatology clinic appointments were cancelled and that 3,272 dermatology consults were cancelled or discontinued between January 2011 and December 2012. OIG reviewed 344 randomly selected patient electronic health records and found that 86 percent of patients with cancelled appointments, who still required dermatology care, received care; however, 30 percent waited more than 3 months, and some waited more than 1 year. OIG found no evidence that 45 patients received dermatologic care after their appointments were cancelled. OIG reviewed 299 randomly selected patient

electronic health records and found that while 65 percent of patients with cancelled or discontinued consults, who still required dermatology care, received care, the average wait time was about 13 months. OIG found no evidence that 89 patients received dermatologic evaluation or care after the consults were cancelled or discontinued. A look-back of patients with diagnosed skin malignancies did not disclose cases where cancelled or discontinued dermatology consults in 2011–2012 negatively impacted patients' subsequent diagnoses or treatment. OIG could not substantiate that facility leadership improperly instructed employees to cancel dermatology appointments. Staff interviewed by OIG did not report instances when they were instructed to cancel dermatology appointments without consideration for patients' needs. For the cases reviewed, OIG did not identify instances where patients experienced clinically significant delays in diagnosis or treatment. A shortage of dermatologists at the facility in 2011–2012 contributed to the appointment scheduling and consult completion delays. The facility has since hired additional dermatology providers at its Wilmington location and continues to use teledermatology and Non-VA Care Coordination to meet demand. OIG made two recommendations. [\[Click here to access report.\]](#)

Review of Alleged Misuse of eBenefits Accounts by a VA Supportive Services for Veteran Families Provider

OIG performed this review in response to allegations received through the OIG Hotline in November 2014. This review sought to assess the merits of allegations of misuse of veterans' eBenefits accounts by a Supportive Services for Veteran Families (SSVF) provider. Allegedly, Volunteers of America in Durango, Colorado (VOA Durango), used a veteran's private information on the eBenefits website to obtain documents including, but not limited to, a Certificate of Release or Discharge from Active Duty (DD Form 214). In addition, the complainant alleged a VOA Durango staff member established eBenefits accounts using private information without the veteran's consent. OIG found no evidence that VOA Durango staff or management misused veterans' private information to access eBenefits accounts, or created eBenefits accounts without a veteran's knowledge. OIG reviewed and analyzed dates of veterans' SSVF participation and reviewed eBenefits accounts associated with the participants listed in the allegation. OIG reviewed documentation in the participants' files, including intake forms, eligibility determinations, DD Forms 214, and the services provided to the participants. OIG reviewed internal controls in place to prevent unauthorized creation and access to eBenefits accounts. OIG found the controls for establishing an eBenefits account required two levels of authentication to access a veteran's DD Form 214 used to verify military service. OIG found no evidence in the case files that eligibility documents were obtained from eBenefits accounts without the veteran's knowledge. OIG made no recommendations, and the Director of the New Mexico VA HCS (the parent health care system for veterans care in southwestern Colorado) did not have any comments on this report. [\[Click here to access report.\]](#)

Operating Room Concerns at the Marion VAMC, Marion, Illinois

OIG's Office of Healthcare Inspections (OHI) conducted a review to determine whether leadership responded to complaints at the Marion VAMC (facility), Marion, IL, that the vacuum suction in the operating room (OR) was not adequate for safe patient care and

that patients were harmed as a result of inadequate vacuum suction. OIG did not substantiate that facility leadership failed to respond to complaints regarding insufficient vacuum suction in the OR. Facility leadership initiated multiple actions. OIG did not substantiate that the vacuum suction was unacceptable for safe airway management. In mid-June 2014, testing showed the vacuum suction was meeting the Advanced Cardiovascular Life Support guideline recommendation. OIG did not substantiate the allegation that three patients were harmed as a result of inadequate vacuum suction in the OR. The allegation did not specifically identify the patients who had reportedly been harmed. OIG identified one patient with similar clinical circumstances as one of the three patients described in the allegation. OIG interviewed staff who were involved in the patient's procedure who indicated that, for this patient, the vacuum suction level was adequate. OIG were unable to identify the other two patients who may have suffered harm as alleged. While not part of the original complaint, OIG found inconsistent documentation of repairs and follow-up testing of the facility's medical gas system. On September 22, 2015, OIG requested and subsequently reviewed 4 quarters of the facility's engineering service monitoring tool showing implementation of the action plan to monitor the medical gas system in the OR and post anesthesia care unit. Because the facility had initiated activities to review the finding and implemented action items, OIG made no recommendations. [\[Click here to access report.\]](#)

Review of Alleged Lack of Access Controls for VA's Project Management Accountability System Dashboard

OIG received an allegation that the Office of Information and Technology (OIT) had ineffective access controls over the Project Management Accountability System (PMAS) Dashboard and related project management data and metric reporting information. OIG substantiated the allegation that PMAS Dashboard access controls were inadequate. OIT did not configure 17 of the 18 PMAS Dashboard access groups to provide the least needed access privileges even though VA policy required OIT grant access to VA systems based on the least need (the practice of limiting access to the minimal level that will allow normal performance of duties). Instead, OIT designed these 17 groups to have full user access privileges to the PMAS Dashboard data, regardless of individual user need. This occurred because the OIT director concluded that the PMAS data were not at risk; thus, OIT should not spend limited funds to develop group access ranging from read-only to full access. When requested, OIT staff could not provide a cost analysis identifying the costs to develop access controls. In addition, OIT did not develop user access logs. This prevented OIT from identifying active users and periodically validating their actions. Thus, OIT could not effectively manage its risk to data integrity. Without configuring all the PMAS Dashboard groups to restrict user access to the data, VA does not comply with Federal Information Technology security requirements and VA Handbook 6500, and has assumed unnecessary risks to the integrity of its project management data. OIG recommended the Assistant Secretary for Information and Technology create read-only access to PMAS and ensure each user's access is based on the least needed privilege. OIG also recommended that the Assistant Secretary develop Dashboard access logs and periodically review all users' access to ensure users still have legitimate needs for system access. The Assistant Secretary for Information and Technology concurred with OIG recommendations and

provided acceptable corrective action plans. OIG will monitor their implementation. [\[Click here to access report.\]](#)

Review of Alleged Manipulation of Quality Review Results at VA Regional Office, San Diego, California

In February 2015, OIG received allegations that data integrity and mismanagement issues were occurring at the San Diego VA Regional Office (VARO). The complainant alleged VARO staff altered individual quality review results and hid claims from the quality review process by completing them during overtime hours. To support the allegations, the complainant provided 23 individual quality reviews completed by Quality Review Team (QRT) staff that VARO management had inappropriately overturned. OIG assessed the merits of the allegations and did not substantiate that VARO management inappropriately overturned, altered, or interfered with established procedures for reconsideration of individual quality review errors. OIG also did not substantiate the allegation that staff at the San Diego VARO worked some cases during overtime hours to avoid having the cases undergo individual quality reviews by QRT staff. During the course of OIG review, OIG observed that VARO management did not provide adequate oversight to ensure staff followed its local policy to correct individual quality review errors within 5 days. Of the 50 errors sampled, 39 required corrective actions, such as revised decision documents, while the 11 remaining errors related to actions, such as improper development for evidence, and did not require revised decision documents. OIG also confirmed that the Veterans Benefits Administration (VBA) did not have a timeliness standard for staff to correct individual quality review errors at its 56 VAROs. Delays in correcting the individual quality review errors at the San Diego VARO resulted in improper benefits payments to some veterans. OIG recommended the San Diego VARO Director implement a plan to ensure staff comply with local policy to correct individual quality review errors, as well as take action to correct the backlog of individual quality review errors pending correction. Furthermore, OIG recommended the Acting Under Secretary for Benefits (USB) establish a timeliness standard for VBA staff to correct individual quality review errors. The Acting USB and VARO Director concurred with OIG findings and the corrective actions were responsive to the recommendations. [\[Click here to access report.\]](#)

Review of VA's Compliance With the Improper Payments Elimination and Recovery Act for Fiscal Year 2015

OIG conducted this review to determine whether VA complied with the requirements of the Improper Payments Elimination and Recovery Act (IPERA) for fiscal year (FY) 2015. VA reported improper payment estimates totaling approximately \$5 billion in its FY 2015 Agency Financial Report (AFR), compared with \$1.6 billion for FY 2014, primarily because of improvements in estimating improper payments for four programs. In both years, VA reported improper payment data based on the previous FY activity. VA did not fully comply with IPERA. VA met four of six IPERA requirements for FY 2015 by publishing the AFR; performing risk assessments; publishing improper payment estimates; and providing information on corrective action plans. VA did not comply with two of six IPERA requirements by not maintaining a gross improper payment rate of less than 10 percent and meeting reduction targets for all programs

published in the AFR. Two programs exceeded the 10 percent threshold: VA Community Care and Purchased Long Term Care Support and Services. Eight programs did not meet reduction targets: Compensation; Education Chapter 1606; Education Chapter 1607; VA Community Care; Purchased Long Term Services and Support; Beneficiary Travel; Supplies and Materials; and Disaster Relief Act—Hurricane Sandy. In addition, the Veterans Health Administration (VHA) underestimated improper payments for one program and did not achieve the expected level of accuracy for two others. Likewise, VBA expended considerable effort to collect improper payments because of a program design issue with drill pay, and it needs to develop a plan and seek the assistance of the Office of Management and Budget to coordinate future resolution. OIG recommended that the Under Secretary for Health take steps to reduce improper payment rates, achieve reduction targets, and improve improper payment estimates. OIG recommended that the Acting USB take steps to achieve reduction targets and address the issue of prohibited concurrent payments of certain program benefits and military reserve pay. OIG recommended that the Principal Executive Director, Office of Acquisition, Logistics, and Construction, take steps to achieve the reduction target for one program. VA management concurred with OIG recommendations, and OIG will follow up on corrective actions in the FY 2016 review. [\[Click here to access report.\]](#)

Combined Assessment Program Reviews

In May 2016, OIG published three Combined Assessment Program (CAP) reviews and one summary report 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, Safety, and Value
- (2) Environment of Care
- (3) Medication Management
- (4) Coordination of Care
- (5) Computed Tomography Radiation Monitoring
- (6) Advance Directives
- (7) Mammography Services
- (8) Suicide Prevention Program
- (9) Quality Management
- (10) Pressure Ulcer Prevention and Management
- (11) Nurse Staffing
- (12) Mental Health Residential Treatment Program

[Northern Arizona VA HCS, Prescott, Arizona](#)

[VA Greater Los Angeles HCS, Los Angeles, California](#)

[Richard L. Roudebush VAMC, Indianapolis, Indiana](#)

[Combined Assessment Program Summary Report – Evaluation of Coordination of Inpatient Consults in VHA Facilities](#)

Community Based Outpatient Clinic and Other Outpatient Clinic Reviews

In May 2016, OIG published four Community Based Outpatient Clinic (CBOC) and other outpatient clinic (OOC) 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 and OOC reviews was to evaluate four operational activities:

- (1) Environment of Care
- (2) Home Telehealth Enrollment
- (3) Outpatient Lab Results Management
- (4) Post-Traumatic Stress Disorder Care

[VA Greater Los Angeles HCS, Los Angeles, California](#)
[Carl Vinson VAMC, Dublin, Georgia](#)
[Richard L. Roudebush VAMC, Indianapolis, Indiana](#)
[James H. Quillen VAMC, Mountain Home, Tennessee](#)

CRIMINAL INVESTIGATIONS**Former Augusta, Georgia, VAMC Chief of Fee Basis Convicted of Making False Statements**

The former Augusta, GA, VAMC Chief of Fee Basis was found guilty at trial of making false statements in relation to health care and making a false statement to a Federal agent. An OIG investigation revealed that the defendant instructed four subordinate employees to improperly close approximately 2,700 non-VA care coordination consults at the VAMC. Specifically, the defendant directed his subordinates to falsely document, "Services provided or patient refused services" in the patients' VA electronic medical records even though employees had not reviewed the records or contacted the patients. OIG's OHI conducted a review of approximately 2,700 patient records and determined that over 450 patients never received care and/or refused services. This case was the first OIG "Wait Time" investigation that resulted in criminal charges and a subsequent conviction.

Former Director of the Phoenix, Arizona, VAMC Sentenced for Making a False Statement

The former Director of the Phoenix, AZ, VAMC was sentenced to 2 years' probation after pleading guilty to making a false statement. An OIG and Federal Bureau of Investigation (FBI) investigation revealed that the defendant received over \$50,000 in gifts from a consultant and failed to report those gifts on her financial disclosure reports. The consultant was a former Veterans Integrated System Network Director who previously served as the defendant's supervisor before working for a Washington, DC, consulting and lobbying firm.

Former Palo Alto, California, VAMC Sub-Contractor Sentenced for Providing a Gratuity to a Public Official

A former Palo Alto, CA, VAMC sub-contractor was sentenced to 12 months' home confinement, 3 years' probation, and a \$27,500 fine after pleading guilty to providing a gratuity to a public official. An OIG and FBI investigation determined that the defendant provided VA officials with approximately \$80,000 in bribes and gratuities to include cash, vehicles, airline tickets, hotel stays, payment of credit card bills, and residential construction work. In exchange for the gifts, the VA officials awarded projects to prime contractors who used the defendant as their sub-contractor. As a result of this investigation, two former VA Contract Officer Representatives who received bribes from the defendant were sentenced, and a former VA Contracting Officer is scheduled to be sentenced next month.

Settlement Agreement Between Company and United States Attorney's Office

A settlement agreement was reached between Holiday Acquisition Corp. and Fortress Investment Group, LLC (collectively Holiday), and the United States Attorney's Office, District of Oregon. Holiday agreed to pay \$8.86 million to resolve alleged False Claims Act violations. An OIG investigation revealed that Holiday recruited veteran tenants to reside in their facilities and promised to assist them in obtaining VA pensions with aid and attendance benefits. Holiday also assisted veterans and surviving spouses of veterans in applying for benefits and completed paperwork, including the care expense report. The facilities were described as assisted living facilities, although they were actually retirement facilities. This misrepresentation allowed VA beneficiaries, who would normally exceed the income limits for pension benefits, to qualify by categorizing their rent at the facilities as a deductible medical expense, thereby lowering their income level.

Defendants Sentenced for Conspiracy To Commit Health Care Fraud

A licensed professional counselor was sentenced to 78 months' incarceration, 3 years' supervised release, and was ordered to pay approximately \$7.7 million in restitution after pleading guilty to conspiracy to commit health care fraud. A second licensed professional counselor was sentenced to 6 months' home confinement, 3 years' probation, and was ordered to pay \$199,796 in restitution after pleading guilty to conspiracy to commit health care fraud. Three former VA employees were also sentenced to between 6 months and 1 year of probation and were ordered to pay restitution of between \$868 and \$4,500 after pleading guilty to false statements and/or fraud to obtain Federal employee's compensation. Twenty-eight defendants, comprised of Office of Workers' Compensation Programs (OWCP) claimants (former Postal Service and VA employees), doctors and medical provider employees, a Department of Labor (DOL) Claims Examiner, and a claims representative were charged with various crimes related to their roles in this health care fraud scheme. A VA OIG, United States Postal Service OIG, DOL OIG, Internal Revenue Service (IRS) Criminal Investigations Division (CID), Treasury Inspector General Tax Administration, and Social Security Administration OIG investigation revealed that the defendants' actions caused more than \$9.5 million to be fraudulently billed to the DOL OWCP.

Veteran Charged With Mail Fraud and Structuring Financial Transactions

A criminal information was filed charging a veteran with mail fraud and structuring financial transactions. An OIG and IRS CID investigation revealed that the defendant fraudulently took payments from 16 veterans by promising them that they would receive VA compensation benefits at a 100 percent rating. The veterans believed the payments to the defendant were to be used to pay an attorney to research and file claims with VA. The defendant subsequently stole over \$400,000 from the veterans and never filed a single claim on their behalf.

Former VA Fiduciary Arrested for Misappropriation

A former VA fiduciary was arrested after being indicted for theft of Government funds and misappropriation by a fiduciary. An OIG investigation revealed that the defendant, appointed as a VA fiduciary to manage three veterans' financial affairs, embezzled approximately \$130,000 of VA funds for her own use.

Subject Indicted for Identity Theft

A subject was indicted for use of an unauthorized access device for transactions, aggravated identity theft, and filing false tax returns. An OIG, IRS, and Tampa Police Department investigation revealed that the defendant used patient inquiry sheets that had been stolen from the Tampa, FL, VAMC by a former VA employee in order to facilitate stolen identity refund fraud. The attempted loss is \$795,446, and the actual loss of Government funds is \$167,120.

Veteran Convicted of Health Care Fraud

A veteran was found guilty at trial of health care fraud. An OIG and FBI investigation revealed that from March 1995 to June 2013, the defendant misrepresented his vision loss to VA and as a result was granted a 100 percent service connection for vision loss, special monthly compensation, and other program benefits to which he was not entitled. The defendant was observed walking without assistance, driving with a valid driver's license, and even receiving a speeding ticket. In addition to approximately \$700,000 in monthly VA compensation benefits, the defendant also received a \$10,000 VA grant to purchase an automobile, which was intended for another person to drive the defendant, and an \$11,000 VA grant towards the installation of an in-ground swimming pool at his residence. In addition, the defendant received over \$75,000 in VA health care benefits to which he was not entitled, to include CHAMPVA, dental services, beneficiary travel pay, blind rehab training, and prosthetics equipment and devices. The loss to VA is approximately \$800,000.

Veteran and Sister Plead Guilty To Committing Fraud Against VA

The sister of a veteran pled guilty to delivery of a false writing and the veteran pled guilty to wire fraud. An OIG investigation revealed that both defendants filed forged documents with VA that lead to the issuance of VBA compensation benefits to the veteran and VHA Caregiver Support Program payments to the sister. The veteran claimed to be totally disabled due to a traumatic brain injury (TBI) and other injuries sustained in Iraq and that he was unable to perform tasks of daily living. As a result, VA appointed the veteran's sister to be the full-time caregiver. In actuality, the veteran did

not suffer from a TBI and lived a lifestyle that required no assistance. The sister facilitated the ongoing fraud by continually making statements to VA that she was the full-time caregiver. The loss to VA is approximately \$82,000.

Great-Nephew of Deceased VA Beneficiary Pleads Guilty To Theft of Government Funds

The great-nephew 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 after the death of his great-aunt in November 2009. The loss to VA is \$109,292.

Nephew of Deceased VA Beneficiary Arrested for Theft of Government Funds

The nephew of a deceased VA beneficiary was arrested for theft of Government funds. An OIG investigation revealed that following the beneficiary's death in August 2007, the mailing address on the beneficiary's checking account was changed to the defendant's home address. The defendant then utilized the bank debit card to make numerous cash withdrawals from the account. The loss to VA is \$102,622.

Son of Deceased VA Beneficiary Indicted for Theft of Government Funds

The son of a deceased VA beneficiary was indicted for theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited after the veteran's death in February 2009. The defendant used the funds for personal expenses. The loss to VA is \$70,211.

Wyoming CBOC Nurse Sentenced for Vulnerable Adult Abuse

A VA nurse assigned to a Wyoming VA CBOC was sentenced to 1 to 4 years' incarceration and was ordered to pay the victim \$39,000 in restitution after being convicted at trial of vulnerable adult abuse. Through her position at the medical facility, the defendant met an elderly veteran and convinced him to give her \$39,000 to attend school. The defendant never used the funds for school, instead spending the funds on personal expenses and a vacation.

Subject Arrested for Mortgage Fraud and Wire Fraud

A subject was indicted and arrested for mortgage fraud and wire fraud relating to a VA Home Loan Guarantee. An OIG investigation revealed that the defendant was an acquaintance of a service-connected veteran and used her access to the veteran's personal information to obtain a fraudulent VA Home Loan Guarantee of approximately \$165,000. In order to qualify for the loan and VA Home Loan Guaranty, the defendant provided fraudulent information and documents to the bank.

Non-Veteran Sentenced for "Stolen Valor"

A non-veteran was sentenced to 18 months' incarceration, 12 months' probation, and was ordered to pay VA restitution of \$13,623. An OIG investigation revealed that the defendant falsely represented himself as both a decorated U.S. Marine Corps and California Army National Guard veteran in order to obtain health care benefits from the Redding, CA, VA CBOC. The loss to VA is \$13,623.

Former Manchester, New Hampshire, VAMC Pharmacist Convicted of False Statements

A former Manchester, NH, VAMC pharmacist was found guilty at trial of False Statements. An OIG and VA Police Service investigation, initiated as a result of a possible drug diversion, revealed that the defendant failed to disclose on his employment application that he was terminated by two prior employers for gross misconduct related to suspected diversion and lack of clinical competence.

Lexington, Kentucky, VAMC Physician Sentenced for Assault by Offensive Contact

A Lexington, KY, VAMC physician pled guilty to Assault by Offensive Contact. In its final Order, the court sentenced him to 6 months' incarceration (suspended) and 11 months and 29 days' supervised probation. The defendant was also ordered to stay away from the victim and to suspend his employment with the Lexington, KY, VAMC. *[This section was edited on August 10, 2016.]*

Veteran Pleads Guilty to Making Threats to a Federal Official

A veteran pled guilty to making threats to a Federal official. An OIG and VA Police Service investigation revealed that the defendant was seeking a certain procedure in a non-VA facility located in Florida, although the veteran was a resident of Vermont. Based on the defendant's military discharge he was not eligible for the procedure, even within the VA system. After the veteran learned that the VAMC denied the consult for the non-VA care, the veteran threatened the Chief of Staff and his family. Specific conditions of the veteran's release from custody included home detention with a location monitoring bracelet and no contact with VA staff or property except through the VA Police Service and the emergency room.

Former Mississippi VA CBOC Contract Employee Indicted for Making Threats

A former Mississippi VA CBOC contract employee, who worked as a social therapist, was indicted for making threats. An OIG investigation revealed that the defendant was terminated from employment for egregious administrative violations that included an outside relationship with a female veteran patient. Four days post-termination, the defendant returned to the CBOC with a weapon and paraded in front of the facility.

Little Rock, Arkansas, VAMC Employee Sentenced for Making a Threatening Communication

A Little Rock, AR, VAMC employee, who is also a veteran, was sentenced to 6 months' incarceration, 2 years' supervised released, and was ordered to participate in mental health counseling/anger management classes after pleading guilty to making a threatening communication. An OIG investigation revealed that the defendant made threats to engage in a mass shooting spree at the VAMC.

Veteran Arrested for Making a Terroristic Threat

A veteran was arrested for making a terroristic threat. An OIG and New York Police Department investigation revealed that the defendant made a series of increasingly violent threats on his Facebook page against his VA psychiatrist, VA staff, OIG agents, and their families. The defendant expressed intent to kill as many VA employees as possible before committing suicide.

Former Providence, Rhode Island, VAMC Nurse Sentenced for Drug Diversion

A former Providence, RI, VAMC registered nurse was sentenced to 2 years' probation and was ordered to pay VA \$1,000 in restitution after pleading guilty to theft of Government property and false statements. An OIG and Drug Enforcement Agency investigation revealed that the defendant diverted oxycodone, morphine, hydrocodone, hydromorphone, and lorazepam from the VAMC Pyxis medication dispensing system. Specifically, the defendant would remove medication from the system and indicate in the Pyxis entry that the medication was being removed in order to be administered to a patient who had a doctor's order for the medication. A search warrant was executed at the defendant's residence and VA pharmaceuticals, empty controlled substance packaging, and syringes were seized from the residence. The defendant admitted to stealing 240 controlled substances for a month and ingesting them either while on duty or at her residence. In addition, the investigation revealed that the defendant had previously been terminated from a private hospital for allegedly diverting controlled substances. However, the defendant falsely denied this information during her application for VA employment.

West Haven, Connecticut, Employee Sentenced for Drug Distribution

A West Haven, CT, VAMC Food and Nutrition Service employee was sentenced to 5 years' incarceration (suspended) and 3 years' probation after pleading guilty to the Sale of a Hallucinogenic Narcotic. The defendant had previously been arrested during an OIG and state narcotics task force investigation that was initiated after it was learned that he was selling drugs to veterans and other employees at the VAMC.

Six Jackson, Mississippi, VAMC Employees/Veterans Arrested for Sale of a Controlled Substance and Conspiracy

Six Jackson, MS, VAMC employees/veterans were arrested for sale of a controlled substance and conspiracy. An OIG and state Bureau of Narcotics investigation revealed that numerous transactions involving the sale of VA-issued hydrocodone occurred on VA property between these employees and were later sold to members of the community. The employees involved were assigned to VA Police Service, human resources, transportation services, housekeeping, and pharmacy. Three employees resigned as a result of the investigation and others have been placed on administrative leave pending further judicial action.

Non-Veteran Arrested for Possession With Intent To Distribute a Controlled Substance

A non-veteran was arrested for possession with intent to distribute a controlled substance. An OIG, VA Police Service, and local police investigation revealed that the

defendant was supplying heroin to VA employees who sold the heroin in and around the West Haven, CT, VAMC. The defendant was in possession of more than six bundles of heroin at the time of his arrest. The investigation is ongoing.

Veteran Pleads Guilty to Possession With Intent To Distribute a Controlled Substance

A veteran pled guilty to 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 inpatient substance abuse treatment program, was selling crack cocaine at the Canandaigua, NY, VAMC. The defendant is currently being held in custody until his sentencing after twice violating his terms of release.

Final Co-Conspirator Sentenced for VA Travel Fraud

The final co-conspirator of a group consisting of nine veterans and two former Seattle, WA, VAMC travel clerks was sentenced to 22 weeks' incarceration, 3 years' supervised release, and was ordered to pay restitution of \$4,222 after pleading guilty to False Claims. An OIG investigation revealed that the veterans participated in a scheme with the VA travel clerks to submit inflated and fictitious travel benefit vouchers. In return for processing the fraudulent travel vouchers, the VA travel clerks received cash kickbacks from the veterans. The loss to VA is in excess of \$180,000.



MICHAEL J. MISSAL
Inspector General