CONGRESSIONAL TESTIMONY
Inspector General Testifies on VA Health Care’s Placement on Government Accountability Office High Risk List
The Honorable Michael J. Missal testified before the Senate Committee on Homeland Security and Governmental Affairs at a hearing on select Federal programs placed on the U.S. Government Accountability Office’s (GAO) 2017 High Risk list. GAO initially designated VA Health Care as a high risk area in its 2015 report, and it remains on the list in 2017. Mr. Missal explained that the Office of Inspector General (OIG) and GAO share analogous missions. He highlighted a number of recent OIG reports that complement the five broad areas of concern noted by GAO and underscore the decision to place VA Health Care on its High Risk list. Mr. Missal emphasized the OIG’s commitment to undertake impactful work that will assist VA in providing appropriate and timely services and benefits to veterans and ensuring the proper expenditure of taxpayer funds. [Click here to access testimony.]

OIG Tells Congress VA Must Strengthen Drug-Free Workplace Program Controls
Nicholas Dahl, Deputy Assistant Inspector General for Audits and Evaluations, testified before the Subcommittee on Oversight and Investigations, Committee on Veterans’ Affairs, United States House of Representatives, on the OIG’s work related to oversight of controlled substances and drug free workplace programs at VA facilities. This oversight is necessary to ensure that VA takes the necessary steps to reduce risks to the safety and well-being of veterans and VA employees by having and following the proper program controls. He explained that the OIG’s March 2015 report, Audit of VA’s Drug-Free Workplace Program, identified program weaknesses and determined VA’s Program was not accomplishing its primary goal of ensuring illegal drug use was eliminated and VA’s workplace was safe. He also discussed the results of a January 2017 OIG review of the Atlanta VA Medical Center (VAMC), Decatur, Georgia, that substantiated allegations of a backlog of unadjudicated background investigations and that mandatory drug testing for new hires in certain positions did not occur for a period of at least 6 months between 2014 and 2015. Mr. Dahl was accompanied by Emorfia (Amy) Valkanos, RPh, from the Manchester Office of Healthcare Inspections. [Click here to access testimony.]

OFFICE OF INSPECTOR GENERAL REPORTS
Alleged Violations of Nurse Practitioner Requirements, Carl Vinson VAMC, Dublin, Georgia
OIG conducted a healthcare inspection at the request of Senator Johnny Isakson, Chair of the Senate Committee on Veterans’ Affairs, to assess allegations that nurse practitioners (NPs) lacked appropriate oversight and were operating beyond their scopes of practice in violation of Georgia Board of Nursing (GBON) licensure requirements at the Carl Vinson VAMC (facility) in Dublin, GA. OIG substantiated that
prior to OIG’s visit in 2015, the facility was not in compliance with GBON and Georgia Composite Medical Board (GCMB) requirements for NPs. However, at the time of OIG’s visit, all NPs were licensed through the GBON. OIG substantiated that facility leadership made a concentrated effort to get protocol agreements in place for 12 NPs; however, OIG determined these actions were appropriate. OIG did not substantiate that facility leadership misled the GBON into believing that the requested protocol agreements were for newly hired NPs, because the application forms did not inquire as to NPs’ length of service at the facility. OIG substantiated that a certified Family Medicine NP assigned to the Mental Health (MH) Clinic was treating MH patients and prescribing psychotropic medications in collaboration with a MH physician. Because the American Academy of Nurse Practitioners permitted this practice and the NP was in the position prior to the requirement that NPs be certified in their fields of practice, this was acceptable. OIG did not substantiate that an NP was acting in the role of a physician and prescribing medications outside his/her scope of practice. OIG found that the NP’s scope of practice reflected expected practices and he/she fully complied with prescribing requirements for medications and abided by all limitations on his/her prescription authority. OIG did not substantiate that the facility Chief of Staff knew that NPs were prescribing medications and failed to report it to GCMB. [Click here to access report.]

**Evaluation of Human Immunodeficiency Virus Screening in Veterans Health Administration Outpatient Clinics**

OIG conducted a systematic review of the Veterans Health Administration’s (VHA) outpatient clinics to evaluate for compliance with selected VHA requirements regarding human immunodeficiency virus (HIV) screening. The objectives were to determine whether outpatient clinics complied with the requirements to: (1) identify an HIV Lead Clinician; (2) establish local policies and procedures; (3) provide HIV screening as part of routine medical care; and (4) document informed consent for HIV testing. OIG performed this focused review at 56 VA facilities through a review of facility documents, evaluation of the electronic health records (EHR) of 1,990 outpatients, and discussion with facility staff. OIG estimated that 96.3 percent of facilities identified a Lead HIV Clinician, and 92.6 percent of facilities established policies, procedures, and guidelines for HIV screening. OIG estimated that clinicians offered screening to 66.4 percent of outpatients. OIG did not find documentation of the offer of screening in 28.9 percent of EHRs. OIG estimated that clinicians documented oral informed consent in 75.1 percent and written informed consent in 6.6 percent of records for outpatients screened for HIV. OIG also estimated that informed consent was not documented in 18.3 percent of records for outpatients screened for HIV. OIG recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that clinical staff offer HIV screening as part of routine medical care and document informed consent for HIV testing. [Click here to access report.]
Audit of Veterans Benefits Administration’s Automated Burial Payments

In October 2014, OIG received an allegation that Veterans Benefits Administration’s (VBA) automated burial benefits system was authorizing improper burial payments. OIG evaluated the effectiveness of VBA controls ensuring proper automated burial payments. VBA controls ensured that the majority of automated burial payments were made to living spouses for deceased veterans in accordance with the Code of Federal Regulations (CFR). However, controls did not consistently ensure proper automated burial payments. OIG found VBA improperly authorized 4,525 of 16,406 automated burial payments (about $2.8 million) from August 2014 through January 2015, including payments to spouses who weren’t on veterans’ records at the date of death or who were deceased, multiple payments, and payments to veterans who were still living. This occurred because VBA lacked controls, policies, procedures, and sufficient quality assurance reviews. If VBA does not implement adequate controls, OIG estimated VBA will continue authorizing improper automated burial payments of about $5.6 million annually and approximately $28 million over the next five years. VBA improperly discontinued 68 living veterans’ monthly disability benefit payments totaling $190,267 because VBA had erroneously recorded the veterans as deceased, possibly causing financial hardship to veterans and their families. OIG recommended the Principal Deputy Under Secretary for Benefits, performing the duties of Under Secretary for Benefits, review the improper payments identified during OIG’s audit, take appropriate corrective actions when warranted and strengthen burial payment controls. OIG also recommended he initiate actions to ensure policies and procedures are consistent with CFR and perform quality assurance reviews. The Principal Deputy Under Secretary for Benefits concurred with four of five recommendations and provided acceptable corrective actions plans, but didn’t agree to enforce the requirement that proof of death be submitted prior to the release of automated burial payments. He also provided additional comments which OIG addressed in this report.

[Click here to access report.]

Echocardiography Scheduling and Quality of Care Concerns, Edward Hines, Jr. VA Hospital, Hines, Illinois

OIG conducted an inspection in response to allegations concerning echocardiography scheduling and quality of care concerns at the Edwards Hines, Jr., VA Hospital (facility) in Hines, IL. OIG substantiated the allegation of scheduling delays for 1,226 echocardiography studies during 2014. OIG found that 1,176 requests were performed between 31–120 days, and 50 requests were performed greater than 121 days from requests. For one of the patients whose imaging study was performed greater than 121 days, the scheduling delay resulted in a delay in diagnosing a condition requiring surgery. This scheduling delay had the potential to cause harm, but no apparent adverse effects occurred. To assess the quality of the echocardiography images, OIG reviewed 50 routine echocardiography studies randomly selected from 1,122 studies completed July 1, 2014, through January 12, 2015. In all 50 studies, OIG’s findings were consistent with, or had only minor deviations from, the final written reports documented in each patient’s EHR and none of the deviations were clinically significant. All of the studies were sufficient for clinical decision making. However, OIG found the quality of the majority of the images reviewed was poor and may have been
due to the technicians’ competency. OIG found no documented evidence of performance improvement activities for the echocardiography technicians. The Chief of Cardiology informed us that a formal performance improvement process was not in place for the echocardiography technicians. OIG recommended that the Facility Director ensure routine echocardiographic studies are scheduled according to VHA policy; confer with counsel about a possible patient disclosure and take appropriate action, if any; ensure echocardiography technicians are provided training and continuing education opportunities; and that managers establish performance improvement activities for echocardiography technicians. [Click here to access report.]

**Documentation of Patient Enrollment Concerns in Home Telehealth, John D. Dingell VAMC, Detroit, Michigan**

OIG conducted an inspection in response to allegations concerning the documentation of patient enrollment in home telehealth (HT) at the John D. Dingell VAMC, (facility) Detroit, MI. OIG substantiated that from September 14, 2013, until October 1, 2013, HT program staff entered documentation of monthly HT monitoring for 836 patients. OIG found that 828 of the 836 patients were not properly enrolled in HT. OIG substantiated that HT staff worked overtime (OT) from September 14, 2013, until October 1, 2013, for the purpose of initiating the enrollment process for new HT patients. The documentation included screening notes and monthly monitor notes that met the criteria for patient care encounters (workload) that contributed to the ability of the Associate Chief of Nursing Service for Specialty Services to meet one of two fiscal year 2013 performance measures for telehealth services. OIG substantiated that during the OT hours that HT staff worked on Sunday, September 29, 2013, and after regular working hours on Monday, September 30, 2013, they entered a total of 634 monthly monitor notes. However, OIG found that HT staff were not required to work OT for several weeks to produce documentation on the enrollment of patients in HT program. Rather, they voluntarily worked OT to complete patient enrollment and clean up missing notes. OIG found that without the use of OT during the last 2 days of FY 2013, the facility would not have reached or surpassed its performance goal of 11,724 HT encounters. OIG recommended that the Facility Director ensure HT staff are retrained and that HT documentation accurately reflects enrollment status, review the circumstances surrounding the entry of monthly monitor notes with the Office of Human Resources and the Office of General Counsel, and take appropriate action as necessary. [Click here to access report.]

**Review of Alleged Improperly Sole Sourced Ophthalmology Service Contracts at the Phoenix VA Health Care System**

OIG reviewed this complaint alleging that the Phoenix VA Health Care System (PVAHCS) improperly sole-sourced ophthalmology contracts to Barnet Dulaney Perkins (BDP), and the Chief of Staff and Interim Associate Director had a conflict of interest with BDP. OIG did not substantiate that the PVAHCS improperly sole-sourced ophthalmology service contracts to BPD, but found that the PVAHCS and Network Contracting Office (NCO) 18 used full and open competition to award BPD three ophthalmology service contracts valued at just over $30.4 million, respectively, on February 1, 2006, and October 1, 2009. However, the NCO 18 contracting officer(s) did
not properly maintain contract documentation in eCMS for two contracts. The PVACHS’s issuance of just over $12.4 million in unauthorized commitments to BDP and the lack of recruitment of VA ophthalmologists may have made it appear that these contracts had been sole-sourced. OIG did not substantiate the allegation of a conflict of interest between the named PVACHS officials and BDP because OIG found no evidence that a business, financial, and/or personal relationship existed between them and BDP. The PVAHCS officials had pressured the contracting officer to sole-source additional contracts to BDP because of concerns over possible delays in care and lapses in the continuity of care, but the contracting staff did not give in to the pressure, and the PVAHCS began using VA’s PC3 contracts in March 2015. OIG recommended the Service Area Office West Director ensure the proper maintenance of contracting files and the PVAHCS Director ratify the unauthorized commitments and develop a business case for the provision of ophthalmology services. The NCO 18 provided contract documents almost one year after the start of the review that showed NCO 18 properly awarded the contracts and that the first allegation was unsubstantiated. The PVAHCS and SAOW Directors agreed with the recommendations and provided responsive action plans. [Click here to access report.]

**Audit of Hurricane Sandy Major Construction Relief Funds for the VA New York Harbor Healthcare System**

OIG performed this audit to determine if the VA New York Harbor Healthcare System (NYHHS) received the goods, services, and deliverables VA paid for in accordance with Public Law 113-2, Disaster Relief Appropriations Act, 2013 (the Act), for Hurricane Sandy recovery. OIG found that the goods, services, and deliverables paid for through March 2016, with funds designated for Hurricane Sandy major construction, were received by NYHHS in accordance with the Act. Because NYHHS received the goods, services, and deliverables paid for by the Disaster Relief Appropriations Act, 2013 through March 2016 in accordance with Public Law 113-2, OIG made no recommendations. [Click here to access report.]

**Audit of Alleged Misuse of VHA Funds at the Northern Arizona VA Health Care System**

OIG did not substantiate an allegation that the Northern Arizona VA Health Care System (NAVAHCS) inappropriately used VHA appropriations to purchase Information Technology (IT) items. From September 2012 through March 2014, the NCO for the Veterans Integrated Service Network overseeing NAVAHCS awarded six contracts to obtain various IT items for this and other medical facilities. NAVAHCS paid about $368,000 for multifunctional devices (MFD) with printing functionality and other expenses using VHA appropriations. Although VA’s 2006 policy memo stated that VA should use the IT systems appropriations for MFDs with printer functionality, OIG did not fault NAVAHCS for its decision to use VHA appropriations because of inconsistent guidance on the correct use of funds for similar copier machines connected to a network that could also serve as printers. OIG also determined that NAVAHCS appropriately used VHA funds on the remaining five contracts to purchase commercial software supporting patient care. Because VA issued guidance to clarify VA’s 2006 policy memo during the audit, OIG made no recommendations. [Click here to access report.]
Combined Assessment Program Review
In February 2017, OIG published one Clinical Assessment Program (CAP) follow-up review containing OIG findings for the facility listed below. The purpose of the CAP review 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 review covered the following seven activities:

(1) Quality, Safety, and Value;
(2) Environment of Care;
(3) Medication Management: Anticoagulation Therapy;
(4) Coordination of Care: Inter-Facility Transfers;
(5) Moderate Sedation;
(6) Community Nursing Home Oversight; and
(7) Management of Disruptive/Violent Behavior.

Overton Brooks VA Medical Center, Shreveport, Louisiana

CRIMINAL INVESTIGATIONS

Veterans Health Administration Investigations

Former Atlanta, Georgia, VAMC Physician’s Assistant Sentenced for Acts Affecting a Personal Financial Interest
A former Atlanta, GA, VAMC physician’s assistant was sentenced to 1 year of probation and 90 days' home confinement after being found guilty at trial of acts affecting a personal financial interest. An OIG investigation revealed that from July 2009 to January 2010 the defendant, while employed with VA, accepted $500 per month from a medical supply distributor to promote a wound care product to fellow medical providers. The defendant continuously placed a large amount of orders for the same product, which was paid for by the medical center. The defendant did not disclose to anyone at the medical center that she received compensation based on the sales of the medical product. Further investigation revealed that the defendant also compiled Protected Health Information and Personally Identifiable Information (PII) from veteran/patients she treated on her personal computer, to compare the effectiveness of wound care treatment options, while using the wound care product. The defendant subsequently resigned from VA and accepted a position with the manufacturer of the wound care product as the company’s Director of Clinical Education. The co-defendant, a medical supply distributor, previously pled guilty to Aiding and Abetting Acts Affecting a Personal Financial Interest and was sentenced to 2 months’ probation.

Former West Los Angeles, California, VAMC Payroll Technician Arrested for Wire Fraud and Theft of Government Funds
A former West Los Angeles, CA, VAMC payroll technician was arrested for wire fraud and theft of Government funds. An OIG investigation resulted in the defendant being
charged with two separate schemes to divert funds at the facility. The first scheme involved diverting 136 payroll allotments, totaling $4,689, from the pay of other employees to the defendant’s own bank account. The defendant is also alleged to have generated fraudulent vendor forms and sent them to the Financial Service Center in order to redirect VA suspense payments to bank accounts under his control. The loss associated with this second scheme is $110,424. The employee confessed to the thefts and subsequently resigned.

Former Palo Alto, California, Health care System Physician Pleads Guilty to Prescription Fraud
A former Palo Alto, CA, Health care System physician pled guilty to prescription fraud. For over 2 months, the physician prescribed oxycodone tablets to multiple patients that had no need for this medication. The physician then explained to these patients that he had made a mistake and retrieved the tablets either directly from the patient or by making arrangements to recover them from UPS during the shipping process. The defendant claimed that a dependence on pain medication led him to divert the oxycodone tablets. The physician’s VA employment was terminated.

Two Little Rock, Arkansas, VAMC Pharmacy Technicians and a Pharmacy Technician Student Trainee Indicted for Drug Diversion
Two Little Rock, AR, VAMC pharmacy technicians and a pharmacy technician student trainee were indicted for charges to include conspiracy to defraud, theft of Government funds, possession with intent to distribute, conspiracy to distribute, and possession with intent to distribute. An OIG investigation resulted in the defendants being charged with diverting and distributing 4,000 oxycodone, 3,300 hydrocodone, 308 ounces of promethazine with codeine syrup, and over 14,000 Viagra and Cialis tablets. Three additional VA employees were identified as part of the drug diversion, resulting in a resignation and reassignments. The monetary loss to VA is over $77,000.

Former Minneapolis, Minnesota, VAMC Nurse Charged with Drug Diversion
A former Minneapolis, MN, VAMC nurse was charged with unlawfully procuring, attempting to procure, possessing or having control over a controlled substance by fraud, deceit, misrepresentation, or subterfuge. An OIG investigation resulted in the defendant being charged with entering false patient information into the medical center Pyxis machine in order to obtain hydrocodone and oxycodone for personal use.

Former Wilkes-Barre, Pennsylvania, VAMC Nurse Sentenced for Drug Diversion
A former Wilkes-Barre, PA, VAMC registered nurse was sentenced to 3 years’ probation after having previously pled guilty to knowingly and intentionally obtaining a controlled substance by fraud. The defendant diverted “wasted” morphine and hydromorphone for personal use from the hospice unit from 2014 to 2015.

Veteran Arrested for Travel Benefit Fraud
A veteran was indicted and arrested for theft of Government funds. An OIG and VA Police Service investigation resulted in the defendant being charged with submitting fraudulent travel benefit claims to the San Francisco, CA, VAMC. The defendant
claimed to drive over 500 miles a day roundtrip to the medical center, 4 to 5 days per week for several years. In actuality, the defendant was living in a mobile RV trailer park not far from the medical center. The loss to VA is approximately $159,000.

Veterans Benefits Administration Investigations

VA Fiduciary Indicted for Misappropriation by a Fiduciary and Wire Fraud
A VA fiduciary was arrested after being indicted for misappropriation by a fiduciary and wire fraud. An OIG investigation revealed that the defendant charged a veteran for room/board fees and caregiver fees during 33 months when the veteran was residing in a VA-contracted nursing home. The defendant spent more than $119,000 of the veteran’s funds on personal living expenses.

Veteran Sentenced for VA Compensation Fraud
A veteran was sentenced to 30 months’ supervised probation and was ordered to pay $19,950 in criminal restitution towards a $270,575 civil debt the defendant incurred with VA. The defendant previously pled guilty to making false statements. An OIG investigation revealed that the defendant falsely claimed to suffer from symptoms of narcolepsy and received a medical discharge from the Navy in 1997. The defendant subsequently applied for VA compensation benefits for service-connected narcolepsy, claiming the condition rendered him homebound and unable to work, which was granted at 100 percent. The defendant later became a Federal employee for the U.S. Army Corps of Engineers and utilized his Federal Employee Health Benefits to obtain treatment and medication for the fraudulently claimed condition in furtherance of his scheme to defraud VA. The defendant also provided material false statements to OIG agents, a VA physician, and a rating veterans service representative about his condition and symptoms. As a result of this investigation, the defendant was also terminated from his position with the U.S. Army Corps of Engineers.

Son of Deceased VA Beneficiary Charged With Theft of Government Funds
The son of a deceased VA beneficiary was charged with theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited into his deceased mother’s bank account after her death in June 2003. The defendant’s attorney told agents that the defendant knew he wasn’t entitled to the benefits and was willing to repay the funds. Full restitution of $188,406 was subsequently received by the Government.

Son of Deceased VA Beneficiary Pled Guilty to Theft of Government Funds
The son of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing $106,583 in VA benefits that were direct deposited into his mother’s bank account after her death in February 2009. The investigation also resulted in the commencement of forfeiture proceedings on a recreational boat partially owned by the defendant.
Nephews of Deceased VA Beneficiaries Indicted for Theft
The nephew of a deceased VA beneficiary was indicted for theft of Government funds, bank fraud, and aggravated identity theft. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited after his aunt’s death in August 2007. The defendant also allegedly changed the mailing address on the beneficiary’s checking account and made cash withdrawals from the account using a debit card. The loss to VA is $102,622.

The nephew of a deceased VA beneficiary was indicted for theft of Government funds and social security fraud by concealment. A VA OIG, Social Security Administration (SSA) OIG, and Office of Personnel Management (OPM) OIG investigation resulted in the defendant being charged with stealing his aunt’s VA, SSA, and OPM benefits that were direct deposited to a joint account after her death in September 1995. The loss to the Government was $363,924, to include a loss to VA of $209,274.

Son of Deceased VA Beneficiary Sentenced for Theft of Government Funds
The son of a deceased VA beneficiary was sentenced to 14 months’ incarceration, 3 years’ supervised release, and was ordered to pay $101,060 in restitution after pleading guilty to Theft of Government Funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited after his mother’s death in April 2005.

Son of Deceased VA Beneficiary Pleads Guilty to Making a False Statement
The son of a deceased VA beneficiary pled guilty to making a false statement. An OIG investigation resulted in the defendant being charged with stealing VA benefits that were direct deposited after his mother’s death in May 2008. The defendant also admitted to forging and submitting a Marital Status Questionnaire to VA in order to make it appear that his mother was still alive. The loss to VA is $97,660.

Daughter of Deceased VA Beneficiary Arrested for Theft of Government Funds
The daughter of a deceased VA beneficiary was arrested by the U.S. Marshals Service in Spokane, WA, for theft of Government funds. An OIG investigation resulted in the defendant being charged with stealing VA benefits from her deceased mother’s account after her mother’s death in December 2009. The defendant is also alleged to have submitted two forged Marital Status Questionnaires after her mother’s death. The defendant is currently pending extradition to Texas. The loss to VA is approximately $93,000.

Other Investigations
Civil Settlement Agreement Involving Service-Disabled Veteran-Owned Small Business
As part of a Civil Settlement Agreement between the Government and the two owners of a Service-Disabled Veteran-Owned Small Business (SDVOSB), $132,000 was transferred to the U.S. Treasury. This transfer of funds represents all remaining assets for the company and brings the total recovered to $1,132,000. An OIG investigation
revealed that the defendants secured approximately $30 million in VA SDVOSB set-aside contracts at VA National Cemeteries. The veteran owner admitted that he was not in control of the company and that the co-owner ran the business. The non-veteran co-owner's family business had been awarded contracts at the cemeteries prior to 2007 before the VA National Cemetery contracts started being designated as SDVOSB set-aside contracts.

**Former Medical Clinic Operator Sentenced for Paying an Illegal Remuneration and Conspiracy**
The former operator of a medical clinic was sentenced to 30 months' incarceration and 3 years' supervised release after pleading guilty to paying an illegal remuneration and conspiracy. A VA OIG, U.S. Postal Service (USPS) OIG, Department of Labor OIG, and Department of Homeland Security OIG investigation was initiated after allegations that the clinic was defrauding VA and other Federal agencies by billing for services not provided. In addition, it was also determined that the defendant had paid more than $1 million in kickbacks for the referral of Federal workers' compensation claimants. The judge incorporated into the defendant’s sentence a previously entered forfeiture money judgment of $2,122,543.

**Husband of a Service-Connected Disabled Veteran Pleads Guilty to Misprision of a Felony and Business Associate Pleads Guilty to Wire Fraud**
The husband of a service-connected disabled veteran pled guilty to misprision of a felony and a business associate pled guilty to wire fraud. A multi-agency investigation revealed that more than $350 million in set-aside construction contracts were fraudulently obtained by several individuals who conspired together to create companies for the sole purpose of obtaining set-aside Government contracts. The companies fraudulently claimed to VA and Small Business Administration that they were controlled by veterans, service-disabled veterans, minorities, or women.

**Former Chief Executive Officer of a Non-Profit Sentenced for Obstruction of a Federal Audit**
A former chief executive officer of a non-profit was sentenced to 3 years' probation and 18 weeks' community service after pleading guilty to obstruction of a Federal audit. An OIG investigation determined that the defendant defrauded VA's Homeless Providers Grant and Per Diem Program and made false statements to a VA auditor. The defendant orchestrated the purchase of two properties by the non-profit for $86,000 above the fair market value price in order to obtain excess VA grant funds. After the close of escrow on the properties, the seller made a $50,000 donation to the non-profit. A Federal civil case is pending against the defendant, the non-profit, and the seller of the properties.

**Defendant Convicted of Identity Theft Charges**
A defendant was convicted at trial of aggravated identity theft, access device fraud, conspiracy to commit identity theft, and conspiracy to commit access device fraud. A VA OIG and Federal Housing Finance Authority OIG investigation revealed that the defendant obtained the PII of dozens of VA employees from a former VA employee.
The defendant used the PII of VA employees and of Freddie Mac pension plan participants to run credit reports, to open credit accounts, to make fraudulent purchases at high-end retailers, and to pay for plastic surgery in Miami, FL.

**Contract USPS Driver Arrested for Mail Theft**
A contract USPS driver was arrested for theft and mail theft. A VA OIG and USPS OIG investigation resulted in the defendant being charged with stealing VA packages containing controlled substances. Hydrocodone pills were also recovered from the defendant’s residence.

**Assaults and Threats Made Against VA Employees**

**Augusta, Georgia, VAMC Nurse Arrested for Elder Exploitation**
An Augusta, GA, VAMC registered nurse was indicted and subsequently arrested for elder exploitation. An OIG investigation revealed that the defendant, assigned to the Critical Care Unit (CCU) as a night shift nurse, allegedly punched an intubated CCU patient in the face and head area and concealed the physical assault by covering the telehealth camera lens in the patient’s room with medical tape. The patient sustained injuries from the assault. The defendant was removed from patient care pending the result of the investigation and the medical center is now proposing termination.

**Fugitive Felons Arrested With OIG Assistance**
A veteran, wanted for bank robbery and unlawful flight to avoid prosecution, was taken into custody without incident at the Seattle, WA, VAMC with the assistance of OIG. A fugitive veteran was arrested at the East Orange, NJ, VAMC by U.S. Marshals Task Force members with the assistance of OIG. The fugitive was wanted for a parole violation related to a bank robbery conviction. During a search incident to arrest, the fugitive was found to be in possession of heroin.

**ADMINISTRATIVE SUMMARIES OF INVESTIGATION**
OIG conducted extensive work related to allegations of wait time manipulation after the allegations at the Phoenix VA Health Care System in April 2014. Since that event and through FY 2015, OIG received numerous allegations related to wait time manipulation at VA facilities nationwide from veterans, VA employees, and Members of Congress that were investigated by OIG criminal investigators.

At this time, OIG has completed more than 90 criminal investigations related to wait times and provided information to VA’s Office of Accountability Review for appropriate action. As other administrative summaries of investigation are completed, OIG intends to post them to our website so that veterans and Congress have a complete picture of the work conducted in their state.

You may view and download these administrative summaries of investigation by clicking on the link to our webpage at [www.va.gov/oig/publications/administrativesummaries-of-investigation.asp](http://www.va.gov/oig/publications/administrativesummaries-of-investigation.asp) and selecting the appropriate state.
### Administrative Summaries of Investigation (February 2017)

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MICHAEL J. MISSAL  
Inspector General