Department of Veterans Affairs
Office of Inspector General
May 2017 Highlights

CONGRESSIONAL TESTIMONY

Deputy Assistant Inspector General for Audits and Evaluations Testifies Before the House Committee on Veterans Affairs Subcommittee on Oversight and Investigations on VA Financial Management

Mr. Nick Dahl, Deputy Assistant Inspector General for Audits and Evaluations, Department of Veterans Affairs (VA), Office of Inspector General (OIG), testified before the House Committee on Veterans' Affairs Subcommittee on Oversight and Investigations on the results of the audit of VA's consolidated financial statements and its progress on reducing improper payments. Mr. Dahl focused on the increase in material weaknesses from fiscal year (FY) 2015 to FY 2016 and the elevation of a significant deficiency to a material weakness. The new material weaknesses relate to (1) education benefits accrued liability and (2) actuarial estimates for compensation, pension, and burial benefits. The issue of the relationship between VA's Chief Financial Officer (CFO) and Veterans Health Administration's (VHA) CFO was elevated from a significant deficiency. The Subcommittee and the hearing witnesses also discussed the definition of improper payments and efforts to reduce them. Mr. Dahl was accompanied by Ms. Sue Schwendiman, Director, OIG Financial Audits Division.
[Click here to access testimony.]

OIG REPORTS

Community Nursing Home Program Safety Concerns, VA Northern California Healthcare System, Mather, California

At the request of Congressman John Garamendi, OIG conducted an inspection to assess allegations concerning patient safety in the Community Nursing Home (CNH) Program at the VA Northern California Healthcare System (HCS), Mather, CA. OIG substantiated that a patient was admitted to a locked CNH Alzheimer care center and the complainant was told he was being held against his will. However, OIG determined the patient's placement was appropriate because a facility psychiatrist deemed the patient lacked decision-making capacity regarding his living situation and demonstrated an inability to safely and independently live in the community. We also substantiated a delay in the patient receiving hearing aids with mitigating circumstances but did not substantiate a patient was given opioid medications against his wishes or was denied physical therapy. However, OIG identified a delay in the patient obtaining prosthesis care and confusion about the provision of his mental health (MH) care. We concluded communication and collaboration between facility and CNH staff needed improvement. OIG did not substantiate facility staff did not report an alleged financial abuse to Adult Protective Services; however, the reporting was not completed timely. OIG substantiated Non-VA Care Coordination (NVCC) consult authorization delays for services. For the reviewed consults, the approval was timely; however, on average, NVCC staff took an additional 24 days before faxing the authorization approval to the CNH. We determined program staff needed to monitor the NVCC process and NVCC staff needed to timely fax authorizations to the CNH. OIG did not substantiate facility

consult service delays. CNH patients generally received the requested services within 30 days. OIG substantiated program registered nurses or social workers did not consistently comply with the required monthly or quarterly patient visits in CNH facilities and determined regular visits would have provided program staff opportunities to identify and resolve CNH patient-specific issues. [Click here to access report.]

Environment of Care and Other Quality Concerns, Cincinnati VA Medical Center, Cincinnati, Ohio

OIG conducted an inspection at the request of Senator Sherrod Brown to assess allegations concerning the environment of care, emergency airway management (EAM) of patients, and clinical practice by a former Acting Chief of Staff (COS) at the Cincinnati VA Medical Center (VAMC), Cincinnati, OH. OIG was asked to determine whether clean and dirty materials were stored together in the same location after an OIG 2015 recommendation to store clean and dirty materials separately; reduced availability of EAM providers may have led to a "close call" [delayed intubation of a patient]; and whether deficiencies regarding the former Acting COS professional clinical practice had been identified by the facility during peer reviews or ongoing professional practice evaluations. We substantiated that clean and dirty patient care equipment items were stored together in the Community Living Center (CLC) following closure of an OIG recommendation made during a review of the facility in October 2014 *(CAP Review of the Cincinnati VA Medical Center, Cincinnati, Ohio, Report No. 14-04215-99, February 4, 2015)*. OIG did not substantiate a reduction in availability of facility providers for EAM or a delay in the intubation of a patient. OIG did not substantiate reported deficiencies in the clinical practice of the former Acting COS.
[Click here to access report.]

Patient Care Concerns at the CLC, Hampton VAMC, Hampton, Virginia

OIG conducted a review of Senator Mark Warner's request to assess complaints about the delivery of care at the CLC, Hampton VAMC, Hampton, VA. OIG substantiated that CLC staff did not consistently have competency validation completed for the care of residents (a term commonly used for patients in a CLC) with suprapubic catheters, failed to carry out some physician orders for catheter irrigation, and did not consistently document checks for well-being and skin assessments. However, OIG did not substantiate that CLC staff failed to weigh residents, take vital signs, offer morning care, or address residents' dining assistance needs; that CLC staff made residents wait for care; that weekend staff were not keeping the same routines for the residents; or that residents were not informed of special events. We substantiated that in the past, residents had to go to the facility barbershop to be shaved and also found that resident call lights could be turned off at the nurses' desk. In response, biomedical staff reconfigured the system so that a call light could only be shut off at a resident's bedside. OIG could not substantiate that CLC staff left medications at a resident's bedside and later tried to give the resident another dose that was still sitting at his bedside or that CLC staff were not routinely cleaning or sanitizing durable medical equipment. OIG substantiated that procedures were not followed and an appropriate mattress was not obtained in a timely manner. [Click here to access report.]

Consult Management Concerns, VA Greater Los Angeles HCS, Los Angeles, California

OIG conducted an inspection at the request of former Chairman Jeff Miller, Committee on Veterans' Affairs, US House of Representatives, to determine the validity of the allegation that 74 deceased patients had open consults at the VA Greater Los Angeles HCS, Los Angeles, CA. We identified 225 deceased patients who had 371 open or pending consults at the time of their deaths or had discontinued consults after their deaths. Of the 225 patients, OIG found 117 patients with 158 consults who experienced delays in obtaining requested consults. OIG substantiated that 43 percent (158 of 371) of consults were not timely because providers and scheduling staff did not consistently follow consult policy or procedures. We did not substantiate the allegation that patients experienced serious or severe impact with long-term consequences or organ dysfunctions or that patients died as a result of delayed consults. However, OIG identified two patients who experienced minor or intermediate clinical impacts. OIG found that providers entered incorrect inpatient/outpatient setting and/or urgency for 14 percent (52 of 371) of the reviewed consults. While not an allegation, OIG observed deficiencies in consult management practices contributing to the delays. Of the 158 delayed consults, We noted that facility staff did not: (1) timely act on clinical consult requests, (2) close completed consults or discontinue duplicate requests or consults no longer indicated, or (3) monitor the electronic wait list for Homemaker and/or Home Health Aide (H/HHA) services. [Click here to access report.]

Alleged Patient Deaths and Management Deficiencies in Home Based Primary Care, Beckley VAMC, Beckley, West Virginia

At the request of former Congressman Nick J. Rahall OIG assessed the merit of allegations made by a complainant regarding patient deaths and management deficiencies in the Home Based Primary Care (HBPC) program at the Beckley VAMC, Beckley, WV. We substantiated that from 2007 through 2012, 25 of 40 patients died while awaiting admission to HBPC. However, OIG did not find that these patient deaths were associated with a delay in admission to HBPC, as the patients continued to receive care from other health care providers prior to their deaths. OIG found that from 2008 through July 2012, HBPC staff kept an unapproved wait list in violation of VHA policy. We did not substantiate that HBPC patient scheduling, wait times, and backlogs were mismanaged. OIG found that, other than the wait list issue, HBPC program managers substantially complied with VHA and facility policies. OIG substantiated that an HBPC provider changed a patient's diagnosis by adding a diabetes diagnosis to the patient's problem list. However, we could not determine that the change was made to obtain prosthetic shoes for the patient. OIG did not substantiate that HBPC providers inappropriately prescribed antibiotics or that providers overprescribed opioids or changed patients' diagnoses in order to prescribe opioids. [Click here to access report.]

Nutrition and Food Service Environment of Care Concerns, Edward Hines, Jr. VA Hospital, Hines, Illinois

OIG responded to a request in May 2016 from then-Senator Mark Kirk and then-Congresswoman Tammy Duckworth to assess Nutrition and Food Service (NFS) environment of care concerns at the Edward Hines, Jr. VA Hospital, Hines, IL. OIG

substantiated the persistent presence of cockroaches in and around NFS areas. During OIG's unannounced site visit on May 10, 2016, OIG found dead cockroaches on glue traps dispersed throughout the facility's main kitchen. OIG observed conditions favorable to pest infestation. We substantiated that several patients received food trays with cockroaches on them. OIG reviewed email correspondence between MH staff to NFS managers from March 11, 2011, through December 28, 2015, and a MH report dated March 13, 2014, that reported six complaints from patients that cockroaches were present on food trays delivered from the facility's main kitchen to the MH unit via a transportation cart. OIG substantiated that leadership had knowledge of unsanitary food service conditions (cockroaches) in the NFS kitchen but had not successfully resolved the problem. The facility leadership relied on its pest control program and did not take additional action to control the problem. We determined that between March 2011 and September 2016, ten different individuals have been assigned to the Director's position. The facility did not have a permanent Director which may have contributed to the failure to readily resolve persistent pest issues. Additionally, environment of care inspection reports for at least the previous 2 years did not document the presence of cockroaches, and facility leadership may have considered the cockroaches on patient trays intermittent. NFS staff informed us that understaffing contributed to the presence of cockroaches in the facility's main kitchen.
[Click here to access report.]

Evaluation of Suicide Prevention Programs in VHA Facilities
OIG completed an evaluation of suicide prevention programs in VHA facilities in order to assess facility compliance with selected VHA guidelines for suicide prevention programs. We conducted this review at 28 VHA medical facilities during Combined Assessment Program (CAP) reviews performed across the country from October 1, 2015, through March 31, 2016. OIG found that most facilities had a process for responding to referrals from the Veterans Crisis Line (VCL) and a process to follow up on high-risk patients who missed appointments. Additionally, when patients died from suicide, facilities generally created issue briefs and when indicated, completed mortality reviews or behavioral autopsies and initiated root cause analyses. However, we identified system weaknesses in outreach activities; suicide prevention safety plan completion, content, and distribution of copies; flagging records of high risk inpatients and notifying the Suicide Coordinator of the admission; evaluating high-risk inpatients during the 30 days after discharge; reviewing flagged high-risk outpatients every 90 days; and clinicians completing suicide risk management training within 90 days of hire.
[Click here to access report.]

Review of VA's Compliance With the Improper Payments Elimination and Recovery Act for FY 2016
OIG determined whether VA complied with the Improper Payments Elimination and Recovery Act (IPERA) for FY 2016. VA reported improper payment estimates totaling approximately $5.5 billion in its FY 2016 Agency Financial Report (AFR). As allowed by Office of Management and Budget (OMB) guidance, VA reported improper payment data based on the previous FY activity. VA did not comply with two of six requirements that constitute compliance according to OMB. VA did not:

(1) Report a gross improper payment rate of less than 10 percent for each program and activity for which an improper payment estimate was published in the FY 2016 AFR. Two VA programs—VA Community Care (VACC) and Purchased Long Term Services and Support—exceeded 10 percent.
(2) Meet annual reduction targets for the following six programs—VACC, Purchased Long Term Services and Support, Beneficiary Travel, Civilian Health and Medical Program of the VA, State Home Per Diem Grants, and Supplies and Materials.

VA met four of the six IPERA requirements for FY 2016 by publishing the AFR, performing risk assessments, publishing improper payment estimates, and providing information on corrective action plans. Although VA published improper payment estimates as required, OIG determined estimates for the Supplies and Materials Program and the Post 9/11 G.I. Bill Program were not reliable because of weaknesses in sample evaluation procedures. OIG also identified further improvements VA could make in estimating improper payments for two programs and in reducing improper payments for another program that resulted from a program design issue. [Click here to access report.]

Review of Alleged Removal of Workload Controls at the VA Regional Office in San Juan, Puerto Rico

In August 2015, the OIG Hotline received complaints alleging San Juan VA Regional Office (VARO) staff were improperly removing workload controls for claims from the Veterans Benefits Administration's (VBA) workload management system. The End Product (EP) system is VBA's primary electronic workload monitoring and management tool and claims identified as EP 930 require additional processing, which may not have been properly performed before the removal of the claims from the system. Further, OIG substantiated the allegation. Specifically, claims processors inaccurately removed 6 of the 30 cases OIG sampled, improperly terminating these veterans' claims without appropriate review and processing. One error delayed paying a veteran about $23,000 in benefits by more than 3 years and the remaining five errors had the potential to affect veteran benefits. OIG also confirmed that processing of this workload was a recurring challenge for Veteran Service Center (VSC) management. Because VSC management did not ensure staff followed plans to process this workload, the inventory continued to increase. [Click here to access report.]

Alleged Pathology and Laboratory Medicine Service Quality of Care Issues, Wilmington, VAMC, Wilmington, Delaware

OIG evaluated allegations that a pathologist misread oncology test results, did not complete pathology tests timely, inappropriately sent some tests outside the facility on a fee for service basis, and altered pathology reports from alternate VHA and non-VHA laboratories to make it appear as though he performed the tests at the facility laboratory. OIG could not substantiate that the pathologist misread oncology tests. However, OIG reviewed electronic health record (EHR) data, and found that the pathologist replaced preliminary pathology results with final results; therefore, initial test results were not available for comparison to final test results or to the facility's data. OIG interviewed oncology staff who could not recall any instances of misread tests. We substantiated that the pathologist did not always have pathology test results available to

ordering providers within required timeframes and had, with facility leadership approval, sent specimens to Fee Basis vendors for processing. OIG did not substantiate that the pathologist altered reports of pathology tests. However, we discovered inconsistent documentation identifying non-VHA pathologists on final pathology reports and incomplete documentation for specimens sent to alternate VHA and non-VHA laboratories. OIG found that the pathologist utilized a non-VHA laboratory to process pathology tests without a required VHA contractual arrangement and inappropriately revised a facility laboratory standard operating procedure. In addition, oversight services and committees did not consistently report accurate statistical and performance information to facility leadership and did not complete and monitor internal review action plans and ongoing professional performance evaluations using current facility performance data. [Click here to access report.]

Alleged Program Mismanagement and Other Concerns at the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon

OIG reviewed allegations regarding program mismanagement and other concerns at the VA Southern Oregon Rehabilitation Center and Clinics (SORCC), White City, OR. The complainant alleged that Home Based Primary Care (HBPC), the Transitional Care Unit (TCU), the Non-Institutional Purchased Care program, specifically, the H/HHA, and the Housing and Urban Development Veterans Affairs Supported Housing (HUD/VASH) program were mismanaged and lacked appropriate oversight. In addition, the complainant alleged that services such as occupational therapy, physical therapy, case management, discharge planning, and MH, were unavailable; services were denied to patients as a result of other patients receiving services inappropriately; TCU patients' lengths of stay (LOS) were based on need for reimbursement rather than clinical criteria; H/HHA service hours were inflated; patients were harmed at the SORCC; and training and educational resources were unavailable for staff. OIG initially substantiated that H/HHA and HUD/VASH programs lacked appropriate oversight as the Community Care Oversight Committee (H/HHA oversight) and the HUD/VASH program committee did not have required attendance or documentation of relevant program issues as described in VHA and SORCC policy. However, based on updated information received in 2016, OIG noted new committee leadership, required attendance, and discussion of relevant program issues. We did not substantiate the other allegations. OIG found the HBPC program and the TCU complied with selected VHA requirements; oversight committees were in place; members attended meetings; and action items were identified, addressed, and resolved. We reviewed selected services and found the patients OIG reviewed had received required services. OIG did not receive or identify the names of any patients who were denied services. We identified and reviewed the EHRs of 11 TCU patients whose LOS were over 90 days. OIG found the LOS were appropriate based on the inability of the patients to be fully successful in the traditional SORCC setting or in the community. OIG did not find an inflation of care needs without clinical justification for H/HHA patients. We found various educational resources were available to staff and that management supported necessary clinical training. [Click here to access report.]

Quality of Care Concerns of a Surgical Patient, Central Arkansas Veterans HCS, Little Rock, Arkansas

OIG assessed allegations about a surgical patient's care at the Central Arkansas Veterans HCS, John L. McClellan Memorial Veterans Hospital, Little Rock, AR. We did not substantiate that physicians failed to examine the patient every day or EHR documentation contained daily assessments. OIG also did not substantiate that the patient was in bilateral wrist restraints continuously for over 30 days or that nursing staff did not follow physician orders regarding the patient's activity level.

EHR documentation showed that restraints were used but removed periodically and that nurses increased the patient's activity level when ordered to do so. The system's restraint policy did not require notification of system leaders of duration of medical restraint use. OIG did not substantiate that the use of restraints caused a full thickness tissue loss or that staff failed to address an issue with the patient's foot and ankle. However, staff did not consistently follow the system's policy regarding wound care documentation. We substantiated that a request for a transfer was denied but did not substantiate that the denial was inappropriate. Services the patient needed were not available at the second hospital. OIG could not substantiate that nursing staff were making bets on how much medication they could give another patient to keep him quiet. The patient had a history of alcohol use, but the EHR did not contain documentation that the surgical team offered preoperative detoxification. It is unknown, however, if the patient would have agreed to the offer. [Click here to access report.]

Delays in the Evaluation and Care of a Patient with Lung Cancer, VA Southern Nevada HCS, Las Vegas, Nevada

OIG assessed the merit of allegations regarding delays in the evaluation and care of a patient with lung cancer at the VA Southern Nevada HCS, Las Vegas, NV, in 2014. OIG substantiated a delay of approximately 6 months occurred in the evaluation of the patient's pleural effusion, and delays occurred in the diagnosis and treatment of the patient's lung cancer. In conjunction with the delay in evaluation, the patient was not timely notified of test results. We identified several contributing factors, including lack of follow-up related to a non-VA provider's lung biopsy recommendation. OIG did not substantiate a Primary Care Physician failed to perform a physical examination during an appointment, but substantiated delays in obtaining NVCC authorizations. We identified several contributing factors to the delays: NVCC staff inconsistently applied the requirement for system providers to see the patient for services offered at the system before an NVCC consult was approved; NVCC staff failed to process the request according to the requesting provider's urgency; Emergency Department (ED) providers failed to follow the NVCC consult request process; and NVCC staff did not appear to be knowledgeable of covered services. OIG substantiated inadequate medication management due to delays in filling medications ordered by non-VA care providers and problems with delivery of medications. We did not substantiate a lack of continuity of care due to changes in the patient's PCP and did not find disruptions in the patient's care due to the changes. However, OIG found inconsistencies with the system's peer review process. [Click here to access report.]

Patient Deaths, Opioid Prescribing Practices, and Consult Management, VA Greater Los Angeles HCS

OIG evaluated allegations related to patient deaths from drug overdose, inappropriate opioid prescribing practices, and improper consult management at the VA Greater Los Angeles HCS, Los Angeles, CA. We did not substantiate that seven patients died from drug overdoses during an 8-month period at the New Directions housing facility. The complainant did not provide names of the seven patients; therefore, we reviewed the EHRs of six patients who the system reported as having died after moving into New Directions from September 2013 through August, 2014. The coroner determined that one of the six patients died from multiple drug intoxication. The drugs listed on the toxicology report had not been ordered by system providers. OIG did not substantiate that system psychiatrists prescribed inordinate amounts of opioids without oversight. We obtained data showing the system had a lower percentage of patients on larger amounts of opioids than the national average. OIG substantiated that cardiology consults were canceled or discontinued by non-physician staff members. However, this was an acceptable practice under certain circumstances. Of the 49 consults OIG reviewed that were canceled or discontinued by non-physician cardiology staff, 5 were inappropriately canceled or discontinued. We did not find documented evidence in the EHRs of patient harm in these five patients; however, patients can be put at increased risk of harm when consults are inappropriately canceled or discontinued.
[Click here to access report.]

Alleged Unsafe Blood Transfusion Practices, Battle Creek VAMC, Battle Creek, Michigan

OIG responded to allegations received in 2014 about unsafe blood transfusion practices at the Battle Creek VAMC (BCVAMC) in Battle Creek, MI. The complainant alleged that a patient experienced an adverse reaction because of a BCVAMC hospitalist's unsafe transfusion practices. OIG substantiated that a BCVAMC hospitalist engaged in unsafe packed red blood cell transfusion practices, which resulted in a patient's adverse reaction. The patient's pre-transfusion medical issues indicated that the hospitalist should have reassessed the need to transfuse 3 units of packed red blood cells and monitored the patient's clinical status, including hemoglobin levels, more closely. The increase in blood volume from 3 units of packed red blood cells contributed to the patient experiencing a potentially life threatening adverse reaction due to circulatory overload. A lack of guidance in the BCVAMC policy, which did not support recommended standards issued by the American Association of Blood Banks for single unit transfusions, likely contributed to the hospitalist's unsafe transfusion practices. Although not directly related to this patient's case, unit staff identified communication barriers that may have affected professional clinical collaboration. BCVAMC policy requires providers to report blood transfusion related adverse reactions to the Blood Usage Review Committee (BURC) to help prevent similar adverse reactions from occurring in the future. Providers did not report this patient's adverse reaction, and the BURC did not analyze the circumstances surrounding the event. The committee Transfusion Officer was the physician ordering and supervising the majority of transfusions, presenting a potential conflict of interest between committee responsibilities and professional responsibilities. OIG also found that the Peer Review

Committee did not follow VHA policy regarding documentation of committee recommendations for actions and follow-up by supervisors.
[Click here to access report.]

Evaluation of Compounded Sterile Product Practices in VHA Facilities
OIG completed a healthcare inspection of compounded sterile product (CSP) practices in VHA facilities. The review determined whether facilities complied with selected requirements for the safe preparation of CSPs. CSPs are pharmaceutical preparations made or modified in a controlled sterile environment. OIG conducted this review at 25 VHA medical facilities during CAP reviews performed across the country from October 1, 2015, through March 31, 2016. OIG noted high compliance in several areas, including that facilities had adequate policies and provided safe conditions for CSP preparation; that staff documented sampling for contamination in required areas and took actions when they identified positive cultures; and that when facilities used non-VA sources for CSPs, the sources were appropriately registered.
[Click here to access report.]

CRIMINAL INVESTIGATIONS

Veterans Health Administration Investigations

Former St. Louis, Missouri, VAMC Supervisor Pleads Guilty to Conspiracy to Steal Government Funds
A former St. Louis, MO, VAMC supervisor pled guilty to conspiracy to steal Government funds. A VA OIG and Federal Deposit Insurance Corporation OIG investigation revealed that from February 2014 to April 2015, the defendant issued purchase card payments totaling $451,853 to three vendors for unnecessary maintenance work at the medical center. The vendors kicked back approximately $136,500 to the defendant. This investigation is ongoing and there is an anticipated loss of $532,876.

Former Seattle, Washington, VAMC Employee Pleads Guilty to Possession of a Weapon at a Federal Facility and Possession of an Unregistered Firearm
A former Seattle, WA, VAMC employee pled guilty to possession of a weapon at a Federal facility and possession of an unregistered firearm. An OIG, VA Police Service, and Alcohol, Tobacco, and Firearms investigation resulted in the discovery of a loaded pistol, narcotics, and stolen VA property in the defendant's vehicle located at the medical center during the execution of a search warrant. The defendant remains in custody pending further judicial action.

Northport, New York, VAMC Employee Sentenced for Larceny
A Northport, NY, VAMC employee and former American Federation of Government Employees president was sentenced to 280 hours' community service and 3 years' probation after pleading guilty to petit larceny. The defendant also made full restitution to the union prior to sentencing. An OIG, Department of Labor Office of Labor Management Standards, and Attorney General's Office investigation revealed that the

defendant embezzled approximately $45,000 from the union's bank account and used the funds for personal expenditures.

Former Lebanon, Pennsylvania, Licensed Practical Nurse Pleads Guilty to Acquiring a Controlled Substance by Fraud
A former Lebanon, PA, licensed practical nurse pled guilty to acquiring a controlled substance by fraud. During an OIG and VA Police Service investigation, the defendant admitted that she diverted hydromorphone, oxycodone, and morphine while working in the medical center's hospice unit.

Cincinnati, Ohio, VAMC Physician Indicted for Drug Distribution Without a License
A physician, who was also the former acting COS at the Cincinnati, OH, VAMC, was indicted for drug distribution without a license. An OIG investigation resulted in the defendant being charged with issuing three controlled substance prescriptions for the former Veterans Integrated Service Network director's wife, a non-veteran, using her Drug Enforcement Agency (DEA) license that was restricted to Federal official duties only.

Former Spokane, Washington, VAMC Nurse Indicted on Drug Charges
A former Spokane, WA, VAMC nurse was indicted for acquiring and obtaining a controlled substance by fraud, misrepresentation, deception, and subterfuge. An OIG investigation resulted in the defendant being charged with fraudulently obtaining prescriptions of the controlled substance phentermine using VA prescription forms containing forged signatures of VA physicians.

Non-Veteran Sentenced for Drug Distribution
A non-veteran was sentenced to 14 months' incarceration and 36 months' supervised release after pleading guilty to conspiracy to distribute and possess with intent to distribute cocaine. An OIG, U.S. Postal Inspection Service, VA Police Service, and DEA New York Organized Crime Drug Enforcement Strike Force investigation identified the defendant as a supplier of narcotics to a criminal enterprise that mailed six U.S. Postal Service (USPS) parcels, each containing one to two kilograms of cocaine, from Puerto Rico to the Bronx, NY, VAMC. Six defendants have been charged, including two former VA employees. To date, five of the defendants have pled guilty.

Veteran Pleads Guilty to "Doctor Shopping"
A veteran pled guilty to deception to obtain a dangerous drug and possession of a dangerous drug (with a prior drug conviction specification). An OIG investigation revealed that the defendant obtained opioids from VA and his non-VA medical provider from 2014 to 2016, resulting in the defendant receiving approximately 1,260 tablets by deception. The defendant admitted to distributing some of the controlled substances he obtained to other individuals.

Veteran Pleads Guilty to Drug Trafficking
A veteran pled guilty to drug trafficking, drug possession, and deception to obtain a dangerous drug. The defendant was admitted to a drug treatment program in lieu of conviction. An OIG investigation revealed that the defendant sold his VA-prescribed medication to another veteran receiving treatment at the Cleveland, OH, VAMC domiciliary. On a daily basis, the defendant received two doses of Suboxone from VA, one he would take while the other was hidden and later sold to other veterans.

Veteran Pleads Guilty to Theft of Government Travel Benefits
A veteran pled guilty to theft of Government funds. An OIG and VA Police Service investigation revealed that the defendant submitted over 700 false travel claims to VA in order to receive a higher amount of beneficiary travel pay. The defendant claimed to travel over 500 miles per day to the San Francisco, CA, VAMC 4 to 5 days per week for several years. In actuality, the defendant was living in a mobile RV trailer much closer to the medical center. The loss to VA is approximately $159,000.

Veteran Indicted for Theft of Government Funds and False Statements
A veteran was indicted for theft of Government funds and false statements. An OIG and VA Police Service investigation resulted in the defendant being charged with submitting fraudulent travel vouchers to the Martinsburg, WV, VAMC. For nearly 5 years, the defendant is alleged to have claimed an address 123 miles from the medical center, when in reality, he resided in HUD/VASH provided housing five miles from the facility. The loss to VA is approximately $30,000.

Veterans Benefits Administration Investigations

Former VA Fiduciary Pleads Guilty to Misappropriation and Other Charges
A former VA fiduciary pled guilty to wire fraud, misappropriation by a fiduciary, and preparing fraudulent tax returns. As part of the plea agreement, the defendant also agreed to pay restitution. An OIG, Federal Bureau of Investigation (FBI), and Internal Revenue Service (IRS), Criminal Investigation Division (CID) investigation determined that from 2007 to 2012, the defendant, who served as VA fiduciary for eight disabled veterans, embezzled more than $250,000 in VA-issued benefits from the veterans' accounts. Some of the VA funds were used for personal mortgage payments.

Veteran's Sister Sentenced for Theft of Government Funds
The sister of a veteran, appointed as her brother's fiduciary, was sentenced to 3 years' probation after pleading guilty to theft of Government funds. The defendant also repaid $215,512. An OIG investigation revealed that the defendant was responsible for more than $200,000 belonging to her brother and subsequently withdrew more than $95,000 to pay off her loans and purchase a new BMW. The defendant also initially failed to transfer the remaining funds to a professional fiduciary appointed as her replacement.

Former VA Fiduciary Pleads Guilty to Misappropriation by a Fiduciary
A former VA fiduciary pled guilty to misappropriation by a fiduciary after admitting to misappropriating approximately $44,000 from two different veterans. An OIG investigation revealed that the defendant transferred approximately $17,903 of VA funds to a corporate credit card in her name and used the card to pay for charges at restaurants, florists, jewelers, grocery stores, hospitals, and furniture stores. The card was not used for the benefit of the veterans.

VA-Appointed Fiduciary Arrested for Theft of Government Funds
A VA-appointed fiduciary was arrested for theft of Government funds. An OIG investigation resulted in the defendant being charged with misusing $24,937 in VA funds intended for a veteran. The fiduciary admitted he made counter withdrawals, wrote checks payable to cash, made ATM withdrawals, and operated outside VA guidelines while using the veteran's funds to pay personal expenses.

VA-Appointed Fiduciary Charged With Larceny
A VA-appointed fiduciary, the former girlfriend of a disabled veteran, was charged with larceny by a single scheme. An OIG investigation resulted in the fiduciary being charged with misusing approximately $14,547 of VA compensation funds intended for the disabled veteran. The investigation was initiated when the veteran, who had been abandoned by the fiduciary, was found by his VA social worker in his apartment where he was unable to care for himself or pay his bills. The fiduciary used the veteran's funds to make personal purchases to include tattoos, car repairs, and hotel rooms.

Veteran Sentenced for VA Compensation Fraud
A veteran was sentenced to 9 months' incarceration, 3 years' supervised release, and was ordered to pay VA $394,800 in restitution after previously pleading guilty to theft of Government funds. An OIG investigation resulted in the defendant being charged with claiming blindness in order to fraudulently collect VA compensation benefits for over 15 years. During the time that the defendant told VA physicians that she was almost completely blind, she obtained driver's licenses with no vision restrictions in three states. The defendant was also observed driving on numerous occasions, to include a daily commute of 40 miles to and from work.

Veteran Sentenced for Theft of Government Funds and False Statements
A veteran was sentenced to 6 months' incarceration, 3 years' supervised release, and was ordered to pay $303,995 in restitution after being found guilty at trial of theft of Government funds and false statements. A VA OIG, Social Security Administration (SSA), and Health and Human Services (HHS) OIG investigation revealed that the defendant fraudulently applied for and received VA, Social Security Administration SSA, and HHS disability benefits by claiming loss of use of her right hand, when in actuality, the defendant had full use of both hands. During the investigation, the defendant also provided false statements to VHA and SSA medical staff regarding the extent of her disabilities.

Veteran Sentenced for "Stolen Valor"
A veteran was sentenced to 51 months' incarceration and ordered to pay VA restitution of $2,289 after pleading guilty to unlawfully exhibiting a military discharge certificate, theft of Government funds, false statements, and attempt to obstruct an official proceeding. An OIG investigation revealed that the defendant submitted a false DD-214 to VA on multiple occasions claiming that he was a Navy Seal and had received Purple Heart and Bronze Star medals. The defendant also failed to disclose sources of income that would have eliminated his VA pension benefit.

Husband and Wife Indicted for Theft and Gross Neglect of a Corpse
A husband and wife were indicted for theft, gross neglect of a corpse, and failure to report the knowledge of a death. A veteran, who was not related to the defendants, resided at their residence for 6 years before he died in November 2016. The defendants failed to report the veteran's death to the local authorities and subsequently stole the veteran's VA and SSA benefits while the veteran's corpse decomposed inside their home.

Assisted Living Facility President Pleads Guilty to Theft of Government Funds
The president of an assisted living facility where a veteran resided pled guilty to theft of Government funds and agreed to pay full restitution of $145,176. An OIG investigation revealed that the defendant continued to receive, endorse, and negotiate (through the facility's business account) U.S. Treasury checks issued after the Veteran's death in March 2009.

Granddaughter of Deceased VA Beneficiary Pleads Guilty to Theft of Government Funds
The granddaughter of a deceased VA beneficiary pled guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited after her grandmother's death in November 2009. The loss to VA is $118,717.

Son of Deceased VA Beneficiary Sentenced for Theft of Government Funds
The son of a deceased VA beneficiary was sentenced to 2 years' probation and was ordered to pay a $3,000 fine and $108,690 in restitution after pleading guilty to theft of Government funds. An OIG investigation revealed that the defendant stole VA funds that were direct deposited into his deceased mother's account after her death in June 2009. The defendant stole most of the funds by forging his deceased mother's signature on personal checks.

Son of Deceased VA Beneficiary Sentenced for Making a False Statement
The son of a deceased VA beneficiary was sentenced to 5 years' probation and was ordered to pay VA restitution of $97,660 after pleading guilty to making a false statement. An OIG investigation revealed that the defendant stole VA benefits that were direct deposited after his mother's death in May 2008. The defendant also admitted to forging and submitting a VA marital status questionnaire in order to make it appear that his mother was still alive.

Summary of Cases Involving Theft of Government Funds by Relatives of VA Beneficiaries Deceased Prior to June 2007

In four separate cases, OIG investigations of theft of Government funds by relatives of VA beneficiaries deceased prior to June 2007 resulted in an arrest, one charge, a guilty plea, and a sentence of 3 years' probation. The loss to VA in these cases was $620,524. For one case, the defendant made full restitution of $101,459 prior to sentencing.

Other Investigations

Trucking School President and Student Coordinator Arrested for Wire Fraud

The president and the former student coordinator of a trucking school were arrested for wire fraud. A VA OIG, FBI, and Department of Justice OIG investigation resulted in charges alleging that between 2011 and 2015 the president, the former vice president, the former student coordinator, and veterans conspired to defraud VA of over $4.3 million by fraudulently enrolling at least 108 veterans who never attended or received training at the school. Some of the veterans involved were Federal and State correctional officers, Federal employees, and a local police officer. The school received inflated, unearned tuition and fees ranging between $5,000 and $13,000 per course, while veterans received basic housing allowance and a books and supplies stipend totaling over $2,000 per month.

Three Non-Veterans Sentenced for Health Care Fraud

Three non-veterans pled guilty to various health care fraud charges and were subsequently sentenced to a combined 144 months' incarceration, 96 months' supervised release, and 1,500 hours of community service. A VA OIG, Defense Criminal Investigative Service, OPM, Federal Drug Administration (FDA), Army CID, and USPS OIG investigation revealed that the defendants submitted false claims to the Department of Defense health care program TRICARE, the VA Civilian Health and Medical Program, other Federal insurance programs, and private insurance companies for compounded prescriptions. Compounded prescriptions were either fraudulently dispensed without a physician's authorization, never dispensed, returned, or dispensed without FDA approval.

Accountant Pleads Guilty to False Statements

The accountant for a Service-Disabled Veteran-Owned Small Business (SDVOSB) pled guilty to false statements after a multi-agency investigation revealed over $350 million in set-aside (Veteran-owned, minority-owned, woman-owned) construction contracts were fraudulently obtained. The investigation revealed that several subjects conspired in creating companies for the sole purpose of obtaining set-aside Government contracts, all while providing false information to VA and the Small Business Administration in order to qualify for the contracts and concealing the fact that the companies were not controlled by veterans, service-disabled veterans, minorities, or women.

Home Health Care Provider Sentenced for Health Care Fraud and Conspiracy
The owner of a Northeast Ohio home health care provider was sentenced to 120 months' incarceration, and her son was sentenced to 87 months' incarceration after being convicted at trial of health care fraud and conspiracy to commit health care fraud. Both defendants were also ordered to pay $8.16 million in restitution, including $429,603 to VA. A former nurse manager was sentenced to 18 months' incarceration and a former billing clerk was sentenced to 8 months' home confinement after previously pleading guilty to conspiracy to commit health care fraud. The former nurse manager was also ordered to pay $1.13 million in restitution, including $250,072 to VA, and the billing clerk was ordered to pay $318,786 in restitution, including $250,072 to VA. A multi-agency health care fraud task force investigation revealed that the defendants submitted fraudulent billings to Medicare, Medicaid, and VA as well as false information and stolen identities on every annual provider agreement submitted and approved by the Cleveland, OH, VAMC. Five defendants were originally charged, one of whom died and two who previously pled guilty.

Veteran Sentenced for Child Pornography
A veteran was sentenced to 9 years' incarceration after pleading guilty to illegal use of a minor in nudity-oriented material or performance, pandering sexually oriented material involving a minor, and possessing criminal tools, with a forfeiture specification. An OIG and Ohio Adult Parole Authority investigation revealed that the defendant, while on post-release control through the state of Ohio for a previous rape conviction, viewed child pornography in the computer lab at the Cleveland, OH, VAMC domiciliary as well as on personal electronic devices.

Veteran Residing at VA CLC Arrested for Failure to Register as a Sex Offender
A veteran residing at The Big Spring, TX, VAMC CLC was arrested for failure to register as a sex offender. OIG, Homeland Security Investigations, and the Texas Department of Public Safety initiated this investigation on a tip from the National Center for Missing and Exploited Children. Allegations included that the defendant used a VA network to access a Google account containing child pornography. The defendant subsequently admitted to possessing and viewing child pornography. Additional Federal charges are pending based on the final number of images identified as a result of this investigation.

Veteran Sentenced for VA Home Loan Fraud
A veteran was sentenced to 3 years' probation and was ordered to pay $46,103 in restitution to HUD. A VA OIG and HUD OIG investigation revealed that the defendant obtained a $190,000 VA guaranteed home loan while he was receiving housing payments from a Section 8 tenant who occupied his home. This is a violation of VA's loan occupancy requirement. The defendant and his tenant conspired to conceal the defendant's true residency and submitted false certifications to the county housing authority.

Non-Veteran Pleads Guilty to Identity Theft Charges
A non-veteran pled guilty to theft of Government funds and aggravated identity theft. An OIG investigation revealed that the subject assumed the identity of a veteran and began

receiving medical treatment and other benefits from the West Palm Beach, FL, VAMC. The defendant obtained the veteran's identifiers after meeting the veteran in Tennessee. The loss to VA is $68,655.

Assaults and Threats Made Against VA Employees

Veteran Arrested for Emailing Threats to Palo Alto, California, VAMC Employees
A veteran was arrested after emailing threats to several Palo Alto, CA, VAMC employees. An OIG investigation revealed that the defendant was a member of the U.S. Special Operations Command and served on a Navy SEAL team. The defendant has a history of making threats to VA employees.

Veteran Arrested for Harassment
A veteran was arrested on a bench warrant for failure to comply with his sentencing after a harassment conviction. An OIG, VA Police Service, and U.S. Capitol Police investigation revealed that the defendant made thousands of repetitive, harassing, and vulgar phone calls to various VA offices throughout the country since 2014, to include several VARO directors and the Office of the VA Secretary. The veteran also made similar calls to several Congressional offices. The veteran was also issued two additional citations by the VA Police Service for disorderly conduct for repeated harassing phone calls to the local VA Suicide Prevention Coordinator and the VCL. These repeated calls, over 200 on one day, severely hampered the VCL's ability to assist veterans who were actually in need of assistance. The defendant is also pending similar charges in State court. The defendant was arrested by OIG and convicted on similar harassment charges in 2011.

ADMINISTRATIVE INVESTIGATION ADVISORIES

OIG independently reviews allegations and conducts administrative investigations generally concerning high-ranking senior officials and other high profile matters of interest to Congress and the Department. While these reviews and investigations may result in the issuance of a formal report, they may also lead to the issuance of an administrative advisory to VA senior leadership. Administrative advisories are issued if allegations are substantiated but no recommendations are made or are unsubstantiated during the course of the investigation and there is a need to notify VA leadership of the investigative results.

A major component of OIG's vision is an unwavering commitment to being a transparent organization. In keeping with this vision, OIG is maintaining transparency with veterans, Congress, and the public by releasing administrative investigation advisories issued by OIG. As other administrative investigation advisories are completed, they will be available on our website if they are not prohibited from public disclosure.

You may view and download these administrative investigation advisories and closure memoranda by clicking on the links below on our webpage.

https://www.va.gov/oig/publications/administrative-investigation-advisories.asp

Administrative Investigation Advisories (May 2017)	
Advisory Number	**Title**
16-04882-216	Administrative Investigation – Alleged Gross Mismanagement, Department of Veterans Affairs
16-00932-203	Administrative Investigation – Alleged Misuse of Position, VA

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 100 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/administrative-summaries-of-investigation.asp** and selecting the appropriate state.

Administrative Summaries of Investigation (May 2017)	
Summary Number	**Location**
14-02890-93	Alexandria, Lousiana, VAMC
14-02890-95	Montgomery, Alabama, VAMC
14-02890-96	Tuskegee, Alabama, VAMC and Montgomery, Alabama, VAMC
14-03368-97	Atlanta, Georgia, HEC
14-02890-104	Las Vegas, Nevada, VAMC
14-02890-110	Phoenix, Arizona, VAMC and Gilbert, Arizona, CBOC
14-02890-112	Montgomery, Alabama, VAMC
14-02890-116	Washington, District of Columbia, VAMC
14-02890-126	Phoenix, Arizona, VAMC
14-02890-127	Atlanta, Georgia, VAMC

14-02890-129	Augusta, Georgia, VAMC
14-02890-169	Beckley, West Virginia, VAMC
14-02890-409	West Roxbury, Massachusetts, CBOC

MICHAEL J. MISSAL
Inspector General