



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

OCTOBER 2018 HIGHLIGHTS

Criminal Investigations Involving Health Care

Former Marion, Indiana, VA Medical Center Nursing Assistant Sentenced for Criminal Deviate Conduct

A former VA Medical Center (VAMC) Nursing Assistant was sentenced to 16 years' imprisonment, of which two years were suspended, after previously being convicted of criminal deviate conduct. A VA Office of Inspector General (OIG) and VA Police Service investigation revealed that the defendant engaged in a sexual act with an inpatient who was on the VAMC's dementia ward.

Former Temple, Texas, VA Medical Center Maintenance and Operations Supervisor and Two Accomplices Charged in Theft Scheme

A former VAMC Maintenance and Operations Supervisor, his wife, and a third-party vendor were charged with theft of government funds and conspiracy. An OIG investigation resulted in charges that allege the defendants created a scheme to use the wife's company to steal funds from VA. The former supervisor and his wife provided the vendor with fraudulent invoices from her company for goods and services that were not provided to the vendor. The vendor paid the wife's company for the fictitious goods and services and then fabricated his own set of fraudulent invoices that he used to bill VA for goods and services that he never provided to VA. The amount of the invoices billed to VA equaled the amount the vendor paid to the wife's company plus a 30 percent commission. The former supervisor then used a VA purchase card to pay the vendor's fraudulent invoices. The loss to VA is approximately \$308,380.

Former San Diego, California, VA Medical Center Program Support Assistant Indicted for Wire Fraud

An OIG investigation resulted in charges that allege the defendant used his VA purchase card to buy computers, electronics, speaker systems, sporting goods, cookware, lingerie, and bicycles. The defendant also bought personal items for coworkers using the purchase card. As a result of this investigation, a second employee pled guilty to conspiracy to steal government property and was terminated. A third employee is pending termination, and a fourth employee is pending other administrative action. The total loss to VA is approximately \$100,000.

Veteran Pled Guilty to Possession with Intent to Distribute a Controlled Substance

A VA OIG, VA Police Service, and Drug Enforcement Administration (DEA) investigation revealed that while participating in an inpatient drug treatment program at the Bath, New York, VAMC, the defendant provided fentanyl to two veterans, causing both to overdose. Both veterans subsequently recovered.

Veteran Pled Guilty to Distribution of Crack Cocaine

A veteran pled guilty to drug distribution as a result of a year-long VA OIG and DEA investigation into the widespread sale of various drugs at the Bedford, Massachusetts, VAMC. This investigation, which

garnered local media and congressional interest, identified four additional individuals who were working with the defendant to distribute drugs to veterans receiving addiction treatment at the VAMC. These defendants were criminally charged and their cases are being adjudicated.

Veteran Indicted for Making Threats Against Fayetteville, North Carolina, VA Medical Center Employees

A veteran was indicted and arrested for transmitting a threat in interstate commerce and possession of a firearm by a convicted felon. The veteran subsequently pled guilty to possession of a firearm by a convicted felon. A VA OIG and Bureau of Alcohol, Tobacco, Firearms and Explosives investigation revealed that the defendant threatened to shoot and kill VA employees at the Fayetteville, North Carolina, VAMC. The defendant admitted during the investigation to possessing several firearms even though he was a convicted felon. As a result, several firearms were seized. The defendant is still being detained pending sentencing due to his threats and exhibited behaviors.

Criminal Investigations Involving Benefits

Veteran and Family Members Pled Guilty for Roles in Compensation Benefits Scheme

A veteran and his wife pled guilty to conspiracy to defraud VA for providing false statements to obtain additional VA compensation benefits and income from the VA Caregiver Support Program. The veteran's father pled guilty to misprision of a felony for providing misleading statements regarding his son's disabilities. An OIG investigation revealed the veteran owned and operated various companies while receiving Individual Unemployability benefits and claiming to be unemployed due to his service-connected disabilities. The veteran obtained multiple government set-aside contracts, most with VA, totaling over \$1 million while being rated permanently and totally disabled with posttraumatic stress disorder (PTSD). An investigation revealed the veteran is a licensed private pilot and an aircraft mechanic who obtained both certifications within days after reporting multiple disabilities, including PTSD, to the VA. However, the veteran did not report these disabilities to the Federal Aviation Administration. The veteran, his father, and the veteran's company were also indefinitely suspended from obtaining future government contracts.

Veteran Indicted for Theft of Government Funds

An OIG investigation resulted in charges that allege the defendant fraudulently led VA to believe he was blind. As a result, the defendant had been receiving 100 percent service-connected disability benefits for blindness since July 1991. The investigation determined that although the defendant had been discharged from the military in 1969 for vision issues, he was in possession of a valid driver's license that was issued in 2017 and he had passed the vision test with 20/40 acuity in both eyes. The investigation also determined that the defendant drove on a routine basis and could perform other activities that were not consistent with blindness. The loss to VA is over \$983,000.

Nonveteran Sentenced for Theft of Government Funds

A nonveteran was sentenced to 24 months' unsupervised probation and ordered to pay restitution to VA of over \$187,000 after pleading guilty to theft of government funds. An OIG investigation revealed that the defendant failed to report the death of his father and continued to receive VA compensation funds intended for his father for over 18 years.

Nonveteran Sentenced for Wire Fraud

A nonveteran was sentenced to 27 months' incarceration and 36 months' supervised release and ordered to pay restitution of more than \$114,000 to VA. An OIG investigation revealed the defendant stole VA benefits from a disabled veteran with whom he resided. The defendant began the scheme by forging the veteran's signature on U.S. Treasury Checks, but he subsequently had the monthly payment directly deposited into an account in his control.

Criminal Investigations Involving Other Matters

Former VA Contracting Officer Sentenced for Role in Conspiracy Scheme

A former VA Contracting Officer (CO) was sentenced to five months' imprisonment, five months' home detention, 12 months' supervised release, and ordered to pay restitution to VA of approximately \$62,000. A VA OIG, Federal Bureau of Investigation, and Internal Revenue Service Criminal Investigation Division (IRS-CI) investigation revealed that between 2003 and 2017, the owner of a parking services company bribed the CO with over \$286,000 in cash to defraud VA of over \$13 million. The company had entered into a sharing agreement with VA, which required the company to pay 60 percent of the collected gross parking revenue to VA. The owner underreported income and overreported improvements to VA, which allowed him to keep over \$13 million that was owed to VA. The owner paid bribes to the CO to continue the conspiracy after the CO retired from VA in 2014.

Two Medical Office Administrators Arrested for Roles in Healthcare Fraud Conspiracy Scheme

Two medical office administrators were arrested for healthcare fraud and conspiracy to commit healthcare fraud. A VA OIG, U.S. Postal Service OIG, Department of Justice OIG, Department of Labor (DOL) OIG, and IRS-CI investigation resulted in charges that allege the defendants submitted false claims to DOL's Office of Workers' Compensation Program (OWCP) on behalf of VA and other federal agencies. The defendants, who worked for a private healthcare provider, assigned inaccurate billing codes to increase the practice's OWCP reimbursement payments. Some of the medical procedures were medically unnecessary, while others were not even performed. The investigation revealed that both defendants conspired with each other and additional accomplices to perpetuate the fraud for a period of approximately six years. The loss to VA is approximately \$2.9 million.

Individual Pled Guilty in Identity Theft Scheme

A subject pled guilty to conspiracy to commit identity theft, false personation of an employee of the United States, and access device fraud. An OIG investigation revealed that the defendant stole personally identifiable information (PII) from 30 elderly veterans by calling them and purporting to be a Veterans Benefits Administration employee. Once the defendant obtained their PII, he fraudulently ordered credit cards in their names and, in some instances, withdrew money from their bank accounts. The defendant was sentenced to 50 months' incarceration and three years' supervised release and was ordered to pay over \$70,000 in restitution.

Audits and Reviews

Emergency Cache Program: Ineffective Management Impairs Mission Readiness

The OIG audited the Veterans Health Administration's (VHA) Emergency Cache Program to determine if it is maintained in a mission-ready status. The VA established the program after 9/11 to ensure drugs and medical supplies are available in the aftermath of a local mass casualty event. Valued at \$44 million, VA maintains emergency caches at 141 VA medical facilities nationwide. The OIG found expired, missing, or excess drugs (or some combination) at all caches. Also, there were no required wall-to-wall inventories conducted by VA. The OIG found the mission-ready status of the caches was impaired by ineffective management. The OIG recommended enhancing oversight of the program, requiring that all caches perform annual inventories, and improving cache inventory management. The OIG also recommended VHA assess whether the program is properly aligned and coordinate with other VA offices to determine responsibilities. Finally, the OIG recommended identifying drugs and supplies that can be used in medical facilities' general operations.

Healthcare Inspections

Alleged Concerns in Sterile Processing Services at the New Mexico VA Health Care System, Albuquerque, New Mexico

An inspection of Sterile Processing Services (SPS) at the New Mexico VA Health Care System did not reveal tampering with equipment or incorrectly stored or damaged sterile sets. Some surgical procedures were, however, delayed or canceled due to unavailable sterile instruments and equipment. While no patients experienced adverse clinical outcomes, three patients were exposed to increased risks for adverse clinical outcomes. The OIG could not establish that a two-month increase in surgical delays after a contract for technicians lapsed in 2017 was related to staffing. Documentation deficiencies related to standard operating procedures and staff training were identified. The Veterans Integrated Service Network (VISN) did not provide effective oversight and the facility did not effectively implement action plans, as evidenced by recurring findings reported in multiple inspections. Recommendations were made related to sterile sets, patient safety event reporting, SPS processes,

implementation of action plans, the SPS risk assessment, and independent verification of action plans by the VISN.

Comprehensive Healthcare Inspection Program Reviews

Comprehensive Healthcare Inspection Program (CHIP) reviews are one element of OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year. The following are OIG's current areas of focus:

- (1) Leadership and Organizational Risks;
- (2) Quality, Safety, and Value;
- (3) Credentialing and Privileging;
- (4) Environment of Care;
- (5) Medication Management;
- (6) Mental Health Care;
- (7) Geriatric Care;
- (8) Women's Health; and
- (9) High-Risk Processes.

In October, CHIP reviews were published for the following sites:

Charles George VA Medical Center, Asheville, North Carolina

VA Boston Healthcare System, Massachusetts

Louis A. Johnson VA Medical Center, Clarksburg, West Virginia

To listen to the podcast on the OIG's October 2018 activity highlights, go to www.va.gov/oig/podcasts.