DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

FEBRUARY 2023 HIGHLIGHTS

Congressional Testimony

Inspector General Testified before the House Veterans' Affairs Committee

Inspector General Michael J. Missal testified before a hearing of the House Veterans' Affairs Committee on February 28, 2023. The hearing focused on enhancing accountability at VA. Mr. Missal spoke about OIG reports that emphasized the need for five foundational elements of accountability: (1) a strong governance structure and clarity of individual roles and responsibilities; (2) adequate staffing of qualified personnel; (3) updated information technology systems and business processes; (4) effective quality assurance and monitoring; and (5) strong and stable leadership. Mr. Missal answered questions regarding OIG findings on military sexual trauma coordinators, processing Camp Lejeune benefit claims, and the effect of frequent turnovers in leadership on accountability. A recording of the hearing is available on the committee website.

Office of Investigations

This office investigates potential crimes and civil violations of law involving VA programs and operations concerning VA employees, contractors, beneficiaries, and other individuals. These investigations focus on a wide range of matters, including healthcare, procurement, benefits, construction, and other fraud; cybercrime and identity theft; bribery and embezzlement; drug offenses; and violent crimes. The following investigations had significant developments this month.

Healthcare Investigations

Medical Equipment Manufacturer Agreed to Pay $2.5 Million to Resolve False Claims Act Allegations

A VA OIG investigation resolved allegations that from 2014 to 2019, a medical equipment manufacturer failed to follow the price reductions clause in a VA contract that required the defendant to provide VA with the lower prices offered to another customer. As a result, VA allegedly paid more than it should have for patient monitoring equipment. The settlement also resolves allegations that the defendant failed to follow a related clause in a Defense Logistics Agency contract. The defendant entered into a civil settlement in the District of Columbia under which it agreed to pay $2.5 million to resolve these alleged False Claims Act violations.

Acupuncture Clinic Also Entered into Civil Settlement for $300,000 to Resolve False Claims Act Allegations

In another False Claims Act case, a VA OIG proactive investigation resolved allegations that an acupuncture clinic billed VA's Community Care program for nonreimbursable acupuncture claims that were not authorized, not allowed as coded, or lacked supporting documentation. The defendant entered into a civil settlement in the Middle District of Tennessee and agreed to pay $300,000.

Former Purchasing Agent at the VA Medical Center in Chicago, Illinois, Sentenced for Role in Bribery Scheme

Between 2018 and 2020, a former purchasing agent at the Jesse Brown VA Medical Center conspired to purchase medical supplies from a vendor in exchange for kickbacks. The vendor received approximately $330,000 in VA purchase card orders, and the purchasing agent received more than $39,000 in kickbacks. The former purchasing agent was sentenced in the Northern District of Illinois to three years' probation and ordered to pay restitution of more than $39,800 after previously pleading guilty to bribery of a public official. The VA OIG investigated the case.

Two Defendants Sentenced for Drug Distribution

An investigation by the VA OIG and Drug Enforcement Administration Narcotics Task Force revealed that in June 2019, a veteran died of a fentanyl-laced oxycodone pill overdose while at a residential VA rehabilitation center. During the investigation, another veteran and his girlfriend were identified as the suppliers of the pills to the decedent. The defendants were sentenced in the Southern District of California to 72 months' imprisonment and 75 months' imprisonment, respectively, after previously pleading guilty to the distribution of fentanyl. Both defendants were also sentenced to three years' probation.

Former VA Psychiatrist Charged with Sexual Battery by Fraudulent Representation

Another VA OIG investigation resulted in charges alleging that a former VA Palo Alto Healthcare System psychiatrist engaged in an inappropriate sexual relationship with one of her assigned VA patients. The psychiatrist was arrested after being charged in Santa Clara County Superior Court with sexual battery by fraudulent misrepresentation.

VA Registered Nurse Charged with Committing a Lewd and Lascivious Act on a Dependent Person

In another case involving a healthcare provider, a VA OIG investigation resulted in charges alleging that a VA Palo Alto Healthcare System registered nurse engaged in inappropriate sexual contact at the facility with a mentally incapacitated veteran who was receiving inpatient treatment. The defendant was arrested after being charged in Santa Clara County Superior Court with committing a lewd or lascivious act on a dependent person.

Benefits Investigations

Two Defendants Indicted in Connection with Education Benefits Fraud Scheme

A VA OIG investigation resulted in charges alleging the owner and certifying official of a non-college-degree school conspired to submit fraudulent information to conceal the school's noncompliance with the rules and regulations of the Post-9/11 GI Bill program. Between September 2012 and August 2018, VA paid more than $17.8 million to the school. The school has since withdrawn from the Post-9/11 GI Bill program. The defendants were indicted in the District of New Hampshire on charges of conspiring to submit a false claim and a false statement.

Career School and its Director Ordered to Pay Over $9 Million to Settle False Claims Act Allegations

The director of a career school entered into a settlement agreement to resolve allegations of falsely certifying to VA and the Texas Veterans Commission that the school had been operating for more than two years in order to obtain approval to enroll Post-9/11 GI Bill students. A nonaccredited career school must operate for at least two years before being eligible to enroll students receiving Post-9/11 GI Bill benefits. The director allegedly provided fictitious documents to appear as though the school had been operating for more than two years despite forming the school less than a year before applying for approval. The loss to VA is approximately $2.3 million. The director and the school were ordered in the Western District of Texas to pay over $9 million in damages and civil penalties under the False Claims Act. The case was investigated by the VA OIG.

Two Defendants Charged with Wire Fraud

Two former owners of a business that claimed they provided home health services to VA beneficiaries allegedly conspired to submit hundreds of fraudulent applications to VA for pension with aid and attendance benefits on behalf of veterans or their surviving spouses. Aid and attendance is a higher monthly pension amount paid to a qualified veteran or surviving spouse for assistance with activities of daily living. The defendants also were alleged to have falsely claimed providing the home assistance to the veterans or surviving spouses before submitting the applications. As a result of these claims, the defendants allegedly received over $2.1 million in VA funds intended for more than 70 veterans or their surviving spouses. Following the VA OIG investigation, the former business owners were charged in the Eastern District of Louisiana with wire fraud.

Defendant Sentenced in Connection with Compensation Benefits Fraud Scheme

An investigation by the VA OIG and Social Security Administration (SSA) OIG revealed that multiple individuals conspired to submit fraudulent documents and misrepresent the severity of their disabilities to obtain VA compensation benefits. The defendant was sentenced in the District of Maryland to five years' probation after being found guilty at trial of conspiracy and theft of government property. The defendant's daughter and ex-son-in-law were previously sentenced in connection with this investigation after pleading guilty to the same charges. The daughter was sentenced to 30 months' imprisonment and 36 months' probation; the ex-son-in-law was sentenced to 18 months' home detention and five years' probation. All three defendants were ordered to jointly pay restitution of approximately $1 million. The loss to VA is approximately $964,000. The daughter also fraudulently received about $36,000 in SSA disability insurance benefits for her claimed disabilities.

Rooming House Operator Sentenced in Connection with Theft Scheme

From March 2009 to February 2020, a rooming house operator used VA and SSA benefit funds for personal expenses that were intended for the care of elderly veterans with mental illnesses or physical disabilities. The house operator was sentenced in the District of Columbia to 32 months' imprisonment, 36 months' supervised release, and ordered to pay restitution of more than $523,600 after previously

pleading guilty to mail fraud and false statements. The scheme resulted in the theft of more than $400,000 in government benefits from tenants of her rooming house, including at least $170,000 in VA funds. The VA OIG, SSA OIG, and the Special Inspector General for the Troubled Asset Relief Program conducted the investigation.

Investigations Involving Other Matters

Former VA Nurse Pleaded Guilty in Connection with Workers' Compensation Fraud Scheme

An investigation by the VA OIG and Department of Labor (DOL) OIG revealed that from 2015 through 2021, a former nurse at the VA Medical Center in Chillicothe, Ohio, submitted fraudulent reimbursement claim forms to DOL's Office of Workers' Compensation Program for medication she claimed to use due to an injury that resulted from her VA employment. In support of these false claims, the defendant attached fraudulent homemade receipts pertaining to medication for which she had not paid nor received. After reimbursing the defendant for the fraudulent medication claims, DOL then charged back those amounts to VA. The loss to VA is approximately $932,000. The defendant pleaded guilty in the Southern District of Ohio to healthcare fraud.

Veteran Sentenced for Assault on a Federal Officer

A veteran assaulted two VA police officers at the San Diego VA Medical Center after facility staff attempted to treat him. During the altercation with police, the defendant gained control of an officer's service-issued firearm and attempted to shoot another officer but missed. The round went through the patient room wall and into a neighboring patient's room that was occupied. The neighboring patient was unharmed. The defendant was sentenced in the Southern District of California to 18 months' imprisonment and three years' supervised release after previously pleading guilty to assault on a federal officer. The VA OIG and VA Police Service conducted this investigation.

Incarcerated Veteran Sentenced for Threatening VA Employees

An incarcerated veteran sent a communication to VA in which he threatened employees at VA and a nonprofit organization after he received a notification from VA that, per policy, his monetary benefits would be reduced during his incarceration. The veteran was sentenced in the District of Massachusetts to 14 months' imprisonment and three years' supervised release after previously pleading guilty to the interstate transmission of a threatening communication. The VA OIG, Federal Bureau of Prisons, and Federal Bureau of Investigation conducted the investigation.

Veteran Sentenced for Making Threats against VA Doctors

A multiagency investigation involving the VA OIG, VA Police Service, and US Marshals found that a veteran called the White House VA Hotline and threatened to injure and kill doctors at the Fargo VA Medical Center in North Dakota. The veteran was sentenced in the District of North Dakota to 12 months' imprisonment and three years' supervised release after previously pleading guilty to communicating interstate threats.

Office of Audits and Evaluations

This office provides independent oversight of VA's activities to advance the integrity of its programs and operations. Its work helps VA improve its program results, promotes economy and efficiency, strengthens controls over the delivery of benefits, identifies potential fraud, verifies compliance with laws and regulations, and enhances veteran care and support. The Office of Audits and Evaluations released the following reports this month.

Featured Report

Security and Incident Preparedness at VA Medical Facilities

VA is responsible for securing 171 nationwide medical facilities. Persistent police staffing shortages and concerns about serious incidents led the OIG to conduct this review to provide VA leaders with a snapshot of observed conditions. OIG teams assessed whether 70 VA facilities had established minimum security plans and taken required actions per VA policy. The OIG identified multiple security vulnerabilities and deficiencies. These included staffing challenges contributing to the lack of a visible and active police presence, and insufficient security personnel resources such as suitable police operations rooms, operable surveillance cameras with consistent monitoring, and adequate equipment. Additional measures were also needed for "target hardening," such as securing doors and restricting access to high-risk areas. Facilities could also improve communication with local law enforcement and incident readiness trainings. VA concurred with the OIG's six recommendations related to police staffing and other measures to improve vulnerabilities in security and incident preparedness. The OIG has produced an introductory video to the report featuring Deputy Assistant Inspector General Leigh Ann Searight with the Office of Audits and Evaluations. In a recent Veteran Oversight Now podcast, an audit director who worked on this report provides a behind-the-scenes look at how the VA OIG evaluated the security posture of 70 VA medical facilities over three days.

Financial Efficiency

Financial Efficiency Inspection of the VA Palo Alto Health Care System in California

This inspection assessed the stewardship and oversight of the healthcare system's funding, specifically whether the system had appropriate controls and monitoring for financial activities and administrative processes. The team could not verify that anyone reviewed 10 financial obligations during the FY 2021 (and available first quarter FY 2022) review period. In addition, two obligations had residual funds totaling approximately $3,100 that should have been deobligated. Based on sampled transactions, the team also estimated that noncompliance errors were not identified in approximately 7,200 of 16,700 purchase card transactions, totaling approximately $26.9 million. Inventory management could improve by verifying correct stock levels and inventory, establishing enhanced inventory processes and

procedures, implementing training, and maintaining supply chain performance measures. Finally, the team found that pharmacy operations could improve by narrowing observed and expected drug cost gaps, keeping turnover rates to recommended levels, and meeting reconciliation requirements. VA concurred with the OIG's nine recommendations.

Financial Efficiency Inspection of the Northern Arizona VA Health Care System

The VA OIG also examined how the Northern Arizona system was managing its funding. The inspection team looked at four areas to determine if appropriate controls and oversight were in place for open obligations, purchase card use, inventory and supply management, and pharmacy operations. The team reviewed available data from fiscal year 2022 and made several determinations. The OIG found inactive obligations were not always being reviewed, some were not deobligated, and quality assurance reviews were not always completed. The healthcare system did not always reconcile transactions promptly or consider using contracts. It also needs to improve the accuracy of inventory data and could increase inventory turnover, as well as ensuring the required reconciliation process is completed. The OIG made 10 recommendations to address the deficiencies identified.

Employment Suitability

Personnel Suitability Process Concerns at the Beckley VA Medical Center in West Virginia

VHA's personnel suitability program is intended to ensure that employees hired to care for patients or handle veterans' sensitive information undergo background investigations and are suited to hold their positions. After a former nursing assistant pleaded guilty in 2020 to second-degree murder of seven patients at a VA medical center in Clarksburg, West Virginia, an OIG inspection found the Clarksburg facility did not adjudicate her background investigation within 90 days. This prompted an OIG audit of the suitability program, during which deficiencies were identified at the Beckley VA Medical Center in West Virginia. Some employees did not have a background investigation initiated or were not fingerprinted, while other investigations were delayed, incorrectly discontinued, or not completed within timelines. This was due to understaffing at the facility and inadequate regional and national oversight. VHA concurred with the OIG's three recommendations to ensure suitability personnel meet background investigation requirements at Beckley.

Office of Healthcare Inspections

This office assesses VA's efforts to maintain a fully functional healthcare program that promotes high-quality patient care and safety and prevents adverse events. Staff conduct inspections prompted by OIG hotline complaints, congressional requests, and other leads. The office also performs inspections of vet centers and individual medical centers, healthcare systems, networks, and community providers. The Office of Healthcare Inspections released the following reports this month.

Healthcare Inspections

Delayed Cancer Diagnosis and Deficiencies in Care Coordination for a Patient at the Overton Brooks VA Medical Center in Shreveport, Louisiana

The OIG evaluated allegations that a primary care provider neither timely identified nor informed a patient of a cancer diagnosis. The OIG identified additional concerns during the inspection. In early 2019, while an inpatient, the patient underwent a scan that showed a liver lesion. The inpatient provider did not document the findings or follow-up needs in the discharge summary. During four primary care visits, the provider's notes lacked documentation of the lesion and follow-up. In summer 2019, the patient reported that imaging at a community hospital identified a liver tumor, and the facility primary care provider ordered a new scan that showed a liver mass and lesion. The OIG found no documentation that the patient was informed of the abnormal findings. The patient died in fall 2019. Facility leaders and staff did not take timely administrative action in response to the patient's adverse event. The OIG made four recommendations.

Inadequate Outpatient Mental Health Triage and Care of a Patient at the Chico Community-Based Outpatient Clinic in California

This inspection evaluated allegations that following an unscheduled VA mental health visit, a patient was involved in a violent incident with family members and that facility leaders did not address clinic employee concerns. The OIG substantiated that the patient presented "highly agitated," "was sent home," and later had a violent altercation. The allegation was not substantiated, however, that facility leaders failed to address employee concerns. In addition, the OIG found that a nurse practitioner did not have same-day availability, align medication management with treatment guidelines, document a rationale for medication choices, document instructions accurately, or schedule a follow-up appointment timely. A triage social worker also did not document risk and protective factors, reasons for the patient's inability to complete the risk assessment, or attempt to ask the family member about risk and protective factors. Facility leaders did not complete an institutional disclosure as well. The OIG made five recommendations to the VA Northern California Health Care System director.

Deficiencies in the Patient Safety Program and Oversight Provided by Facility and VISN Leaders at the Tuscaloosa VA Medical Center in Alabama

The OIG reviewed concerns related to the Patient Safety Program at the Tuscaloosa VA Medical Center (the facility) and the oversight provided by facility and Veterans Integrated Service Network (VISN) 7 leaders. A VA issue brief detailed concerns including failures to timely finalize approximately 160 patient safety incident reports and to complete required patient safety root cause analyses and risk assessments. Additional concerns related to the former Patient Safety Manger (PSM) not attending facility and VISN committee meetings. The former PSM attributed deficiencies in part to lack of support, supervisory engagement, and resources. Although the facility's organizational structure permitted multiple pathways for oversight of the Patient Safety Program, there were missed

opportunities to identify or mitigate gaps in the program. The OIG concluded that these missed opportunities were in part due to lack of action by facility leaders. VA concurred with the OIG's 11 recommendations related to patient safety event reporting, program oversight, and accountability.

Comprehensive Healthcare Inspections

Comprehensive Healthcare Inspection Program (CHIP) reports are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis. See the Purpose and Scope section of each report for the areas of focus at the time of the inspection. This month's reports focused on the Memphis VA Medical Center in Tennessee.

Featured Hotline Case

The OIG's hotline staff accept complaints from VA employees, the veteran community, and the public concerning criminal activity, waste, abuse, and mismanagement of VA programs and operations. The following is a case opened by the Hotline Division that was not included in the inspections, audits, investigations, or reviews detailed above.

Veteran Improperly Received Full VA Disability Compensation after Being Incarcerated

An anonymous complainant reported a veteran was collecting full VA disability compensation benefits while incarcerated for a felony conviction. The complainant provided information from the Federal Bureau of Prisons' inmate locator tool showing the veteran had been incarcerated at a federal corrections facility eight months prior to the date the OIG received the complaint. The matter was referred to the St. Paul Regional Office for further investigation. As a result of the investigation's findings, the veteran's VA disability compensation benefits were retroactively reduced, resulting in an overpayment of more than $15,000. The veteran did not dispute the incarceration but admitted to being unaware that incarceration for felony convictions affects VA disability compensation. VA was advised of the findings.

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To listen to the podcast on the February highlights, go to www.va.gov/oig/podcasts.