# AUGUST 2025 HIGHLIGHTS

## 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 in August.

### Healthcare Investigations

#### Former Nurse at Texas VA Medical Center Pleaded Guilty to Falsely Claiming She Had Checked on a Patient Who Ultimately Died

A VA OIG investigation revealed a former nurse at the Michael E. DeBakey VA Medical Center in Houston, Texas, made false entries in the VA's Computerized Patient Record System in which she claimed to have observed a patient on several occasions during her shift on July 26–27, 2024. Contrary to these entries, evidence revealed the former nurse did not have any contact with the patient at those times. Early on July 27, medical personnel found the patient unresponsive and ultimately pronounced him dead. The former nurse pleaded guilty in the Southern District of Texas to making or using false writings or documents.

#### Two Former VA Employees and Two Surgical Sales Representatives Sentenced for Bribery Scheme

A multiagency investigation revealed that two surgical sales representatives, who were employed as independent contractors for an orthopedic product distributor, defrauded VA with the help of two VA employees who were working at that time at the James H. Quillen VA Medical Center in Mountain Home, Tennessee. Following VA-authorized orthopedic surgeries involving their employer, the sales representatives billed the medical center for both prosthetic-related implant items and non-implant items such as surgical instruments and components. They sent their employer's invoices for implant items to the appropriate medical center department and VA paid the orthopedic product distributor. However, they directed invoices for the non-implant items to two VA employees who sent payments to a pair of shell companies created by the sales representatives. As the scheme evolved, the sales representatives often double-billed VA by submitting fraudulent invoices for non-implant items from both shell companies for the same single surgery. The invoices regularly included a vast array of unnecessary surgical instruments and costs were often 7 to 10 times higher than non-implant costs for similar surgeries previously completed by the medical center. For their roles in the scheme, these former VA employees routinely received envelopes of cash totaling more than $80,000 from the sales representatives.

They were sentenced in the Eastern District of Tennessee to eight months' imprisonment, 36 months' supervised release, and each ordered to pay restitution of about $213,000 to VA after pleading guilty to "honest services" fraud. The two sales representatives were sentenced to 12 months and one day of imprisonment, 36 months' supervised release, and each ordered to pay restitution of about $120,000 to VA after pleading guilty to bribery. The loss to VA is about $3.7 million. The investigation was conducted by the VA OIG, Internal Revenue Service Criminal Investigation (IRS-CI), and General Services Administration OIG.

### Physical Therapy Practice Employee Sentenced for Healthcare Fraud Conspiracy

A former medical biller from a physical therapy practice was sentenced after pleading guilty to conspiracy to commit healthcare fraud. The multiagency investigation revealed that between January 2007 and October 2021, the practice's two founders and its employees used unlicensed technicians to provide physical therapy treatment and billed the treatment as if it were performed by a licensed physical therapist or physical therapy assistant. They also regularly billed for treatment time in excess of the actual treatment time spent with patients. The former medical biller is 1 of 18 defendants, including the practice founders, who either pleaded guilty or were found guilty at trial. Two additional employees were charged but were found not guilty at trial. The former medical biller was sentenced in the Western District of Pennsylvania to 36 months' probation and ordered to pay restitution of $26,000. The total loss to the government is about $20.3 million. Of this amount, the total loss to VA is about $500,000. The VA OIG, Defense Criminal Investigative Service, Department of Health and Human Services OIG, Office of Personnel Management OIG, Pennsylvania Office of Attorney General, and FBI conducted this investigation.

## Benefits Investigations

### Son of Deceased VA Beneficiary Charged with Wire Fraud

A VA OIG and Social Security Administration OIG investigation resulted in charges alleging that from about April 2005 through March 2022, a son withdrew VA and social security benefits payments totaling about $350,000 from his deceased mother's bank account—who was a surviving spouse of a World War II veteran. Of this amount, the total loss to VA is more than $305,000. He was charged in the Middle District of Pennsylvania with wire fraud.

### Veteran Indicted in Connection with a Compensation Benefits Fraud Scheme Was Arrested After Evading Law Enforcement for More than a Year

Another VA OIG and Social Security Administration OIG investigation supported charges alleging that a veteran fraudulently represented to VA in May 2023 that he had been wheelchair-bound since 2004 and was unable to walk or stand. However, he was documented and recorded walking and standing without the assistance of any mobility devices on numerous

occasions, to include three times after evaluation appointments that he attended in a wheelchair. In February 2024, the US Attorney's Office issued the veteran a target letter (a formal notification informing him of being the subject of a federal criminal investigation) and subsequently provided him with defense counsel. In April 2024, the veteran allegedly fled the state of Maine after faking his own death. When it was discovered he had not died, a search was initiated. He was charged in the District of Maine with false statements and subsequently indicted for the same offense in October 2024. After a search lasting more than a year, he was arrested by the US Marshals Service at an Amtrak train station in La Plata, Missouri. The total loss to VA is more than $244,000.

### Veteran Indicted on Theft and Fraud Charges Related to Veterans Benefits and Federal Student Loans

A VA OIG investigation prompted charges alleging a veteran submitted fraudulent documents to VA to support her claims for monthly compensation benefits. She then used her fraudulent VA disability rating to unlawfully obtain a discharge of her federal student loan debt of more than $242,000. The veteran was indicted in the Northern District of West Virginia on charges of theft of government money, false statements, and student loan fraud. The loss to the government is about $355,000. Of this amount, the loss to VA is about $120,000.

### Owner of Dog Training School Pleaded Guilty to VA Post-9/11 GI Bill Program Fraud

The owner of a dog training school fraudulently accepted payments from the VA Post-9/11 GI Bill Program to train veteran students to become handlers. The VA OIG investigation revealed inconsistences between the training provided to veterans and non-VA supported students. Investigators also identified instances in which the school trained dogs to be service dogs for the veterans but provided those veterans with little or no handler training. The owner also falsified documents submitted to the state approving agency confirming the school's compliance with the two-year operational rule and 85/15 rule.[1] Between May 2018 and July 2020, VA paid $95,700 to the school and $25,021 to veteran students. The owner pleaded guilty in the Western District of Louisiana to theft of government funds.

[1] "Education and Training: School Program Approval," VA, accessed September 8, 2025, https://benefits.va.gov/gibill/School_Program_Approval.asp. Private and not-for-profit educational institutions that do not offer a standard college degree must have been operational for at least two years. "Education and Training: Supported and Non-Supported Students", VA, accessed September 8, 2025, https://benefits.va.gov/GIBILL/85_15/Supported_Non_Supported_Students.asp. The 85/15 rule prohibits paying VA benefits to students enrolling in a program when more than 85 percent of the students enrolled are having any portion of their tuition, fees, or other charges paid for them by the school or VA.

### Former VA Fiduciary Charged with Stealing from Elderly Veterans

Another VA OIG investigation led to charges alleging a VA-appointed fiduciary stole more than $133,000 from an elderly veteran who resided at the Cincinnati VA Medical Center and stole about $15,000 from three other veterans. The former fiduciary used the money for shopping, dining, and traveling to New Orleans, Montego Bay, Cancun, London, Panama, Zurich, Vienna, and the Maldives. She also submitted fraudulent documents to VA to cover up her theft.
The VA referred the case to the VA OIG after ending her fiduciary appointment for possible misuse. She was charged in the Southern District of Ohio with misappropriation by fiduciary and false statements.

## Investigations Involving Other Matters

### Government Contractor Agreed to Pay $3.1 Million to Resolve False Claims Act Allegations

A multiagency investigation resolved allegations that a service-disabled veteran-owned small business (SDVOSB) submitted false bid proposals to obtain 49 government set-aside contracts involving multiple federal agencies by misrepresenting their size, ability to perform on contracts, and the identity of the company's leadership. The business also allegedly violated the limitations on subcontracting by paying more than 50 percent of the contract amount to a non-SDVOSB.
The contractor held a landscaping contract valued at more than $1.3 million at the Boise VA Medical Center that was terminated as a result of this investigation. The business entered into a settlement agreement in the District of Idaho under which they agreed to pay $3.1 million to resolve allegations that it violated the False Claims Act. The settlement total includes restitution of $1 million, from which VA will receive more than $676,000. This investigation was conducted by the VA OIG, Department of Commerce OIG, Air Force Office of Special Investigations, Army Criminal Investigation Division, and Defense Criminal Investigative Service.

### Married Couple Sentenced for Fraudulently Obtaining CARES Act Funds

Another multiagency investigation revealed that a husband and wife improperly used $2 million in Coronavirus Aid, Relief, and Economic Security (CARES) Act funds to purchase their home and engaged in a scheme to avoid paying workers' compensation insurance premiums. The husband was sentenced in the District of Massachusetts to 12 months' imprisonment, 24 months' supervised release with the first six months on home confinement and ordered to pay restitution of more than $627,000 after previously pleading guilty to conspiracy to commit mail, wire, and bank fraud. The husband was further ordered to jointly pay additional restitution of more than $1.6 million with his wife, who was previously sentenced to 27 months' supervised release with the first three months on home confinement. This investigation was conducted in connection

with the Pandemic Response Accountability Committee Fraud Task Force by the VA OIG, Insurance Fraud Bureau of Massachusetts, IRS-CI, and FBI. As a task force member, the VA OIG has assisted federal efforts to prosecute instances of fraud even if these cases do not have a direct nexus to VA programs and operations.

### Orlando VA Medical Center Employee Pleaded Guilty to COVID-19 Fraud Scheme

An investigation by the VA OIG and IRS-CI supported charges alleging an Orlando VA Medical Center employee defrauded the government by obtaining Paycheck Protection Program and Economic Injury Disaster loans for a business that did not exist. She and her husband allegedly used the funds for their own personal expenses, although the husband has yet to be charged. The total loss to the government is about $140,000. The employee pleaded guilty in the Middle District of Florida to making a false claim.

### Veteran Sentenced for Threatening a Mass Casualty Event

A multiagency investigation revealed that a veteran threatened a mass casualty event during calls to the Veterans Crisis Line and the Crisis Center in Comal County, Texas. During a subsequent search of the veteran's home, investigators seized a cache of weapons and ammunition. The veteran was sentenced in the Western District of Texas to 25 months' imprisonment and 36 months' supervised release after previously pleading guilty to the illegal possession of a machine gun, possession of an unregistered firearm, and attempted tampering with records or objects. This investigation was conducted by the VA OIG, Texas Department of Public Safety, and Bureau of Alcohol, Tobacco, Firearms, and Explosives.

## Administrative Investigation

The Office of Special Reviews within the Office of Investigations conducts administrative investigations and increases the OIG's flexibility and capacity to conduct reviews of significant events and emergent issues not squarely within the focus of a single OIG directorate or office. This office released the following report in August.

### Former Acquisition Academy Executive Violated Ethical Standards and VA Policy

The VA OIG investigated allegations that the chancellor of the VA Acquisition Academy engaged in misconduct in connection with an August 2023 training symposium held at a conference center hotel in Aurora, Colorado. The VA OIG found that the former chancellor accepted gifts from the conference center and failed to disclose them on her 2023 public financial disclosure as required. She also directed VA staff to solicit and accept sponsorships for social events held during the symposium and discouraged her executive assistant from asking questions or seeking guidance regarding possible ethics violations. The VA OIG recommended that VA consider whether additional training is necessary regarding sponsorships for VA events,

acceptance of free meals, and whether VA ethics officials need to take additional steps regarding the then chancellor's 2023 public financial disclosure. VA concurred and provided acceptable responses to the VA OIG's recommendations.

# 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 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 released the following reports in August.

## Featured Report

### VISN 12 Needs to Improve How It Administers the Veterans Community Care Program

This review found VISN 12 medical facilities, covering parts of Illinois, Indiana, Michigan, and Wisconsin, did not consistently identify veterans eligible for community care, inform them of their care options, and deliver timely care. Among the causes, schedulers lacked the means to identify all available appointments. VHA guidance was also uneven, requiring schedulers to check all eligibility criteria for *new* patients but only check wait times for *established* patients, hindering care option notifications to existing patients. VISN 12 took 44 days on average from scheduling to appointment for community care and 35 days for VA care—exceeding timeliness goals. In addition, it had about 250 consults incomplete for longer than one year. The VISN 12 director concurred with the OIG's four recommendations to improve scheduler performance. The OIG has two planned follow-up national reviews regarding eligibility and care option notifications, as well as timeliness of care.

## Health Care

### Pharmacy Automated Dispensing Cabinets Need Improved Monitoring for Accountability over High-Risk Medications

The VA OIG reviewed whether controls at VHA medical facilities ensure accountability when staff remove high-risk medications from automated dispensing cabinets using generic, rather than patient-specific, information. Of the two types of cabinets reviewed—referred to as A and B—the OIG estimated that in fiscal year 2024, medical facilities could not fully account for 46 percent of medications removed using generic information from cabinet A. Cabinet B transactions could not be projected due to data limitations but may have similar risks.

Medical facilities' procedures and local policies did not address the monitoring of medication removals using generic information, and some staff used generic information for convenience or efficiency. The OIG reviewed 40 transactions in which staff removed controlled substances using generic information and found one instance in which a facility could not trace a controlled substance to a specific patient. VHA policy does not prohibit using cabinets to store controlled substances, but it does require facilities to maintain full accountability over them through an electronic record that tracks the medication's removal from a cabinet to its final dispensation. Removing medications without using a patient's name increases the risk of drug diversion, so this practice should be closely monitored. VHA concurred with the VA OIG's three recommendations.

### Facilities Faced Challenges Retrieving Medical Records from Community Providers and Importing Them into Veterans' Electronic Health Records

Community providers must return medical records to VHA when veterans receive care in the community. If they do not, VHA staff must document that the veteran received care and attempt to retrieve the records. The OIG reviewed whether VHA appropriately retrieved and documented medical records from community providers and imported them into veterans' electronic health records. As of December 2024, VHA had closed nearly three million community care consults, and more than 2.4 million (82 percent) had medical records attached. However, 71,447 consults remained open, virtually all for more than 90 days beyond the scheduled appointment. While 62 facilities imported records 90 percent or more of the time, 11 facilities did so less than 60 percent of the time. Competing priorities and unclear policy, among other challenges, affected records processing. VHA concurred with nine of the OIG's 10 recommendations, with one concurrence in principle, to correct identified deficiencies.

## Financial Efficiency

### Independent Audit Report on Invoices Submitted by a Graduate Medical Education Affiliate to the VA Nebraska–Western Iowa Health Care System

Under an agreement with VA, a Nebraska university provides the services of health professions trainees (residents) to the Omaha VA Medical Center, and VA reimburses the university for the residents' services. The medical center received a complaint that a university official inflated the time worked, potentially resulting in overbilling of $1.9 million, and signed the records as the VA site director, an act that would constitute a conflict of interest. Because the medical center did not have the required educational activity records for July 1, 2016, through June 30, 2020, the OIG could not determine whether the invoices were accurate. The OIG could not determine whether VA overpaid for resident services during that time. On July 1, 2020, the medical center began keeping educational activity records, enabling the OIG to verify attendance.

Finding no overbillings and no conflicts of interest, the OIG made no recommendations to the medical center.

## Management Advisory Memorandum

### VA's Compliance with the Statutory Transfer of Funds Authority and Change of Program Requirements During the Presidential Transition

Senator Bill Hagerty of Tennessee requested that the OIG assess VA's compliance with statutory transfer of funds limitations listed in sections 202, 217, 218, 227, 230, 231, 245, and 405 of the Consolidated Appropriations Act, 2024, for the period of the presidential transition and while under a continuing resolution. The OIG found no issues with six of the eight sections reviewed. While the OIG found quarterly reports provided under section 217 were late, no action was requested because a previous OIG recommendation in this area remains open. Additionally, under section 227, in some cases, VA did not notify Congress 15 days before organizational changes that resulted in the transfer of 25 or more full-time equivalents from one organizational unit of the department to another as required. The OIG requested that the Office of Management inform the OIG what action, if any, is taken to notify Congress 15 days before these types of organizational changes occur.

## Information Technology

### VA Can Strengthen Appeals Processing and Tracking by Improving Caseflow Program Management

Veterans can submit compensation claims for disabilities associated with active service, and if they disagree with VA's decision on the claim, they may appeal it. To support a new appeals system, VA adopted a technology system called Caseflow. The OIG conducted this audit to assess the Office of Information and Technology's program management of Caseflow. Overall, the OIG found VA lacked an enterprise-wide governance structure over the system, limiting oversight during development and leading to inefficient reporting and inadequate functionality. The contractor's development process and staffing were inconsistent with contract requirements, which also affected development. Consequently, some VBA program offices have decided to stop using Caseflow. The OIG made one recommendation to the assistant secretary for enterprise integration to evaluate the need for an enterprise-wide governance structure and two recommendations to the assistant secretary for information and technology and chief information officer to develop a road map and enforce contract requirements. VA concurred with these recommendations.

# 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 inspects vet centers and individual medical centers, healthcare systems, networks, and community providers. The Office of Healthcare Inspections issued the following August reports.

## National Reviews

### OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2025

As mandated by law, the OIG annually collects responses via surveys to VHA facilities and determines a minimum of five clinical and five nonclinical VHA occupations with the largest "staffing shortages" (as defined by statute) within each VHA medical center.[2] The OIG also compared the number of severe shortages against the previous seven years' reports to assess changes. The most significant findings in this year's staffing report included the following:

- In fiscal year 2025, VHA facilities reported a total of 4,434 severe occupational staffing shortages, a 50 percent increase from fiscal year 2024.
- Ninety-four and 79 percent of facilities reported severe occupational staffing shortages for medical officer and nurse occupations, respectively.
- Psychology was the most frequently reported severe clinical and Hybrid Title 38 occupational staffing shortage.
- Police was the most frequently reported severe nonclinical occupational staffing shortage (reported by 58 percent of facilities) and the most frequently reported of all occupations.
- All 139 VHA facilities identified staffing shortages.

### Inconsistent Implementation of VHA Oncology Program Requirements Due to Insufficient Oversight

The OIG conducted a national review to examine the infrastructure and oversight of VHA oncology programs and found inconsistent implementation of VHA requirements. Not all VISNs had an established multidisciplinary cancer committee, and no VISNs had submitted an inventory of oncology services or facility points of contact within the last year to the National

[2] The governing statutes are the Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 Stat. 1754 (2014) and the VA Choice and Quality Employment Act of 2017, Pub. L. No. 115-46, 131 Stat. 958 (2017) § 201.

Oncology Program Office as required. Only 66 percent of facilities had an established cancer committee or had partnered with another facility or VISN to provide the required committee functions, and a majority of VISNs had not fully complied with the requirement for complexity level 1 and 2 facilities to pursue membership in specific clinical trial organizations. The OIG found a lack of oversight contributed to the inconsistent implementation of oncology program requirements. The under secretary for health concurred with the five recommendations and provided an action plan to address them.

## Healthcare Inspections

### Leaders Did Not Adequately Review and Address a Dental Hygienist's Quality of Care at the VA Southern Nevada Healthcare System in Las Vegas

The OIG inspected the VA Southern Nevada Healthcare System in Las Vegas to analyze the facility leaders' response to allegations that a dental hygienist failed to follow VHA and facility policies and provide quality care. The OIG determined that supervisors did not ensure the correction of patient safety concerns after having knowledge of repeated care concerns for about two years. Specifically, there were supervisory deficiencies related to a "factfinding," a performance improvement plan, patient safety reporting, and the state licensing board reporting process. Additionally, the chief of staff did not ensure the consideration of a management review of the dental hygienist's care or use high reliability organization principles to seek knowledge of the extent of the patient safety concerns. The VISN and facility directors concurred with the eight recommendations.

### Deficiencies in Quality of Care and the Root Cause Analysis Process at the Overton Brooks VA Medical Center in Shreveport, Louisiana

The OIG assessed the care of a hospitalized patient at the Overton Brooks VA Medical Center and found deficiencies with clinical management. Specifically, a physician mismanaged the patient's medication and the staff mismanaged the patient's distressed behaviors. The physician lacked knowledge about the patient's diagnosis and clinical response to a medication before discontinuing it. Facility staff did not implement strategies to mitigate the patient's distressed behaviors, such as implementing a one-to-one observation, activating a behavioral patient record flag, or using the electronic health record as a communication tool according to policy. The OIG also identified concerns related to a root cause analysis, finding the application of the analysis process did not align with VHA requirements. The facility director concurred with the five recommendations.

## Healthcare Facility Inspections

The Healthcare Facility Inspections (HFI) Program reviews VHA medical facilities approximately every three years to measure and assess the quality of care provided in five areas: (1) culture, (2) environment of care, (3) patient safety, (4) primary care, and (5) veteran-centered safety net (for vulnerable populations such as those served by homeless programs). The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, in addition to the well-being of patients and staff. August's HFI reports examined the following VA healthcare systems:

- Central Ohio Health Care System in Columbus
- Cincinnati Healthcare System in Ohio
- Spokane Healthcare System in Washington
- Texas Valley Coastal Bend Healthcare System in Harlingen

## Vet Center Inspections

Vet Center Inspection Program (VCIP) reports provide a focused evaluation of the quality of care delivered in these community-based clinics that provide a wide range of psychosocial services to clients. Clients include eligible veterans, active-duty service members, National Guard members, reservists, and their families, to support a successful transition from military to civilian life. August's VCIP reports focused on (1) suicide prevention; (2) consultation, supervision, and training; (3) outreach; and (4) environment of care at vet centers in the following areas:

- Midwest District 3 Zone 1: Vet Centers in Fort Wayne, Indiana; Detroit and Escanaba, Michigan; and Cincinnati, Ohio
- Midwest District 3 Zone 3: Vet Centers in Des Moines and Sioux City, Iowa; Kansas City, Missouri; and Rapid City, South Dakota

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To listen to the podcast on the August 2025 highlights, go to the podcasts page on the OIG website.