OCTOBER 2025 HIGHLIGHTS

Congressional Testimony

The OIG actively engages with Congress on issues affecting VA programs and operations. The OIG's participation in congressional hearings helps focus legislative action and elevates national attention on topics of concern within the veteran community. All written statements to Congress can be found on the OIG website.

IG Mason Testified on VA Disability System

Inspector General Cheryl L. Mason testified at a hearing before the Senate Committee on Veterans' Affairs on October 29 about how the OIG combats fraud in the compensation and pension programs administered by the Veterans Benefits Administration. Her testimony highlighted the work of the OIG's Office of Investigations and Office of Audit and Evaluations in protecting those programs from fraud and identifying weaknesses in VA operations.
IG Mason's written statement is available on the OIG website. Watch the full hearing on the Senate Committee on Veterans' Affairs 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 developments in October.

Healthcare Investigations

Former Nurse at Texas VA Medical Center Sentenced for Falsely Claiming She Had Checked on a Patient Who Ultimately Died

A VA OIG investigation revealed a 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 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. She subsequently resigned from VA in February 2025. She was sentenced in the Southern District of Texas to 36 months' probation and ordered to pay a fine of $2,000 after previously pleading guilty to making or using false writings or documents.

Former Inventory Management Specialist at the Cleveland VA Medical Center and Coconspirator Pleaded Guilty to Purchase Card Theft Scheme

A multiagency investigation revealed that an inventory management specialist at the Cleveland VA Medical Center misused his VA-issued purchase card by procuring electronics and other items for his personal use. He sold some of the stolen property to a coconspirator, who then transported the items out of state for resale. The inventory management specialist subsequently resigned from the VA in September 2023. He pleaded guilty in the Northern District of Ohio to theft of government property. The coconspirator pleaded guilty in the same judicial district to the interstate transportation of stolen goods. The total loss to VA is about $198,000. This investigation was conducted by the VA OIG, Lake County (Indiana) Sheriff's Office, and VA Police Service.

Benefits Investigations

Disabled Veteran's Nephew Pleaded Guilty to Concealing Veteran's Death to Steal VA and Social Security Benefits

The nephew of a quadriplegic veteran, who was supposedly residing with and providing care for his uncle, concealed his uncle's death in 2019 and then stole the veteran's VA and Social Security benefits. He used the funds to purchase exotic reptiles and pay for lavish vacations. In March 2025, the Salem Police Department in Missouri discovered the veteran's partially frozen body wrapped in a black trash bag and stuffed inside a garbage can in the nephew's shed as well as multiple firearms during the execution of a search warrant. The loss to the government is more than $1.7 million. Of this amount, the loss to VA is about $1.5 million. The nephew pleaded guilty in the Eastern District of Missouri to charges of wire fraud, aggravated identity theft, and being a convicted felon in possession of firearms. The VA OIG, Social Security Administration OIG, Salem Police Department, and Bureau of Alcohol, Tobacco, Firearms and Explosives investigated this case.

Owner of Barbering and Cosmetology School in Tennessee Convicted of GI Bill Fraud Scheme

An investigation conducted by VA OIG and Internal Revenue Service Criminal Investigation resulted in charges alleging that the owner of a barbering and cosmetology school defrauded VA of about $625,000 in Post-9/11 GI Bill education funds. The owner enrolled veterans in barbering and cosmetology programs at her school but did not provide any actual instruction or training to the students. In furtherance of the scheme, the owner received tuition payments from VA, and the veteran students received monthly housing allowance payments for as long as they were enrolled at the school. The owner paid at least two veterans to recruit other veterans to use their GI Bill benefits to enroll in courses at her school. She advised the veterans that they did not

have to attend class after enrolling to receive payments from VA for monthly housing, books, and supplies. She also made numerous false statements and misrepresentations to VA regarding veterans' attendance, to include submitting false attendance records. The total loss to VA is about $2 million. The owner was found guilty at trial in the Western District of Tennessee on charges of conspiracy to defraud the United States and wire fraud.

Veteran Sentenced for VA Disability Compensation Benefits Fraud

After medically retiring from the Army in 1983 due to an eye condition, a veteran received VA disability compensation benefits with a 100 percent service-connected rating for legal blindness while maintaining a Florida driver's license. The VA OIG proactive investigation revealed the veteran misrepresented his true visual acuity during VA examinations in order to fraudulently receive 100 percent service-connected disability benefits for blindness. Despite his claims to VA, the veteran maintained a Florida driver's license (since 1993) and passed multiple associated vision examinations with the Florida Department of Motor Vehicles. The loss to VA is about $1.1 million. The veteran was sentenced in the Middle District of Florida to 60 months' probation and ordered to pay restitution of about $468,000 to VA after previously pleading guilty to theft of government funds. By pleading guilty, the veteran acknowledged that he fraudulently led VA to believe that he was blind when he was capable of operating a motor vehicle.

Former VA Fiduciary Sentenced for False Statements

A VA OIG and Social Security Administration OIG investigation revealed that between February 2021 and January 2024, the daughter of a veteran, who served as the veteran's VA-appointed fiduciary, withdrew more than $116,000 in VA compensation benefits and almost $74,000 in Social Security benefits from the veteran's account without permission. She used the funds to make personal purchases. She was sentenced in the Southern District of Ohio to 60 months' supervised release and ordered to pay restitution of more than $190,000 after previously pleading guilty to making false statements. Of this amount, VA will receive about $116,000.

Investigations Involving Other Matters

Former Employee of the Manchester VA Regional Office Pleaded Guilty to COVID-19 Fraud Scheme

A veterans service representative with the VA regional office in Manchester, New Hampshire, obtained more than $1 million in Paycheck Protection Program and Economic Injury Disaster loans to supposedly support companies, including a restaurant, he owned and to continue paying his employees during the pandemic. He certified that he would use the loan proceeds solely as working capital and would not use the funds for personal expenses or to relocate the businesses from one location to another. Instead, he fraudulently used some of the funds to help purchase a golf course in Hillsborough. He pleaded guilty in the District of New Hampshire to wire fraud.

As part of the terms of the plea agreement, he agreed to forfeit about $1.1 million in cash. He resigned from the VA regional office during this investigation, which was conducted by the VA OIG, Internal Revenue Service Criminal Investigation, and Small Business Administration (SBA) OIG.

Woman Sentenced for Role in Unemployment Insurance Fraud Scheme

A VA OIG and Department of Labor OIG investigation revealed that a woman obtained fraudulent SBA-backed Paycheck Protection Program loans totaling more than $1 million and both defrauded and attempted to defraud various states by submitting for herself and other individuals approximately 100 fraudulent unemployment insurance applications. She charged individuals for whom she made filings between $1,200 to $1,500 per fraudulent application. Through this scheme, she obtained more than $267,000. The total loss to the government is more than $1 million. She was sentenced in the Eastern District of Louisiana to 41 months' imprisonment and ordered to pay restitution of more than $18,000 to the California Employment Development Department and more than $13,000 to the Louisiana Workforce Commission after previously pleading guilty to conspiracy to commit mail fraud, conducting mail fraud, and making false statements. A restitution hearing to determine the amount owed to the SBA is scheduled for December. The VA OIG conducted the investigation, which was the result of a referral from the COVID-19 Pandemic Response Accountability Committee. As a committee member, the VA OIG assists federal efforts to prosecute instances of fraud even if these cases do not have a direct nexus to VA programs and operations.

Cleveland VA Medical Center Employee Sentenced for COVID-19 Fraud Scheme

A VA employee at the Cleveland VA Medical Center defrauded the government by obtaining two SBA-backed Paycheck Protection Program loans totaling more than $41,000 for a business that neither had any earnings nor was in operation. The VA employee was sentenced in the Northern District of Ohio to six months' home confinement, 60 months' probation, and ordered to pay restitution of more than $41,000 after previously pleading guilty to theft of government funds. Administrative action by VA against the employee is pending. The VA OIG investigated this case.

Former VA Firefighter Sentenced for Workers' Compensation Benefits Fraud

An investigation by the VA OIG and Department of Labor OIG revealed a firefighter at the Lyons VA Medical Center in New Jersey received workers' compensation benefits for injuries incurred while on duty at the facility that purportedly did not allow him to return to work in any capacity. While receiving these benefits and completing annual certifications confirming that he was unable to return to work, he performed firefighting duties for a local municipality and was employed as a long-haul truck driver. He was sentenced in the District of New Jersey to

12 months' home confinement, 36 months' supervised release, and ordered to pay restitution of approximately $479,000 to VA after previously pleading guilty to workers' compensation fraud. He retired from VA during this investigation.

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 October.

Healthcare Delivery

Review of Clinical Contact Centers to Assess Leadership and Oversight

A 2020 initiative to transform VA medical facilities' call centers into regionally managed clinical contact centers, providing veterans 24-hour access to primary care scheduling, pharmacy support, clinical triage, and virtual provider care, was supposed to be complete by December 31, 2021. Center staff were expected to answer calls promptly, with different targets set for different types of calls. The OIG conducted its review from October 2024 through July 2025, with a focus on operations during FY 2024, and found that core services, centers, and schedulers did not meet all expectations, including answering calls promptly, due in part to inadequate oversight. VHA allowed centers to request a temporary exemption, but the waiver policy did not specify what information to include with the request or require review by VHA's chief operating officer. The OIG made nine recommendations. VHA concurred with eight recommendations and concurred in principle with one.

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 released the following reports in October.

Featured Report

Concerns Around Acute Ischemic Stroke Practice

The OIG issued this preliminary result advisory memorandum to highlight a serious patient safety risk related to acute ischemic stroke (AIS) management at the Wm. Jennings Bryan Dorn VA Medical Center (facility) in Columbia, South Carolina. During a healthcare inspection, the OIG found that the facility's AIS practices did not align with VHA or facility policy, leading to delays in diagnosis, evaluation, treatment, and patient disposition. These concerns were shared with VISN and facility leaders during an August 28, 2025, site visit, prompting immediate interim actions. Although facility policy outlined a code stroke protocol and use of the VA National Telestroke Program, the OIG found these were not implemented in inpatient units. The facility has since developed a new standard operating procedure and initiated staff training, and plans to revise its AIS policy. The OIG will continue monitoring progress. Given the critical nature of the issue, the OIG is broadly sharing this preliminary finding to ensure other VHA facilities have information to proactively address similar vulnerabilities across the enterprise. A full inspection report will be published.

Healthcare Inspections

Review of Response to Changes in a Patient's Condition and Quality Reviews at the VA Greater Los Angeles Healthcare System in California

The OIG conducted an inspection to assess care concerns and inadequate quality reviews related to a patient's death. Clinical staff did not timely recognize, address, and further investigate changes in the patient's condition. Neither the resident nor attending physician reviewed or acted upon abnormal laboratory values and did not ensure completion of stat imaging studies. Nurses lacked accurate contact information for the on-call provider and were unable to reach the on-call provider to treat the patient's pain. Nurses missed early warning signs of the patient's clinical deterioration and did not conduct National Early Warning Score assessments as required or intervene when indicated. Nurses also did not complete shift assessments timely. Facility leaders did not conduct a comprehensive review of the patient's care preceding death, and attempts to complete an institutional disclosure were unsuccessful. The facility director concurred with and submitted action plans to address the OIG's seven 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. October's HFI reports examined the following VA systems:

- Eastern Oklahoma Health Care System in Muskogee
- Detroit Healthcare System in Michigan
- Louisville Healthcare System in Kentucky

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. The following VCIP report was published in October.

Inspection of Midwest District 3 Vet Center Operations

This inspection evaluated leadership stability, morbidity and mortality reviews, and the high risk suicide flag (HRSF) SharePoint site within Midwest District 3. There were no findings in leadership stability. The morbidity and mortality review identified that district leaders did not ensure reviews had the required Readjustment Counseling Service (RCS) panel members and contained all required components. The HRSF review identified noncompliance with documentation requirements for high-risk client contacts and outcomes in both RCSNet and the HRSF SharePoint site. This noncompliance was attributed to unclear or insufficient guidance provided to staff. The OIG issued two recommendations for improvement to the district director and one recommendation to the chief officer.

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