NOVEMBER 2025 HIGHLIGHTS

Due to the government shutdown that impacted OIG from October 18 until November 12, fewer reports were completed and released last month. The OIG published six oversight reports in November covering topics such as mental health care, a review of community care utilization and timeliness at the VA Boston Healthcare System, and healthcare facility inspections that examine patient care and safety. Several of these reports are highlighted below, followed by selected criminal investigative updates. Links to a comprehensive list of November reports and investigative updates can be found on page 3.

The OIG has also begun issuing Preliminary Result Advisory Memorandums (PRAMs) in place of brief reports such as the *Management of Personally Owned Insulin Pumps* below. PRAMs are intended to broadly share preliminary findings, given the critical nature of the issue(s) identified, to ensure that VHA facilities have the necessary information to proactively address similar vulnerabilities across the enterprise.

Highlighted Oversight Reports

Management of Personally Owned Insulin Pumps for Patients at Risk for Suicide in Emergency Departments and Inpatient Units

The OIG issued a brief report to flag the lack of VHA guidance related to a patient who attempted suicide at the Lexington VA Healthcare System. During a review of a patient's electronic health record, OIG inspectors learned that multiple clinical staff did not recognize the patient's personally owned insulin pump as a lethal means and did not remove the pump as a safety measure. The OIG report recommended that VHA facilities would benefit from national guidance regarding patients who use insulin pumps and are seen at emergency departments or inpatient units with suicidal ideation to decrease the risk of patient harm.

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.

November HFI reports examined the following systems:

- VA Tennessee Valley Healthcare System in Nashville
- Miami VA Healthcare System in Florida
- Minneapolis VA Health Care System in Minnesota

Environment of Care

Environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff. To understand veterans' experiences, the OIG evaluates the facility's features that assist veterans in accessing the facility and finding their way around, including transit and parking, the main entrance, and navigation support. The OIG also interviews staff and physically inspects patient care areas, focusing on safety, hygiene, infection prevention, and privacy.

In all three reports, the OIG made recommendations for VA to correct identified deficiencies related to the environment of care.

Highlighted OIG Investigations

Nonveteran Found Guilty at Trial of Stolen Valor and Benefits Fraud

A nonveteran obtained VA compensation benefits by fraudulently claiming to be a decorated US Marine Corps veteran who had been a prisoner of war during deployment to Iraq in 2005. The nonveteran also claimed to suffer from posttraumatic stress disorder and other injuries caused by an improvised explosive device attack while serving in Iraq. He forged and falsified documents in support of his VA benefits application, including a fraudulent DD Form 214 and Purple Heart certificate. The loss to VA is more than $140,000. He was found guilty at trial in the District of Minnesota on charges of wire fraud, mail fraud, using a false military discharge certificate, and the fraudulent use of military medals. The VA OIG investigated this case.

- Department of Justice press release: *Clay County Man Found Guilty of "Stolen Valor" and $140,000 in Benefits Fraud*

Former VA Veterans Service Representative Sentenced for Unlawfully Receiving Gratuities

Another VA OIG investigation revealed that a veterans service representative (VSR) employed at the Huntington VA Regional Office received illegal payments from 13 veterans totaling about $25,000. The scheme involved taking money from veterans in exchange for assistance in improperly obtaining a higher service-connected disability rating, resulting in more VA monthly compensation benefits. The VSR charged the veterans about 10 to 20 percent of any retroactive payment they received. VA terminated the employment of the VSR in January 2025. The former employee was sentenced in the Southern District of West Virginia to five months' imprisonment, 36 months' probation (with the first five months to be served on home confinement), and ordered to pay restitution of more than $24,500 to the veterans targeted after previously pleading guilty to receiving gratuities while being employed by the executive branch of the US government.

- Department of Justice press release: *Huntington Man Sentenced to Prison for Unlawfully Receiving Gratuities While Salaried Federal Employee*

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Click the following links to read November's six published reports and for all investigative updates.
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