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OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

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

REVIEW | REPORT #21-03718-47 | FEBRUARY 23, 2023

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Executive Summary

While performing fieldwork for an audit of the Veterans Health Administration's (VHA) personnel suitability program, the VA Office of Inspector General (OIG) identified issues related to the program's background investigations process at the Beckley VA Medical Center in West Virginia. The OIG concluded that these issues warranted further analysis and should be brought to the attention of VA leaders, even as the wider personnel suitability audit continues.

The personnel suitability program is intended to ensure that employees hired to care for patients or handle veterans' sensitive information are suited to hold those responsibilities. In addition to fingerprint checks, the program requires background investigations be scheduled within 14 days of an employee's first day on the job and adjudicated within 90 days of the date the investigation is closed.[1] After a former nursing assistant pled guilty in 2020 to second-degree murder in the deaths of seven patients at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, the OIG undertook an inspection that found the medical center did not adjudicate her background investigation within 90 days.[2] Timely adjudication of her background investigation could have disqualified her from VA employment or prevented her from filling a position that provided direct patient care because she had concerning conduct identified in prior non-VA positions.

To address broader implications across all VA medical facilities, the OIG started an audit of the personnel suitability program in January 2022, which is a follow-up to a 2018 audit of the program.[3] The follow-up audit is evaluating controls governing the background investigation process for VA medical facility personnel and determining if adjudication actions were completed in a timely manner and recorded reliably. If VHA's Veterans Integrated Service Networks (VISNs) follow these steps, it helps ensure that employees have passed the required background checks and are suitable for interacting with patients at VA medical facilities.[4] During the fieldwork phase of the 2022 audit, the OIG team discovered issues concerning breakdowns in the background investigation process for the Beckley VA Medical Center. The OIG decided to conduct a review of Beckley VA Medical Center's background investigations process and deliver its findings to VA leaders before the full suitability audit is complete.

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[1] 5 C.F.R. § 731.203, 5 C.F.R. § 736.201; VA Handbook 0710, *Personnel Security and Suitability Program*, May 2, 2016. VA defines "adjudication" as the evaluation of the results of a background investigation along with any other available information that is relevant and reliable to determine whether a person is suitable for employment with the government.

[2] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021.

[3] VA OIG, *Audit of the Personnel Suitability Program*, Report No. 17-00753, March 26, 2018.

[4] VHA divides the United States into 18 regional networks, known as VISNs, which manage day-to-day functions of medical centers and provide administrative and clinical oversight. Beckley VA Medical Center is in VISN 5.

What the Review Found

The team reviewed the investigation actions for 48 employees onboard as of September 30, 2021, who required a background investigation to be processed by the human resources office supporting the Beckley VA Medical Center.[5] Of these 48 employees, the review team found multiple issues with the background investigations and fingerprinting for 29 of them:[6]

- **Failure to initiate:** Investigations were not initiated for eight employees, four of whom were still employed at the Beckley facility as of July 2022.[7]
- **Delays in investigation:** Six employees' investigations were scheduled beyond the required 14 days from their employment start dates.[8] These delays ranged from 16 to 739 days, with four exceeding 180 days. As of June 2022, all six investigations had been closed and favorably adjudicated.
- **Improper discontinuance:** One employee's background investigation was scheduled but then discontinued. The Beckley adjudicator stated that he was informed by human resources staff that the employee had a qualifying exemption: a completed investigation within the previous two years. VISN 5, which oversees Beckley, identified that this exemption was an error and reinitiated the investigation. As of August 2022, the investigation had been returned to VA and favorably adjudicated.
- **Adjudication exceeded required deadline:** Sixteen employees' investigations were adjudicated more than 90 days after the date of the final investigative report. These delays ranged from 98 to 903 days, with three exceeding two years. Ultimately, all 16 adjudications were favorable.
- **Fingerprint checks not completed:** Two employees also did not have fingerprint checks completed as required.[9] One of the employees received a personal identity verification

[5] In October 2018, VHA began implementing a shared services human resources model that consolidated human resources offices at all 140 facilities under their respective VISNs. Personnel suitability functions, such as initiating background investigations and adjudicating closed investigations, reside with the VISNs at this writing. In particular, Beckley VA Medical Center's personnel suitability function was realigned to VISN 5 in October 2020. More information on the sampling methodology can be found in appendix B.

[6] Four employees' records had more than one issue, so the records across all categories do not total to 29 employees.

[7] Of the four employees who were no longer employed, three had resigned from their positions and one passed away by July 2022.

[8] 5 C.F.R. § 736.201; VA Handbook 0710.

[9] VA Directive 0710, *Personnel Security and Suitability Program*, June 4, 2010; VA Handbook 0710; VA Handbook 0735, *Homeland Security Presidential Directive 12 (HSPD-12) Program*, March 24, 2014.

(PIV) card before a fingerprint check had been adjudicated.[10] Another employee did not have a fingerprint check adjudicated for over a year and did not have a background investigation adjudicated.

In some cases, these lapses were concerning because of the potential for harm. For example, a home-based primary care nurse worked for about one year, and a specialty care physician worked for over two years, even though suitability staff had not initiated background investigations. Both examples illustrate instances in which individuals were in positions to provide direct patient care without VA having even started the process to determine if they were suited to those duties.

Suitability Personnel Support Was Understaffed

These lapses occurred in part because the Beckley VA Medical Center, a facility with more than 800 employees, had significantly understaffed the human resources positions responsible for making personnel suitability decisions. The understaffing persisted after the duties were realigned under VISN 5 in October 2020. From August 2019 to September 2021, just one employee was responsible for adjudicating background investigations and operating the facility's PIV office, which involved taking fingerprints and issuing identification cards.

As of November 2020, the suitability function at two other VISN 5 facilities in West Virginia—the Louis A. Johnson VA Medical Center in Clarksburg and the Martinsburg VA Medical Center—were also each supported by a single employee. These facilities may warrant closer examination by VISN 5 to identify whether suitability determinations occurred within required timeframes. The OIG noted that VISN 5 hired two personnel security assistants at Beckley in September 2021. Similarly, by March 2022, VISN 5 increased the suitability staff by one employee in Clarksburg.

Missed Opportunities for Oversight and Inspections

Although suitability staff supporting the Beckley VA Medical Center were responsible for the background investigation issues described in this report, both VA and VHA did not adequately perform their oversight responsibilities of the suitability program at Beckley, nor did VISN 5.

- **VA.** VA's Office of Identity, Credential, and Access Management is responsible for conducting oversight and functional program reviews to evaluate compliance and

[10] A personal identity verification card is a federally issued credential that is used by authorized individuals to gain access to federal facilities and information systems commensurate with the cardholder's security level and allows for multifactor authentication.

implementation of the requirements.[11] However, since at least May 2019, a suboffice responsible for supporting suitability functions, Personnel Security and Credential Management, had not conducted inspections of the VISN human resources offices, including at VISN 5, as required.

- **VHA.** Workforce Management and Consulting's Personnel Security Program Office conducts oversight for VHA's personnel suitability program. However, the OIG found that the office's staff did not conduct program reviews or inspections of the personnel suitability program at VISN 5. Instead, Workforce Management and Consulting largely delegated remediation efforts to the VISNs.
- **VISN 5.** Although VHA's Personnel Security and Suitability Program Policy requires VISN personnel security chiefs to ensure that investigations are conducted in a timely manner and adjudications are made within the required timeframes, VISN 5 did not have a stable organizational structure with a permanent, dedicated suitability chief overseeing the program until February 2022.[12]

The OIG concluded that VA and VHA had many opportunities to improve their oversight of personnel suitability decisions in VISN 5, generally, and at the Beckley VA Medical Center in particular. Ultimately the assistant secretary for Human Resources Administration/Operations, Security, and Preparedness and the under secretary for health are responsible for ensuring VHA complies with personnel suitability policies and procedures.[13] Timely and adjudicated background investigations are an important measure that could reduce the chances unsuitable individuals are in positions where they are entrusted with caring for VA patients.

What the OIG Recommended

Given the OIG's ongoing audit of controls over the background investigation process for VA medical facilities, these recommendations are limited to the issues found at VISN 5 and the Beckley VA Medical Center. The under secretary for health should ensure responsible officials in VISN 5 conduct a comprehensive audit of background investigations for Beckley VA Medical Center personnel, establish a plan to conduct compliance checks at other VISN 5 facilities, and evaluate staffing levels and allocate staff as needed for the personnel suitability program.

[11] VA Handbook 0710. The handbook specifies requirements for the (a) timeliness of fingerprint checks, (b) initiation and adjudication of background investigations, (c) uploading of investigation documentation into an employee's personnel file, and (d) updating data systems with relevant information.

[12] For the requirements, see VHA Workforce Management and Consulting, *Personnel Security and Suitability Program Policy*, rev. February 2020.

[13] The ongoing audit begun in January 2022 will address the oversight of all 18 VISNs.

VA Management Comments and OIG Response

The under secretary for health concurred with all recommendations and submitted acceptable corrective action plans. This includes having VISN 5's human resources personnel oversee "a compliance review of Beckley VA Medical Center's investigation profile" and report the findings to VHA Workforce Management and Consulting, establishing an integrated project team to develop a project plan for ongoing compliance processes to be shared with all VISNs, and "developing a staffing model review for all HR functional areas" that includes personnel security. Interim staffing guidelines will be provided to VISN 5 by February 2023 while the national model is being completed. Appendix C provides the full text of the under secretary's comments. The OIG will monitor implementation of planned actions and will close the recommendations when VHA provides documentation demonstrating sufficient progress addressing the issues identified.

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Contents

Abbreviations

DCSA	Defense Counterintelligence and Security Agency
HRA/OSP	Human Resources and Administration/Operations, Security, and Preparedness
OIG	Office of Inspector General
PIV	personal identity verification
VA-CABS	VA Centralized Adjudication Background Investigation System
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

In 2017 and 2018, Reta Mays, a former nursing assistant at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, deliberately administered insulin overdoses to eight patients, resulting in seven deaths. On July 14, 2020, Ms. Mays pled guilty to seven counts of second-degree murder and one count of assault with the intent to commit murder. The VA Office of Inspector General (OIG) issued a report in May 2021 regarding care and oversight deficiencies related to these homicides.[14] That report found that the medical center did not adjudicate Ms. Mays's background investigation within 90 days, as required.[15] Instead, the Office of Personnel Management closed her investigation in September 2015, and the responsible VA official did not adjudicate her investigation before her employment was terminated in March 2019, after the murders. Timely adjudication of her background investigation could have disqualified her from VA employment or prevented her from filling a position that provided direct patient care because she had concerning conduct identified in prior non-VA positions.

Given the gravity of this situation and the importance of ensuring that employees have passed the required background checks and are suitable for interacting with patients at VA medical facilities, the OIG started a national audit in January 2022, which is a follow-up to a 2018 report regarding the Veterans Health Administration's (VHA) personnel suitability program.[16] The follow-up audit's objective is to evaluate controls over the background investigation process for VA medical facility personnel and determine if adjudication actions were completed in a timely manner and recorded reliably.

While performing fieldwork for this follow-up audit, the team identified suitability process issues warranting further analysis at the Beckley VA Medical Center in West Virginia. The audit team determined that the findings of that analysis should be brought to the attention of VA leaders and publicly released at this time. Accordingly, the OIG is publishing this report on the issues at the Beckley facility, even as the audit continues.

[14] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021.

[15] 5 C.F.R. § 731.203; VA Handbook 0710, *Personnel Security and Suitability Program*, May 2, 2016. The handbook defines "adjudication" as the evaluation of the results of a background investigation along with any other available information that is relevant and reliable to determine whether a person is suitable for employment with the government.

[16] VA OIG, *Audit of the Personnel Suitability Program*, Report No. 17-00753, March 26, 2018.

Background Checks for New VA Employees

When VA hires new employees, candidates must submit to a three-part background check to determine if they are suitable for federal employment. Figure 1 details the background check process.

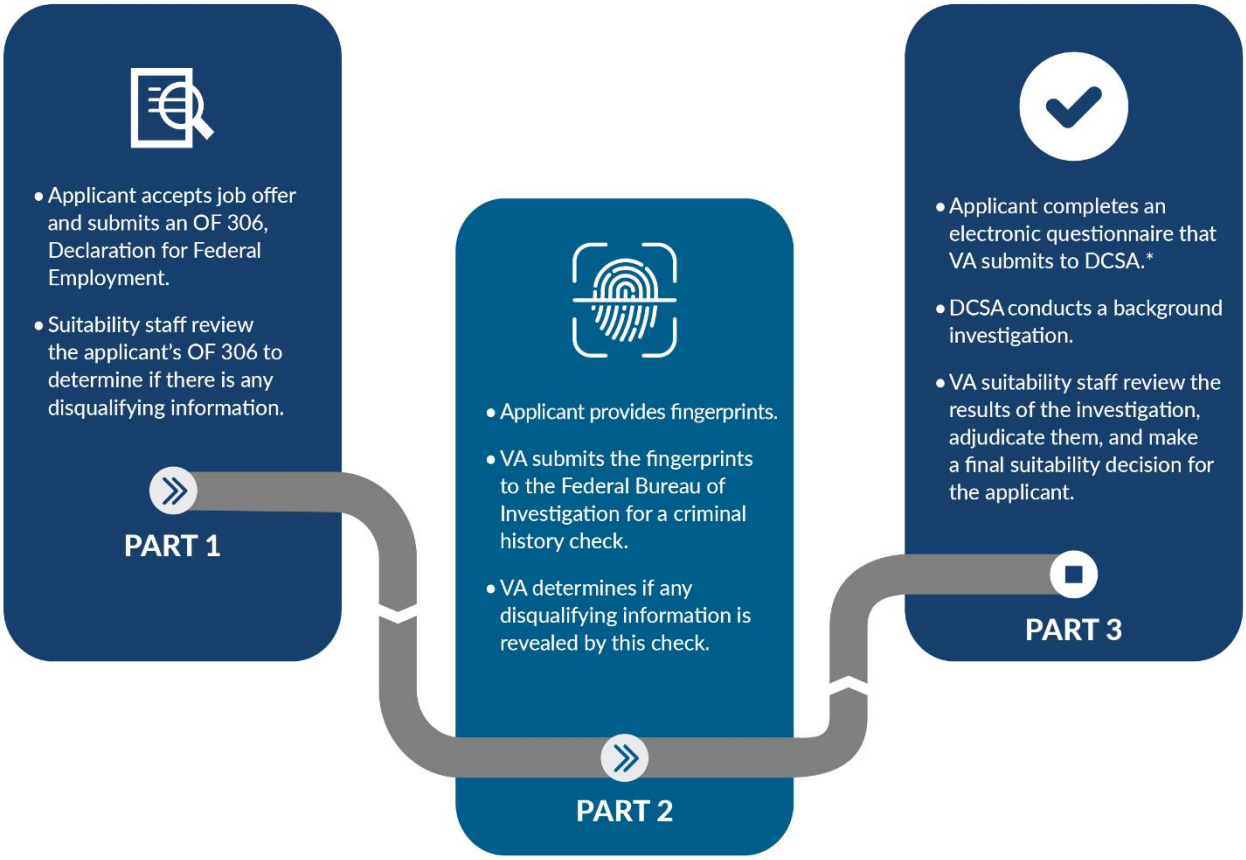

Figure 1. *VA's background check process.*
Source: OIG analysis of VA and VHA policy and forms used for the investigation process.
**DCSA stands for Defense Counterintelligence and Security Agency.*

First, when candidates accept a tentative offer for employment, they submit their OF 306, Declaration for Federal Employment, which allows candidates to self-report information related to past or ongoing legal violations, prior termination of employment, and delinquent federal debt.[17] Suitability staff for the VA facility then review the candidates' responses and compare them to the relevant position descriptions to determine if the reported information would disqualify them from being appointed to their respective jobs. For example, if a candidate reported a recent conviction for prescription drug theft, that information may disqualify the

[17] To depict the full background investigation process, the team's explanation assumes that the candidate has accepted a tentative offer.

person from a position with potential access to a pharmacy. However, this type of issue might not affect candidacy for a groundskeeper position.

The second screening is referred to as a special agreement check. VA obtains the candidate's fingerprints and submits them for a Federal Bureau of Investigation criminal history check. This check provides a degree of assurance that the individual is not subject to an ongoing inquiry or does not have a prior criminal conviction that could affect suitability for the position. The screening should generally be completed before employment but may be conducted up to five days after "entrance on duty."[18] Similar to the OF 306 screening, if this check uncovers information that would disqualify an individual from the relevant position, then VA could decide to rescind the tentative offer or not retain the employee.

Finally, the employee completes an electronic questionnaire that VA submits to the Defense Counterintelligence and Security Agency (DCSA) to conduct the required background investigation.[19] At a minimum, this investigation includes (1) a name check with the Federal Bureau of Investigation and other federal databases and (2) written inquiries to employers, candidate-supplied references, and places of education and residence. Most VA employees are subject to this type of investigation, referred to as a Tier 1 investigation.[20] This process is intended to provide VA with the comprehensive background information it needs to verify suitability for employment and must be scheduled within 14 days of an employee's entrance on duty.[21]

Once DCSA completes the investigation, the resulting information is submitted to VA for adjudication, which involves reviewing any negative information from the investigation on the individual's suitability for employment. Suitability staff review the results of the background investigation, consider any negative information, and validate suitability for employment. A suitability determination must be rendered within 90 days after the background investigation was closed.[22] If suitability staff make an unfavorable determination within the probationary employment period, VA can take action to include removing the employee from the position.[23]

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[18] The "entrance on duty" date is when the employee takes the oath of office on the first day of work.

[19] For sampled records from the Beckley VA Medical Center, the background investigation process generally took less than two months to complete, on average, from the date it was scheduled to the date it was closed. The review team did not calculate or verify an average process time specific to VHA.

[20] VA determines the level of investigation needed by assessing the position risk, rated as low (Tier 1), moderate (Tier 2), or high (Tier 4). Tiers 3 and 5 are for sensitive national security positions with potential access to classified information. Most medical facility staff, including physicians, nurses, pharmacists, and laboratory technicians, are rated as low risk and receive a Tier 1 investigation. As such, the review team did not include information on higher levels of investigation.

[21] 5 C.F.R. § 736.201; VA Handbook 0710.

[22] 5 C.F.R. § 731.203; VA Handbook 0710.

[23] Title 5 and Hybrid Title 38 employees are subject to a one-year probationary period pursuant to 5 C.F.R. § 315.802. Title 38 employees are subject to a two-year probationary period pursuant to 38 U.S.C. § 7403.

After the investigation is complete, information from the investigation is recorded in VA systems, including HR Smart and the VA Centralized Adjudication Background Investigation System (VA-CABS). This information is also transmitted to the Personnel Investigations Processing System, which is owned by DCSA. Supporting documentation, such as a certificate of investigation, is uploaded into an employee's electronic personnel folder.

Together, these checks help ensure that VA employees are suitable for working with patients at medical facilities or handling veterans' sensitive information. If these checks are circumvented or not completed on time, then VA runs the risk that patients and their records may be exposed to individuals who have not been fully vetted.

Governance of VA's Suitability Program

Although the responsibility for making suitability decisions about individual employees resides at the Veterans Integrated Service Network (VISN) level, VA's national program offices are responsible for adequately governing the suitability program and ensuring that VISNs have the resources they need to complete the necessary background checks.[24]

Several VA leaders have responsibility for the department's suitability program, starting with the **assistant secretary for human resources and administration/operations, security, and preparedness** (HRA/OSP). According to VA guidance, this position has the authority to establish and maintain personnel suitability programs throughout the department consistent with applicable laws, rules, regulations, and executive orders.[25]

The **Office of Identity, Credential, and Access Management**, under HRA/OSP, is responsible for developing, coordinating, and overseeing the implementation of policy, programs, and guidance for the department's suitability program. A suboffice, **Personnel Security and Credential Management**, is required to conduct oversight and functional program reviews to evaluate compliance with the handbook's requirements.[26]

Each of the three VA administrations is required to establish a personnel security program manager to coordinate departmental regulations and policies involved with the overall personnel security and suitability program.[27] According to VA guidance, the **under secretary for health** must ensure that VHA complies with personnel suitability policies and procedures.[28] The under

[24] The Veterans Health Administration divides the United States into 18 regional networks, known as VISNs, which manage day-to-day functions of medical centers and provide administrative and clinical oversight. Beckley VA Medical Center is in VISN 5.

[25] VA Directive 0710, *Personnel Security and Suitability Program*, June 4, 2010.

[26] VA Handbook 0710. The handbook specifies requirements for the (a) timeliness of fingerprint checks, (b) initiation and adjudication of background investigations, (c) uploading of investigation documentation into an employee's personnel file, and (d) updating data systems with relevant information.

[27] VA Handbook 0710.

[28] VA Directive 0710.

secretary is also required to establish and maintain an effective suitability and fitness determination program using automated processes and by taking actions to address and correct conditions that are noncompliant with regulatory guidance.[29] VHA's personnel suitability oversight is conducted by the **Personnel Security Program Office** within **Workforce Management and Consulting**.

Finally, VHA's Personnel Security and Suitability Program Policy requires **VISN personnel security chiefs** to ensure that investigations are conducted in a timely manner and adjudications are made within the required time frames.[30] In October 2018, VHA began implementing a shared services model for human resources that consolidated all 140 facilities' human resources offices under their respective VISNs. Personnel suitability functions, such as initiating background investigations and adjudicating closed investigations, reside with the VISNs at this writing. Figure 2 provides an overview of VA's organizational structure for governance of the personnel suitability program.

[29] VA Handbook 0710.

[30] VHA Workforce Management and Consulting, *Personnel Security and Suitability Program Policy*, rev. February 2020.

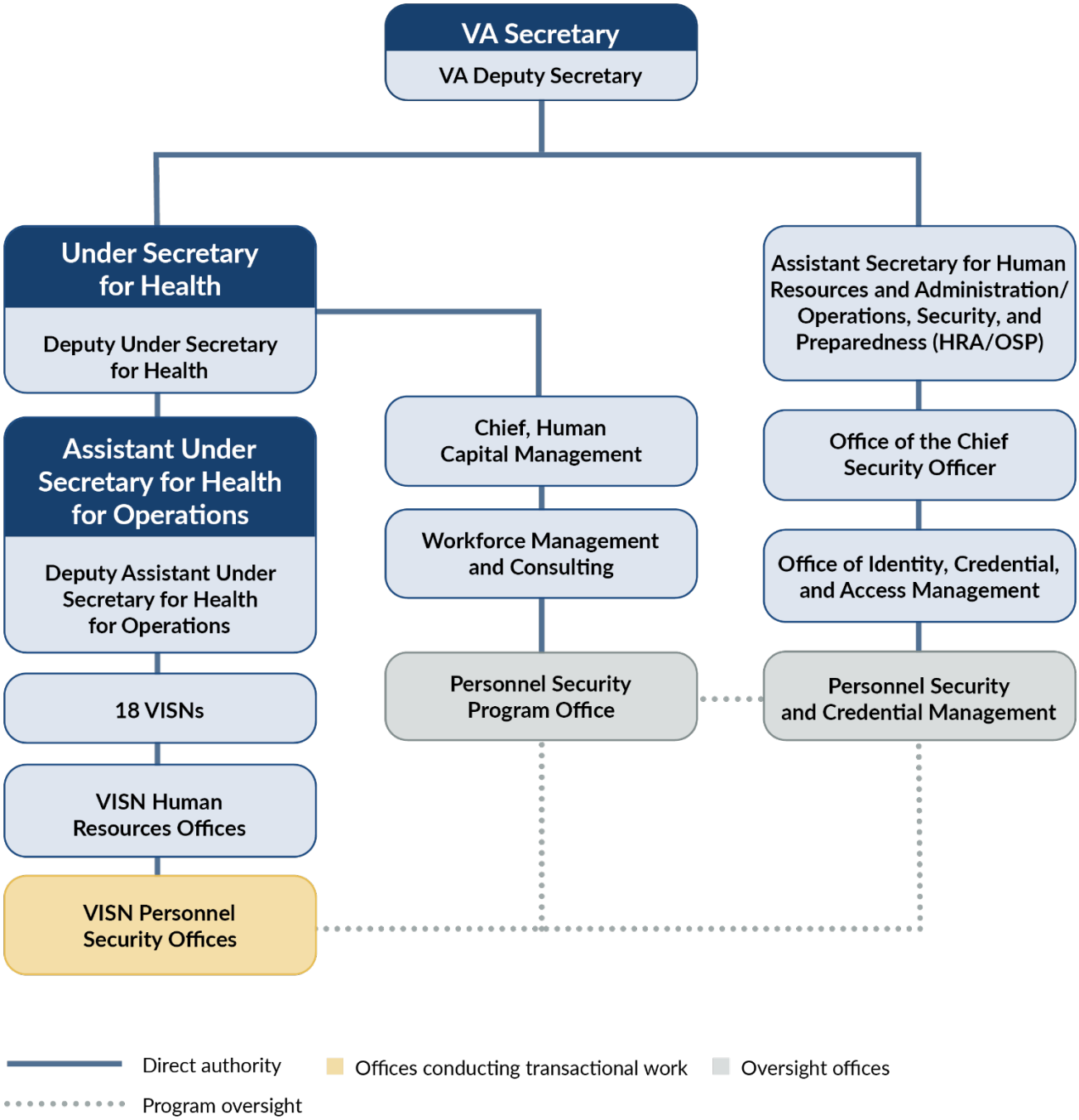

Figure 2. *Overview of VA's organizational structure for governance of the personnel suitability program.*
Source: OIG analysis of organizational charts, VA and VHA policy, and VHA websites and position descriptions.
Note: This chart reflects that VA guidance assigns responsibility to offices and, at other times, specific positions.

Each of these officials and offices have responsibilities for ensuring that background investigations of new employees are completed in a timely manner and are recorded reliably in

VA's systems. VA policy dictates that these offices must collaborate with one another to ensure that the personnel suitability program is effective and efficient.[31]

Prior OIG Report on VHA's Personnel Suitability Program

On March 26, 2018, the OIG published a report evaluating controls for the adjudication of background investigations at VA medical facilities to determine whether adjudication actions were completed in a timely manner and reliably recorded.[32] The OIG found VA did not effectively manage the personnel suitability program to ensure investigations were completed for facility staff and estimated that about 6,200 required investigations were not initiated. Adjudicators had not been reviewing investigations in a timely manner, and suitability staff were not maintaining the required official personnel records. These irregularities occurred in part because the Office of Operations, Security, and Preparedness (OSP) did not monitor compliance with program requirements.[33] Also, OSP and VHA did not effectively manage human capital or ensure that sufficient and appropriate staff were assigned suitability functions.

The OIG made several recommendations to correct these issues, including recommending OSP establish robust oversight, implement and report on the monitoring program, ensure reliable data are collected and maintained, establish quality and performance metrics, evaluate human capital needs to manage workload, and obtain VHA's corrective action plans. The OIG also recommended VHA ensure investigations are initiated and adjudicated, evaluate human capital needs to manage workload at medical facilities, and implement requirements to improve governance. The OIG recommended OSP coordinate with VHA to correct identified data integrity issues and improve data accuracy, as well as implement a plan to review the suitability status of all VHA personnel and correct delinquencies.

In response to the OIG's 2018 audit of the personnel suitability program, HRA/OSP, in January 2020, implemented a review of all personnel with access to facilities and systems to confirm that they were properly vetted. By July 2020, VHA completed a scrub of suitability records in HR Smart. Further, in August 2021, VHA directed its suitability coordinators to conduct a second review of all personnel who had access to facilities and systems, with a full remediation of errors by December 31, 2021.

Additionally, in response to the OIG's audit, VHA assessed its staffing metric and determined that it did not account for the realignment of personal identity verification duties, organizational changes, and increased security workload. The implementation of the updated metric was

[31] VA Directive 0710.

[32] VA OIG, *Audit of the Personnel Suitability Program*.

[33] Effective September 12, 2018, the position of assistant secretary for operations, security, and preparedness was eliminated. The Office of Operations, Security, and Preparedness and its associated functions were reassigned to the assistant secretary for human resources and administration.

projected to be completed in May 2023. VHA also published an updated personnel suitability directive in October 2018 that established a VHA personnel security program office and appointed suitability coordinators for the VISNs.

Lastly, in December 2019, VHA began providing each VISN suitability coordinator with a delinquent adjudication listing every quarter, requiring that the delinquencies be reduced by 10 percent each month and requiring that the coordinators provide Workforce Management and Consulting with quarterly updates on the status of these delinquencies. As of March 2022, all recommendations from this report have been closed. The OIG is evaluating the effectiveness of VA and VHA's changes to the program and assessing the controls within the suitability process as part of the follow-up audit of VHA's personnel suitability program, which is ongoing as of February 2023.

Results and Recommendations

Finding: VA Needs to Improve the Personnel Suitability Program at the Beckley VA Medical Center

VA's suitability program is intended to ensure that employees hired to care for patients or to handle veterans' sensitive information have been screened before carrying out those responsibilities. To assess whether new employees were vetted consistent with VA requirements, the OIG examined a sample of 48 employees at the Beckley VA Medical Center who were onboard as of September 30, 2021, and who required a background investigation. Among those requirements, investigations must be scheduled within 14 days of an employee's entrance on duty and adjudicated within 90 days of the date the investigation is closed.[34] The review team found multiple issues with the background investigations and fingerprinting for 29 of them:[35]

- **Failure to initiate:** Investigations were not initiated for eight employees, yet four were still employed at the Beckley facility as of July 2022.[36]
- **Delays in investigation:** Six employees' investigations were scheduled beyond the required 14 days from the entrance-on-duty date. These delays ranged from 16 to 739 days, with four exceeding 180 days. As of June 2022, all six investigations had been closed and favorably adjudicated.
- **Improper discontinuance:** One employee's background investigation was scheduled but then incorrectly discontinued. The VISN reinitiated the investigation, and as of August 2022, it had been returned to VA and favorably adjudicated.
- **Adjudication exceeded required deadline:** Sixteen employees' investigations were adjudicated more than 90 days after the date of the final investigative report. These delays ranged from 98 to 903 days, with three exceeding two years. Ultimately, all 16 adjudications were favorable.
- **Fingerprint checks not completed:** Two employees also did not have fingerprint checks completed as required.[37] One of the employees received a personal identity verification

[34] 5 C.F.R. § 731.203; 5 C.F.R. § 736.201; VA Handbook 0710.

[35] Four employee records had more than one issue, so the sum of records across all categories does not total to 29 employees.

[36] For the remaining four employees who were no longer employed, three had resigned from their positions and one had passed away by July 2022.

[37] VA Directive 0710; VA Handbook 0710; VA Handbook 0735, *Homeland Security Presidential Directive 12 (HSPD-12) Program*, March 24, 2014.

(PIV) card before a fingerprint check had been adjudicated.[38] Another employee did not have a fingerprint check adjudicated for over a year.

The immediate cause of these issues with employees' background investigations at the Beckley VA Medical Center (with more than 800 employees) was significant understaffing of the suitability staff duties. The understaffing continued after the suitability functions were realigned under VISN 5 in October 2020. From August 2019 to September 2021, only one suitability staff member was responsible for adjudicating background investigations and operating the facility's PIV office, which involved taking fingerprints and issuing identification cards.

Additionally, VA and VHA were not always adequately fulfilling their responsibilities for governing the suitability program at the Beckley VA Medical Center. Ultimately, the assistant secretary for HRA/OSP and the under secretary for health are responsible for establishing and maintaining effective suitability and fitness determination programs and correcting any deficiencies. Since at least May 2019, HRA/OSP's Personnel Security and Credential Management office had not conducted inspections of the supporting human resources offices, including VISN 5, as required. Further, VHA's Personnel Security Program Office, within Workforce Management and Consulting, did not conduct program reviews or inspections of the personnel suitability program at VISN 5. These inspections could have identified instances for which investigations had not been initiated and adjudicated in a timely manner. Ultimately, several officials within VA and VHA shared responsibility for overseeing the suitability program at the Beckley VA Medical Center, but they did not perform inspections that could have identified the issues reported by the OIG.

Unless VA improves both the performance and oversight of its employee suitability program at the Beckley VA Medical Center, VA lacks assurance that the employees caring for patients are fit to hold their positions, which presents a risk to the wellbeing of veterans in that facility.

The following sections support the OIG's finding:

- VHA suitability staff did not consistently complete background investigations at the Beckley VA Medical Center as required; some were not initiated while others were delayed, discontinued, or not adjudicated within timelines.
- Fingerprint and PIV card issues were also identified, with two employees lacking required checks.
- Suitability personnel support was understaffed, with only one employee performing all the suitability functions at Beckley from August 2019 to September 2021.

[38] A PIV card is a federally issued credential that is used by authorized individuals to gain access to federal facilities and information systems commensurate with the cardholder's security level and allows for multifactor authentication.

- VA and VHA were responsible for overseeing the suitability program at VISN 5, but they did not perform required inspections of the program.

What the OIG Did

In January 2022, the OIG began a follow-up audit of VHA's personnel suitability program. The team statistically selected four VISNs in addition to VISN 5, which was chosen as a "certainty site" due to the issues previously identified at the Clarksburg facility.[39] After conducting a virtual site visit and data review with VISN 5, the team determined that the personnel suitability program supporting the Beckley VA Medical Center warranted further analysis. The team subsequently examined a sample of 50 employees at the facility who were initially hired from October 1, 2019, through September 30, 2021.

The review team then excluded two employees from the sample. One was a transfer from another VISN, where the employee's background investigation was adjudicated; another had an existing investigation from prior federal employment that was reciprocally accepted. The team reviewed the suitability records for the remaining 48 employees who were onboard as of September 30, 2021, and required a background investigation to be processed by the human resources office supporting the Beckley VA Medical Center.

The team reviewed data from VA-CABS, the Personnel Investigations Processing System, the Electronic Questionnaires for Investigations Processing, the employees' personnel folders, and documentation such as certificates of investigation. The team also interviewed officials and staff responsible for the personnel suitability program for the Beckley VA Medical Center.

VHA Suitability Staff Did Not Consistently Complete Background Investigations of New Employees at the Beckley VA Medical Center as Required by VA's Suitability Program

VA is responsible for initiating, adjudicating, and recording the results of the background investigations for new employees.[40] These responsibilities are assigned to human resources offices supporting VA medical facilities such as the Beckley VA Medical Center. The goal is to ensure that these employees are fit to care for patients and handle sensitive records in the facility. However, as mentioned earlier, for the 48 employees examined at the Beckley VA Medical Center who were onboard as of September 30, 2021, and who required a background investigation, the OIG found issues with the background investigations and fingerprinting for 29 employees. Those issues included background investigations that were never initiated, were scheduled later than required, incorrectly discontinued, and adjudicated beyond the 90-day

[39] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*.

[40] VA Handbook 0710.

requirement.[41] Additionally, two employees also did not have fingerprint checks completed as required.[42] Four employees' records had more than one issue, so the sum of records across all categories does not total to 29 employees.

The review team shared the results of the sample analysis—detailed in each section that follows—with the suitability adjudicator assigned to support the Beckley VA Medical Center as well as responsible officials in VISN 5 and Workforce Management and Consulting. The team noted any completed actions when they received sufficient evidence supporting that the deficiency was corrected. The OIG will monitor corrective actions through the report follow-up process.

Suitability Staff Did Not Always Initiate Background Investigations for New Employees at the Beckley VA Medical Center

As detailed in figure 1, new VA employees must receive a fingerprint-based screening, referred to as a special agreement check, which is a limited investigation including law enforcement checks.[43] Additionally, most VA employees receive a minimum of a Tier 1 investigation to verify that the individual is suitable for employment. Most medical facility staff, including physicians, nurses, pharmacists, and laboratory technicians, are required to undergo this type of investigation.

However, the OIG found that required investigations were not initiated for eight of the 48 employees whose records were assessed by the team. For example, a home-based primary care nurse worked for about one year, and a specialty care physician worked for over two years, even though suitability staff had not initiated background investigations. Both examples illustrate instances in which individuals were in positions to provide direct patient care without VA starting the process to determine if it was suitable for them to do so. The other six employees without an initiated background investigation held positions as housekeeping aides, a file clerk for community care, and security clerks for the police service. Overall, four of the eight employees were still working at the Beckley facility as of July 2022.

The adjudicator assigned to the Beckley VA Medical Center initiated corrective action for the four remaining employees after the review team inquired about the sample records. As of August 2022, two of the employees had the electronic questionnaire initiated in advance of submission to DCSA. The other two employees had completed and submitted their questionnaires to DCSA. One employee's investigation was automatically adjudicated by DCSA

[41] 5 C.F.R. § 731.203; 5 C.F.R. § 736.201; VA Handbook 0710.
[42] VA Directive 0710; VA Handbook 0710; VA Handbook 0735.
[43] VA Directive 0710.

on the date it was closed because no issues were found. The other investigation had been scheduled with DCSA but as of August 2022 had not yet been closed or returned to VA.

Initiating a background investigation promptly is of critical importance to reveal information that could cause VA to reconsider the new employee's suitability to care for patients and access sensitive information.

Suitability Staff Also Delayed Initiating Background Investigations for New Employees at the Beckley VA Medical Center

Even when background investigations were initiated, suitability staff supporting the Beckley VA Medical Center sometimes initiated them later than required. Supporting human resources offices are required to initiate the background investigation process within 14 calendar days of an employee's appointment.[44] However, of the 40 employees in the OIG sample who had their background investigations initiated, six employees' investigations were scheduled more than 14 days after the entrance-on-duty date.[45] These cases ranged from 16 to 739 days, with four instances exceeding 180 days.

For example, a pharmacy technician at the facility did not have a scheduled background investigation for about two years from entrance on duty. In another instance, a social worker began working at the Beckley facility and did not have an investigation initiated for six months. The individual was then reassigned to the VA Pittsburgh Healthcare System in Pennsylvania, which is under VISN 4. Before the reassignment, VISN 4 initiated a background investigation for this employee.[46]

As of June 2022, all six investigations were closed and favorably adjudicated. However, action may still be needed to ensure delays in initiating background investigations do not recur.

Suitability Staff Incorrectly Discontinued a Beckley VA Medical Center Employee's Background Investigation

Background investigations can be discontinued for several reasons. For example, DCSA might not be able to obtain required information from the requesting agency and so cannot continue the

[44] 5 C.F.R. § 736.201; VA Handbook 0710. Federal regulations and VA Handbook 0710 do not define when an investigation is considered "initiated." Additionally, VA and VHA suitability officials could not provide a consistent definition for the initiation date. An Office of Personnel Management memorandum from December 15, 2020, states that an investigation is considered initiated when the department or agency has submitted the request for investigation to the federal background investigation provider and that provider has scheduled the investigation. As such, for the purposes of this review, the OIG used the date the investigation was scheduled with DCSA.

[45] As discussed previously, a background investigation was not initiated for eight employees in the sample group. Removing these employees reduced the number of personnel examined in this analysis from 48 to 40.

[46] This employee's investigation was automatically adjudicated by DCSA on the date it closed because no issues were found.

investigation. The submitting agency can also request the investigation be discontinued. Additionally, if another investigation for that employee was closed within the prior two years, the requesting agency's investigation could be discontinued. An investigation also might be closed because another investigation was already in progress. In these instances, DCSA notifies the agency that the investigation has been discontinued.[47]

However, the review team found that suitability staff supporting the Beckley VA Medical Center initiated a background investigation for one employee with DCSA but then discontinued that investigation. The adjudicator supporting the facility told the review team he had been informed by other human resources personnel that this employee had been previously employed by the federal government and did not need another background investigation.[48] Therefore, he discontinued the investigation.

The OIG review team determined this decision was incorrect. The employee, who was an administrative secretary, did not have an existing investigation and worked without a completed investigation for over one year. When the review team questioned this discontinuation, the VISN reinitiated the investigation, and as of August 2022, it had been returned to VA and favorably adjudicated.

Suitability Staff for the Beckley VA Medical Center Adjudicated Employees' Background Investigations More Than 90 Days after the Final Investigative Report

As discussed previously, once DCSA completes the background investigation, the resulting information is returned to VA for adjudication. This involves reviewing any negative findings and determining if they affect the individual's suitability for employment. VA's human resources offices must report adjudicative decisions to DCSA within 90 days of the closure date of the final investigative report.[49] However, the OIG found that 16 of the 39 remaining background investigations examined at the Beckley VA Medical Center were adjudicated beyond the 90-day requirement.[50] These delays ranged from 98 to 903 days, with three exceeding two years. Table 1 summarizes the age of the delinquent adjudications.

[47] Federal Investigations Notice No. 21-01, *Daily Notifications from DCSA*, February 26, 2021.

[48] When an employee has previously been subject to a background investigation, an agency may accept that suitability determination in lieu of initiating a new investigation.

[49] 5 C.F.R. § 731.203; VA Handbook 0710; Exec. Order No. 13869, 84 Fed. Reg. 18,125 (April 29, 2019).

[50] Because background investigations were not initiated for eight employees in the sample, and the investigation was discontinued for one employee, the cohort analyzed here is composed of 39 employees.

Table 1. Age of Delinquent Adjudications

Days to Adjudicate	Cases
91–120	2
121–180	5
181–270	3
271–365	3
Over 365	3*
Total	**16**

Source: Certificates of Investigation received from VISN 5 and retrieved from employee electronic personnel folders.
**The three investigations exceeding 365 days took 797, 852, and 903 days to adjudicate.*

In some cases, employees at Beckley faced very long delays before their background investigations were adjudicated. For example, an advanced medical support assistant at the Beckley facility did not have an investigation adjudicated for almost one year. Similarly, a suicide prevention counselor at the facility did not have an investigation adjudicated for about two and a half years. It was not adjudicated until the review team requested information in June 2022.

Timely adjudication of background investigations is essential for VHA staff to properly consider any negative information revealed by the vetting process that could affect suitability. While the former nursing assistant convicted of murder in the medical facility in Clarksburg represents an extreme example, it illustrates the importance of suitability staff adjudicating investigations within prescribed timelines.[51] The risks are particularly concerning for new hires entrusted with providing patient care or handling veterans' or VA's sensitive information.

At the Beckley VA Medical Center, the 16 delinquent adjudications included four employees providing patient care—three nurses and a dentist. These four delays averaged 132 days (ranging from 98 to 174 days). All four individuals ultimately received a favorable suitability determination. Despite the positive outcome, unnecessary risk was introduced into the process.

In sum, as of June 2022, suitability staff favorably adjudicated all 16 delinquent adjudications identified by the team's sample. However, the OIG maintains that action is needed to ensure that background investigations are routinely adjudicated within 90 days as required. Timely adjudication is a necessary control to ensure VA is positioned to take appropriate action to remove unsuitable staff.

[51] VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*.

Fingerprint and PIV Card Issues Were Also Identified

The review team found issues with how suitability staff supporting the Beckley VA Medical Center were checking the fingerprints of new employees and issuing PIV cards. All individuals employed with VA must undergo a fingerprint check. This screening should generally be completed before employment but may be conducted up to five days after entrance on duty.[52] The results of this fingerprint check must be adjudicated no later than five business days after the results are received.[53] Finally, before VA issues a PIV card—which allows access to information systems and physical access to the facility—an employee must have both an adjudicated fingerprint check and have the background investigation scheduled.[54]

The OIG identified two employees at the Beckley VA Medical Center who did not have their fingerprint checks completed as required. First, a security clerk did not have an adjudicated fingerprint check for over one year. The employee was hired in October 2020, but fingerprints were not taken, and the check was not adjudicated until December 2021. Additionally, no background investigation was ever initiated for this employee. The security clerk worked for the medical facility for one and a half years but has since resigned.

Second, the review team identified a food service worker at the facility who was issued a PIV card without the fingerprint check being adjudicated. The employee had a closed background investigation, but neither the fingerprint check nor the background investigation were adjudicated until the audit team requested information in June 2022—more than two years after the entrance-on-duty date. When the team questioned this delay, the facility's adjudicator responded that he reviewed this employee's fingerprint check but did not record an adjudication into the system.

Fingerprint checks are a baseline internal control intended to provide a degree of assurance that an individual is not subject to an ongoing inquiry and does not have a prior criminal conviction that could affect suitability for the position. Failure to enforce and document this security requirement undermines VA's ability to protect patients and sensitive information.

Suitability Personnel Support Was Understaffed for the Beckley VA Medical Center

When the review team spoke to the adjudicator supporting the Beckley VA Medical Center about the issues described in this report, the adjudicator attributed them to his significant workload and told the review team that he was the only employee responsible for performing all the suitability functions at Beckley from August 2019 to September 2021. In addition to his responsibilities

[52] VA Handbook 0710.

[53] VA Directive 0710.

[54] VA Handbook 0735, *Homeland Security Presidential Directive 12 (HSPD-12) Program*, March 24, 2014.

initiating and adjudicating background investigations, the adjudicator stated that he also solely operated the facility's PIV office, which involves taking fingerprints and issuing identification cards. Furthermore, the adjudicator stated that, when he was on leave, the workload remained until his return.

The OIG notes that having a single employee operating the entire personnel suitability function at a medical center conflicts with federal standards, which stipulate that managers are responsible for establishing a control environment that includes appropriate staffing and training.[55] As of November 2020, the suitability function at two other VISN 5 facilities in West Virginia—the Louis A. Johnson VA Medical Center in Clarksburg and the Martinsburg VA Medical Center, with about 200 and 1,200 more employees than Beckley, respectively—were also each supported by a single employee. These facilities may warrant closer examination by VISN 5 to identify whether suitability determinations occurred within required timeframes. The OIG noted that, at Beckley, two new personnel security assistants were hired by the VISN in September 2021. Similarly, by March 2022, VISN 5 increased the suitability staff by one employee at the Clarksburg facility.

VA and VHA Missed Opportunities to Oversee the Personnel Suitability Program in VISN 5

Although suitability staff supporting the Beckley VA Medical Center were responsible for the background investigation issues described in this report, VA and VHA each had responsibilities for overseeing the personnel suitability program in VISN 5 and missed opportunities to identify and correct deficiencies. Particularly after the OIG report on the homicides at the Clarksburg facility identified issues with the personnel suitability program, VA, VHA, and VISN 5 should have proactively reviewed their suitability programs to ensure that any risks were identified and mitigated.

The review team did not identify additional oversight conducted by these entities to address risks to the program. The team also noted that several program inspections established in response to the OIG's 2018 audit of the personnel suitability program were discontinued.[56] Lastly, some oversight responsibilities were delegated to VISN personnel security chiefs, but the VISN 5 human resources office lacked permanent staff to carry out those delegated tasks. Overall, the OIG identified missed opportunities, discussed in the sections that follow, to detect and correct the deficiencies described in this report.

[55] GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014, principles 4 and 10.

[56] VA OIG, *Audit of the Personnel Suitability Program*.

National Program Offices Did Not Conduct Required Inspections of the Personnel Suitability Program in VISN 5

As discussed previously, HRA/OSP's Office of Identity, Credential, and Access Management is responsible for developing, coordinating, and overseeing the implementation of policy, programs, and guidance for the department's suitability program. VA policy also requires the Personnel Security and Credential Management office to conduct oversight and functional program reviews to evaluate compliance and implementation of the handbook's requirements.[57] However, since at least May 2019, the Personnel Security and Credential Management office had not conducted inspections of the human resources offices supporting suitability, including VISN 5, as required. These inspections could have identified instances in which investigations had not been initiated and not adjudicated within required timelines.

VA guidance directs each of the three VA administrations to establish a personnel security program manager to coordinate departmental regulations and policies involved with the overall personnel security and suitability program.[58] VHA's personnel suitability oversight is conducted by Workforce Management and Consulting's Personnel Security Program Office, but the OIG found that the office's staff did not conduct program reviews or inspections of the personnel suitability program at VISN 5. Instead, Workforce Management and Consulting largely delegated remediation efforts to the VISNs.

The issues involving oversight deficiencies by VA's national program offices responsible for the personnel suitability program will be addressed in greater detail by the report that will be released at the conclusion of the OIG's ongoing audit. As such, this report does not make recommendations related to these issues.

VISN 5's Human Resources Office Lacks Permanent Staff, and Available Officials Did Not Ensure Adequate Oversight of the Personnel Suitability Function

VA and VHA missed several other opportunities to improve how personnel suitability decisions were being made at the Beckley VA Medical Center. Although VHA's Personnel Security and Suitability Program Policy requires VISN personnel security chiefs to ensure that investigations are conducted in a timely manner and adjudications are made within the required timeframes, VISN 5 did not have a stable organizational structure with a permanent, dedicated suitability chief overseeing the program until February 2022.[59] Before that date, suitability staff told the

[57] VA Handbook 0710. The handbook specifies requirements for the (a) timeliness of fingerprint checks, (b) initiation and adjudication of background investigations, (c) uploading investigation documentation into an employee's personnel file, and (d) updating data systems with relevant information.

[58] VA Handbook 0710.

[59] VHA Workforce Management and Consulting, *Personnel Security and Suitability Program Policy*.

review team that the VISN did not have a permanent chief of suitability or a VISN suitability coordinator. The staff also said that the suitability service had reported directly to the chief human resources officer. Given this lack of stability, the review team did not identify oversight from the VISN that would ensure investigations were timely initiated and adjudicated.

In response to the OIG's 2018 audit of the personnel suitability program, VHA, in December 2019, began providing each VISN suitability coordinator with a delinquent adjudication listing every quarter, requiring that the delinquencies be reduced by 10 percent each month and requiring that the coordinators provide Workforce Management and Consulting with quarterly updates on the status of these delinquencies. However, according to figures provided by Workforce Management and Consulting, delinquency totals for VISN 5 generally remained unchanged from the issuance of the OIG's May 2021 Clarksburg report until May 2022, as shown in table 2.

Table 2. Delinquent Adjudications in VISN 5

Date	Delinquent Cases
May 25, 2021	515
August 10, 2021	515
November 15, 2021	519
February 16, 2022	516
May 18, 2022	483
August 8, 2022	353

Source: Summary totals of VISN 5 delinquent adjudications received from Workforce Management and Consulting.

In August 2021, Workforce Management and Consulting also required the VISNs to conduct an audit of all personnel with access to VA facilities and information systems. Workforce Management and Consulting provided the VISNs with a report of employees and instructed the VISNs to compare HR Smart—VA's human resources information system—against DCSA's Personnel Investigations Processing System and remediate invalid or missing investigations. Though the audit was to be completed by December 31, 2021, VISN 5's audit was only 70 percent complete as of May 2022, as a former suitability coordinator did not forward the report to staff for action. VISN 5's remediation efforts had not begun until December 2021. These efforts should have identified employees who were working without completed background investigations, but in several cases these employees were only identified when the OIG team began this review.

The OIG concluded that VA and VHA had many opportunities to improve how they are overseeing personnel suitability decisions in the VISNs generally and at the Beckley VA

Medical Center in particular. Ultimately, responsibility for this oversight belongs to the assistant secretary for HRA/OSP and the under secretary for health, who are required to ensure that VHA complies with personnel suitability policies and procedures.[60] The under secretary must also establish and maintain an effective suitability and fitness determination program that uses automated processes and addresses and corrects conditions that are noncompliant with regulatory guidance.[61]

Conclusion

The Beckley VA Medical Center's personnel suitability program experienced deficiencies with background investigations that resembled those the OIG found at the Clarksburg facility. Some employees were working in the facility without having a background investigation initiated; other employees' background investigations were delayed, discontinued incorrectly, or not adjudicated within required timelines. Several employees were caring for patients even though they had not yet passed the VA-mandated suitability checks. The review team's approach did not analyze patient outcomes for veterans served by these employees, but no evidence was produced indicating that care had been compromised.

These personnel suitability issues were caused, in part, by the reliance on only one adjudicator to handle a wide range of functions from August 2019 to September 2021. Additionally, several offices in VA and VHA were not consistently fulfilling their responsibilities for governing the suitability program at the Beckley VA Medical Center or other facilities in the region. The under secretary for health needs to take action to ensure that adequate oversight of personnel suitability decisions is occurring at the Beckley VA Medical Center, the other facilities in VISN 5, and all VISNs.

Recommendations 1–3

Given the OIG's ongoing audit of controls over the background investigation process for VA medical facilities, these recommendations are limited to the issues found at VISN 5 and the Beckley VA Medical Center. The under secretary for health should ensure responsible officials in VISN 5 take the following actions:

1. Conduct an all-personnel audit of Beckley VA Medical Center staff to ensure background investigation requirements were met, to include considering an all-personnel data match of relevant suitability records against comparable datasets from the Personnel Investigations Processing System, and report results to the Workforce Management and Consulting office for verification.

[60] VA Directive 0710.

[61] VA Handbook 0710.

2. Establish a project management plan to conduct compliance checks at other Veterans Integrated Service Network 5 facilities and share the plan with other networks.
3. Evaluate staffing levels for the personnel suitability program and allocate staff as needed to meet VA timelines.

VA Management Comments

The under secretary for health concurred with the three recommendations and provided corrective action plans. These actions include VISN 5 overseeing a compliance review of Beckley's investigation profile and reporting results to Workforce Management and Consulting, an integrated team developing a plan for compliance processes that will be shared with all VISNs, and Workforce Management and Consulting developing a comprehensive national staffing model for human resources functional areas that includes personnel security. Interim staffing guidelines will be provided to VISN 5 prior to completing the national model. Appendix C provides the full text of the under secretary's comments.

OIG Response

The under secretary for health's comments and corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VHA provides evidence demonstrating sufficient progress in addressing the issues identified.

Appendix A: Scope and Methodology

Scope

The review team conducted its work from August 2022 through December 2022. The scope of the review focused on Beckley VA Medical Center employees as of September 30, 2021, who were initially hired within the previous two years. The team evaluated investigation actions for those employees through August 2022.

Methodology

To accomplish the objective, the team identified and reviewed applicable executive orders, regulations, and VA and VHA policies and procedures.

During its follow-up audit of the personnel suitability program, the team interviewed officials in the Personnel Security and Credential Management office and Workforce Management and Consulting. Additionally, the team conducted a virtual site visit with VISN 5 and interviewed human resources management and staff responsible for the personnel suitability program. Evidence collected from these steps was relevant and therefore incorporated into this review. As part of the analysis particular to the Beckley VA Medical Center, the team also conducted interviews with three suitability staff assigned to the facility.

The team further reviewed a statistical sample of 50 records of Beckley VA Medical Center employees, as of September 30, 2021, who had been initially hired within the previous two years. Appendix B contains details of the statistical sampling methodology. The review team independently extracted certificates of investigation and personnel action documentation from employee personnel files and, if documentation was not available, solicited the VISN 5 human resources office supporting the Beckley VA Medical Center. In addition, the team reviewed data from VA-CABS, the Personnel Investigations Processing System, and the Electronic Questionnaires for Investigations Processing to determine the status of investigations. The team provided the results of this analysis to Workforce Management and Consulting and VISN 5 officials, in addition to the adjudicator responsible for the Beckley VA Medical Center.

Internal Controls

The review team assessed the internal controls of the personnel suitability program supporting the Beckley VA Medical Center significant to the review objective. This included an assessment of the five internal control components to include control environment, risk assessment, control activities, information and communication, and monitoring.[62] In addition, the team reviewed the principles of internal controls as associated with the objective. The team identified the following

[62] GAO, *Standards for Internal Control in the Federal Government*.

two components and two principles as significant to the objective.[63] The team identified internal control weaknesses during this review and proposed recommendations to address the following control deficiencies:

- Component: Control Environment
    - Principle 4: Management should demonstrate a commitment to recruit, develop, and retain competent individuals.
- Component: Monitoring
    - Principle 16: Management should establish and operate monitoring activities to monitor the internal control system and evaluate the results.

Fraud Assessment

The review team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the review objectives, could occur during this review. The team exercised due diligence in staying alert to any fraud indicators. The OIG did not identify any instances of fraud or potential fraud during this review.

Data Reliability

HR Smart is VA's human resources information system that supports position management, payroll, and personnel suitability. The team used HR Smart data to establish the universe of employees by selecting those employees at the Beckley VA Medical Center who were initially hired during a two-year period ending September 30, 2021. To test for reliability, the team compared information extracted from personnel action documentation from employee personnel folders to confirm when individuals were initially hired, when they were initially assigned to the Beckley VA Medical Center, and if they were still onboard as of September 30, 2021. The team found that the data were sufficiently reliable and appropriate for sample selection only.

Instead of relying on HR Smart data, the team used documentation, such as personnel action files and certificates of investigation, and compared data among multiple systems to assess the timeliness of investigation actions for Beckley VA Medical Center employees. The team found that these data were sufficiently reliable to develop the findings, conclusions, or recommendations for this report.

[63] Since the review was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this review.

Government Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation.*

Appendix B: Statistical Sampling Methodology

To accomplish the objective, the team reviewed a statistical sample of records as of September 30, 2021, for Beckley VA Medical Center employees who were initially hired during the previous two fiscal years. The team used statistical sampling to quantify the number of investigation actions that were not completed in a timely manner for Beckley VA Medical Center employees.

Population

The review population included 204 records for Beckley VA Medical Center employees as of September 30, 2021, who were initially hired during the prior two fiscal years. These data were obtained from HR Smart, VA's human resources information system.

Sampling Design

The review team selected a statistical sample of 50 records from the population of Beckley VA Medical Center employees. The population was stratified by the number of employees hired per year and categorized in three strata as seen in table B.1.

Table B.1. Strata

Hiring year	Number of records	Sample size
2019	20	5
2020	103	25
2021	81	20
Total	**204**	**50**

Source: VA OIG statistician's stratified population. Data were obtained from HR Smart.

Appendix C: VA Management Comments

Department of Veterans Affairs Memorandum

Date: January 20, 2023

From: Under Secretary for Health

Subj: OIG Draft Report, Review of Personnel Suitability Concerns at the Beckley VA Medical Center (OIG Project No. 2021-03718-AE-0127) (VIEWS 9247692)

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Review of Personnel Suitability Concerns at the Beckley VA Medical Center. The Veterans Health Administration concurs with the recommendations and provides an action plan in the attachment.

The OIG removed point of contact information prior to publication.

Shereef Elnahal, M.D., MBA.

Attachment

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan
OIG Draft Report: Personnel Suitability Process Concerns at the Beckley VA Medical Center in West Virginia
(#2021-03718-AE-0127)

Recommendation 1. Conduct an all-personnel audit of Beckley VA Medical Center staff to ensure background investigation requirements were met, to include considering an all-personnel data match of relevant suitability records against comparable datasets from the Personnel Investigations Processing System and report results to the Workforce Management and Consulting office for verification.

VHA Comments: Concur. On August 1, 2022, VA's Centralized Adjudication and Background Investigation System (VA-CABS) became the system of record for investigation and adjudication records within the agency. VA-CABS facilitates the receipt and adjudication of background investigations through data interchanges with the Defense Counterintelligence and Security Agency's Clearance Verification System/Personnel Investigations Processing System. Veterans Integrated Service Network (VISN) 5's Human Resources (HR) Shared Services Unit will oversee a compliance review of Beckley VA Medical Center's investigation profile based on relevant suitability records obtained from VA-CABS and report record validation results to VHA's Office of Workforce Management and Consulting Center (WMC) of Expertise: Vetting and Identity Credentialing.

Status: In Progress Target Completion Date: July 2023

Recommendation 2. Establish a project management plan to conduct compliance checks at other Veterans Integrated Service Network 5 facilities and share the plan with other networks.

VHA Comments: Concur. WMC, VISN 5 and stakeholder participants will establish an integrated project team to develop a project plan for ongoing compliance processes for vetting and identity credentialing activities. The final product will be shared with all VISNs.

Status: In Progress Target Completion Date: August 2023

Recommendation 3. Evaluate staffing levels for the personnel suitability program and allocate staff as needed to meet VA timelines.

VHA Comments: Concur. WMC is developing a staffing model review for all HR functional areas. The staffing model development for personnel security is underway. Interim staffing guidelines will be provided to VISN 5 by February 2023. The national model is expected to be completed in fiscal year 2023.

Status: In Progress Target Completion Date: September 2023

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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