Department of Veterans Affairs
Office of Inspector General
July 2012 Highlights

OIG REPORTS

Minneapolis, Minnesota, VA HCS Criticized for Suicide Prevention, Monitoring, and Follow-up Activities for High Risk Patient

The VA Office of Inspector General (OIG) conducted a review at the request of Congressman Tim Walz regarding alleged improper medication management and discharge planning practices for a patient under the care of the Minneapolis, MN, VA Health Care System (HCS) who ultimately committed suicide. OIG did not substantiate the complainant's allegations but did find that the facility did not complete suicide prevention activities as required. As a result, the patient in question did not receive the prescribed level of monitoring and follow-up. OIG found that the facility's review of the patient's death did not address the overall suicide risk management issues central to the case, and the facility did not adequately follow up on systems issues identified by the review. Further, facility policy lacked several important provisions for managing patients at high risk for suicide, and some staff were unaware of administrative requirements related to managing these high-risk patients. OIG made eight recommendations to improve quality of care and administrative processes related to suicide prevention. [Click here to access report.]

Fayetteville, North Carolina, VA Physician with Prior Performance Deficiencies Misdiagnosed ED Patient, Privileging Process Also Faulted

OIG evaluated allegations of misdiagnosis and courtesy lapses in the Fayetteville, NC, VA Medical Center (VAMC) Emergency Department (ED). OIG's review substantiated that the patient did not receive an accurate diagnosis during his ED visit. Further, the ED physician did not complete a comprehensive evaluation and did not review the medical record or ask the patient about his current medications. The Service Chief did not adequately address the ED physician's history of performance deficiencies related to medication reconciliation, and responsible managers did not follow policy when they renewed the ED physician's clinical privileges. The medical center conducted quality of care reviews, but those reviews did not address the deficiencies identified in this report. OIG could not confirm or refute the allegation that the ED physician was rude during the patient's ED visit. OIG made three recommendations to improve care and processes. [Click here to access report.]

Gainesville, Florida, Nurse Failed To Monitor and Adjust Patient's Insulin Dosage, Falsified Documentation

OIG reviewed allegations regarding a nurse's practice on a critical care unit at the Malcom Randall VAMC in Gainesville, FL. OIG substantiated the allegations that the registered nurse (RN) falsified documentation and did not administer insulin as ordered for a patient. OIG did not substantiate the allegation that the RN was practicing medicine without a license or that patient care was not documented until the end of a shift. OIG did not substantiate the allegation that the RN failed to provide pain medication for a patient; however, the RN did not provide pain medication as ordered

nor did she adhere to local policy for pain management. OIG substantiated the allegation that previous concerns about the RN were reported to the Nurse Manager (NM), but not that nothing was done. The review found that there was a pattern of quality of care issues associated with the RN and that the NM did not address the issues following appropriate managerial protocol. OIG recommended that the VAMC Director follow through with Administrative Investigative Board recommendations and request that Regional Counsel evaluate relevant documents to determine if the RN's actions meet criteria to report them to State licensure governing boards. The Veterans Integrated Service Network (VISN) and VAMC Directors agreed with the findings and recommendation and provided an acceptable action plan.
[Click here to access report.]

Allegations Unfounded Surrounding Supervision of Dayton, Ohio, VAMC Nurse Anesthetists
An OIG inspection did not substantiate an allegation that the Anesthesia Section Chief at the Dayton, OH, VAMC did not provide oversight to Certified Registered Nurse Anesthetists (CRNAs). OIG found that all CRNAs were properly credentialed and privileged to perform their assigned duties within the scope of their licenses. In addition, the Anesthesia Section Chief assigned a preceptor anesthesiologist to assess each CRNA twice each month through observation and chart review of specific anesthesia procedures. OIG made no recommendations. [Click here to access report.]

Inspection Results for VA Clinics in Multiple VISNs
During the weeks of April 2 and 9, 2012, OIG reviewed four Community Based Outpatient Clinics (CBOCs), including two VISN 3 facilities in Pine Plains (Eastern Dutchess) and Port Jervis, NY, and two VISN 4 facilities in Allentown and Tobyhanna, PA. The purpose of the reviews was to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care. The review topics included women's health, management of diabetes mellitus-lower limb peripheral vascular disease, heart failure follow-up, credentialing and privileging, and environment and emergency management. OIG noted opportunities for improvement and made seven recommendations to the VISN and facility managers.
[Click here to access report.]

OIG conducted similar reviews of four CBOCs during the weeks of March 19 and 26, 2012, in VISN 16 at Fort Smith, AR, and Lafayette, LA; and in VISN 17 at Denton and Tyler, TX. OIG noted opportunities for improvement and made nine recommendations to the VISN and facility managers. [Click here to access report.]

OIG reviewed three CBOCs in VISN 23 during the week of February 21, 2012, which included those at Mission, Pierre, and Rapid City, SD. OIG noted opportunities for improvement and made 25 recommendations to the VISN and facility managers. [Click here to access report.]

Lincoln, Nebraska, VA Regional Office in Top 6 Percent for Claims Processing Accuracy

OIG conducted an inspection at the Lincoln, NE, VA Regional Office (VARO) to evaluate how well it accomplishes its mission. Of the 51 VAROs OIG has inspected since April 2009, the Lincoln VARO ranked in the top 6 percent for claims processing accuracy. Lincoln VARO leaders attributed their successful operations to robust training efforts resulting in a highly skilled workforce and a unified management team providing exceptional oversight. Generally, VARO staff processed traumatic brain injury (TBI) and herbicide exposure-related disability claims correctly. However, the VARO did not always accurately process temporary 100 percent disability evaluations. These errors occurred when staff did not schedule required medical reexaminations. Overall, VARO staff did not accurately process 11 (13 percent) of 85 disability claims sampled as part of OIG's inspection; however, these results do not represent the overall accuracy of disability claims processing at this VARO because OIG sampled specific claims considered to be at higher risk of processing errors. VARO staff did not always address Gulf War Veterans' entitlement to mental health (MH) treatment as required, prompting OIG to recommend the Lincoln VARO Director develop and implement a plan to address this shortcoming. [Click here to access report.]

VA Regional Office Inspection Results for Little Rock, Arkansas

OIG's inspection of the Little Rock, AR, VARO, found that the VARO accurately processed 97 percent of both the TBI and herbicide exposure-related claims sampled by OIG. The VARO inaccurately processed 60 percent of the temporary 100 percent disability evaluations OIG reviewed because staff did not schedule required medical reexaminations to determine whether to continue these evaluations. Although OIG's inspection results show VARO staff did not process 20 (22 percent) of the 89 disability claims accurately, these results do not represent the overall accuracy of disability claims processing at this VARO because OIG sampled specific claims at higher risk of processing errors. VARO staff corrected errors identified by the VBA's STAR program as required. However, management did not provide adequate oversight to ensure Veterans Service Center staff completed all annual SAOs with sufficient data to support their analyses and conclusions. Insufficient management oversight also allowed for improper processing of mail; consequently, raters may not always have all available evidence to make accurate and timely claims decisions. OIG also noted Gulf War Veterans were not always informed of entitlement to treatment for MH disorders. Further, outreach to homeless shelters and service providers was not provided as required. The Acting VARO Director concurred with OIG's recommendations. [Click here to access report.]

VA Regional Office Inspection Results for Phoenix, Arizona

OIG conducted a benefits inspection to evaluate the Phoenix, AZ, VARO. OIG found the VARO lacked effective controls and accuracy in processing some of the disability claims sampled during the inspection. Inaccuracies in processing 87 percent of the 100 percent disability evaluations claims resulted when staff did not establish controls to schedule future medical reexaminations. In total, VARO staff did not correctly process

39 (47 percent) of the 83 disability claims. These results do not represent the overall accuracy of disability claims processing at this VARO given that OIG sampled claims considered at higher risk of processing errors. VARO staff followed VBA's policy on correcting errors identified by STAR program staff. However, VARO managers did not ensure staff completed or used adequate data to support SAOs. OIG recommended the VARO Director develop and implement training on processing TBI and herbicide exposure-related disability claims, and addressing Gulf War Veterans' entitlement to MH treatment. The VARO Director concurred with the recommendations.
[Click here to access report.]

QUI TAM AND CIVIL FRAUD

GlaxoSmithKline Pleads Guilty to Off-Label Promotion; Agrees to Largest Health Care Fraud Settlement in U.S. History

Multinational Corporation GlaxoSmithKline pled guilty to a three-count criminal information, including two counts of introducing misbranded drugs into interstate commerce and one count of failing to report drug safety data to the Food and Drug Administration. The settlement involved GlaxoSmithKline's best-selling anti-depressants and top diabetes drug. Under the terms of the plea agreement, the corporation will pay a criminal fine of $956,814,400, a criminal forfeiture of $43,185,600, and an additional $2 billion to resolve its civil liabilities under the *qui tam* provisions of the *False Claims Act*. The company also executed a 5-year Corporate Integrity Agreement with the Department of Health and Human Services OIG, which is designed to increase accountability and transparency and prevent future fraud and abuse. The outcome, which is the largest health care fraud settlement in U.S. history and the largest payment ever by a drug company, is the result of a multiagency investigation that included OIG. The plea agreement also resolves two additional OIG criminal investigations.

CRIMINAL INVESTIGATIONS

VA Contractor Charged with Conspiracy to Commit Wire Fraud

Authorities filed a criminal information against a VA contractor, charging him with conspiracy to commit wire fraud. If convicted, the contractor is also subject to a criminal forfeiture of up to $400,000 of his assets. OIG took part in a multiagency investigation that revealed the defendant submitted statements to the Small Business Administration and other Government agencies falsely representing that the business was owned and managed by a service-disabled, minority Veteran in order to qualify for contracts set aside for such Veteran-owned and operated businesses.

Former St. Louis, Missouri, VAMC Employee Sentenced For Accepting Illegal Gratuities

A former VA employee received a sentence of 15 months' incarceration for accepting illegal gratuities from Government contractors from 2007 to 2010 while employed at the St. Louis, MO, VAMC. The defendant admitted to accepting approximately $20,000 in cash, luxury baseball tickets, meals, and entertainment at a local club from two Government contractors while he was steering $3.4 million in Service-Disabled Veteran-Owned Small Business set-aside contracts to their companies. The contractors

established a front company, purportedly owned and operated by a service-disabled Veteran, when in actuality, it was controlled and managed by the contractors. Both contractors previously pled guilty to charges in this case, with one ordered to forfeit $1,557,439 and a 2011 Jaguar vehicle valued at over $83,000.

Veteran Pleads Guilty to Theft of Government Funds after Making False Claims
A Veteran pled guilty to the theft of Government funds after an OIG investigation revealed that he submitted a false claim for post-traumatic stress disorder (PTSD) to VA claiming that he was wounded during a mortar attack in Beirut, Lebanon. The defendant provided VA with a fraudulently obtained Purple Heart certificate to support his claim of having a combat-related injury. A review of the defendant's military records revealed that he was never deployed to a combat area. The defendant admitted that he purchased the Purple Heart certificate from an Internet vendor. The loss to VA is $24,488.

Veteran Sentenced for Compensation Fraud after Submitting Fraudulent DD-214s
After pleading guilty to making false statements, a Veteran was sentenced to 10 months' incarceration, 3 years' supervised release, and ordered to pay restitution to VA and the Navy in the amounts of $26,367 and $93,029, respectively. An OIG and Defense Criminal Investigative Service investigation revealed that the defendant submitted a fraudulent DD-214 to VA and the Navy indicating that he had been awarded a Purple Heart and a Combat Infantry Badge and that he served 6 years in the Army. The fraudulent DD-214 allowed the defendant to qualify for VA compensation benefits for PTSD. He then used the fraudulent DD-214 to generate a second DD-214, which was used as the basis to fraudulently receive a military retirement.

Veteran Arrested for Compensation Fraud
A Veteran was indicted and subsequently arrested for mail fraud, theft, false statements, and using a fictitious name or address. The defendant, who was receiving VA benefits for individual unemployability, reported to VA on multiple occasions that he was unemployed. An OIG and U.S. Postal Inspection Service investigation revealed that the defendant falsely claimed to have developed a drug that provided a cure for various ailments including human immunodeficiency virus and cancer. In return for selling the rights of his product to a California-based pharmaceutical company, the defendant received $150,000 and several hundred shares in the company. The defendant received additional income by selling his shares to other Veterans and receiving consulting fees from the pharmaceutical company.

Former VA Fiduciary Sentenced for Embezzling $242,000 in VA Benefits
A former VA fiduciary received a sentence of 6 months' incarceration, 6 months' home confinement, 3 years' supervised release, and was ordered to pay $92,817 in restitution to her brother-in-law, a disabled Veteran. An OIG investigation revealed that from October 2003 to April 2010, the defendant misused her position as her brother-in-law's fiduciary to embezzle approximately $242,000 in VA benefits. The defendant used the stolen funds for unauthorized purposes, which included building an addition onto her

house. The defendant falsified annual accountings submitted to VA by misstating the amounts of money on deposit in the Veteran's custodial bank accounts.

Former VA Fiduciary Pleads Guilty to Misappropriation after Embezzling $65,811
A former VA fiduciary pled guilty to misappropriation by a fiduciary and entered into a pretrial diversion program. The defendant was ordered to pay $39,811 in restitution to an insurance company, after having previously repaid $26,000. An OIG investigation disclosed that the defendant, who was the VA-appointed fiduciary for her son, embezzled $65,811 of the Veteran's benefits and used the stolen funds to pay off her home loan.

Son of Deceased Beneficiary Indicted for Theft of $133,000 in Government Funds
The son of a VA beneficiary was arrested after being indicted for theft of Government funds. An OIG investigation resulted in the defendant confessing to stealing more than $133,000 in VA benefits that were direct deposited to a joint account after his mother's death in May 2003.

Friend of Deceased Veteran Sentenced for Stealing VA Funds
The friend of a deceased Veteran was sentenced to 12 months' incarceration, 3 years' probation, and ordered to pay $177,824 in restitution after an investigation conducted by OIG and the Federal Bureau of Investigation revealed that the defendant attempted to hide withdrawals from the deceased Veteran's bank account by transferring funds through two PayPal accounts into the defendant's bank account.

Stepdaughter of Deceased VA Beneficiary Pleads Guilty to Theft
The stepdaughter of a deceased VA beneficiary pled guilty to theft of public money. An OIG and Social Security Administration (SSA) OIG investigation revealed that the defendant stole $215,000 of VA and Social Security funds that were direct deposited into joint accounts after her mother's death in March 2001 and her stepfather's death in December 2002.

Widow Arrested for Grand Theft
The widow of a deceased active duty service member was arrested for grand theft. An OIG, Naval Criminal Investigative Service, and local police investigation determined that the defendant failed to notify VA of her remarriages since the death of her third husband in 2005. The defendant further instructed her most recent husband to keep their marriage a secret so she would not lose her VA benefits. The defendant is also charged with stealing over $5 million from her former employer, former mother-in-law, and the Department of Defense. The loss to VA is $73,449.

Defendant Sentenced for Theft of Government Funds
A defendant was sentenced to 35 months' incarceration, 3 years' supervised release, and ordered to pay $79,799 in restitution to the Government, including $18,360 to VA. The defendant previously pled guilty to a criminal information charging her with felony theft and theft of Government funds. An OIG, SSA OIG, and local police investigation determined that the defendant received benefits as part of several fraudulent schemes

involving VA, SSA, Department of the Treasury, and the Missouri Department of Social Services. The defendant admitted to stealing funds from a deceased VA beneficiary who died in August 2008.

Cleveland, Ohio, VAMC Supervisor Charged for Selling Counterfeit Goods and Copyrighted Works
A Cleveland, OH, VAMC supervisor was charged in a criminal information with trafficking in counterfeit goods and infringement of copyrighted works. An OIG investigation revealed that the defendant solicited his employees to purchase bootlegged DVDs and counterfeit replicas of brand name purses on VA property during official duty hours. The total value of the counterfeit items seized from the defendant was $16,061.

Former West Los Angeles, California, VAMC Employee Convicted of Possession of Child Pornography
A former West Los Angeles, CA, VAMC employee was found guilty at trial of possession of child pornography, which was found in his residence located on the grounds of the West Los Angeles VAMC. The defendant is currently incarcerated after having previously pled guilty to the sexual abuse of his daughter.

Veterans Plead Guilty to Drug Distribution at Bedford, Massachusetts, VAMC
Three Veterans pled guilty to distributing controlled substances after having previously been charged with selling buprenorphine and oxycodone and conspiring to distribute oxycodone. An OIG, VA Police Service, and Drug Enforcement Administration investigation revealed the defendants were distributing drugs on the grounds of the Bedford, MA, VAMC, a facility that has multiple services for substance abuse rehabilitation. In some of the cases, the defendants were selling drugs that had been provided to them by the VAMC.

Contract Postal Worker Arrested for Stealing VA Narcotics
A highway contract route driver for the U.S. Postal Service was arrested for stealing mail after an OIG and U.S. Postal Inspection Service investigation revealed that the defendant stole controlled pharmaceuticals shipped by the VA Consolidated Mail Outpatient Pharmacy in Murfreesboro, TN, to Veterans residing outside of Louisville, KY. Since February 2012, the theft of at least 30 VA packages can be attributed to this defendant.

Veteran Sentenced for Assault of White River Junction, Vermont, VAMC Nurse
As a result of an OIG and VA Police Service investigation, a Veteran was sentenced to time served and 2 years' supervised release, ordered to participate in a substance abuse and MH treatment program, and banned from seeking treatment at the White River Junction, VT, VAMC. The defendant previously pled guilty to felony assault with a dangerous weapon. The investigation revealed that while in the VAMC emergency room, the defendant locked the door, took a scalpel from a hospital cart, and used the scalpel to gain control of a nurse by holding it to her throat. VA Police Service officers were able to subdue the defendant, and the nurse sustained no injuries.

Man Indicted for Assaulting Jackson, Mississippi, VAMC Police Officer
Authorities indicted the grandson of a Veteran for assaulting a Jackson, MS, VAMC police officer. An OIG investigation revealed that the defendant grazed the VA police officer with his vehicle as he attempted to flee the scene while the officer was in the process of issuing him a traffic citation for a moving violation. Subsequent to grazing the officer, the defendant continued his attempt to flee, accelerating at a high rate of speed and steering towards the officer, who had repositioned himself in an attempt to stop the defendant. The officer was able to move out of the way and avoid serious injury. The defendant fled the medical center, but returned after a few hours and was arrested by OIG and VA Police Service for felony assault on a Federal officer.

Veteran Pleads Guilty to Assault of Phoenix, Arizona, VAMC Social Worker
A Veteran pled guilty to assault on a Federal employee after an OIG investigation revealed that he physically assaulted and attempted to sexually assault a female VA social worker at the Phoenix, AZ, VAMC. The Veteran removed his clothing while in the employee's office and used physical force to prevent the employee from leaving the office. The defendant remains in custody pending sentencing.

Veteran Pleads Guilty to Travel Benefit Fraud
A Veteran pled guilty to theft of Government funds as the result of an OIG and VA Police Service investigation. The investigation revealed that on 198 occasions, the Veteran claimed he was traveling 306 miles roundtrip between Bartlesville, OK, and the Oklahoma City VAMC, while in actuality he traveled within the Oklahoma City area. The loss to VA is $24,572.

Veteran Sentenced for Submitting False Travel Benefit Claims and Threats
A Veteran was sentenced to 30 months' incarceration and ordered to pay $5,867 in restitution after pleading guilty to false statements and threats against a Government official. An OIG investigation revealed that between November 2008 and May 2011, the defendant submitted 181 fraudulent claims to the Hampton, VA, VAMC for travel benefits totaling $8,271. After the subject was interviewed and benefits were terminated, the Veteran made threats to harm the case agent.

Veteran Arrested for Travel Benefit Fraud
A Veteran was indicted and arrested for theft of property. An OIG investigation revealed that the defendant submitted approximately 200 fraudulent claims for travel benefits to the Nashville, TN, VAMC. The loss to VA is $21,326.

(original signed by Richard J. Griffin,
Deputy Inspector General for:)
GEORGE J. OPFER
Inspector General