Department of Veterans Affairs
Office of Inspector General
September 2012 Highlights

CONGRESSIONAL TESTIMONY

Statement by the Office of Inspector General on VA Fee Basis Program

The Office of Inspector General (OIG) provided a statement for the record for a hearing before the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives, on the OIG's work related to VA's purchase of health care services from non-VA providers. Our statement focused on the seven reports that OIG issued in the last 3 years on this topic that identified weaknesses and inefficiencies. OIG reported that VA had not established effective policies and procedures to oversee and monitor services provided by non-VA providers to ensure they are necessary, timely, high quality, and properly contracted and billed. [Click here to access testimony.]

OIG REPORTS

IG Faults VA Senior Human Resource Leadership for Lax Financial Oversight of Multimillion Dollar Conferences

OIG opened an administrative investigation upon receiving allegations of wasteful expenditures related to Human Resource conferences held in Orlando, FL, in July and August 2011. While VA reported lower estimates of conference costs to Congress, OIG reconstructed the costs of the two conference events to be approximately $6.1 million, but could not gain reasonable assurance that this figure represents a complete accounting for these conferences. In our opinion, VA held these conferences to fulfill valid training needs. However, VA's processes and the oversight were too weak, ineffective, and in some instances, nonexistent. Thus, many conference costs were not sufficiently documented, which made them difficult to clearly justify, or identify whether they were accurate, appropriate, necessary, or even reasonably priced. In fact, OIG questioned about $762,000 as unauthorized, unnecessary, and/or wasteful expenses. Further, OIG found that 11 VA employees, tasked with conference management responsibilities, improperly accepted gifts from contractors seeking to do business or already doing business with VA. The VA Secretary agreed to take action on our findings and OIG will monitor the Department's progress on implementing all proposed corrective actions. [Click here to access report.]

VA Overstated $710 Million in Savings Under Office of Management and Budget's Acquisition Savings Initiative

OIG conducted this audit to determine if Veterans Health Administration (VHA) reported accurate and supportable savings as part of Office of Management and Budget's acquisition savings initiative for fiscal years (FY) 2010 and 2011. VA set a 2-year savings goal of approximately $1.5 billion for FYs 2010 and 2011, which included a $721 million goal for VHA. OIG found VHA inaccurately reported $710 million (65 percent) of the approximately $1.1 billion in savings reported under the OMB acquisition savings initiative. Reported savings included errors like unreportable savings, duplicate transactions, and a lack of sufficient documentation. The

overstatement occurred due to incomplete guidance or inadequate oversight. OIG recommended improved policy and controls to ensure more effective responses to future savings reforms and initiatives. [Click here to access report.]

Ineffective Management at VA Security & Investigation Center Leads to Backlog in Contractor Background Investigations

OIG evaluated the merits of a Hotline complaint alleging VA had a backlog of contractor background investigations; was inappropriately requiring completion of contractors' background investigations before the contractors could begin work; and was not meeting its 20-day standard for starting investigations. OIG substantiated all three allegations. Despite process improvements and a recent reduction in pending cases, VA had a backlog of 3,000 contractor background investigations; inappropriately prohibited contractors from working on contracts; and was not meeting its 20-day standard for starting background investigations with the Office of Personnel Management. Delays were due to ineffective VA management within VA's Security and Investigative Center; staff misunderstanding VA's personnel security requirements and investigative process; and the lack of a central system to monitor progress in addressing the backlog. OIG recommended VA implement improved policies and procedures and implement a central case management system to monitor contractor status and costs associated with the background investigation process.
[Click here to access report.]

IG Recommends 15 Steps To Improve Pricing Accuracy, Reduce Open Market Purchases in Pharmaceutical Prime Vendor Contract

OIG conducted a review of open market purchases and to a limited extent contract purchases under VA's Pharmaceutical Prime Vendor contract with McKesson Corporation (McKesson). The review determined that open market purchases were overstated due to inconsistencies in McKesson's ordering system, many of which were due to delays by VA in updating prices. Ultimately price adjustments were made over time to reflect correct contract prices through McKesson's credit and rebill process and internal pricing reviews conducted by VHA's Pharmacy Benefits Management. In general, VA open market purchases are increasing due to the growing number of product shortages and allocation issues, problems that are not unique to the VA. In addition, the lack of training and the use of known workarounds by VA staff using McKesson's purchasing system led to open market purchases over contract purchases. OIG made 15 recommendations to VHA and the Office of Acquisition, Logistics, and Construction to improve pricing accuracies under the Pharmaceutical Prime Vendor contract and to minimize open market purchases. [Click here to access report.]

VA Overpaid for Space and Services at Cleveland Facility, Increased Security Risks Also Noted

VA Management inappropriately used VA's Enhanced Use Lease (EUL) authority to procure office space, parking, and domiciliary services at the Louis Stokes VA Medical Center (VAMC). The space and services procured through the EUL with Veterans Development, LLC, significantly exceeded any in-kind consideration for the Brecksville campus. By using VA's EUL authority, VA Management was able to circumvent the

normal rules and processes for procuring space and services, including health care services. This eliminated competition and caused VA to overpay for space and services and caused an increased risk in security. VA Management largely disagreed with our findings; however, our review of their response found it to be unsupported and unresponsive to our concerns and findings. [Click here to access report.]

IG Recommends Reevaluation of Inpatient Nurse Staffing and Overtime at Hot Springs, South Dakota, Health Care System

At the request of Senators Tim Johnson and John Thune and Representative Kristi Noem, OIG performed an inspection at the VA Black Hills Health Care System (HCS), Hot Springs, SD, to determine the validity of allegations they received regarding staffing, quality of care, and safety concerns. The complainants expressed concerns that only temporary staff were hired for critical clinical positions and that staffing issues may lead to quality of care issues and patient/staff safety concerns. While onsite, OIG also received allegations that the pharmacy and an inpatient unit (1E) were understaffed and 1E nursing staff were working excessive amounts of mandatory overtime. OIG did not substantiate that only temporary staff were hired for critical clinical positions, hiring temporary staff led to quality of care or safety issues, or 1E was understaffed with nursing staff working excessive amounts of mandatory overtime. OIG did not review pharmacy staffing due to unavailability of workload data. OIG recommended that the HCS Director reevaluate Hot Springs division 1E staffing and overtime and obtain a VA Pharmacy external review of the pharmacy workload and staffing needs.
[Click here to access report.]

IG Notes Vast Improvements in Dental Instrument Cleaning at St. Louis VAMC

OIG conducted a review to follow-up on our report, *Follow-Up Evaluation of Dental Instrument Reprocessing Deficiencies, St. Louis VAMC, St. Louis, Missouri* (Report No. 10-03346-152, April 5, 2012). The purpose was to determine whether the adverse conditions identified have been resolved and whether OIG's recommendations were implemented. In the past several months, Veterans Integrated Service Network (VISN) and facility managers have taken multiple corrective actions and many of the conditions identified in the April 2012 OIG report have been resolved. Supply Processing Service (SPS) leadership positions have been filled, SPS has moved into its fully-renovated state-of-the-art space, and communication and oversight processes are improving. The facility has made vast improvements in its reusable medical equipment related policies and practices over the past 6 months and the central issue of patient safety during dental procedures has been addressed. While OIG identified some additional improvement opportunities, facility and VISN managers have verbalized their commitment to ongoing compliance with VHA requirements. Therefore, OIG considers the recommendations from the April 2012 report closed. [Click here to access report.]

IG Makes Six Recommendations To Improve Hampton VAMC Intensive Care Unit Operations

At the request of Senator Jim Webb, OIG conducted a review to determine the validity of 13 allegations regarding nurse orientation and training, medication integrity and security, security over patient information, availability of medical supplies, patient

monitoring and staff response to patient care needs, and environment of care issues at the Hampton VAMC, Hampton, VA. The allegations largely focused on the Intensive Care Unit (ICU). OIG substantiated five of the allegations: (1) ICU medication refrigerator temperatures are frequently outside the appropriate range, (2) ICU medication carts do not always lock properly, (3) medical supplies are not adequately stocked in the ICU, (4) negative air pressure is not maintained in patient isolation rooms in the ICU and Step Down Unit, and (5) the ICU physician call schedule is not clear to nurses on the night shift. OIG did not substantiate six of the allegations and could neither confirm nor refute two of the allegations. In addition, OIG identified two issues related to telemetry monitoring. OIG made six recommendations that the VISN and Acting Facility Directors agreed with and provided acceptable improvement plans. [Click here to access report.]

IG Recommends Reassessment of Nurse Staffing in Surgical Intensive Care Unit at Houston Facility

OIG conducted an inspection in response to anonymous complainants' allegations of unsafe patient care and delivery of services in the Surgical Intensive Care Unit (SICU) at the Michael E. DeBakey VAMC in Houston, TX (facility). OIG found that the facility's average actual SICU nursing hours per patient day (NHPPD) staffing levels were below the unit's target NHPPD. OIG determined that the facility assigned nurses to units without proper training, tolerated disruptive behavior, and did not properly use nurse staffing methodology. OIG substantiated that the SICU cardiac monitors were outdated and in need of replacement, and that equipment was in short supply. OIG substantiated that the pharmacy placed SICU patients' medications in a bin in the medication room and was slow to fill requests for urgent medications. OIG recommended that the Facility Director ensure that: (1) SICU nursing management reassess the nursing methodology to ensure the target NHPPD is appropriate, (2) nursing staff receive unit-specific training for each unit they are assigned, (3) outdated monitors are replaced and equipment is in sufficient supply, (4) disruptive behaviors are addressed, and (5) medications are dispensed in a safe manner. The VISN and Facility Directors agreed with our findings and five recommendations and provided acceptable improvement plans. [Click here to access report.]

IG Makes Four Recommendations at the VA Illiana HCS, Danville, Illinois

OIG conducted an inspection to determine the validity of allegations regarding pharmacy response, surgical and mental health (MH) consultant response times, nurse staffing, deep dives, and inadequate leadership communication regarding proposed changes at the VA Illiana HCS (facility) in Danville, IL. OIG substantiated that the MH Service did not respond to "emergency," "within one hour," and "within 24 hour" consults for patients diagnosed with suicidal ideation within facility policy timeframes. Patients, however, are kept on a one-to-one observation basis until evaluated and cleared by a psychiatrist. OIG also substantiated that registered nurses were assigned to units without the required competencies validated as required by The Joint Commission. OIG did not substantiate that Surgical and Pharmacy Services are not providing timely services as required by VHA directives and facility policy, or that nursing leadership was deficient in its staffing plans. However, OIG did substantiate that nurse staffing on two

units did not comply with unit staffing plans. OIG also did not substantiate that punitive action was taken against an employee based on results of a deep dive facility review, or that facility leadership has not communicated with staff proposed changes. The VISN and Facility Directors agreed with our findings and four recommendations and provided acceptable improvement plans. [Click here to access report.]

St. Louis VAMC Takes Appropriate Action to Correct Medication Errors
OIG evaluated allegations regarding the quality of care provided by a nurse at the John Cochran Division, St. Louis VAMC, St. Louis, MO. A complainant alleged that a registered nurse (RN) was involved in serious medication errors, and that management did not respond when complaints were brought to their attention. The facility took appropriate actions in response to the allegations by removing the subject RN from patient care and initiating an Administrative Investigation Board (AIB) to review the alleged medication errors. The AIB substantiated the allegation of substandard care and OIG concurred with their findings and recommendations. OIG did not substantiate the allegation that management did not respond to prior complaints. OIG also reviewed the facility's RN competencies, medication administration system, and quality and safety programs, and OIG made no recommendations. [Click here to access report.]

Inspection Results for VA Regional Office in Winston-Salem, North Carolina
OIG conducted this inspection to evaluate how well the Winston-Salem VA Regional Office (VARO) accomplishes its mission. OIG found the VARO accurately processed most herbicide exposure-related claims but needed to improve accuracy in processing traumatic brain injury (TBI) claims. VARO staff inaccurately processed 50 percent of the temporary 100 percent disability evaluations because medical reexaminations were not scheduled as required. Although our results show VARO staff did not accurately process 20 (22 percent) of the 90 disability claims, these results do not represent the overall accuracy of disability claims processing at this VARO as OIG sample selected types of claims at higher risk of processing errors. VARO staff corrected errors identified by VBA's Systematic Technical Accuracy Review (STAR) program, and management ensured staff completed all elements of Systematic Analysis of Operations (SAOs). VARO staff correctly processed incoming mail but errors occurred in other stages of mail processing. VARO staff did not always advise Gulf War Veterans of their entitlement to MH treatment, however the VARO's outreach to homeless Veterans was provided. Furthermore, the VARO lacked adequate space for approximately 37,000 claims folders. [Click here to access report.]

IG Notes Areas of Improvement at the Spokane VAMC, Spokane, Washington
OIG reviewed allegations of inappropriate consultation cancellation causing delays in care and potential harm to patients, poor communication between consultants and primary care providers (PCPs) and patients, and inappropriate requests for PCPs to order tests for consultants at the Spokane VAMC, Spokane, WA. OIG substantiated that requests for consultations were inappropriately cancelled or discontinued, and that patients consequently had unnecessary delays in the amelioration of symptoms. OIG substantiated that there was poor communication between consultants and PCPs that resulted in requests for consultations being discontinued or cancelled. OIG did not

substantiate that consultants inappropriately asked PCPs to order tests. However, OIG noted opportunities for improvement, such as the use of service agreements to define workflow processes and expedite efficient patient care. OIG recommended that the Medical Center Director: (1) ensure that there is a comprehensive consultation process in place and that staff are educated on the process, (2) ensure that all requests for consultations be appropriately generated, tracked to completion, and that consultation completion data is shared with clinical staff, and (3) ensure that persistent staff conflicts and communication issues are appropriately addressed and resolved. The VISN and System Directors agreed with the findings and recommendations and provided acceptable action plans. [Click here to access report.]

Results for Benefits Inspection of VA Regional Office Cleveland, Ohio
OIG conducted this inspection to evaluate how well the Cleveland VARO accomplishes its mission of providing Veterans with access to high-quality benefits and services. OIG found VARO staff inaccurately processed 26 percent of the disability claims OIG reviewed. These results do not represent the overall accuracy of disability claims processing at this VARO as OIG sampled claims specific to certain medical conditions OIG considered at higher risk of processing errors. They inaccurately processed 53 percent of the temporary 100 percent disability evaluations; and 17 percent of the sampled TBI were inaccurately processed. In contrast, VARO staff accurately processed 93 percent of the herbicide exposure-related claims OIG reviewed. They generally corrected errors identified by VBA's STAR program. Management ensured staff completed and used adequate data to support SAOs. However, insufficient oversight caused the improper processing of mail. They also inconsistently addressed Gulf War Veterans' entitlement to MH treatment. The VARO did provide outreach to homeless Veterans. The VARO Director concurred with our recommendations.
[Click here to access report.]

Wichita, Kansas, Benefits Inspection Results
OIG conducted this inspection to evaluate how well the Wichita VARO accomplishes its mission of providing Veterans with access to high-quality benefits and services. OIG found the VARO accurately processed 50 percent of both the TBI and herbicide exposure-related claims sampled. However, because staff did not schedule medical reexaminations as required, the VARO inaccurately processed 53 percent of the temporary 100 percent disability evaluations OIG reviewed. Although our results show VARO staff did not accurately process 36 (51 percent) of the 70 disability claims, these results do not represent the overall accuracy of disability claims processing at this VARO as OIG sample selected types of claims at higher risk of processing error. VARO staff corrected errors identified by VBA's STAR program, however, management did not ensure staff timely completed all elements of SAOs. VARO performance in mail processing was effective and outreach to homeless Veterans was adequate. Processing of competency determinations was ineffective resulting in incompetent beneficiaries receiving payments without a fiduciary in place.
[Click here to access report.]

Inspection Results for VA Clinics in Multiple VISNs
OIG reviewed four Community Based Outpatient Clinics (CBOCs) during the weeks of June 11–25, 2012. CBOCs were reviewed in VISN 11 at Flint, MI; and Toledo, OH; and, in VISN 12 at Appleton and Union Grove, WI. The purpose of the review was to assess whether CBOCs are operated in a manner that provides Veterans with consistent, safe, high-quality health care. The review covered the following focused topic areas: 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 a total of 14 recommendations to the VISN and facility managers.
[Click here to access report.]

OIG reviewed four CBOCs and two satellite clinics during the weeks of June 4–18, 2012. CBOCs were reviewed in VISN 23 at Chippewa Valley and Hayward, WI; and St. James (South Central) and Montevideo, MN. OIG noted opportunities for improvement and made a total of 16 recommendations to the VISN and facility managers. [Click here to access report.]

OIG reviewed four CBOCs during the weeks of June 18–25, 2012. CBOCs were reviewed in VISN 6 at Wilmington, NC; and, in VISN 7 at Columbus, GA; Goose Creek, SC; and Savannah, GA. OIG noted opportunities for improvement and made a total of 17 recommendations to the VISN and facility managers. [Click here to access report.]

CRIMINAL INVESTIGATIONS
Attorney Pleads Guilty to Conspiracy and Filing a False Tax Return
An attorney pled guilty to conspiracy and filing a false tax return. The defendant, who served as a court appointed guardian and Federal fiduciary for 54 Veterans, stole approximately $2.3 million from the Veterans' bank accounts. The defendant also failed to report the stolen funds to the Internal Revenue Service. The defendant's wife, who worked as his legal assistant, previously pled to the same charges.

Contractor Sentenced for Service-Disabled Veteran-Owned Small Business Fraud
A VA contractor was sentenced to 41 months' incarceration, 36 months' supervised release, and ordered to pay a $30,000 fine and a $600 special assessment. The sentence was based on the defendant's conviction, following a 5 day trial, to major frauds against the Government, making false statements to a Federal law enforcement officer, and witness tampering. A VA OIG, Small Business Administration (SBA) OIG, and U.S. Army Criminal Investigation Command (CID) investigation determined that from June 2007 to June 2010 the defendant falsely claimed that he was both a Veteran and/or a disabled Veteran in connection with VA or U.S. Army construction contracts that were set-aside for either Veterans or disabled Veterans and valued at approximately $16 million.

Fiduciary Sentenced for Exploitation of a Vulnerable Adult and Forgery
The sister-in-law of a Veteran, who was also his fiduciary, was sentenced to 7 years' incarceration and ordered to pay the Veteran $53,180 in restitution after pleading guilty

to exploitation of a vulnerable adult and forgery. An OIG and local sheriff's office investigation revealed that the defendant stole VA and Social Security benefits intended for the Veteran and used the stolen funds for personal expenses.

Former Detroit, Michigan, VAMC Nursing Assistant Sentenced for Sexual Assault
A former Detroit, MI, VAMC nursing assistant was sentenced to 6 months' incarceration, followed by 12 months' electronic monitoring, and 3 years' probation. The defendant must also register as a sex offender, have no contact with the victim, and pay an administrative fee of $1,453. The former employee provided a signed sworn statement during an OIG investigation in which he admitted to sexually assaulting a job corps student while working together at the medical center.

Former West Los Angeles, California, VAMC Chief Accountant Pleads Guilty to Theft of Government Funds
A former West Los Angeles, CA, VAMC chief accountant pled guilty to theft of Government funds. An OIG investigation determined that the accountant embezzled $681,087 of VA funds. To date, $229,191 of the stolen funds is still missing.

Veteran Charged with Mail Theft and Aggravated Identity Theft
A Veteran was charged with mail theft and aggravated identity theft after an OIG investigation revealed that she assumed the identities of six other Veterans in order to receive $18,000 in advanced education payments under the Post-9/11 GI Bill. When interviewed, the defendant confessed that while on active duty she obtained a personnel roster that contained personal identifiers of service members. After the defendant was discharged, she used the list to assume the identities of the Veterans in order to request advance education payments online. The defendant had the checks, in the names of the other Veterans, mailed to her address and then created false powers of attorney in order to negotiate the checks.

Loan Broker Sentenced for Fraud
A loan broker was sentenced to 63 months' incarceration, 3 years' supervised release, and ordered to pay restitution after pleading guilty to wire fraud, aggravated identity theft, making false statements on a loan application, and concealing assets in bankruptcy. A VA OIG and Housing and Urban Development (HUD) OIG investigation determined that the defendant fabricated VA certification letters that were subsequently used to establish the credit worthiness of buyers for three different properties. These properties were subsequently listed as assets in bankruptcy filings. The loss to three banks was $1,033,500.

VA Contractor Charged with Conspiracy to Commit Wire Fraud
A VA contractor was charged in a criminal information with conspiracy to commit wire fraud and is subject to forfeiture of his assets in an amount not greater than $38,000. A VA OIG, General Services Administration OIG, SBA OIG, Department of Labor OIG, and U.S. Army CID investigation revealed that the defendant submitted statements to the SBA and other Government agencies falsely representing that a minority and a service-disabled Veteran owned and managed the daily operations of the business in

order to get Federal Government contract awards that were set aside for or preferentially awarded to disadvantaged minority and service-disabled Veteran-owned and operated businesses.

Bay Pines, Florida, VAMC Employee Arrested for Theft of Government Funds
A Bay Pines, FL, VAMC employee was arrested for theft of Government funds and access device fraud. An OIG investigation revealed that the employee used a GSA fuel card, issued to a VA vehicle, for personal profit. The approximate loss to VA is $33,000.

Sixteen Veterans Charged with Travel Benefit Fraud
Sixteen Veterans were charged with theft of Government property and false statements. A VA OIG, VA Police Service, and HUD OIG investigation revealed that the defendants filed fraudulent travel vouchers at the Cleveland, OH, VAMC in order obtain travel benefits they were not entitled to receive. The loss to VA is over $242,000.

Patients Arrested for Theft of Government Property
Two Hines, IL, VAMC patients were arrested for theft of Government property. A VA OIG and VA Police Service investigation revealed that the two defendants stole computers, monitors, video cameras, and various items from the area of a patient lab room after having sexual intercourse in the room. Both defendants admitted to the theft and most of the equipment was recovered. The stolen items were valued at $37,066.

Former Tampa, FL, VAMC Employee Sentenced for Theft
A former Tampa, FL, VAMC employee was sentenced to 8 months' home detention, 60 months' probation, and ordered to pay VA $88,879 in restitution. An OIG investigation determined that the defendant ordered low vision-enhancing equipment in the form of iPads and Apple laptops, claiming that they were needed by vision-impaired Veterans. The defendant subsequently sold the equipment on Craigslist for his own personal gain.

Veteran Pleads Guilty to Falsifying a Military Discharge Certificate
A Veteran waived indictment and pled guilty to falsifying a military discharge certificate. An OIG investigation revealed that the defendant falsely claimed to have been awarded a Purple Heart Medal and submitted to VA, in relation to a claim for benefits, a fraudulent Purple Heart certificate, medical notes, and fraudulent military forms to include a DD-214.

Former U.S. Postal Service Employee Pleads Guilty to Possession of a Controlled Substance by Fraud and Theft of Mail
A former U.S. Postal Service (USPS) employee pled guilty to possession of a controlled substance by fraud and theft of mail. During a VA OIG and Postal OIG investigation, the defendant was found in the parking lot of a USPS processing plant with opened VA packages containing controlled substances. The VA had reports of lost and missing controlled medications processed through the same plant for a number of years.

Non-Veteran Sentenced for Identity Theft
A non-Veteran was sentenced to 48 months' incarceration, 3 years' supervised release, and ordered to pay VA $71,812, HUD $10,077, and the victim $123 in restitution after pleading guilty to theft and identity theft. An OIG investigation revealed that the defendant assumed the identity of a Veteran and for over 4 years received more than $70,000 in VA medical care to which he was not entitled.

West Haven, Connecticut, VAMC Pharmacy Technician Arrested for Drug Theft
A West Haven, CT, VAMC pharmacy technician was arrested after a VA OIG, VA Police Service, and local police investigation revealed that for 6 months she diverted nearly 900 pills from the pharmacy. When confronted with video evidence of her crimes, the defendant admitted to diverting generic percocet from prescriptions that were waiting to be mailed from the outpatient pharmacy.

Defendants Charged with Passing Forged Prescriptions
Four defendants were charged with altering and passing forged VA oxycodone prescriptions. An OIG investigation revealed that one of the defendants, a Veteran receiving VA medical care, obtained and then forged VA prescriptions using the signature and Drug Enforcement Administration number of a VA contract nurse working at a local CBOC. The defendant then conspired with the other defendants to fabricate additional prescription orders using various fictitious names and addresses and then passed them at retail drug stores in several adjoining counties.

Girlfriend of Deceased Beneficiary Sentenced for Theft of VA Funds
The girlfriend of a deceased VA beneficiary was sentenced to 10 months' incarceration, 36 months' probation, and ordered to pay $56,000 in restitution after pleading guilty to making false statements. An OIG investigation revealed that the defendant obtained, forged, and negotiated VA checks intended for a Veteran after his death in October 2006 by submitting forged employment questionnaires to VA.

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