Office of Inspector General

REVIEW OF SELECTED CONSTRUCTION CONTRACTS, PURCHASE CARD ACTIVITIES, AND VEHICLE ADMINISTRATION AT VETERANS AFFAIRS MEDICAL CENTER (VAMC) CLARKSBURG, WEST VIRGINIA

Action is needed to address significant management deficiencies and control weaknesses that have adversely impacted the facility's administration of construction contracts, purchase card program activities, and Government vehicles.

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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to the Acting Director, Veterans Affairs Medical Center (VAMC) Clarksburg, West Virginia

Review of Selected Construction Contracts, Purchase Card Activities, and Vehicle Administration at Veterans Affairs Medical Center (VAMC) Clarksburg, West Virginia

1. The Office of Inspector General (OIG) conducted a limited scope review of construction contracts, purchase card program activities, and the administration of Government vehicles at the VAMC Clarksburg, West Virginia. Review work performed supported an OIG investigation assessing hotline allegations that focused upon the actions of specific VA employees working in Facility Management operations, certain construction contractors, and local vendors. The allegations received alleged improper contract and construction related activities; violations of acquisition regulations; a lack of appropriate management controls over construction projects; purchase card expenditures; and improper trading of VA-owned vehicles. As part of this effort, we examined payments made to certain contractors and vendors, and assessed actions and management controls.

2. Management deficiencies and control weaknesses were identified that impacted the administration of construction contracts, the purchase card program, and Government vehicles. The following key findings were identified.

- Supervision over Facility Management operations was found to be ineffective and resources available to support acquisition functions were inadequate.

- Significant performance deficiencies, and unexplained and unsupported project costs have put the facility at unnecessary business, performance, and financial risks associated with its construction contracts.

- Oversight over purchase card transactions needed to be enhanced to help detect and prevent paying excessive prices, over-expenditures in control points, and to ensure transactions are adequately documented to support need.

- Accountability over VA-owned vehicles in the facility’s inventory could not be reasonably assured.

- Overall, we found little management control over Facility Management operations. As a result, top management's attention is needed to assure the integrity and accountability over the facility's construction program, purchase card expenditures, and vehicle property management.

We concluded that there is an immediate need to improve the management and work environment of Facility Management operations. This report includes 12 recommendations to enhance Facility Management operations at VAMC Clarksburg.

3. During the review, senior officials at VAMC Clarksburg advised that medical center police found and stopped Facility Management personnel from discarding official records just prior to our initial site visit. Some records were recovered, however reasonable assurance could not be obtained that all pertinent records were recovered. Certain information, needed to adequately assess allegations, was not available and we noted serious deficiencies in record keeping existed in Facility Management operations. As a result, information was subpoenaed from various external sources to help address certain allegations. Additional issues are being addressed as part of an Office of Investigations review.

4. The Acting Director concurred with the report recommendations and provided appropriate implementation actions. We consider the report issues resolved and will follow up on planned actions until they are completed.

For the Assistant Inspector General for Auditing

(Original signed by:)

Stephen L. Gaskell
Director, Central Office Operations Division

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SUMMARY OF RESULTS

Management deficiencies and control weaknesses resulted from inadequate supervision and resources over the administration of construction contracts, the purchase card program, and Government vehicles. Problems in contracting occurred as the result of a management decision to place the supervision and control of procurement activities under the Facility Management Program Team Leader. This organizational change increased pressures to perform work without regard to following regulations, and resulted in inappropriate influence over contracting officers' (CO) performance. The resources assigned to acquisition support activities were also inadequate to administer the associated duties and responsibilities effectively. As a result, we found a serious breakdown of management controls that were necessary to administer and ensure construction, purchasing activities, and Government vehicle acquisition and disposal were performed effectively and efficiently.

This report identifies major deficiencies in the current management of construction contracts. Official contract records and acquisition support files were disorganized, missing documentation such as change orders to contracts, and were not adequately restricted to protect proprietary and source selection information. Key deficiencies included performance of unauthorized construction, i.e. helicopter pad construction, and authorization of contractor work performance before the award of a major contract and certain change orders. Contract modifications were also identified for work outside the scope of original contracts and some contract modifications lacked support for increasing project costs.

One major contract, valued at about $3.4 million, awarded to construct a 30-bed nursing home care unit is in default after the general contractor became delinquent on payments to its subcontractors and failed to meet its payroll. Before the default, the general contractor was pursuing an equitable adjustment claim against the facility valued at $213,870 for unabsorbed overhead expenses incurred after a stop work order was issued. Their claim was based upon additional work performed beyond the contract's scope of work. We concluded that this project is encumbered with performance problems, management actions increased costs unnecessarily, and excessive schedule delays have occurred because of unauthorized management changes and inadequate contract and project oversight. Unauthorized changes in project scope such as redesigning the planned nursing home care space to accommodate administrative space for relocation of the facility Director's office increased project costs. However, after such changes were made Veterans Integrated Service Network (VISN) 4 officials insisted the space be used as originally planned for nursing home care and project construction was changed back consistent with original plans. According to the Contracting Officer's Technical Representative (COTR) these changes escalated project costs unnecessarily.

While adequate supervision may not have prevented the default of a major construction contract, adequate management and oversight of performance and ensuring effective controls are in place over progress payments, could have identified problems earlier and reduced performance and financial risks that the VAMC now has to address. Analysis of contract costs for another architectural and engineering (A&E) contract showed that overhead and profit were excessive in comparison to direct project costs. Thus, we concluded the facility lacked reasonable assurance that they had received good value for the work performed. We also concluded that supervision over acquisition support activities and the facility's construction program appears almost non-existent.

Prior year funds were used inappropriately and construction projects experienced unexplained and significant performance delays while controls over other construction contract progress payments were non-existent. Certain contract actions support that the authority provided COs has been usurped and that construction has been permitted by VA employee(s) who lacked the authority to enter into such actions.

A limited review of purchase card transactions showed that purchase card files contained little or no documentation supporting the price reasonableness of the services they were acquiring. We found that the facility paid excessive prices for services, and staff continually split work requirements to circumvent competition requirements. The facility did not have formal policies and procedures in effect to prevent inappropriate splitting of work requirements. Controls were so weak that uncontrolled credit card purchases led to over-expenditures in Facility Management program fund allotments and purchase card reconciliations were not performed timely.

The administration of Government vehicles was also considered inadequate. Records supporting the acquisition and disposition of Government vehicles were incomplete because they were missing pertinent information such as vehicle identification numbers, dates of acquisition, disposition, and/or mileage. Thus, accountability over vehicles in the facility's inventory could not be reasonably assured. We utilized three independent sources of vehicle records; however, we could not account for all vehicles owned, leased, or donated to the facility.

We concluded that communications between COs and other key Facility Management senior staff were not conducted and that serious lapses in management occurred within Facility Management operations. As a result, there is a need for senior facility management to re-establish the integrity, accountability, and management control of these operations. New leadership strategies need to be implemented to re-establish integrity and accountability over Facility Management operations, inclusive of acquisition support activities.

RECOMMENDATIONS

We recommend that the Acting Director, VAMC Clarksburg implement the following actions to improve Facility Management operations:

(1) Realign the organizational structure to ensure COs can operate independently, eliminating pre-existing conflict of interest situations. *(Review details are on pages 7-20.)*

(2) Improve supervision over contract award and administration activities, the purchase card program, and vehicle management. *(Review details are on pages 7-33.)*

(3) Ensure resources are made available to accomplish necessary acquisition support activities. *(Review details are on pages 8- 9.)*

(4) Restrict access to files containing proprietary and source selection information to only personnel authorized to receive it, such as COs. *(Review details are on pages 19-20.)*

(5) Ensure all construction work is designed, planned, approved, and constructed consistent with strategic goals, performance plans, and industry standards. *(Review details are on pages 11-20.)*

(6) Obtain a safety inspection and take action to repair the helicopter pad as required. *(Review details are on pages 11-13.)*

(7) Ensure all future work requirements are authorized by warranted COs and contracted for using appropriate contractual mechanisms. *(Review details are on pages 11-20.)*

(8) Determine what actions may be required to address the performance of the Facility Management Program Team Leader for failure to follow procurement regulations, and for the other serious management lapses noted within Facility Management operations. *(Supporting details are provided throughout the report.)*

(9) Update and ensure the currency of files maintained in support of architectural and engineering (A&E) professional qualifications, i.e. Standard Forms 254 and 255, and enhance the membership of the facility A&E Source Selection Board to include individuals from other independent sources. *(Review details are on pages 15-16.)*

(10) Formalize a facility Purchase Card Program policy to provide guidelines for the effective use and control of purchase cards. *(Review details are on pages 21-22.)*

(11) Ensure training is provided to cardholders and approving officials prior to issuance of purchase cards, or at such times as an employee needs additional guidance. *(Review details are on pages 21-23.)*

(12) Establish an adequate level of supervision over vehicle administration responsibilities. This should include completion of a physical inventory of facility vehicles and an update of official records to include pertinent information, resolution of inventory discrepancies, disposal of unusable vehicles from facility grounds, and completion of all required annual inventory reports in a timely manner as required. *(Review details are on pages 31-33.)*

Acting Director, VAMC Clarksburg Comments

The Acting Director, VAMC Clarksburg concurred with the report recommendations 1-12.

Implementation Plan

The Acting Director provided the following implementation actions that address the report recommendations.

(1) The Acquisition functions have been removed from the Facility Management line and realigned as a separate entity reporting to the Associate Director.

(2) The Director, Acquisition and Materiel Management Service (A&MM), VAMC Coatesville, is directly responsible for reviewing all contracts being awarded and for the Clarksburg purchase card program. These responsibilities will not be transferred to Clarksburg until personnel involved are retrained; new management is in place; and proper internal auditing functions are being completed timely and accurately.

(3) We plan to commence recruitment by March 31, 2001, for an employee to manage daily A&MM operations at VAMC Clarksburg.

(4) All proprietary and source selection information has been secured in those areas only accessible to Acquisition.

(5) The Contracting staff has been realigned under the Associate Medical Center Director. Immediate supervision has been transferred to the Director, A&MM, Coatesville, PA, who will ensure construction work is designed and approved utilizing Federal and VA Acquisition Regulations as well as other governing laws.

(6) The feasibility of having a helicopter pad is being reviewed. If determined feasible, appropriate safety inspections will be completed.

(7) The Director, A&MM Coatesville, is ensuring all future work requirements are authorized by warranted COs utilizing appropriate Federal laws.

(8) The Facility Management Program Leader has been relieved of all Facility Management responsibilities and is located off Medical Center grounds.

(9) The Director, A&MM, VAMC Coatesville, has established a local A&E Board in accordance with the Federal Acquisition Regulation. In addition, the need for two COs has been recognized and additional Full-Time Equivalent Employees are being pursued.

(10) A Clarksburg Credit Card Policy has been written and implemented. A Clarksburg Purchase Card Coordinator and alternate have been designated. These individuals and all training will be completed and be independently operational, with the proper audit functions in place, by February 1, 2001.

(11) The Director, A&MM, VAMC Coatesville, has conducted a review of all purchase cardholders and approving officials. A fileman routine has been developed to identify out-of-line purchases. Re-Training of all purchase cardholders and approving officials will be completed by February 1, 2001.

(12) With the detail of the Facility Management Program Leader and redistribution of workload between individuals within Facility Management, vehicle administration controls have been re-instituted and internal audits put in place. The disposal of unusable vehicles is ongoing, with the completion to be in late February 2001.

(See Appendix VIII on pages 49-53 for the full text of the Acting Director's comments.)

Office of Inspector General Comments

The Acting Director's implementation actions are acceptable and responsive to the recommendation areas. These actions should help enhance Facility Management operations at VAMC Clarksburg. We consider these report issues resolved and will follow up on planned actions until they are completed.

RESULTS OF REVIEW

1. LACK OF SUPERVISION AND INADEQUATE RESOURCES RESULTED IN A SERIOUS BREAKDOWN OF MANAGEMENT CONTROLS WITHIN FACILITY MANAGEMENT OPERATIONS

VAMC Clarksburg has not established effective supervision over its administration of construction contracts, purchase card programs, and Government vehicles. The lack of supervision is a result of a management decision to place the supervision and control of acquisition support activities under the Facility Management Program Team Leader. That decision has resulted in inappropriate influence over acquisition personnel and a serious breakdown of controls needed to effectively administer construction contracts and purchasing activities.

During three separate onsite visits we observed staff communications on the Facility Management Team to be ineffective and direct supervision of program activities to be inadequate. In addition, facility senior management, contracting officers (CO), and other staff officials voiced concerns over the working environment in Facility Management, including use of intimidation tactics by the Program Team Leader. Facility senior management described employee tension in Facility Management to be high and not conducive to a healthy working environment. We also concluded that resources available to support acquisition activities were inadequate. As a result of employee distrust for the Facility Management Program Team Leader, inadequate acquisition support resources, lack of communication, and inadequate supervision in Facility Management, there is a need for facility top management to re-establish effective staff communications and a healthy work environment.

The lack of effective contract and construction project administration and supervision resulted in unsupported and unnecessary construction costs, and significant performance delays. One major contract, valued at about $3.4 million, to construct a 30-bed nursing home care unit is in default after the general contractor became delinquent making payments to its subcontractors and failed to meet its payroll. Payments outstanding from the general contractor to one subcontractor exceeded $600,000. In addition, the CO received complaints that as least two other subcontractors have not been paid for work performed, but did not have information on payments due these subcontractors. Before the default, the general contractor was pursuing an equitable adjustment claim against the facility valued at $213,870 for unabsorbed overhead expense costs incurred after a stop work order was issued. Their claim was based upon additional work completed beyond the contract’s scope of work.

This project is encumbered with performance problems, increased costs, and schedule delays because of unauthorized management changes and inadequate contract and project oversight. Inappropriate changes in the project scope occurred such as redesigning the

planned nursing home care unit space to accommodate administrative space for relocation of the facility Director's office. However, after the changes were made, Veterans Integrated Service Network (VISN) officials insisted the space be used for nursing home care and project construction was changed back consistent with original plans. If management and oversight of the contractor's performance were in place over progress payments, management could have identified problems earlier and reduced performance and financial risks that VA must now address. We concluded that supervision over acquisition support activities and the facility's construction program appears almost non-existent.

We also found that Facility Management staff authorized to act as Contracting Officer Technical Representatives (COTR) were not providing adequate oversight needed to ensure compliance with contract technical requirements. A COTR, managing over 10 contracts, advised that based on the heavy workload assigned, duties such as spending time on review of project progress reports had lapsed and noted lower priority work such as report preparation has not been accomplished for months.

Based on the nature and seriousness of the management lapses evident within Facility Management operations, the Program Team Leader for Facility Management should be held accountable as the responsible senior official. New leadership strategies are required to ensure adequate levels of supervision are established to monitor operations and to establish accountability over Facility Management operations.

Organizational change resulted in a strong perception of conflict of interest over acquisition support activities.

An October 1998, change in the facility's organizational structure resulted in unnecessary pressure, low employee morale, distrust in management, and a lack of communication between program management and acquisition support staff. It also escalated concerns of the facility's COs that the latitude needed to exercise independent business judgment was not ensured or protected to the maximum extent possible. COs viewed that their current organizational structure resulted in a conflict of interest by requiring them to report directly to the Facility Management Program Team Leader because the Program Team Leader was directly responsible for both the construction program and acquisition support activities at the facility.

Acquisition support resources were not sufficient to administer contracts and purchase card program responsibilities effectively.

Acquisition support resources assigned to the Facility Management team were inadequate to effectively administer current operations relating to the award and administration of construction contracts and the purchase card program workload. We found that one full-time CO had been on sick leave in excess of 18 months, and the need to allocate

additional resources to manage this long-term staffing shortage was never addressed by management. This CO's absence reduced contract and acquisition support resources by about 50 percent. These resources were needed to effectively administer the facility's current workload and contributed to the serious breakdown of management controls we identified in Facility Management operations.

The Program Team Leader in Facility Management was designated to act as a senior management official in key positions at the facility for extended periods spanning a total of 7 months. He was assigned such positions as Acting Medical Center Director and Acting Associate Medical Center Director. These temporary assignments and the Program Team Leader's use of extended leave effectively left the Facility Management team without adequate professional engineering and management resources needed to provide an appropriate level of oversight over the facility's construction program and other newly assigned acquisition support responsibilities.

Conclusion

We concluded that supervision over acquisition support activities was generally ineffective. Also, the resources available to support acquisition functions were inadequate and there was little management control over key Facility Management operations.

2. SIGNIFICANT IMPROVEMENTS ARE NEEDED TO ENHANCE THE CONTRACT AWARD AND ADMINISTRATION PROCESS

Our review of the facility's contract award and administration process identified significant performance deficiencies, and unexplained and unsupported project costs that put the facility at unnecessary business, financial, and performance risks *(A summary of the contracts reviewed is presented in Appendix III on page 39).* The following significant problems and control weaknesses were identified:

- A helicopter pad was constructed without design plans, specifications, or establishing a contract to cover work requirements, performance liabilities, or associated expenses.
- Construction work was performed before the award of a major contract.
- Contract modifications were issued for work outside the scope of original contracts.
- Some contract awards lacked or did not adequately justify determinations of price reasonableness and some modifications lacked support for increasing project costs.
- Prior year funds appeared to be used inappropriately and construction projects included unexplained and significant performance delays.
- Controls over construction contract progress payments were non-existent.
- Serious record keeping and administrative deficiencies exist.

The conditions found were a result of not following and adhering to Department regulations and policies regarding acquisitions. Authorizing or permitting construction work to begin prior to the award of a contract results in usurping the COs' authority. Permitting the construction of a helicopter pad without a proper contract, design plans, specifications, or fund certification by officials lacking appropriate contracting warrants represent serious lapses in construction program management and violates the anti-deficiency act. Warranted COs must exercise their official duties and responsibilities over construction contracts. COs' performance of their official duties and responsibilities will provide needed management control over the facility's contracting actions to help ensure: (i) sufficient funds are available for obligation; (ii) contractors are receiving impartial, fair and equitable treatment; and (iii) that all necessary actions for effective contracting are in place in order to ensure compliance with the terms of contracts.

Construction of a helicopter pad on VAMC property was not authorized or contracted for in accordance with VA regulations and policies.

We found that a helicopter pad *(Pictured in Appendix IV on page 41)* was constructed without a contract. This project was initiated without preparing appropriate design plans or work specifications. During a site visit, patient safety concerns were raised by facility staff because the concrete base of the helicopter pad has started to chip. Based on our observations, we also had concerns that the helicopter pad was built too close to a facility

building. As a result, current conditions may pose a potential flight hazard to a helicopter using the pad. Immediate action is needed to assess and ensure safety issues.

Accountability was lost because the helicopter pad construction work, valued at $25,500, was not authorized or contracted for by a warranted CO. The facility's contracting staff advised us that they did not authorize this work. There was no documentation to identify the terms of agreement between the contractor and the VAMC regarding estimated or agreed price for work performed, contract performance period, and terms of payments, etc. We concluded that the COs were excluded from performing key responsibilities, such as ensuring a contract or another appropriate procurement mechanism was established and that no funds were made available or obligated to pay the contractor that performed the work. Further, we could not identify any justification supporting the facility's need to have the helicopter pad built or that completed construction work met specifications or industry standards.

The Facility Management Program Team Leader is the accountable official and should not have permitted construction work to proceed without ensuring a proper contract(s) or buying mechanism was in effect. As a result of identifying these conditions, we concluded that the Program Team Leader did not adhere to VA policies and usurped the CO authority inappropriately because construction was allowed to occur. Administration of VA's construction program in this manner is unacceptable because such actions increase VA's risks unnecessarily. Actions authorizing construction work outside the scope of original contracts, for non-emergency purposes, exceed the authority of the Facility Management Program Team Leader and represent serious lapses in management, supervision, and administration of the facility's construction program. There is an immediate need to provide improved leadership, oversight, and supervision over construction activities at the facility to help prevent such actions from occurring in the future.

The current CO advised that he reviewed the available documentation and determined that the Facility Management Program Team Leader was trying to include this work as part of another construction contract, titled Improve Patient Environment. However, the CO determined this work was not part of the scope of that construction contract and would not process a change order to that contract (V540C-225). Our review of the limited documentation available supports that no formal supplemental agreement or contract modification was ever requested or authorized. Documentation supports that Facility Management staff tried to process a modification for the helicopter pad after it was installed. No one at the facility we interviewed would identify or accept responsibility or accountability for authorizing the construction of the helicopter pad, but there was a general concern among staff that someone had acted beyond their authority.

Veterans Affairs Acquisition Regulation (VAAR) Subpart 801.602(a)(1) states that only COs can execute, award and administer contracts, purchase orders and other agreements

for the expenditure of funds involved in acquiring personal property, services, and construction. Under no circumstances will individuals who have not been delegated contracting authority commit the Government for purchases of supplies, equipment, or services; individuals making such commitments may be held financially liable for the amount of the obligation [VAAR Subpart 801.601(b)].

The VAMC did not ensure work was performed consistent with industry minimum specifications or plans because there were no design specifications or plans prepared. Interviews conducted also surfaced concerns that the helicopter pad is unsafe because pieces of cement are breaking away and may result in problems during landings and take-offs. As a result, an inspection is needed to review safety issues associated with future usage. The Facility Management Program Team Leader is ultimately responsible for the construction program and should be held accountable for permitting unauthorized construction work on the VAMC property.

The contractor sought assistance from the VAMC on obtaining payment for work performed. Because this work was not covered by a contract, the CO recommended the contractor donate the work and take a tax deduction which the contractor agreed to do and presented a letter to the VAMC Associate Director to acknowledge the tax deduction. The vendor agreed to donate the value of the work performed ($25,500) to the VAMC.

Accountability and the integrity over the facility's procurement actions is lost when a unauthorized project such as this helicopter pad is constructed and no funds are obligated to pay the contractor prior to the work being performed. VA is put at financial and performance risk unnecessarily and there is no assurance that the work performed represents the highest priority need of the facility, or that safety standards and specifications have been successfully met. Such actions demonstrate a lack of management controls over the construction program, and result in noncompliance with acquisition regulations.

Construction work was performed before the award of contracts and contract modifications were processed.

Review results identified the following three significant examples where construction work were performed prior to the award of a contract or issuance of a contract modification.

- Construction work on contract V540C-241, valued at $331,933, was performed prior to the notice to proceed was given. According to Facility Management staff, construction work was authorized by the Facility Management Program Team Leader. We found that a notice to proceed was issued to the contractor on July 29, 1998, and the first progress payment for $331,933 was also paid covering the period ending July 29, 1998. The progress payment was certified by a COTR for work that was 68

percent complete as of July 29, 1998. This documentation shows that work was performed prior to the notice to proceed. Although the contract file provided was lacking the official contract, documentation in the file also supports that a CO questioned whether the contractor was working on the project before receiving official notification to proceed and whether performance of work was legal. In addition, we were advised by a facility COTR that there were no design specifications prepared for the construction work performed on this project involving Ward 3B, but the VAMC used the same plans prepared for the 5th floor work and just changed the cover page.

- Documentation in contract files for contract V540-C-224 shows that the contractor was given permission to start work on changes by the Program Team Leader prior to issuance of modification # 5, valued at $19,650. In addition, documentation supporting modification # 3, valued at $32,077.78, included a notation that work was verbally approved by the Chief Engineer prior to the contract modification being issued and was necessary to keep the project moving. A series of facility E-mail records supports the CO's concerns that work was authorized without a formal change order. Records also support that the CO requested a copy of the contractor's proposal in support of the work requirements, but never received such a proposal until after the work was approved.

- One of the facility's COs identified contract V540C-226, modification #7, valued at $3,048, as another example of a change order that was not initiated by the CO prior to the work being performed. The CO noted that the actions were a paperwork transaction processed after the fact.

Permitting non-emergency construction work to be performed prior to contract award puts VA at significant unnecessary risk and does not demonstrate adherence or intent to follow acquisition regulations. Also, permitting such work represents serious lapses in construction program management. From the actions detailed above, we concluded that construction program management and controls were inadequate to protect VA's interests because warranted COs were circumvented from performing official duties and responsibilities. The Program Team Leader permitted work to begin although the individual lacked authority to direct such action. We concluded that top management attention is needed to ensure work performance does not precede the issuance of a contract or contract modification in the future.

Contract modifications were issued for work outside the scope of original contracts.

Certain contract modifications were determined to be outside the scope of the original contract. Within the selection of construction contracts reviewed, we identified 11 instances where modifications were inappropriately added to existing contracts that appeared to be beyond the scope of the original contract *(Details are provided in*

Appendix V on page 43). As a result, we did not obtain assurance that construction project costs were reasonable or that appropriate contract costs were paid. Based on the high frequency of instances identified in our limited selection of contracts, we concluded that immediate top management attention is needed to re-establish and strengthen management controls, supervision, and integrity in this area.

Some contract awards and modifications lacked, or COs did not adequately justify, determinations of price reasonableness.

We found that certain contract awards and determinations of price reasonableness were not justified or documented. Overall, there was little support that demonstrated price reasonableness was ensured during award of major construction contracts or when contract modifications were issued increasing project costs. Other cost claims related to change orders were not adequately explained or supported, and there were significant unexplained performance delays impacting the facility's construction projects. As a result, we concluded that the facility was at risk for incurring excessive construction costs because accountability and visibility over construction project expenditures was reduced by a lack of documentation and/or missing documentation. Information retained in support of awards was not sufficient to obtain reasonable assurances that the facility was obtaining reasonable prices for work performed. *(Details on the contract actions that needed improved determinations of price reasonableness are presented in Appendix VI on page 45).*

Senior facility officials raised concerns to us that a subcontractor expected to compete for follow-on construction work, may have inappropriately assisted the A&E firm with the development of the independent Government cost estimate. Facility management was concerned that there may be a conflict of interest present based upon information they had received from staff at the VAMC. In discussions with a CO, we confirmed that the CO also had concerns regarding a subcontractor's involvement with the A&E firm based on information he had obtained. The CO advised that the procurement for the construction portion of the planned work had not yet been advertised or awarded in a contract. But, we found two awards had been made to an A&E firm to design and develop the construction work specifications. The initial A&E contract (V540P-1449) was awarded with competition, then became the basis for a subsequent sole source award to the same A&E firm (V540C-1463). Our review of the subsequent award supported that the A&E contract contained overhead costs and profit that was excessive in comparison to direct project costs *(Details on the A&E contract are presented in Appendix VII on page 47).*

Also, we concluded that the work requirements should have been identified as a complete project and not split into two projects. The subsequent procurement lacked competition as it was awarded as a sole source contract. Federal Acquisition Regulation (FAR) 36.601-2 directs that acquisition of A&E services in accordance with the procedures of

the cited regulation will constitute a competitive procedure. In consideration of the priced proposal and lack of competition, we concluded that the facility had not received good value for the work performed. In addition to our review, a business review was conducted by an acquisition team from VA Central Office (VACO), Acquisitions and Materiel Management that identified similar weaknesses within A&E contracts to those identified in this review.

Through discussions with a facility CO, we determined that the facility utilizes a source selection board to identify and select A&E contractors to support work requirements. The CO complained that the board had selected the A&E firm and that the board is too heavily weighted with staff from Facility Management. The CO also said the current membership mix results in the CO role being a "paper-pushing function only". We found that the voting membership of that board is comprised of three staff from Facility Management and a CO. The Chairman of the A&E Selection Board is the Facility Management Program Team Leader. The Program Team Leader is also the CO's immediate supervisor which we concluded results in additional undue pressure over the process.

Contracts for A&E services should be based on the demonstrated competence, competition, and qualifications of prospective contractors to perform the services at fair and reasonable prices. FAR 36.602-2 provides appropriate guidance that when a selection board is used; membership should collectively have experience in architecture, engineering, construction, and Government related acquisition matters. In light of the CO's concerns stated above, we concluded the selection of qualified, competent A&E firms could be enhanced by improving the membership mix of the facility's source selection board so that no one voting member can drive the selection process. The role of COs and the execution of official responsibilities must have sufficient latitude to exercise sound business judgement in order to ensure contractors receive impartial, fair, and equitable treatment. In addition, the facility's senior management agreed to initiate actions to update and ensure the currency of its files maintained in support of A&E's professional qualifications, i.e. Standard Forms 254 and 255.

Prior year funds[1] were used inappropriately.

Because of the absence of controls, the facility could be viewed as using prior year funds as slush funds for expanding projects without approval, for completing unnecessary or questionable construction, and for correcting avoidable mistakes in project management.

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[1] In November 1990, Congress passed the National Defense Authorization Act of 1991, which in VA is commonly called the Expired Funds Control Act. The purpose of the Act was to address the concern that Federal Agencies could accumulate prior year funds from several accounts called "merged" or "M" accounts and could then use these funds as "slush funds" that had little congressional oversight. There was particular concern that these funds could be used to pay for contract changes that were outside the original scope of contracts as approved and funded by Congress.

Prior year funds are supposed to be used only to pay for contract changes[2] that are within the scope of a contract, yet we identified instances where prior year funds have been used inappropriately. We found that there were significant delays waiting for the receipt of prior year funding from VACO, and as a result some projects were not completed in a timely manner. We also found that work was performed outside the performance period established by the official contract and the modifications approving time extensions. In fact, this condition occurred in 4 of the 5 completed contracts we examined. Examples are provided below that support that prior year funds were used inappropriately.

- Construction contract V540C-226 for the replacement of sewer lines was expanded by including this as part of actions to relocate the facility Director's and Personnel office furniture into other space. Prior year funds were needed to support work under contract modification numbers 4, 5, 6, and 7. Each of these actions provides a vague justification that unforeseen site conditions existed and indicate that sewer lines were not shown on original drawings.

- A final change order was processed under contract V540C-222 valued at $7,292.00 on March 11, 1998, using prior year funds. We found that the Chief Engineer certified work was complete on April 29, 1996. The use of prior year funds in this instance supports that the funds were used to correct an avoidable mistake. The condensate lines were never capped and dripped for almost 2 years after the work was certified as complete. Contract funds were also used to pay for oil heaters that were determined to be beyond the scope of the original contract.

The absence of controls and delays experienced for receipt of prior year funding from VACO also directly contributed to excessive time delays in project completions. As we reviewed project slippage, we identified a more serious contract administration weakness that work was performed outside the period authorized in the official contract and approved time extensions. The chart on the next page shows that for 4 of the 5 construction contracts completed, work was performed outside the official contract period including official time extensions.

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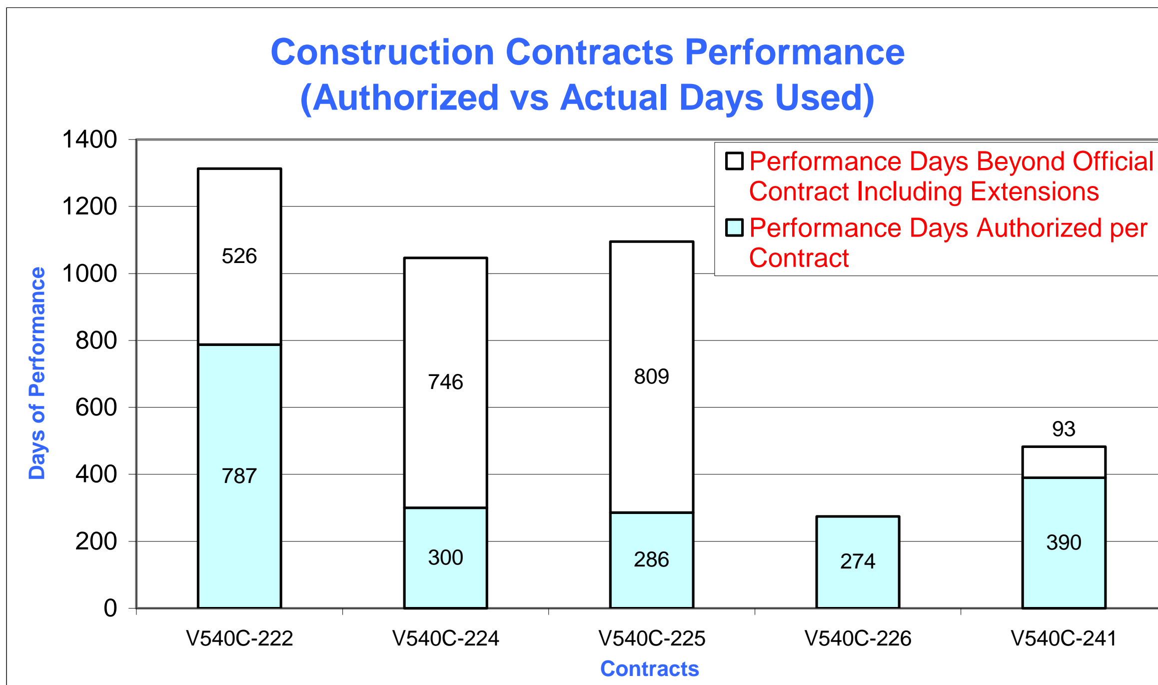
[2] VA Office of Financial Policy determined that the only VA contracts covered by the Act were nonrecurring maintenance construction contracts.



Controls over construction contract progress payments were non-existent.

Controls over construction contract progress payments were determined to be essentially non-existent. Internal controls were not in place to assure VA payed only for completed work and materials purchased by contractors for VA construction projects. One COTR indicated that he had not performed inspections of work completed or materials stored for construction projects prior to certification that articles and/or services have been received, or provided sufficient oversight to obtain reasonable assurance that work was performed in accordance with the terms of contracts.

Progress payments were processed that were not approved in writing by a COTR. Also, staff lacking the official designation of a COTR[3] had signed and certified progress payments. In fact, there were numerous progress payments that lacked proper approvals. We also noted that there were significant delays between the date of work performed and approval of some progress payments by facility staff. As a result, we concluded there is a need to ensure only authorized personnel approve progress payments and that progress payments are reviewed prior to payment. Top management attention is needed to ensure improvements in controls over approval/certification of progress payments are put in place so that the basis for these payments is adequately supported.

Progress payments that were inappropriately certified as to compliance with the quality and quantity requirements of contracts and progress payments made without the written approval of the CO are listed below.

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[3] VAAR 801.603-71(a) (1) describes a COTR's duties as the inspection and certification as to compliance with the quality and quantity requirements of the purchase order or contract.

- **<u>V540C-222, Replace Condensate Lines</u>**

  Twelve of the thirteen progress payments (valued at $384,236) received for this $392,688 contract award were certified by VA staff, not the official COTR.

- **<u>V540C-232, 30 Bed Nursing Home Conversion Unit</u>**

  Although this project was not completed at the time of our review, 9 of the 34 progress payments received (valued at $596,067) lacked the written certification and approval of a COTR. We did not identify a letter designation for the appointment of an official COTR in our review of the contract files, but our review of the progress payment documentation supported that four different VA staff had certified compliance with the quality and quantity requirements of this contract.

- **<u>V540C-233, Asbestos Removal, Phase III</u>**

  Six of the eight progress payments (valued at $443,035) reviewed lacked the written approval of a COTR. We did not identify a letter designating an appointment of an official COTR in our review of the contract file. As a result, we concluded that all eight of the progress payments valued at $589,535 were not approved by an official COTR. In fact, four different staff certified the progress payments received.

Serious record keeping and administrative deficiencies exist.

Contract files were incomplete, disorganized, and access to the files was not sufficiently restricted to ensure the protection of proprietary and source selection information. Our review found that contract logs were incomplete and included duplicate numbers assigned to the same contract. The review showed that COs used 16 discrete contract numbers twice, omitted dollar amounts for 5 contracts, and reserved 5 contract numbers for future use. In addition, four contract numbers were lined out, without explanation, and one contract ending date was missing.

Files generally lacked organization and were missing key documentation that supports contracting actions taken. A review of the installation of a fire sprinkler system, under contract V540C-224, showed that the contract file was poorly maintained and disorganized. We were unable to reconcile the contract modification and SA documentation included in the official files with the actual progress payment claims submitted by the construction contractor. There was no audit trail within the contract file to support whether contract modifications # 5 and # 6 were paid or whether this work was included in the claims processed for payment. Information provided in contract modification # 7, which added $41,806 to the value of the contract, was insufficient to draw a conclusion or to determine how many additional sprinkler heads were to be replaced. As a result, we could not determine whether work identified in contract

modifications # 5 and # 6 (valued at $30,754) was appropriately claimed by the contractor when they submitted progress payment claims or whether the facility paid for all work performed.

Access to contract files was not adequately restricted to ensure the protection of proprietary and source selection information. Office space is shared between the COs and the key program staff in Facility Management. As a result, access to procurement files containing contract information is not sufficiently restricted to adequately protect the files. We found serious deficiencies within the contract files reviewed, including missing records of contract change orders or modifications, and the official contract was missing from one file. Certain contract files lacked adequate support for:

- CO's determinations of price reasonableness.
- Required technical and legal review.
- Required General Counsel concurrence for contract modifications granting time extensions.
- A current chronology list identifying the awarding and successor COs, with inclusive dates of responsibility.

Contract files contained outdated documentation identifying the lines of accountability for the responsible COTRs and CO(s). There is an immediate need to restrict access of contract files to authorized personnel only, such as COs, to ensure all existing contracts are properly accounted for and assigned unique numbers for proper identification, and to provide the technical support and supervision needed to organize contract files for future use.

Conclusion

The Facility Management Program Team Leader disregarded VA program policy, regulations, and authorization law. The facility construction program was mismanaged. Construction was authorized without a contract, design, specifications, or certification of the availability of funds. As a result, significant safety issues have occurred that must be addressed by the facility. In addition, the management function of the construction office and the contracting office function requirements have been ignored.

3. EFFECTIVE PROGRAM CONTROLS AND MANAGEMENT OVERSIGHT IS NEEDED OVER PURCHASE CARD ACTIVITIES

The administration of the facility's purchase card program[4] needs top management's attention because of a systemic breakdown in program controls. Allegations of splitting purchase orders to avoid competition and paying excessive prices for services were substantiated. We also identified that multiple orders had been processed for the same work. Our review found that one vendor was paid non competitively approximately $90,000 over 17 months by splitting orders inappropriately. We also found that purchase cardholders working in Facility Management, sometimes at the direction of supervisors, split work requirements into multiple orders to keep below the $2,500 micro-purchase limit. In addition, procurements for repetitive services were not rotated among various businesses that in certain cases resulted in paying excessive prices for services and certain recurring work requirements were not consolidated into annual contracts.

Cardholders routinely placed orders without verifying the availability of funds. Since Fiscal Year (FY) 1996, uncontrolled credit card purchases regularly led to over expenditures in one of the Facility Management fund control points. Thus, we concluded that expenditure controls were not adequate to protect against overspending program allotments. We identified two instances where a vendor requested the VAMC to reimburse cost overruns that were paid without VAMC staff obtaining support for why the price for services was higher. In addition, we found that cardholders were not reconciling accounts within 5 working days and approving officials were not certifying accounts within 14 calendar days of reconciliation. Untimely performance of reconciliations and budget allotment over-expenditures demonstrate an inadequate level of management and oversight over purchase card purchases by the Facility Management Program Team Leader (Designated Approving Official).

We concluded that the number of purchase cards issued in Facility Management was also excessive *(Chart on next page provides additional supporting details)*. Maintenance of such a high number of purchase cards in Facility Management has helped to escalate the breakdown in acceptable program oversight.

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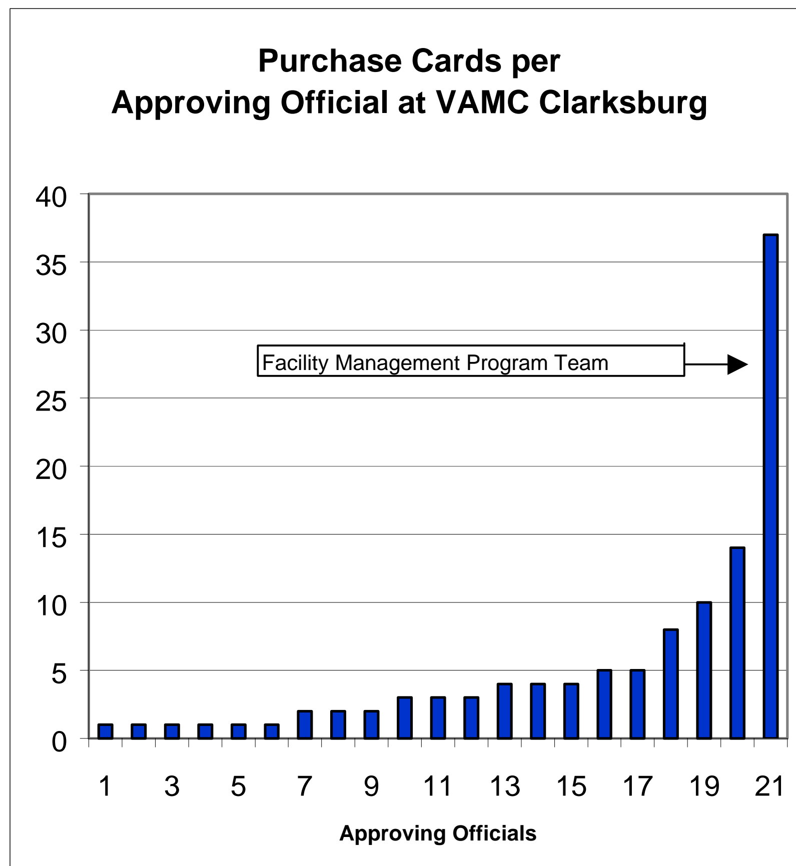
[4] Executive Order 12931 dated October 13, 1994, urged agencies to expand the use of their Government-wide commercial purchase card program and to delegate micro-purchase authority to program officials rather than keeping it within procurement offices. The official name of the purchase card program is International Merchant Purchase Authorization Cards (IMPAC).



Formal policies and procedures are needed to enhance the purchase card program.

The facility has operated without a purchase card program policy since the Department issued its policy and procedures in May 1997 and the Veterans Health Administration (VHA) released its Handbook 1730.1 on July 22, 1998. The facility had drafted a policy and procedures for its program; however, the policy had remained in draft for almost 2 years because of lack of agreement among service chiefs. A purchase card program policy needs to be formalized to provide guidelines for the effective use and control of purchase cards. The policy at a minimum should include:

- Purpose and scope of the program at VAMC Clarksburg.
- Delineation of responsibilities for the program coordinator, dispute officer, cardholders, approving officials, and the VAMC Business Office.
- Mandatory training requirements for cardholders and approving officials, including prime vendor policy and procedures relating to purchase card transactions[5].
- Documentation requirements in support of procurements, reconciliation's, and certification of payments.

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[5] *PrimeVendor Payment and Guide*, Department of Veterans Affairs, Office of Financial Operations, January 1999 (Draft).

Additional purchase card training is needed for all VAMC cardholders.

We found that there was no assurance that all cardholders at the facility had received required purchase card training and we were told that some Facility Management staff also needed computer training to learn how to input transactions into the VA computer system. The Purchase Card Coordinator told us that certain employees had refused to take cardholder training. We were also unable to confirm that the Facility Management Program Team Leader (the designated approving official) had received approving official training as a result of conflicting statements and inadequate training records.

Generally we found that the Purchase Card Coordinator's efforts to implement an effective training program have been only marginally successful. The Purchase Card Coordinator had too many responsibilities and administrative duties associated with managing both the purchase card program and other acquisition support responsibilities, and limited support resources available to be effective. The availability of acquisition support resources was further reduced as a result of one CO's use of extended leave. As a result of the control weaknesses identified, we concluded that the facility needs a policy to ensure that training occurs prior to issuing cards or certifying purchases.

We concluded that purchase card training needs to be improved after identifying numerous unacceptable cardholder actions. Management control deficiencies and weaknesses included actions that split orders inappropriately to avoid competitive requirements, performing untimely reconciliations of purchases, providing limited oversight over purchases, paying excessive prices for services, maintaining poor records, and little or no documentation in support of purchases. Control weaknesses also resulted in a high number of unauthorized commitments[6]. We also noted that recurring services were not consolidated into annual contracts or other appropriate buying mechanisms or evaluated and awarded competitively as a best value selection. Top management attention is needed to re-establish the integrity and accountability over purchase card activities.

Fiscal oversight of purchase card expenditures was discouraged.

The VAMC's Business Office has not effectively executed the responsibilities prescribed in the Department's policy for purchase card transactions for the past 3 years. We found that the Business Office met resistance from Facility Management cardholders and approving officials when reviewing and questioning the appropriateness of certain purchase card transactions and resolving over-expenditures within Facility Management's control point.

[6] An agreement that is not binding solely because the Government representative who made it lacked the authority to enter that agreement on behalf of the Government. Ratification is the act of approving an unauthorized commitment by an official who has the authority to do so.

Business Office staff advised that they sought guidance from top management regarding Business Office responsibilities outlined in VHA Handbook 1730.1. The staff interpreted the prior Facility's Management response and guidance as a hands-off policy. In addition, staff advised that the elimination of the voucher examiner position within that office appeared designed to eliminate future fiscal oversight over purchase card activities. As a result, the integrity of the purchase card program has been impacted by limited oversight. The integrity of the purchase card program at the VAMC was considered to be at risk for not adequately ensuring and maintaining effective controls needed to help detect fraud, waste, and other abuses related to purchase card expenditures.

To ensure integrity and accountability over the program, top management should assure that the Business Office carries out its responsibilities without interference. Without cooperation and accountability of all employees assigned purchase card responsibilities, e.g., cardholders, approving officials, and service chiefs, the Business Office cannot carry out its mandated responsibilities effectively. These responsibilities include:

- Ensuring that single and monthly purchase limits of Facility Management cardholders are within fund control limits.
- Providing training to cardholders on costing procedures, reconciliation procedures, and receipt records maintenance.
- Oversight of cardholders and approving officials to ensure compliance with applicable policy and procedures.
- Collecting funds from cardholders for inappropriate procurements.
- Oversight for the final certifying authority on the use of any item procured.

An excessive number of orders were identified that were split inappropriately to avoid competition requirements.

Cardholders used purchase cards to procure services whose aggregate cost exceeded the micro-purchase threshold of $2,500. In doing so, we found that cardholders split job requirements into more than one purchase order on numerous occasions in order to stay below the $2,500 program authority level for micro-purchases. During our review of payments made to one local vendor, we identified cardholders had split 46 out of 96 orders between May 1997 and July 1998. Sixty-five percent of the split orders were same day purchases and the remaining were made within a 7-day period. We identified nine additional orders that could have been consolidated into requirements for like services. In addition, we found that cardholders did not routinely rotate repetitive procurements among businesses. Essentially, cardholders gave $90,000 of work in about 17 months to one local vendor without competition while acquiring these services. The following orders (41) were included in the 46 orders that were inappropriately split, and issued to a vendor that in some cases provided services of unacceptable quality.

- Six orders for cleaning air ducts.
- Seven orders for cleaning paved parking lot and sidewalk surfaces.
- Three orders for mulching flowerbeds.
- Eight orders for tree removal and shrub trimming.
- Eight orders for removing brush.
- Four orders for repairing exterior doors (painting and installing kickplates).
- Five orders for signs and lettering vehicles.

Cardholders should use the government purchase cards for the acquisition of supplies and services, the aggregate amount of which does not exceed the micro-purchase limit of $2,500[7]. Approving officials should ensure that single and monthly purchase limits of cardholders are not exceeded and that repetitive procurements are rotated among businesses or consolidated into annual contracts where appropriate.

Excessive prices were paid for certain Facility Management services.

We found that cardholders paid excessive prices for services acquired from one local vendor and often lacked support for the price reasonableness of the services it had acquired. Procurement files contained little or no documentation that supported cardholders took action to verify the price reasonableness of services they were acquiring.

Services where we found the VAMC paid excessive prices included applying lettering to vehicles and making and installing signs at two Community Based Clinics. The chart on the following page shows the local vendor's markups, ranging from 112 percent to 2,302 percent above the subcontractor's cost. VAMC cardholders could have issued orders directly to the subcontractor and achieved significant programmatic savings since the subcontractor's place of business was located less than one mile from the facility.

[7] The micro-purchase limit is $2,000 for construction.

Vendor Markups

Description of Services	Cost of Service	Local Vendor's Portion	Subcontractor's Charge	Vendor's Markup
Install clinic signs.	$1,655.00	$1,586.10	$68.90	2302%
Design & apply lettering to 5 vehicles.	$1,325.00	$1,158.05	$166.95	694%
Provide 11 signs for CBC (clinic).	$1,965.00	$1,572.80	$392.20	401%
Furnish & install signs on pick-up truck.	$355.00	$270.20	$84.80	319%
Furnish 12 decals for 3 vans and apply lettering to passenger bus.	$1,563.00	$1,179.81	$383.19	308%
Furnish & apply lettering to 3 vehicles.	$855.00	$627.10	$227.90	275%
Install signs on new Expedition (White)	$355.00	$260.00	$95.00	274%
Apply lettering to 3 station vehicles.	$1,020.00	$702.53	$317.47	221%
Furnish & install signs on ambulance.	$620.00	$423.90	$196.10	216%
Provide 7 signs for CBC (clinic).	$1,985.00	$1,354.30	$630.70	215%
Place phone numbers on 9 vehicles.	$810.00	$428.40	$381.60	112%
Totals	$12,508.00	$9,563.19	$2,944.81	

In addition to the extraordinary markups we identified, the facility incurred additional costs as a result of the poor workmanship for certain services provided by the vendor. On at least one occasion, the vendor's performance was so poor that the VAMC had to pay another contractor at a cost of $2,876 to repair and reconstruct a wall built on VA property. The VAMC also incurred additional costs when the vendor submitted a $3,600 cost overrun on a job originally bid at $1,950. Purchase card program policy should require that cardholders routinely rotate repetitive services among various businesses and obtain fair prices for services.

Over-expenditures in the Facility Management budget allotments have been a continued problem as a result of uncontrolled purchase card activity.

Uncontrolled credit card purchases have been a problem in Facility Management since FY 1996. For example, during the last quarter of FY 1996, Facility Management identified over-expenditures valued at approximately $40,000 as a result of cardholders not verifying that funds were available prior to placing orders. According to the facility's Business Office staff, over-expenditures have continued in subsequent fiscal years; however, some compensating controls have been implemented to lessen the financial impact associated with managing over-expenditures at the fund control points in Facility Management. Cardholders should verify fund availability prior to placing purchase card orders.

Reconciliation of purchase card expenditures needs to be performed in a more timely manner.

Facility Management has not adequately ensured that reconciliation of purchase card transactions are regularly performed in a timely manner. In January 1997, the Assistant Chief, Fiscal Service reported the situation to the facility Director. Based on our review of transactions with one local vendor, we found that the problem remains unresolved. Our review of the vendor's transactions showed that cardholders did not reconcile nearly 50 percent of the transactions within 5 working days, as required, between May 8, 1997 and October 13, 1998. One cardholder averaged 12 days and 13 percent of the reconciliations exceeded 30 days. Several were not reconciled for months after the transaction date. On 10 occasions the local vendor billed a cardholder in error. The billing errors totaled $16,735.

Performing timely reconciliations provides reasonable assurance that the facility received the goods and services at the agreed upon price. Untimely reconciliations can affect the Department's ability to dispute erroneous charges and weakens the facility's fund control management. Untimely reconciliations also affect the Business Office's ability to ensure that single purchase and monthly purchase limits are within fund control limits.

Maintenance of appropriate purchase records needs improvement.

Cardholders' files lacked the minimum documentation needed to support reconciling payment charges from the purchase card program contractor, performing certification of payments, and justifying the need for purchases. We reviewed the files kept by 11 cardholders and concluded that cardholders generally kept receipts for supplies purchased from merchants, but not for the acquisition of services. Facility Management cardholders had no documentation for 72 of 96 procurements made with a local vendor for services acquired. As a result, we determined that cardholders had not provided the approving official appropriate, if any, receipt records to enable certification of payment.

Within our selection of transactions processed, we were unable to verify that all purchases were received, necessary, and appropriate. For example, a cardholder purchased a total of 10 electronic organizers costing approximately $100 each between August 1997 and February 1998. Most of the electronic organizers could not be located at the facility during our fieldwork. Interviews with staff who acknowledged receiving the electronic organizers supported that most staff did not know how to use the item and/or were not using the item because the batteries were dead. The need for purchasing the electronic organizers was questionable. Cardholders should maintain appropriate documentation to enable matching payments made to items and services received, and to support the programmatic and/or administrative need for said purchases.

Controls need to be enhanced to prevent staff from processing orders that split procurement requirements inappropriately and result in circumventing competition requirements.

Supervisors routinely told cardholders to place orders for them without providing adequate documentation to support reconciliation and payments made. Under these circumstances, cardholders lacked assurance that the item or service was received, necessary, and appropriate before either placing the order or reconciling payments. We identified instances in which cardholders had no documentation to support procurements requested by supervisors that split procurements into multiple orders and among cardholders.

Cardholders are responsible for safeguarding the card and not allowing others to use their card. Since cardholders are personally liable for purchases made on their cards and subject to reimbursing the Government for unauthorized or fraudulent use of their cards, they should maintain proper procurement files. Because it is not unreasonable for supervisors to instruct cardholders to place orders, supervisors should provide cardholders with sufficient documentation to enable proper reconciliation and certification of payments.

Improved supervision and oversight of purchase cardholder activities is needed.

Activities of cardholders in Facility Management were not well supervised by approving officials. The service had 27 purchase cardholders and 4 approving officials. Within our limited scope review and selection of transactions, we found that certification of cardholder transactions by approving officials was untimely 38 percent of the time. Normally, certification should take place within 14 calendar days after reconciliation by cardholders. The approving official who certified 75 percent of these purchases averaged 43 days after reconciliation and took as long as 84 days. There was no support that approving officials reviewed transactions for inappropriate actions like splitting orders or verified that items were actually received.

Conclusion

We concluded that better supervision of cardholder activities, as well as a finalized facility policy and training, are needed to improve control over the purchase card program. Improved training is needed to stop unacceptable practices and actions, e.g., fragmenting purchases to stay within cardholder limits, unauthorized purchases, and untimely reconciliations. Oversight over purchase card transactions also needs to be enhanced to help detect and prevent paying excessive prices, over-expenditures in control points, and to ensure transactions are adequately documented to support need. Improved controls are also needed over receipt and certification for services provided and to ensure duplicate or erroneous data be detected and resolved in a timely manner.

4. IMPROVED CONTROLS ARE NEEDED TO ENSURE ACCOUNTABILITY OVER THE FACILITY'S VEHICLE INVENTORY

While reviewing allegations of improper trading of VA-owned vehicles, we found significant management deficiencies and control weaknesses exist in the facility's management of vehicles. Although we used three different sources of records, we could not verify that all vehicles owned, leased, or donated to the facility were accounted for. There was no evidence that the facility submitted the required annual inventory of VA owned and commercially leased vehicles (*Agency Report of Motor Vehicle Data*, SF 82) to VACO for FYs 1998 and 1999. We concluded that poor supervision contributed to a lack of accountability over vehicles. We also concluded that there were some poor business decisions made in trades and acquisitions of vehicles. We identified one trade that had resulted in a conflict of interest, because we found that the VA employee directly responsible for the administration of vehicles inappropriately acquired VA property for personal use as part of a multiple vehicle trade transaction. A VA employee is not entitled to any profit or advantage by reason of his or her official position and the sale of a Government vehicle should not have been allowed by the Facility Management Project Team Leader. As a result, we concluded that both the employee and the immediate supervisor failed to properly exercise their fiduciary duties over management of VA vehicles.

Accountability of VA vehicles could not be reasonably established.

To assess the completeness and accuracy of the facility's vehicle inventory, we conducted a physical inventory. We included in our review, the disposition of six vehicles transferred to VAMC Clarksburg from VAMC Perry Point in 1994. We concluded that Facility Management was not effectively managing the vehicles or maintaining a current and accurate inventory of all official Government tags assigned to VA-owned and GSA leased vehicles. There was no evidence that management systematically conducted physical inventories of vehicles. Inventory records covering a 3-year period consisted of three separate pieces of paper, including one 5 by 8-inch index card with numerous changes (i.e., strikeouts and white outs).

The results of our physical inventory showed the following five vehicles having a current average retail value of at least $86,000 that were not included on any of the inventory lists provided to us:

	Vehicle Description	Estimated Value[8]
•	2000 Dodge Caravan	$20,000
•	2000 Dodge Caravan	20,000
•	1999 Ford Taurus	14,700
•	1998 Chevrolet Express	15,600
•	1998 Ford Crown Victoria	15,850
	Total Estimated Value	$86,150

In addition, the location or disposition of two vehicles transferred from VAMC Perry Point could not be explained to us. The two vehicles were:

	Vehicle Description	Estimated Value at Transfer[9]
•	Tractor	$ 2,360
•	Truck	12,537
	Total Estimated Value	$14,897

Poor business decisions were evident during the trade and acquisition of VA vehicles.

Our review of a multi-vehicle transaction concluded that the VAMC did not acquire good value from the trade. In December 1997, we found that the facility traded in seven vehicles to a local used car dealer in exchange for a 1991 Dodge van and a 1989 Chevrolet Celebrity. The allowance for the seven vehicles at auction was $7,770. The Dodge van had an estimated value of $6,500 and Celebrity was valued at $1,800. We concluded that the transaction was a poor business decision because VA's acquisition was not justified or necessary. The Celebrity has been parked and deteriorating in a field behind the laundry facility since 1997. According to facility staff, the vehicle had been there since it was acquired in 1997. The vehicle has never been used according to motor vehicle operators at the facility and the keys are missing.

VA staff did not properly exercise their fiduciary responsibility over VA vehicles.

A VAMC employee with responsibilities for day-to-day administration of the facility's vehicles may have benefited financially when a vehicle was purchased from the same

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[8] The value is estimated based on the cost of new Caravans and blue book averages for other vehicles without adjusting for vehicle condition, mileage, and options.

[9] Value of vehicle at the time of the transfer.

local auto dealer. We confirmed that the employee arranged for a personal purchase of a 1976 Dodge truck with an estimated value of $1,650 and paid only $200. We concluded that better assurance was needed that the VAMC was receiving appropriate value for vehicles traded and acquired. The employee retired shortly after the purchase.

Conclusion

We concluded that poor supervision of the program contributed to a lack of accountability over vehicles and inventory records were incomplete and unreliable. We also concluded that there were some poor business decisions made in trades and acquisitions of vehicles. In addition, we concluded that the responsible immediate supervisor failed to properly exercise his fiduciary duty over VA vehicle management.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Allegations were received that improprieties had occurred at VAMC Clarksburg concerning the facility's construction program, trading of VA vehicles, violations of acquisition regulations, and a lack of appropriate management controls over construction projects and purchase card expenditures. Review objectives included: (i) a review of selected construction contracts to determine whether change orders were consistent with the scope of the original contract; (ii) an assessment of whether contract pricing was fair and reasonable; and (iii) determining whether the terms of and the circumstances relating to the contract(s) provided for and/or justified the use of prior year funds. We also assessed whether purchase card expenditures made to acquire Facility Management support services were appropriate and assessed accountability for VAMC vehicle inventories.

Scope and Methodology

A limited scope review was performed to assess hotline allegations in support of an OIG investigation that focused upon the actions of VAMC employees assigned to the Facility Management Program Team and certain contractors/vendors working at VAMC Clarksburg. Site visits were conducted that included observing construction activities and interviewing key VAMC management and staff. During a facility tour, we identified an unauthorized helicopter pad that had been constructed at the facility. Review efforts were also coordinated with appropriate VISN 4 acquisition personnel. Interviews were also conducted with the prior Director, the current Acting Director, the Associate Director at the facility, and other key VAMC officials.

Senior VAMC officials advised that facility police had found Facility Management staff discarding records just prior to the initial OIG site visit. As a result of this action, we were unable to obtain reasonable assurance that all pertinent information was available. Therefore, we expanded testing in certain areas, interviewed specific vendors, and subpoenaed records to obtain sufficient information to examine pricing aspects of specific purchase card activity.

We examined selected construction contracts, purchase card activities, and vehicle inventory records to assist with the resolution of specific hotline allegations received. A selection of construction contracts and purchase card activities from FYs 1996 through 1999 were reviewed. The selection of construction contracts focused primarily on three contractors. We reviewed contract files including award documents, change orders, and progress payments. In addition, we assessed the timing issues associated with contract modifications, project schedules, contract pricing, and justifications for approval to use

prior year funds. Work also included a review of applicable Federal acquisition regulations, VA and facility policies, procedures, regulations, and examined specific transactions involving disposal of Government vehicles.

Our review of purchase card transactions focused on an examination of three specific vendors and purchases made and/or approved by certain VAMC staff. We analyzed transactions by the type and timing of work performed. We also reviewed Facility Management purchase cardholders' files. Interviews were conducted with certain cardholders, and documentation supporting purchases was examined.

Construction projects and certain sites where purchase order work was performed were observed. We identified and assessed controls over several key areas including contracts and modifications, progress payments, purchase card activities, and vehicle inventories. We reviewed station vehicle inventory records relating to acquisition and disposition of vehicles. The available records were found to be incomplete and contained inaccurate data. As a result, we performed additional tests including performing a physical inventory of the vehicles to determine whether accountability over vehicles could be reasonably assured. We could not locate some of the vehicle files and there were multiple vehicle inventory lists that were not dated. Therefore, we could not accurately determine the disposition of all station vehicles from the files maintained by Facility Management.

APPENDIX II

BACKGROUND

VAMC Clarksburg is a 143-bed acute and intermediate secondary care hospital with medical, surgical, and psychiatric services. This includes a 30-bed Transitional Care Unit. A clinical addition, dedicated in 1989, includes an emergency room, surgery and recovery suites, a 15-bed intensive care unit, an expanded clinical laboratory, a modernized imaging service that includes computerized tomography scan and diagnostic nuclear medicine capabilities, and inpatient and outpatient pharmacies. The primary care outpatient clinics are supported by specialty clinics for oncology, mental hygiene, post-traumatic stress disorder, urology, surgery, dermatology, optometry, and otolaryngology. Other outpatient services include a satellite dialysis unit and ambulatory surgery.

During our review, the VISN 4 Director reassigned a VISN representative to fill a 120-day assignment as Acting Medical Director to oversee operations at the facility. This appointment was needed to provide coverage for an extended absence by the facility Director.

In October 1998, Engineering Service was re-organized into the Facility Management Program Team. The Chief of Engineering Service's official title was changed to Program Team Leader for Facility Management. The Program Team Leader for Facility Management acquired the acquisition functions including contracts and purchasing, environmental management, and laundry while overall responsibilities were maintained for the operation of the physical plant, maintenance and repair, utilities, bio-medical equipment repair, and warehouse activities. The Program Team Leader is responsible for effective management of the entire Facility Management program, including the construction program and supervises development of recurring and nonrecurring projects, budgets for station projects, repair needs, and utility costs. There are approximately 60 full-time positions in Facility Management, including two warranted COs acquired with the transfer of functions.

Available resources in key positions on the Facility Management Program Team were limited as a result of high leave usage and staff assignments to other positions in order to provide coverage for vacancies. The Program Team Leader in Facility Management had been designated to act as a senior management official in key positions at the facility for extended periods spanning at least 7 months. He filled such positions as the Acting Medical Center Director and Acting Associate Director. Designations occurred as a result of the facility Director's use of extended leave and to provide coverage for other vacancies in key positions.

During the course of our review, an acquisition team from VACO, Acquisition and Materiel Management conducted an on-site review of the management, staff, and

operations at the facility related to procurement and contracting. Their findings also identified significant weaknesses in acquisition support areas.

APPENDIX III

SUMMARY OF CONTRACTS SELECTED FOR REVIEW

Construction Contract(s)	Contract V540C-	Project Number	Date of Contract Award	CO at Award	Original Contract Cost	Mods	Total Cost of Contract	Contract Days Extended
Replace Condensate Lines	222	540-94-101	03/17/95	A	$339,600	$53,088	$392,688	+45+90 +90+90
Installation of Fire Sprinkler System	224	540-95-120	09/16/95	A	$481,315	$92,452	$573,767	+60+60
Improve Patient Environment	225	540-95-113	09/16/95	A	$219,816	-$1,861	$217,955	+60
Replace Sewer Lines	226	540-95-109	09/21/95	A	$347,561	$75,808	$423,369	+30+30 +30
30-Bed Nursing Home Conversion	232	540-030	09/30/96	A	$2,420,000	$1,042,374	$3,462,374	+100+60 +60+30 +30+30 +45+60 +45+50 +60+10 +10+10 +10+10 +10+100
Asbestos Removal, Phase III	233	540-96-108	10/18/96	A	$552,000	$228,637	$780,637	0
Renovate Ward 3B	241	540-98-113	07/15/98	B	$492,875	$220,749	$713,623	+15+100 +20+20
TOTAL CONSTRUCTION CONTRACTS					$4,853,167	$1,711,246	$6,564,413	
A & E Contract(s)	**Contract V540P-**	**Project Number**	**Date of Contract Award**	**CO at Award**	**Original Contract Cost**	**Mods**	**Total Cost of Contract**	**Contract Days Extended**
Upgrade primary electrical distribution system for entire complex	1449	540-99-101	03/25/99	B	$37,700	0	$37,700	
Correct Emergency Generator Deficiencies, Phase I	1463	540-99-101	03/13/00	B	$122,000	0	$122,000	
TOTAL A & E CONTRACTS					$159,700	0	$159,700	

APPENDIX IV

CONSTRUCTION OF AN UNAUTHORIZED HELICOPTER PAD

The helicopter pad was constructed without a contract, design plans, or specifications. No contract vehicle was put in place to authorize payment for this construction at the facility.

The helicopter pad has not been evaluated for safety issues such as obstacle clearance (buildings, trees, etc.), weight bearing capacity (capability to support helicopter dropping onto pad), and foreign object damage resulting from concrete chipping or other matter.

SUMMARY OF ACTIONS THAT WERE OUTSIDE THE SCOPE OF THE ORIGINAL CONTRACT

Contract Number	Contract change or modification not consistent with original contract
V540C-222, Replace Condensate Lines	• Modification # 3 was for $1,441.65 to purchase oil heaters that were not used for the project. However, oil heaters were used to support hospital operations. • Final modification valued at $7,292 occurred after Chief Engineer certified work was complete on 4/29/96. Modification is questionable because it approved work completed on 3/11/98.
V540C-224, Installation of Fire Sprinkler System	• Modification # 22 valued at $589.00 and # 23 valued at $821.50 were considered out of scope because these orders were for work originally identified under other contracts.
V540C-225, Improve Patient Environment	• $7,162 labor and materials for a sitz bath was not part of the advertised project. • $34,926 labor and materials for a smoking shelter was not part of the advertised project. • $4,235 labor and materials for a staff communication system was not part of the advertised project. • The contract's statement of work included installation of new finish floors in various areas, replacement of drop ceiling and lights in hallways, and cleaning of all supply and exhaust ductwork which was not accomplished. Only installation of chilled water balancing valves for patient rooms, painting, and re-insulation was done. As a result, we concluded that only $73,435 of the contract award valued at $219,816 was within scope.
V540C-226, Replace Sewer Lines	• Modification # 2 included $9,996 costs to relocate Personnel and Director's office. • Modification # 3 included $800 for covering and protecting file cabinets in room #132A. • Modification # 3 installed 75 parabolic light fixtures valued at $18,310 at various locations throughout the facility, however a CO indicated that this work should have been a separate project. • Modification # 7 included $2,434 to move the Director's suite furniture a second time and included an additional $614 to insulate the Director's office.

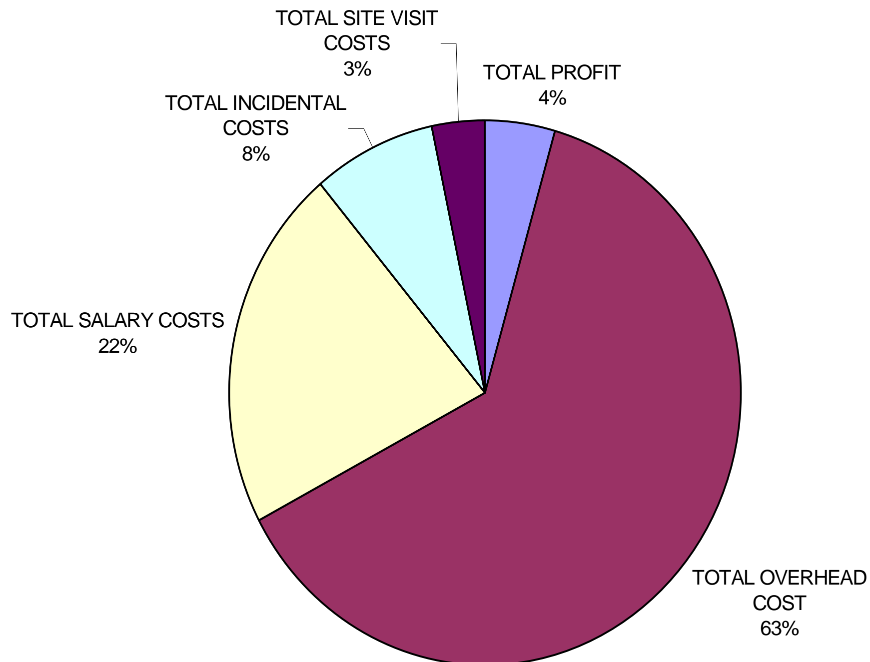
SUMMARY OF CONTRACT ACTIONS THAT NEEDED IMPROVED DETERMINATIONS OF PRICE REASONABLENESS

Contract Number	Contract awards, change orders, modifications, or supplemental agreements lacking support of price reasonableness
V540C-224, To Extend Sprinkler System Throughout Building # 1	• Award was not made to low bidder. • Contract file supported that CO awarded a contract valued at $481,315. The contract award included $386,100 for subcontract work, combined overhead costs and profit, without any details of what this price includes. Pricing information in the file was hand-written on two sheets of paper that appeared more representative of scratch paper than a priced proposal. • Modification # 7 lacked details to support the reasonableness of increased project costs valued at $41,806.
V540P-1463, To Correct Emergency Generator Deficiencies, Phase I	• $122,000 contract award was made. CO did not prepare a required price negotiation memorandum and the contract file did not contain a formal indirect/overhead rate agreement negotiated with a Federal agency to support overhead costs included in the proposal. Our review supports that 67 percent of this contract award was for overhead and profit. We considered this percentage too high and concluded the VAMC received little direct value in comparison to the indirect cost and profit included in this award. *(Pie chart shown in Appendix VII on page 47 displays the excessive overhead costs we identified.)*
V540C-241, Renovate Ward 3B	• Modification # 2 valued at $95,639.95 does not describe work in sufficient detail or provide details of pricing information. • Modification # 8 valued at $7,547.99 was missing from contract file.

APPENDIX VII

CONTRACT CONTAINING EXCESSIVE OVERHEAD AND PROFIT

A&E CONTRACT V540P-1463
(TO CORRECT EMERGENCY GENERATOR DEFICIENCIES)



The pie chart above demonstrates that the A&E contract reviewed contained overhead costs and profit that were excessive in comparison to direct project costs. The CO did not prepare a required price negotiation memorandum that supported a determination of price reasonableness, stating he did not have time. However, the CO did raise concerns regarding actions that occurred while the A&E firm was performing work on site. We concluded that this procurement lacked competition because it was awarded as a sole source contract and that the VAMC had not received good value for the work performed.

ACTING DIRECTOR, VAMC CLARKSBURG COMMENTS

Department of
Veterans Affairs

Memorandum

Date: December 20, 2000

From: Acting Medical Center Director (540/00), VAMC Clarksburg, WV

Subj: Reply to 11/7/00 OIG Draft Report

To: Assistant Inspector General for Auditing (52)
ATTN: Director, Central Office Operations Division

1. Please find subject reply attached. We concur in audit findings and recommendations. Detailed action taken or planned is provided in the attachment.

2. Thank you for this opportunity to provide comments.

/s/BRADLEY P. SHELTON

Attachment

Cc: Director, VA Stars and Stripes Health Care Network (VISN4)

APPENDIX VIII

ACTING DIRECTOR, VAMC CLARKSBURG COMMENTS

REPLY TO OIG DRAFT REPORT

VAMC Clarksburg concurs with the audit findings and recommendations 1-12 in the OIG Draft Report of the Review of Selected Construction Contracts, Purchase Card Activities and Vehicle Administration at VAMC Clarksburg dated November 7, 2000. Actions have been taken to address all recommendations and are explained below.

Recommendation 1: Realign the organizational structure to ensure Contracting Officers can operate independently, eliminating pre-existing conflict of interest situations.

Action: The Acquisition functions have been removed from the Facilities Management line and realigned as a separate entity reporting to the Associate Director. Immediate supervision of the Contracting staff has been transferred to the Director, Acquisition and Materiel Management Service (A&MM), Coatesville, PA. The Director, A&MM, reviews all contractor management functions and is also responsible for Purchase Card Activities. The transfer of responsibility for the Purchase Card Program and re-training all cardholders and approving officials will be completed by February 1, 2001.

Recommendation 2: Improve supervision over contract award and administration activities, the purchase card program and vehicle management.

Action: The Director, A&MM, VAMC Coatesville, is directly responsible for reviewing all contracts being awarded and for the Clarksburg Purchase Card Program. These responsibilities will not be transferred to Clarksburg until personnel involved are retrained; new management is in place and proper internal auditing functions are being completed timely and accurately. The Facilities Management Program Leader has been detailed to assignments not pertaining to any Facilities Management functions and is located off Medical Center grounds. Vehicle Management responsibilities have been reassigned to designated Facilities Management staff. Appropriate internal auditing functions are now in place.

Recommendation 3: Ensure resources are made available to accomplish necessary acquisition support activities.

Action: We plan to commence recruitment by March 31, 2001, for an employee to manage daily A&MM operations at VAMC Clarksburg.

Recommendation 4: Restrict access to files containing proprietary and source selection information to only personnel authorized to receive it, such as Contracting Officers.

APPENDIX VIII

ACTING DIRECTOR, VAMC CLARKSBURG COMMENTS

Action: All proprietary and source selection information has been secured in those areas only accessible to Acquisition.

Recommendation 5: Ensure all construction work is designed, planned, approved, and constructed consistent with strategic goals, performance plans, and industry standards.

Action: The Contracting staff has been realigned under the Associate Medical Center Director. Immediate supervision has been transferred to the Director, Acquisition & Materiel Management, Coatesville, PA, who will ensure construction work is designed and approved utilizing Federal and VA Acquisition Regulations as well as other governing laws.

Recommendation 6: Obtain a safety inspection and take action to repair the helicopter pad as required.

Action: The feasibility of having a helicopter pad is being reviewed. If determined feasible, appropriate safety inspections will be completed. VA specifications for Helicopter pads are being reviewed to determine if the existing pad meets specifications.

Recommendation 7: Ensure all future work requirements are authorized by warranted Contracting Officers and contracted for using appropriate contractual mechanisms.

Action: The Director, A&MM, VAMC Coatesville, is ensuring all future work requirements are authorized by warranted Contracting Officers utilizing appropriate Federal laws. In addition, at the request of the Senior Acquisition Manager, VISN 4, and the Acting Medical Center Director, a team from the Office of Acquisition and Materiel Management (OA&MM), VA Headquarters, conducted an on-site review of the management, staff, and operations of the contracting office, VAMC Clarksburg, WV. Findings and recommendations were provided with short- and long-term solutions, which resulted in action plans being formulated for the Contracting, Logistics, and Supply Processing and Distribution Sections.

Recommendation 8: Determine what actions may be required to address the performance of the Facility Management Program Team Leader for failure to follow procurement regulations; actions that resulted in authorization of construction work beyond his authority; and for the other serious management lapses noted within Facility Management operations.

Action: The Facilities Management Program Leader has been relieved of all Facilities Management responsibilities and is located off Medical Center grounds. In addition an Acting Associate Director is supervising Facilities Management directly and putting in place the necessary and proper internal controls to ensure no future occurrences.

APPENDIX VIII

ACTING DIRECTOR, VAMC CLARKSBURG COMMENTS

Recommendation 9: Update and ensure the currency of files maintained in support of A&E professional qualifications, i.e. Standard Forms 254 and 255, and enhance the membership of the facility A&E Source Selection Board to include individuals from other independent sources.

Action: The Director, A&MM, VAMC Coatesville, has established a local A&E Board in accordance with the FAR. In addition, the need for two Contracting Officers has been recognized and additional FTEE are being pursued.

Recommendation 10: Formalize a facility Purchase Card Program policy to provide guidelines for the effective use and control of purchase cards.

Action: A Clarksburg Credit Card Policy has been written and implemented. A Clarksburg Purchase Card Coordinator and alternate have been designated. Training for these two individuals is on going with all cardholders and approving officers being retrained. These individuals and all training will be completed and be independently operational, with the proper audit functions in place, by February 1, 2001. A Purchase Card Program action plan has been developed and is presently being implemented.

Recommendation 11: Ensure training is provided to cardholders and approving officials prior to issuance of purchase cards, or at such times as an employee needs additional guidance.

Action: The Director, A&MM, VAMC Coatesville, has conducted a review of all purchase cardholders and approving officials. A fileman routine has been developed to identify out-of-line purchases. A Clarksburg Purchase Card Program Coordinator and Alternate have been designated. Re-Training of all Purchase Cardholders and approving officers will be completed by February 1, 2001. The VAMC Clarksburg Purchase Card Program action plan details further implementation.

Recommendation 12: Establish an adequate level of supervision over vehicle administration responsibilities. This should include completion of a physical inventory of facility vehicles and an update of official records to include pertinent information, resolution of inventory discrepancies and disposal of unusable vehicle inventory from facility grounds, and completion of all required annual inventory reports in timely manner as required.

Action: With the detail of the Facilities Management Program Leader and redistribution of workload between individuals within Facilities Management, vehicle administration controls have been reinstituted and internal audits put in place.

APPENDIX VIII

ACTING DIRECTOR, VAMC CLARKSBURG COMMENTS

All complete physical inventory has been achieved and bar coding is ongoing. The disposal of unusable vehicles is ongoing, with the completion to be in late February 2001. All required annual inventory reports are completed resources to facilitate future compliance is being pursued.

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