

The Fall 2020 COVID-19 Outbreak at the LaSalle Veterans' Home

*A Summary of the Illinois Department of Human Services Office of Inspector General's
Investigation*

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CONTENTS

- I. INTRODUCTION 1
 - A. IDVA and LaSalle Home Background..... 2
 - B. Outbreak at LaSalle Veterans’ Home 3
 - C. Scope and Methodology 5
 - D. Related Outbreaks..... 6
- II. COVID-19 in Illinois..... 6
 - A. Timeline..... 6
 - B. LaSalle County..... 8
 - C. COVID-19 in Nursing Homes..... 8
- III. BACKGROUND: The Illinois Department of Veterans’ Affairs 9
 - A. Organization and Duties..... 9
 - B. Applicable Illinois Rules and Regulations..... 11
 - C. Applicable Federal Rules and Regulations..... 12
 - D. Third-Party Infection Control Guidance 13
 - E. Other Guidance Relevant to the Veterans’ Homes Regarding the COVID-19 Pandemic 14
- IV. FINDINGS..... 17
 - A. Observations and Concerns within the Home..... 17
 - B. Observations and Concerns Outside of the Home..... 30
- V. RECOMMENDATIONS 40
- VI. CONCLUSION 45
- VII. APPENDIX A..... 47
- VIII. APPENDIX B. 48



I. INTRODUCTION

This report is a summary of the Illinois Department of Human Services, Office of the Inspector General's (the "OIG") investigation into the fall 2020 outbreak of COVID-19 at the State of Illinois Department of Veterans' Affairs' LaSalle Veterans Home (the "Home"). In October, November, and December 2020, more than 200 Veterans and staff at the Home tested positive for the virus, and 36 Veterans died. The Governor asked OIG to conduct an investigation into the COVID-19 outbreak and OIG subsequently retained the law firm of Armstrong Teasdale, LLP to assist it in investigating the circumstances surrounding this outbreak, and in drafting this report.

Ultimately, our investigation determined that the Illinois Department of Veterans' Affairs' ("IDVA") lack of COVID-19 preparation contributed to the scope of the outbreak at the Home. In addition, failures in communication at the Home and within the IDVA leadership also contributed to a delayed response to the outbreak.

More specifically, and as detailed further below:

- The lack of a comprehensive COVID-19 plan at the Home, including the absence of any standard operating procedures in the event of a COVID-19 outbreak, was a significant contributing factor to the Home's failure to contain the virus. The risks concerning transmission and control of COVID-19 were well known by October 2020; yet, the Home lacked any formal preparedness and response plan. With no documented COVID-19 specific policies or outbreak plan, the Home's staff was confused on the appropriate course of action during the outbreak, and thus, its operations were inefficient, reactive, and, at times, chaotic.
- The Home's leadership failed to effectively communicate, train, and educate its employees on the dangers of COVID-19 and the precautions required to monitor and control the virus within the Home. As a result, some staff members were unaware of certain basic infection control directives, contributing to a culture of non-compliance.
- The Home did not have a COVID-19 task force or committee for which leadership and supervisors determined and designated the responsibilities necessary for managing and monitoring COVID-19. Thus, it was unclear who was responsible for various COVID-19 related tasks within the Home leading to important tasks being left unattended.
- IDVA's executive leadership team also contributed to the Home's failed COVID-19 response by: 1) consolidating too many responsibilities in one individual; 2) failing to

delegate and assign clear responsibilities; 3) failing to learn from outbreaks at other long-term care facilities—including another Illinois Veterans’ Home; 4) failing to effectively communicate; and 5) failing to identify, seek, or accept external resources to assist in responding to the outbreak.

Although this report identifies a number of deficiencies within the Home and IDVA in their preparation for and response to this outbreak, it is important to note the frontline staff’s dedication and care for Veterans amid the pandemic’s demanding conditions. We acknowledge that this was a challenging period for everyone involved in the tragic outbreak and stress that IDVA’s and the Home staff’s genuine care for the Veterans was apparent in our investigation.

A. IDVA and LaSalle Veterans’ Home Background

The IDVA operates four long-term, skilled nursing care facilities in Illinois (“Homes”).¹ Across its four Veterans’ Homes, the IDVA, which is an Illinois executive agency administered under the jurisdiction of the Governor, provides more than 1,000 beds for Veterans in need of skilled long-term nursing care.² The Homes are located in Anna, LaSalle, Manteno, and Quincy, with a fifth home in Chicago currently under development.³ The Veterans’ Homes provide long-term care and rehabilitative services including physical, speech, and occupational therapy by on-site registered nurses and physicians.⁴ Each year, the Veterans’ Homes are required to be surveyed, inspected, and certified by its U.S. Department of Veterans Affairs’ medical center of jurisdiction in areas of Veterans’ rights, quality of care, and safety.⁵ The Veterans’ Homes are also licensed by the Illinois Department of Public Health (“IDPH”).⁶

The LaSalle Veterans’ Home, located at 1015 O’Conor Avenue in LaSalle, Illinois, opened in December 1990.⁷ Across the Home’s four units (West, Northwest, East and Northeast), it

¹ <https://www2.illinois.gov/veterans/about-us/Pages/default.aspx>

² <https://www2.illinois.gov/veterans/homes/Documents/VETHOME%20FAQS.pdf>

³ <https://www2.illinois.gov/veterans/about-us/Pages/FAQ.aspx>

⁴ <https://www2.illinois.gov/veterans/homes/Documents/VETHOME%20FAQS.pdf>

⁵ https://www.va.gov/geriatrics/pages/State_Veterans_Homes.asp;
<https://www2.illinois.gov/veterans/homes/Pages/Default.aspx>. While the U.S. Department of Veterans Affairs (the “VA”) provides certification and some funding and other resources for the IDVA, IDVA is an Illinois executive agency that operates independently of the VA.

⁶ <https://www.dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/veterans-homes#:~:text=Each%20Home%20is%20licensed%20by,health%20care%20needs%20are%20met.>

⁷ <https://www2.illinois.gov/veterans/homes/Pages/LaSalle.aspx>

accommodates up to 184 Veterans.⁸ During all relevant times detailed in this report, the Home’s leadership included its Home Administrator Angela Mehlbrech, Director of Nursing Jackie Cook, Assistant Director of Nursing Danielle Vanko, and Infection Control Nurse Adam Mize (the “Management Team”). The IDVA was led by Director Linda Chapa LaVia, Chief of Staff Tony Kolbeck, and Assistant Director Anthony Vaughn (Ret. MSgt.) (the “Leadership Team”).

B. Outbreak at LaSalle Veterans’ Home

On November 1, 2020, the Home notified IDVA that two Veterans and two employees tested positive for COVID-19.⁹ These were the first Veterans to test positive for COVID-19 within the Home. Within a week, 60 Veterans and 43 staff members tested positive for COVID-19.¹⁰ Veterans and staff positive numbers and, ultimately, Veteran deaths continued to climb in the Home over the next month.¹¹ *See also* Appendix A.

The Northwest and West units experienced the first positive Veteran cases. The Northwest hall was previously equipped to serve as the Home’s quarantine and isolation halls. The Northwest hall housed 44 Veterans across two halls: one set up for negative pressure (wherein the air pressure inside the room is lower than the air pressure outside the room which helps prevent airborne diseases from escaping the room and infecting other people) and used for isolation of confirmed positive Veterans, with the other reserved for potentially positive Veterans awaiting test results. The West unit provided overflow support for the COVID-19 unit. As the outbreak progressed, the Home dedicated the entire Northwest and West units to the isolation and service of infected Veterans. The East and Northeast halls housed all uninfected Veterans. For reference, a layout of the Home is shown below with the Northwest and West units outlined in red:

⁸ *Id.*

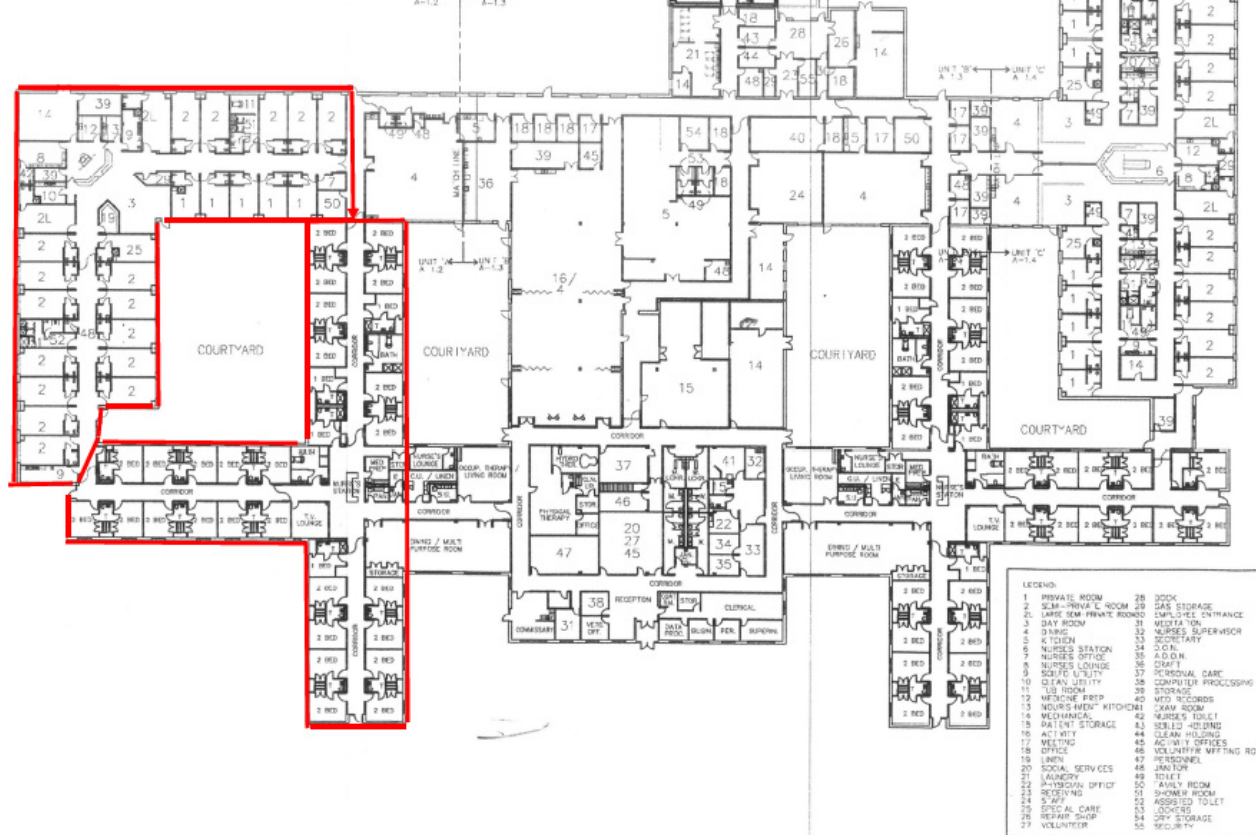
⁹ https://www2.illinois.gov/veterans/homes/Notifications/LaSalle%2011_01_2020%20IDVA%20Illness%20Notification%20of%20COVID-19.pdf

¹⁰ https://www2.illinois.gov/veterans/homes/Notifications/LaSalle%2011_7_2020%20Covid-19%20Update%20Letter%20to%2011_1%20Notice.pdf

¹¹ HANNAH MEISEL/NPR ILLINOIS; <https://www.nprillinois.org/post/lasalle-veterans-home-administrator-fired-after-32-residents-dead-covid-19-outbreak#stream/0>

During Outbreak in November 2020:

NW (44 beds) and West (53 beds) were used for COVID isolation.



On November 12, the IDPH and the United States Department of Veterans Affairs (the “VA”) conducted a site visit to observe infection control practices, which included a tour and observation of the Home’s staff and Veterans.¹²

On November 24, 2020, the IDVA released two reports addressing COVID-19 at the Home prepared by the IDPH and the VA.¹³ The Reports recommended re-training staff on personal protective equipment (“PPE”) requirements, replacing non-alcohol based hand sanitizers that were less effective against COVID-19 with alcohol-based hand sanitizer, and improving the screening process for employees’ arrival at work and periodic workday checks.¹⁴

¹² <https://news.wttw.com/2020/11/24/officials-release-reports-covid-19-outbreak-lasalle-veterans-home>

¹³ <https://www2.illinois.gov/Pages/news-item.aspx?ReleaseID=22392>

¹⁴ <https://www2.illinois.gov/news/release?ReleaseID=22392>

According to Mr. Kolbeck, in early December 2020, the Governor’s staff instructed the IDVA to terminate Home Administrator Ms. Mehlbrech and place Director of Nursing Angela Cook on administrative leave.¹⁵ The Home is currently overseen by Assistant Director Anthony Vaughn and Ms. Vanko serves as the Acting Director of Nursing.¹⁶ A search for a permanent Administrator is ongoing.¹⁷ As of the Home’s COVID-19 update on March 2, 2021, 36 Veterans passed away due to COVID-19 and 109 Veterans and 116 employees tested positive.¹⁸

The Governor asked the OIG to conduct an independent investigation of the Home’s COVID-19 outbreak, in order to discover any lapses in protocol and employee compliance with the applicable rules and regulations.¹⁹ The OIG subsequently retained Armstrong Teasdale, LLP, a law firm with significant experience in investigative matters, to assist in conducting its investigation and preparing this report.

C. Scope and Methodology

The investigation included analyzing COVID-19 data, trends and protocol in the Home and assessing IDVA’s preparation, response and compliance with protocols and regulations. The investigation included 29 individual interviews and the review of hundreds of documents. Investigators interviewed Home personnel, including administrators and infection control, nursing, medical, social work, housekeeping, and environmental services employees, as well as IDVA and IDPH personnel. Home employees were notified of the investigation and provided an opportunity to discuss with investigators their observations and concerns regarding the Home’s operations throughout the pandemic. In addition to interviews, investigators conducted an onsite visit of the Home.

¹⁵https://www2.illinois.gov/IISNews/22448-IDVA_Annncs_Asst_Director_Anthony_Vaughn_to_Serve_as_Interim_Administrator_of_LaSalle_Veterans%E2%80%99_Home.pdf

¹⁶https://www2.illinois.gov/IISNews/22448IDVA_Annncs_Asst_Director_Anthony_Vaughn_to_Serve_as_Interim_Administrator_of_LaSalle_Veterans%E2%80%99_Home.pdf

¹⁷https://www2.illinois.gov/IISNews/22448IDVA_Annncs_Asst_Director_Anthony_Vaughn_to_Serve_as_Interim_Administrator_of_LaSalle_Veterans%E2%80%99_Home.pdf

¹⁸<https://www2.illinois.gov/veterans/homes/Notifications/LaSalle%203-2-2021%20Update%20notification%20Letter%20to%2011-1-2020%20Notice.pdf>; for the most recent update, see <https://www2.illinois.gov/veterans/homes/Notifications/LaSalle%20Initial%20Covid%20%20Letter%204-13-2021.pdf>

¹⁹<https://www2.illinois.gov/news/release?ReleaseID=22392>; The Office of the Governor of the State of Illinois (“OOG”), pursuant to its powers under Section 7 of the Illinois Emergency Management Act, requested and authorized OIG to conduct this investigation.

Interviews were generally conducted via video conferencing at the Home or at the residence outside working hours.²⁰ The investigative team minimized the number of in-person (versus video) interviews it conducted in order to protect the interviewees and Veterans from further COVID-19 exposure. Current IDVA employees had a duty to cooperate with the OIG's investigation. However, former IDVA employees did not have a duty to cooperate and former Home Administrator Ms. Mehlbrech and former IDVA Director Ms. Chapa LaVia ultimately declined requests to be interviewed.²¹ No interviews were conducted on an anonymous basis.

This report contains statements from interviewees presented as direct quotes. The quoted language represents the best approximation of what was stated by the witness and is intended to convey the substance of the communication.

D. Related Outbreaks

The Home was not the only IDVA facility to experience an outbreak of COVID-19. From early May to mid-June 2020, the Manteno Veterans' Home experienced a smaller but significant outbreak that resulted in 15 Veterans' deaths.²² During that time period, 48 Manteno Veterans tested positive for the virus, along with 33 Manteno staff members.²³

At the Quincy Veterans' Home, 25 Veterans have died due to COVID-19, with 134 Veterans and 170 employees testing positive since the start of the pandemic.²⁴

II. COVID-19 in Illinois

A. Timeline

On January 24, 2020, IDPH announced the first case of an Illinois resident with COVID-19.²⁵ By March 5, 2020, this number had grown to five confirmed cases, and Governor J.B. Pritzker issued a Disaster Proclamation on March 9. Five days later, on March 14, State officials identified

²⁰ The interviews referred to in this report took place between December 10, 2020, and April 2, 2021.

²¹ More specifically, Ms. Chapa LaVia, through counsel, indicated that she would consider sitting for an interview if the investigative team provided her the questions in writing beforehand. The investigative team declined to be subject to such a limitation or to give Ms. Chapa LaVia treatment different from the other witnesses. As a result, the investigative team was not able to interview Ms. Chapa LaVia.

²² <https://www2.illinois.gov/veterans/homes/Notifications/Manteno%206-16-20%20Update%20to%205-9-20%20Notice.pdf>

²³ <https://www2.illinois.gov/veterans/homes/Notifications/Manteno%206-16-20%20Update%20to%205-9-20%20Notice.pdf>

²⁴ <https://www2.illinois.gov/veterans/homes/Notifications/Quincy%2003-26-2021%20COVID-19%20Update%20Letter%20to%207-6-20%20Notice%20IVHQ.pdf>

²⁵ <https://www.kwqc.com/2021/03/15/timeline-covid-19-cases-in-the-state-of-illinois/>

the first case associated with a long-term care facility, and on March 17, 2020, IDPH announced the first death due to COVID-19 in the state, with officials reporting that they were monitoring an outbreak at a private long-term care facility in DuPage County. By March 20, 2020, the total number of confirmed cases in the state was 585. The next day, Governor Pritzker issued a Stay at Home order, and by March 22, 2020, the number of known cases in the state had nearly doubled to 1,049. By April 12, cases surpassed 20,000, and two weeks later, the count rose to 43,903 COVID-19 cases.

Against this backdrop, on May 28, 2020, IDPH filed emergency rules mandating long-term care facilities to comply with infection control practices, including testing all nursing home residents and staff for COVID-19.²⁶ By August 5, 2020, IDPH reported it was conducting more than 46,000 COVID-19 tests a day. On September 7, 2020, the state surpassed 250,000 confirmed COVID-19 cases, and on October 16, 2020, IDPH announced 34 Illinois counties, including LaSalle County, were at a warning level for COVID-19, meaning two or more COVID-19 risk indicators were not meeting targeted metrics. The risk indicators being measured in each county were:

- (1) **new cases per 100,000 people** (the targeted value is fewer than 50),
- (2) **number of deaths** (the targeted value is “decreasing or stable”),
- (3) **test positivity percentage** (the targeted value is less than or equal to 8 percent),
- (4) **number of tests performed** (the targeted value is related to the test positivity rate),
- (5) **number of emergency department visits for COVID-19-like illnesses** (the targeted value is “decreasing or stable”),
- (6) **hospital admissions for COVID-19-like illnesses** (the targeted value is “decreasing or stable”),
- (7) **cluster percentage of cases** (no targeted value, but monitored to explain large increases in cases), and
- (8) **ICU bed availability** (the targeted value is at least 20 percent of beds available).²⁷

A week later, on October 23, 2020, IDPH announced that 51 counties were now at a warning level for COVID-19.²⁸ As of March 31, 2021, there have been a total of over 1.2 million cases in the state, with 20.3 million tests performed, more than 21,000 confirmed deaths, and over 2,200 “probable deaths.”²⁹

²⁶ <https://www.dph.illinois.gov/covid19/governor-pritzkers-executive-orders-and-rules>

²⁷ <https://www.dph.illinois.gov/countymetrics?county>

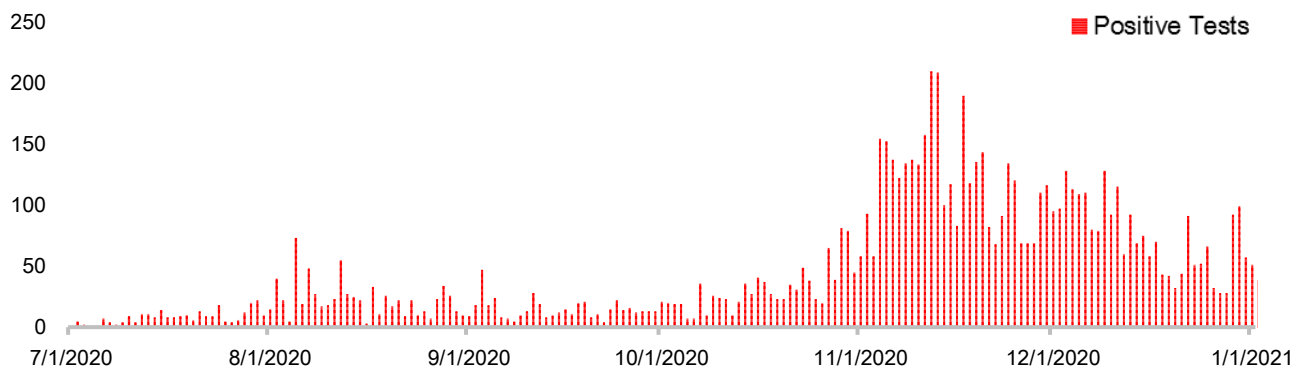
²⁸ <https://www.kwqc.com/2021/03/15/timeline-covid-19-cases-in-the-state-of-illinois/>

²⁹ <https://www.dph.illinois.gov/covid19>

B. LaSalle County

Cases began to spike in LaSalle County shortly before the outbreak at the Home. Home personnel, the Management Team, and the Leadership Team acknowledged that cases were increasing in the community in the weeks leading up to the outbreak, which is borne out by the data. Specifically, in the week prior to the Home’s first positive test on October 31, the county went from 226 to 336 cases per 100,000 people (well over the “50 per 100k” warning threshold), 7.5% to 13.4% test positivity rate (over the 8% warning threshold),³⁰ from 4 deaths to 6 deaths, a rate of increasing emergency department visits from 406.2% to 611.2% for COVID-19-like illnesses (when the target is “decreasing or stable”), and a rate of increasing hospital admissions from 1100% to 1500% for COVID-19-like illnesses (when the target is “decreasing or stable”).³¹

New Reported Cases by Day in LaSalle County, Illinois



As of March 31, 2021, there have been 11,283 confirmed COVID-19 cases in LaSalle County and 226 deaths.³² Of these, 225 cases and 36 deaths are linked with the outbreak at the Home.

C. COVID-19 in Nursing Homes

Illinois has approximately 1,200 long-term care facilities serving more than 100,000 residents.³³ With proper protocols in place, it is clear that even with the unique challenges presented by the long-term care facility setting, infection control is the rule, not the exception, at other long-

³⁰ <https://www.dph.illinois.gov/countyschool?county=LaSalle>

³¹ <https://www.dph.illinois.gov/countymetrics?county=LaSalle>

³² <https://www.dph.illinois.gov/covid19/statistics>

³³ <https://www.dph.illinois.gov/topics-services/health-care-regulation/nursing-homes>

term care facilities in the state. A detailed study of other outbreaks in Illinois long-term care facilities is beyond the scope of our investigation. However, the data generally reflects that facilities of comparable resident population to the Home better controlled their outbreaks among residents and staff.³⁴ See Appendix B.

This comparative analysis is important to consider in the context of testimony from some members of the Management and Leadership Teams claiming that the Home's management of COVID-19 was the same as any other long-term care facility.

In the state as a whole, as of April 7, 2021, there have been 77,934 total COVID-19 cases and 10,323 deaths among residents in long-term care facilities.³⁵ Nationally, as of April 7, 2021, 644,247 residents of federally licensed nursing homes had tested positive for COVID-19 and 131,386 had died as a result.³⁶ Within VA facilities overall, as of April 7, 2021, there have been 245,414 cumulative COVID-19 cases with 7,569 known related deaths.³⁷

As evidenced by the above outbreak data, long-term care facilities like the Home are particularly susceptible to COVID-19 due to the Veterans' age and health condition. The Home serves as the Veterans' residence, presenting additional challenges: Veterans are not expected to wear PPE in every location of the Home, Veterans require medical care and outside medical appointments for various conditions, and the Home's employees are exposed to transmission in the community. Although COVID-19 has required more rigorous practices for preventing the illness evolving in real time, by summer and fall 2020, COVID-19's potential effect on long-term care facilities was well known to the Management and Leadership Teams.

III. BACKGROUND: The Illinois Department of Veterans' Affairs

A. Organization and Duties

The IDVA has supervisory and administrative responsibility for the Veterans' Homes. It is empowered under the Illinois Department of Veterans' Affairs Act (the "Act") to "make reasonable rules and regulations to govern the admission, maintenance, and discharge of residents of the Illinois

³⁴ <https://dph.illinois.gov/covid19/long-term-care-facility-outbreaks-covid-19>

³⁵ *Id.*

³⁶ <https://data.cms.gov/stories/s/bkwz-xpvg>

³⁷ <https://www.accesstocare.va.gov/Healthcare/COVID19NationalSummary> (last visited April 7, 2021). The figures cited for total VA COVID-19 cases include cases across all VA facilities, including VA hospitals. The figures cited for COVID-19 deaths, however, are extracted only from the "Known other" category, which indicates the death was reported to VA but occurred outside of a VA hospital (in other words, in a VA Home)

Veterans Homes.” 20 ILCS 2805/2.06. It is also required to “employ and maintain sufficient and qualified staff at the veterans’ homes (i) to fill all beds, subject to appropriation, and (ii) to fulfill the requirements of this Act.” 20 ILCS 2805/2.08. The IDVA is further required to “maintain case files containing records of services rendered to each applicant, service progress, and a follow-up system to facilitate the completion of each request.” 20 ILCS 2805/3.

Under the Act, the IDVA must establish an administrative office in Springfield, a branch office in Chicago, and “such field offices as it shall find necessary to enable it to perform its duties.” 20 ILCS 2805/3. Each field office must have a service officer who meets the following qualifications:

- An honorable discharge from service in the United States Armed Forces,
- Served during a time of hostilities with a foreign country, and
- Either (i) served at least six months total, (ii) served for the duration of hostilities regardless of the length, (iii) was discharged on the basis of hardship, or (iv) was released from active duty because of a service connected disability.³⁸

In addition, the Act establishes a “Veterans Advisory Council” (the “Council”) made up of the following:

- (1) Four members of the General Assembly, appointed by various legislators in leadership positions.
- (2) Six Veterans appointed by the Director of Veterans’ Affairs.
- (3) One Veteran appointed by each federal or state veterans service organization in Illinois.
- (4) One person appointed by the Adjutant General of the Illinois National Guard.
- (5) One person appointed by the Illinois Attorney General.
- (6) One person appointed by the Illinois Secretary of State.
- (7) One person appointed by the Director of the Illinois Department of Employment Security.
- (8) One person appointed by each federal military family organization in Illinois.³⁹

³⁸ 20 ILCS 2805/4

³⁹ 20 ILCS 2805/15

The Council must be made up of at least 21 individuals, and no Council member may be an employee or representative of the IDVA. Council members serve for two years without compensation or reimbursement. The Council meets quarterly or as needed, and it has the power to study issues of significance to Illinois Veterans, advise the IDVA about these issues, report to the Illinois Governor and the General Assembly annually about these issues, make recommendations for future action, and generally advise the IDVA about fulfilling its statutory duties. 20 ILCS 2805/15.

Each facility is also required to have a full-time administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act.⁴⁰ However, there is no express statutory or regulatory requirement that Council members, the Director of the IDVA, or other members of the IDVA have any nursing home, health care, or medical experience. At the time of the outbreak, no one on the Leadership Team had this experience.

B. Applicable Illinois Rules and Regulations

To remain licensed, the Home must comply with the IDPH's established rules and regulations (the "Veterans' Homes Code").⁴¹ Non-Veteran nursing homes follow a different set of regulations.⁴²

The Veterans' Homes Code requires that facilities have publicly-available, "written policies and procedures governing all services provided by the facility."⁴³ The regulations also require an "advisory physician, or a medical advisory committee composed of physicians" to advise the administrator on the general medical management of the Veterans' Homes and to develop policies and procedures to be followed during medical emergencies.⁴⁴ Each facility must have a Director of Nursing Services who is a registered nurse and who does not provide direct Veteran care unless the facility has fewer than 50 beds.⁴⁵ Facilities with 100 or more beds must also have an assistant director of nursing service who is a licensed nurse.⁴⁶ The Home generally complied with these requirements, except that before the outbreak, its Medical Director, Dr. Michael Morrow, was focused primarily on general medical management, rather than on policy-making.

⁴⁰ 77 Ill. Adm. Code 340.1370

⁴¹ 77 Ill. Adm. Code 340

⁴² 77 Ill. Adm. Code 300

⁴³ 77 Ill. Adm. Code 340.1300

⁴⁴ *Id.*

⁴⁵ 77 Ill. Adm. Code 340.1375

⁴⁶ *Id.*

Under the regulations, each Veteran at a Home must be provided direct care staff at least two hours a day, of which at least 20 percent or 24 minutes must be care from a licensed nurse,⁴⁷ and the Home must provide a “sufficient number of nursing and auxiliary personnel on duty each day to provide adequate and properly supervised nursing services to meet the nursing needs of the residents.”⁴⁸ In addition, Veterans should receive adequate personal care, including at least one “complete bath and shampoo weekly,” and clean bed linens at least once weekly.⁴⁹ There is no evidence to suggest that these threshold personal care requirements were not met.

In terms of infection control, the Veterans’ Homes Code requires that in the event of two diagnoses of an “infectious disease” in any Veterans’ Home within one month or less, the Veterans’ Home must, within 24 hours of being notified of the second diagnosis:

- (1) Provide a written notification about the infectious disease to each resident of the facility and the resident’s emergency contact or next of kin,
- (2) Post a notification about the infectious disease in a conspicuous place near the main entrance to the Veterans’ Home,⁵⁰
- (3) Provide a written notification to the IDVA and the IDPH about the infectious disease and the Home’s compliance with notification requirements, and
- (4) In addition to the initial written notifications, IDVA and IDPH must post about the incidence of the infectious disease, any updates, and any options that are available to the residents on their websites.⁵¹

C. Applicable Federal Rules and Regulations

Along with State rules and regulations, the Veterans’ Homes must also comply with the federal requirements of 38 CFR Part 51, titled “Per Diem for Nursing Home, Domiciliary, or Adult Day Health Care of Veterans in State Homes.”⁵² Compliance is subject to certification by the jurisdictional VA Medical Center (“VAMC”).⁵³ Among other things, 38 CFR Part 51 requires that

⁴⁷ 77 Ill. Adm. Code 340.1375

⁴⁸ 77 Ill. Adm. Code 340.1560

⁴⁹ 77 Ill. Adm. Code 340.1570

⁵⁰ As noted below, evidence of poor communication within the Home suggests that some staff members were not immediately informed of the Home’s outbreak status.

⁵¹ Public Act 100-0632; 20 ILCS 2805/2.01c

⁵² Nursing homes, on the other hand, must comply with the requirements of 42 C.F.R. 483. Their compliance is subject to certification by the Centers for Medicare and Medicaid Services.

⁵³ 38 CFR § 51.30(b). Hines VA Hospital is the jurisdictional VAMC for Illinois Veterans’ Home at LaSalle.

the facility designate a primary care physician to serve as a medical director.⁵⁴ The medical director must participate in “establishing policies, procedures, and guidelines to ensure adequate, comprehensive services,” direct and coordinate medical care in the facility, advise the administrator on employee-health policies, and make recommendation to the Administrator regarding health hazards.⁵⁵ Again, Dr. Morrow’s role was primarily in directing and coordinating medical care, and he had a limited role in establishing policies or in advising the Home’s Administrator prior to the outbreak.

Part 51 also requires that the facility establish and maintain an infection control program for the investigation, control, and prevention of infections; establishes procedures for infection management, such as isolation; and records infection incidents and corrective actions.⁵⁶ Part 51 mandates that facilities take the following actions to prevent the spread of infection:

- (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident.
- (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease.
- (3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.⁵⁷

The Homes’ certification and federal funding is dependent on their compliance with these requirements.⁵⁸

D. Third-Party Infection Control Guidance

In May 2019, consulting firm Tetra Tech, Inc. conducted a health and safety audit of Illinois Veterans’ Homes’ policies, protocols, and procedures for the IDVA.⁵⁹ Tetra Tech, Inc. found that policies were inconsistent between Homes, that several policies were incomplete or outdated, and, importantly, that while various infection control policies existed, “it is not clear how they are

⁵⁴ 38 CFR § 51.210(i)(1)

⁵⁵ 38 CFR § 51.210(i)(2)

⁵⁶ 38 CFR § 51.190(a)

⁵⁷ 38 CFR § 51.190(b)

⁵⁸ An analysis of the rigor of the Home’s certification process and the process whereby the Home demonstrated its compliance with these requirements is beyond the scope of this investigation.

⁵⁹ March 9, 2021 Interagency Memorandum

integrated into an Infection Control Management Program.”⁶⁰ At that time, IDVA was encouraged to develop an evidence-based policy structure that would apply to and be standardized across all of the Homes, as well as to implement a procedure for ensuring that policies would be revised annually and communicated accurately to staff. The Home did not adopt these recommendations prior to the outbreak.

E. Other Guidance Relevant to the Veterans’ Homes Regarding the COVID-19 Pandemic

i. IDPH

IDPH issued one COVID-19 rule applicable to the Illinois Veterans’ Homes Code. In May 2020, it published the following general emergency provision that addressed IDVA visits to the Homes:

Section 340.1 COVID-19 – Emergency Provisions

EMERGENCY

In conducting on-site investigations and surveys, the Department will minimize the impact on facility activities, while ensuring facilities are implementing actions to protect the health safety of residents, staff, and other individuals in response to the COVID-19 pandemic.⁶¹

Later, on May 28, 2020, IDPH issued a comprehensive emergency rule specific to long-term care facilities, which are licensed under a different chapter and follow separate regulations.⁶² That rule provided guidance for day-to-day operations, requiring that facilities establish policies and procedures for testing, review their infection control activities at least annually, conduct testing of nursing home residents and staff when experiencing an outbreak or when directed by IDPH or their local health department, and comply with infection control recommendations made by IDPH or local health departments.⁶³ This emergency rulemaking was amended on July 14, 2020 to remove the emergency requirement that facilities comply with IDPH or local health department infection control recommendations, and instead added a requirement that facilities adhere to six specific COVID-19 guidelines issued by the CDC.⁶⁴

⁶⁰ *Id.*

⁶¹ <https://www.dph.illinois.gov/covid19/governor-pritzkers-executive-orders-and-rules>

⁶² *Id.*

⁶³ *Id.*

⁶⁴ <https://www.dph.illinois.gov/covid19/governor-pritzkers-executive-orders-and-rules>. The rule referenced the following guidelines: “Testing Guidelines for Nursing Homes (July 1, 2020),” “Interim Guidance on

IDPH also listed resources for long-term care facilities, including Veterans' Homes, on its website.⁶⁵ Initially, IDPH's guidance treated COVID-19 like the flu:

The general strategies CDC recommends to prevent the spread of COVID-19 in LTCF are the same strategies LTCF use every day to detect and prevent the spread of other respiratory viruses like influenza.⁶⁶

By July 2020, however, IDPH was instructing long-term care facilities to take additional steps to address COVID-19's unique traits and to mitigate the risk of asymptomatic transmission, explicitly directing long-term care facilities to multiple CDC guidelines.⁶⁷ But it appears that many staff at the Home continued to treat COVID-19 like the flu and did not comply with more rigorous protocols, like facemasks.⁶⁸

ii. Centers for Disease Control and Prevention

Since February 2020, the CDC has consistently published guidelines directed at preventing the spread of COVID-19 infections in nursing homes and long-term care facilities.⁶⁹ These guidelines advise facilities to anticipate which location will serve as a COVID-19 care unit and which personnel will staff that unit if residents in the facilities contract COVID-19. The guidelines also recommend infection prevention training and placing individuals whose COVID-19 status is unknown in separate observation areas to be monitored for evidence of COVID-19.⁷⁰ While the Home did prepare a quarantine unit with equipment for treating Veterans with COVID-19, it did not train staff on how to use the new equipment, nor did it have a staffing contingency plan in the event of an outbreak.

Testing Healthcare Personnel for SARS-CoV-2 (July 2, 2020),” “Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes (May 19, 2020),” “Preparing for COVID-19 in Nursing Homes (June 25, 2020),” “Responding to Coronavirus (COVID-19) in Nursing Homes (April 30, 2020), and “Nursing Home Reopening Recommendations for State and Local Officials (May 18, 2020).”

⁶⁵ <http://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/coronavirus/long-term-care-guidance>;

<https://dph.illinois.gov/sites/default/files/03.19.21%20Updated%20LTC%20guidance.pdf>

⁶⁶ <https://web.archive.org/web/20200310003911/http://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/coronavirus/long-term-care-guidance>

⁶⁷ <https://web.archive.org/web/20200730183750/http://www.dph.illinois.gov/topics-services/diseases-and-conditions/diseases-a-z-list/coronavirus/long-term-care-guidance>

⁶⁸ See *infra*, IV.A.1.d-g

⁶⁹ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

⁷⁰ <https://web.archive.org/web/20200502170619/https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html/>

The CDC suggested procedures for what to do upon discovery of infections among staff members or residents, including testing and contact tracing.⁷¹ The CDC further advised that facility-wide testing should be used when possible, especially following the identification of any COVID-19-infected residents or staff.⁷² At the time of the outbreak, the Home was testing staff once a week and Veterans once every two weeks. It generally was not employing rapid tests, so there was a delay in when the Home received tests results.

The CDC emphasized how vulnerable long-term care facilities are to COVID-19 outbreaks: “Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19[.]”⁷³ For these reasons, the CDC instructed long-term care facilities to follow certain “core practices”:

- Assign one or more individuals with training in infection control to provide on-site management of an infection prevention and control program.
- Educate residents, staff, and visitors about COVID-19 and the facility’s policies and procedures in response, including the actions they should take to protect themselves.
- Ensure staff and residents wear facemasks.
- Have a plan for visitor restrictions to minimize the risk of COVID-19 transmission.
- Create a COVID-19 testing plan for residents and staff that includes expanded testing in the event of an outbreak, and repeat testing to ensure no new infections among residents.
- Screen employees for COVID-19 symptoms at the beginning of their shifts and develop plans to mitigate staffing shortages.
- Provide sufficient hand hygiene supplies, PPE, and environmental cleaning and disinfection supplies.
- Screen residents for symptoms of COVID-19 and evaluate and manage residents with symptoms of COVID-19.

⁷¹<https://web.archive.org/web/20200502170619/https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html/>

⁷² <https://web.archive.org/web/20200630225713/https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>

⁷³ <https://web.archive.org/web/20200704034055/https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

This guidance also emphasized that each facility with more than 100 residents (like the Home) should have at least one person in a full-time infection prevention and control role, and that Homes should conduct contact tracing.⁷⁴ The CDC further advised that staff who had been exposed to or contracted COVID-19 only return to work if at least 10 days had passed since symptoms first appeared, at least 24 hours had passed since the last fever, and symptoms had improved.⁷⁵

In terms of returning to work, the Home generally required staff to wait 14 days to return to work following exposure to COVID-19, though in some cases only 10 days. Nevertheless, there was no evidence that meaningful contact tracing was done—again, likely because there was no one in a full-time role to accomplish this contact tracing. While the Home had an infection control nurse, Adam Mize, infection control was one third of Mr. Mize’s core responsibilities: he was also a staff educator and a wound nurse on the floor. The Home had no one in a full-time role dedicated to managing the Home’s infection prevention and control.

The CDC guidelines were not specifically incorporated into the Illinois Veterans’ Home Code, but they were publicly available and widely adopted by long-term care facilities nationwide. As discussed in further detail below, there were broad lapses in the Home’s implementation of COVID-19 prevention and control practices.

iii. Centers for Medicare and Medicaid Services

The Home is not required to comply with Centers for Medicare and Medicaid Services (“CMS”) directives. However, in coordination with the CDC, CMS provided additional guidance specific to preventing and managing COVID-19 infections in the long-term care setting. CMS made this guidance publicly available, and its directives were required to be implemented at thousands of nursing homes nationwide, including Illinois.

IV. FINDINGS

A. Observations and Concerns within the Home

The Home’s staff are dedicated to the Veterans they serve. While the Home was fortunate not to have COVID-19 infections during the first seven months of the pandemic, the Management

⁷⁴ <https://web.archive.org/web/20200704034055/https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

⁷⁵ <https://web.archive.org/web/20200901025048/https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>

Team and staff did not anticipate and were not prepared for an outbreak. As one nurse at the Home noted, “We were prepared for COVID, but not an outbreak.” Interviews revealed concerns about the Home’s operations and leadership in the months before the outbreak, revealing operational deficiencies and unpreparedness: (1) the absence of any outbreak plans and insufficient COVID-19 policies, (2) the failure to communicate, train, and educate staff members concerning COVID-19 policies, and (3) repeated non-compliance with PPE protocols.

1. Insufficient Policies and Procedures

a. No Outbreak Plans and Procedures

The lack of a comprehensive COVID-19 plan, including the absence of any standard operating procedures in the event of an outbreak within the Home, was a significant contributing factor to the Home’s failure to contain the virus. The risks concerning transmission and control of COVID-19 were well known by October 2020, yet the Home lacked any formal preparedness and response plan. Moreover, the rising positivity rates within LaSalle County should have alerted the Management Team to the emerging urgency for infection control at the Home. Despite this forewarning in the community, the Home was complacent and did not develop comprehensive COVID-19 policies. With no documented COVID-19 specific policies or outbreak plan, the Home’s staff were confused on the appropriate course of action throughout the outbreak, and thus, its operations were inefficient, reactive, and chaotic.

The lack of COVID-19 infection within the Home prior to the outbreak provided the Home ample time to develop and test comprehensive policies and plans, yet none were created. This failure was evidenced by the Home’s disorganization in moving Veterans during the outbreak. General guidance concerning the movement of Veterans in the event of an outbreak was provided, but the cursory plan proved insufficient. While staff understood that Veterans required movement to the COVID-19 unit upon testing positive, simple details explaining this movement procedure were not conveyed. For example, there was no guidance as to which staff or unit were responsible for the various aspects of a Veteran’s transition to the COVID-19 unit. The Home did not conduct any stress tests or drills to evaluate or identify inefficiencies within its outbreak plan.

When the outbreak began, this lack of preparedness or a detailed plan caused confusion amongst staff. Several staff members indicated that the Northwest unit was unprepared as a COVID-19 unit and there was insufficient direction and supervision in the transition of positive Veterans into the unit and negative Veterans out of the unit. Indeed, the testing and movement of

Veterans at the start of the outbreak was described as a “whirlwind” that was “frantic” and “chaotic,” as one nurse stated, “nobody seemed to know what to do.” In the absence of any instruction, during the testing of all Veterans in the COVID-19 unit, staff simply yelled out Veterans’ tests results while trying to isolate positive Veterans together and remove all negative Veterans from the unit.

This unstructured approach caused complications and cross-contamination of positive and negative Veterans. For example, in one instance during this testing and movement process, a nurse discovered that a positive Veteran and a negative Veteran were accidentally placed in the same room awaiting additional movement. Despite the negative Veteran’s recent exposure to a positive Veteran, a member of the Management Team instructed that the negative Veteran still be moved to a non-infected wing. At this time, there was space in the quarantine unit for suspected positive Veterans, but uncertainty in procedure and the immediate need to vacate rooms for confirmed positive Veterans led to the recently exposed Veteran not being quarantined or isolated at this time. The failure to quarantine or isolate the exposed Veteran was later acknowledged as an error.

Another nurse at the Home recalled a similar instance in which two sets of roommates were tested and both sets of roommates contained one positive Veteran and one negative Veteran. Again, the negative Veterans who were recently exposed to positive Veterans were moved to a non-infected wing of the Home without any quarantine period. The following day, the same two Veterans were rapid tested, and their results returned positive.

Testing and Veterans’ transition during the outbreak was further complicated by the Home’s half-measures the previous month. In the beginning of October, the Home decided to relocate 10 of the 20 Veterans housed in the Northwest unit to vacant rooms in other units to convert the Northwest unit into a quarantine unit. Although space was available elsewhere in the Home, relocation of Veterans stopped on October 7, 2020, leaving 10 Veterans in the future quarantine hall. When the outbreak began just a few weeks later, these 10 Veterans required relocation, again causing avoidable movement and interaction amongst positive and negative Veterans. The Home’s decision to leave half of the Veterans regularly housed in the future quarantine hall demonstrates a lack of foresight that contributed to the prolonged outbreak in the Home.

The Home’s lack of prior planning was also exhibited in its movement of Veterans throughout the outbreak. There was little or no communication as to the procedure for moving Veterans from a non-infected hall to the COVID-19 unit. When a Veteran tested positive in a non-infected hall, staff were instructed to move the Veteran along with the Veteran’s belongings and bed

without any prior decontamination. But when a Veteran's belongings were moved outside of the housekeeping department's staffing hours, no procedure was in place to inform the incoming housekeeping staff that the Veteran's belongings and vacated room required decontamination. When IDPH conducted a site visit at the Home on November 12, 2020, the Home still did not have appropriate procedures in place. The visiting IDPH nurse observed a staff member moving a Veteran's belongings wearing full PPE and gloves, but then later saw that staff member wearing the same gloves while touching other items.

These incidents demonstrate confusion and complications that were avoidable with more deliberate outbreak procedures. A detailed outbreak plan was necessary based on the known risks and rising community positivity rates at that time. The absence of such a plan resulted in unnecessary and unsafe movement of positive and potentially positive Veterans throughout the Home, contributing to the outbreak's rapid spread.

b. Relaxed Quarantine Policy

Complacency within the Home was also demonstrated in the implementation of its quarantine policy for Veterans that had been outside the Home for medical appointments. At the beginning of the pandemic, the Home required all Veterans that left the Home—for any reason—to quarantine for 14 days upon return to the Home. There was no written policy for the quarantine process, but staff understood and complied with the directive that quarantining was required for all returning Veterans. While no Veterans tested positive while this quarantine policy was in place, at some point in the summer, the Home eliminated this quarantine requirement for Veterans returning from appointments at St. Margaret's Hospital. A determination was made that these visitations were considered "low risk" and did not require quarantining upon return to the Home. Several nurses noted that the first positive tests within the Home were Veterans and accompanying staff members who had recently returned from a visit to St. Margaret's Hospital without quarantining.

Because there was no written policy in place, it remains unclear who authorized this relaxed quarantine policy. Some nurses were under the impression that this change was directed by Dr. Morrow, but no witnesses had a clear recollection of how or when the policy changed or who was responsible. The consensus among staff was that the quarantine policy changed frequently. The first written quarantine guidance was not provided to the Home until January 21, 2021, after a member of the Management Team requested direction from the Medical Director. Still, the guidance did not

provide a detailed policy and merely noted definitions of the three quarantine and isolation states: (1) isolation, (2) quarantine, and (3) COVID-19 isolation.⁷⁶ Notably, the IDPH has recently implemented a similar risk assessment analysis for whether quarantining is necessary, but this assessment tool was not in place at the time the Home eliminated quarantining for certain external visits. Dr. Morrow is now involved in the review and authorization of these assessment determinations.

c. COVID-19 Employee Screening Process

The Home's COVID-19 employee screening process was inadequate throughout the pandemic and outbreak. Prior to the outbreak, employees' initial screening within the Home was not adequately supervised. Employees were required to enter through the same entrance and proceed to an initial screening desk. Because there was often no staff member at the initial screening desk, employees were required to self-administer and document a temperature check, which was verified only by the employee's initials. Surgical masks were not available to staff until reaching this temperature screening desk and N95 masks were not available until nurses reached the COVID-19 unit, even during the early part of the outbreak. Staff who worked on other units were never provided N95 masks, despite the Home's active outbreak status. In addition, many staff had never been fitted for an N95 mask before or during the outbreak. Thus, employees' arrival for the busy dayshift resulted in large employee groups entering the Home without a requirement to wear a mask. Staff members were surprised to discover that the screening process remained mostly unchanged during the outbreak. PCR, rapid tests, and all screenings were still conducted inside the building.

While the Home did not have any Veterans test positive in the Home from March until the end of October, it failed to capitalize on this early success. One staff member noted that there were limited policy changes from March to October, and that he did not think the Home was any more prepared in October than it was in March. As the threat and complications of the virus became more understood—and its severity demonstrated in other IDVA long-term care facilities—the Home was complacent in its operations and never developed any outbreak plans or procedures. Considering the pandemic's effect on the community and other Veterans' Homes within the IDVA, the need for outbreak drills and stress tests became obvious, at the very latest, in October. Yet, the Home failed to appreciate this necessity resulting in unstructured, ineffective, and reactive outbreak

⁷⁶ January 21, 2021 "Isolation/Quarantine Definitions"

management in which staff were not provided sufficient instruction and procedures involving Veteran care and infection control.

d. Communication, Training, Education and Compliance

Communication, training, and staff education are imperative to effective infection control. The severity and novelty of COVID-19 presented some unique challenges in training and educating Home employees, which the Home failed to meet. The virus exposed longstanding communication and training deficiencies within the Home. As discussed below, the Home's leadership failed to effectively communicate, train, and educate its employees on the dangers of COVID-19 and the precautions required to monitor and control the virus within the Home. As a result, some staff members were unaware of general infection control directives contributing to a culture of non-compliance.

e. Ineffective Communication

Communication failures within the Home fostered an environment in which COVID-19 policies were often unknown or not complied with by staff and uncommunicated or unenforced by the Management Team. Some staff stated they felt uninformed of the evolving guidance and policies within the Home, which, according to some staff, seemed to change daily. With guidance constantly evolving throughout the pandemic, consistent, reliable, and transparent communication between the Management Team and staff is critical to ensuring that the Home maintains proper PPE and infection control measures. Yet, as one staff member stated, "communication is a very big problem that we have in this building." Other staff members similarly stated that the Management Team's failure to communicate the daily policies was "frustrating" and "communication was not the greatest." This lack of communication caused staff uncertainty on proper protocols and strained relationship dynamics between the Home's staff and Management Team.

During the pandemic, policies at the Home were disseminated in various manners, including bulletin board postings, signage, policy binders, and email. The Home also conducted daily meetings with some supervisors. For the first few weeks of the pandemic, all supervisors would meet with the Management Team to discuss developments within the Home and information received from the IDVA. These supervisor meetings ceased in April and resumed in late May or early June when some supervisors complained that they felt unapprised of the changing COVID-19 directives and developments. Independent Home departments also met daily to discuss daily plans and directives. Supervisors were expected to convey information from their meetings with the Management Team

to frontline staff at internal department meetings, but not all supervisors communicated the policies to their department's staff.

Additionally, at the early stages of the pandemic, Ms. Mehlbrech held brief meetings one to three times a day, to verbally inform the staff of the evolving policies within the Home. These meetings, however, contained no in-service training and became increasingly less frequent before stopping in the summer.

While the Home had numerous sources of communication, this ultimately led to inconsistent messaging and increased uncertainty on the most current policies rather than redundant, clear communication. Staff's awareness and access to communication sources also varied as some staff were unaware of the bulletin boards, or policy binders, or did not have an email account. For example, many staff members who provide direct care to the Veterans, such as nursing assistants, do not have State email accounts. Other frontline staff members with email access do not regularly check email as part of their daily work duties. Moreover, multiple and stratified meetings—rather than an all-staff meeting—resulted in some staff feeling “left in the dark.” Because the frontline staff members were not present at the supervisors' meetings with the Management Team, the dissemination of any policies or guidance from these meetings depended on supervisors relaying the information to their department staff, creating an erratic game of telephone. This communication method was particularly challenging for departments with changing or interim supervisors. One staff member noted that reliance on supervisors to provide instruction and guidance on daily directives was difficult because “half the time [the staff member] didn't know who [the] supervisor was.”

Ms. Mehlbrech contributed to the Home's disjointed messaging through her communication approach, which involved providing guidance by either phone or email. One member of the Management Team stated that Ms. Mehlbrech would send out “blanket emails” to every staff member and “hope for the best.” Some staff noted that Ms. Mehlbrech rarely interacted with frontline staff and spent most of her time at the Home within her office. Ms. Mehlbrech's detachment did not promote or encourage in-person training and contributed to the communication issues within the Home.

Staff members' misunderstanding and the Management Team's miscommunication are unsurprising given the lack of a defined communications and training structure within the Home. The Home did not have a COVID-19 task force or committee for which leadership and supervisors determined and designated the responsibilities necessary for managing and monitoring COVID-19. Thus, it was unclear who was responsible for various tasks within the Home leading to certain

important tasks left unattended. For example, during the November IDPH onsite visit, it was discovered that the wall-mounted hand sanitizer dispensers set up around the Home contained a non-alcohol-based sanitizer that was less effective against COVID-19. Although the Home had set up separate more effective alcohol-based hand sanitizer dispensers at various locations, the IDPH observed many staff members still using the less effective option. It is unclear from our investigation who was ultimately responsible for ensuring that effective hand sanitizer was stocked and used throughout the Home. What is clear is that no single witness was able to definitively state who was responsible for ensuring that the sanitizer was effective. Regardless of who was responsible for the continued use of the less effective hand sanitizer, this uncertainty is emblematic of larger communication and organizational failures within the Home. As further evidence of the Home's disjointed communication and leadership, some staff members indicated that they were not formally informed of the Home's outbreak status. Some staff members recalled discovering the Home's outbreak status from their coworkers while others learned from the news.

Without a centralized committee or task force within the Home, the Management Team's responsibilities were indefinite. Further, infection control tasks and communication of the same were ignored without accountability. The failure to define duties and responsibilities at a management level was a significant contributing factor to the Home's communication issues and resulting mismanagement of the outbreak.

f. Insufficient Training

In addition to mixed messaging, the Home's communication methods were not conducive to in-service instruction. While there is conflicting testimony concerning the extent employees were trained on COVID-19 policies, the weight of the evidence suggests that training was, at best, inconsistent in form, substance, and frequency. Many staff members stated they never received any training on COVID-19 policies prior to the outbreak. The Home required staff members to complete COVID-19 training provided by Centers for Medicare and Medicaid Services upon the IDVA's recommendation, but the training was generic and not tailored to the Home's operations. On-going COVID-19 guidance was also placed in binders for staff review. It was the various department supervisors' responsibility to ensure that their staff reviewed the materials. Policy review compliance, however, was clearly not monitored. One staff member stated she had never read the policy binders and was never trained on the binder's policies or procedures. Even if reviewed, the policy binders did not always include the most current guidance from the IDVA. Indeed, on one occasion, the Home did not receive detailed COVID-19 policies that were dated September 29, 2020

until December.⁷⁷ The Home has a digital database for policies, but it is infrequently updated and was not a known resource to some staff members.

Training during a pandemic is a substantial and extensive responsibility. However, active instruction and in-service training were not a priority at the Home. Mr. Mize's regular duties include training the Home's staff, but this responsibility became more burdensome during the pandemic. In addition to training, contact tracing was added to Mr. Mize's infection control responsibilities. The increased training obligations and contact tracing were difficult to balance with his regular duties as the infection control nurse, which included wound nursing and general infection control. Some members of the Management Team and staff thought Mr. Mize's responsibilities were too much for one person to effectively manage. Mr. Mize had also struggled to meet some members of the Management Team's expectations for staff development and training before the pandemic. From the Home's Medical Director's observation, Mr. Mize was "over his skis" with the additional pandemic expectations. The increased responsibilities of the pandemic were, in fact, overwhelming for Mr. Mize, and he began to neglect certain responsibilities. For example, Dr. Morrow routinely saw less effective masks, like ones with an exhalation valve, in the Home's supply stock, despite his regular requests that Mr. Mize remove the masks from stock. Moreover, when staff members began informing Mr. Mize of their positive test results during the outbreak, Mr. Mize failed to conduct contact tracing in a systemic, effective manner.

Mr. Mize admitted that more time could have been invested into training, but after a certain point, training became deprioritized as his infection control focus became more reactive than preventive. The Home particularly failed in providing staff members sufficient PPE training, and various departments received no PPE training. The lack of PPE training was highlighted by the Home's handling of N95 mask fit testing. With assistance from St. Margaret's Hospital, Mr. Mize was expected to fit test all employees for N95 masks. However, interviews revealed numerous complications with the fit testing process resulting in some staff members' testing being delayed or failed tests going unresolved. Mr. Mize did circulate a notice for fit testing and signage was placed around the Home reminding staff to coordinate fit tests with Mr. Mize. But when some staff members requested and scheduled testing, Mr. Mize was unavailable and no one at the Home followed up with staff members that were unable to coordinate a test. As of the time of this report, several staff members still have not been fit tested for effective N95 mask usage. Some employees

⁷⁷ See LaSalle Policies regarding Suspected or Confirmed COVID-19 Cases

that did not work in the COVID-19 unit have never worn an N95 mask at the Home and instead wore surgical masks throughout the outbreak.

Even the employees that were fit tested did not wear N95 masks before the outbreak. When fit tested, Mr. Mize informed staff they could not wear N95 masks “until it was needed.” This necessity did not arise until staff arrived to work during the outbreak. The Management Team’s failure to appropriately provide PPE training was a likely contributing factor to the outbreak.

In addition to the infection control risks associated with untested PPE, the lack of fit testing further demonstrated the Home’s failure to prioritize training and follow basic, available infection control guidance. Fit testing presents an opportunity to actively instruct staff on the importance of PPE and procedures for its use. Because many staff members were not fit tested, those staff members did not have the requisite PPE training to safely test and care for Veterans when the outbreak occurred.

During the initial stage of the outbreak, the Home’s policy did not require staff to change PPE, such as gowns and gloves, after exiting a Veteran’s room. As a result, staff wore some of the same PPE as they went room by room conducting rapid tests of every Veteran. This policy was not corrected until observed by the IDPH during its initial November site visit. Other staff members in the COVID-19 unit were observed removing their PPE within the quarantine hall or wearing their masks below their noses. At the time of the outbreak, some staff interacted with coworkers in their office or certain common areas like the activities room without a mask. One staff member recalled interacting with the employee’s supervisor and colleagues in a small common room on November 2, 2020, without masks. That same day, the staff member was sent home with a fever and tested positive the next day. The obvious risks associated with unchanged PPE and interacting with colleagues in any portion of the Home without a mask were either not appreciated by leadership or not properly conveyed to or enforced with the staff.

The lack of training and frequently changing directives resulted in staff members feeling unprepared and ill-equipped to safely provide care and service to Veterans during the pandemic and outbreak. Many attributed this unpreparedness to Mr. Mize’s cursory training approach. Staff members expected more guidance from Mr. Mize. One nurse stated that Mr. Mize rarely interacted with staff on the floor, did not answer questions, and never provided in-service training. Another nurse similarly stated Mr. Mize was dismissive of questions concerning COVID-19 policies and failed to provide any clarification, guidance, or training when asked. Instead, when asked for detail or clarification on a policy, Mr. Mize stated “that’s just the way they told us.”

Prior to the outbreak, the Home procured new IV pumps and suction equipment for the COVID-19 unit. While the Home had the foresight to purchase new equipment in preparation for a dedicated isolation and quarantine unit, this preparation was squandered by a lack of training. When the need for this equipment quickly arose with the outbreak, some nurses and aides did not know how to use the new equipment and were trained only informally by word of mouth amidst the outbreak. Other non-nursing staff members were instructed to assist in the COVID-19 unit without any prior training or guidance.

g. Inadequate Education and Compliance

Insufficient training was further evidenced at the Home by the staff and Management Team's failure to adequately educate staff on the severity and transmissibility of COVID-19. The Home's Medical Director noted that supervisors could have done a better job educating their staff. He attributed this concern partly to the Home's location in a rural community that did not have many personal experiences with COVID-19 for the first several months of the pandemic. He further stated that this unfamiliarity with COVID-19 fostered misconceptions on certain aspects of COVID-19.

At the time of the outbreak, the threat of an asymptomatic individual transmitting COVID-19 was clear in guidance from the CDC.⁷⁸ COVID-19 transmission from asymptomatic individuals has been estimated to account for more than half of all transmissions⁷⁹ Despite this CDC guidance, the Home failed to appreciate the potential of asymptomatic transmission of COVID-19. In the initial days of the outbreak, the Management Team requested multiple staff members report to work or complete a shift after testing positive if they were not exhibiting symptoms. While these staff members ultimately began experiencing symptoms and did not report to work positive, this request showed either unawareness of or indifference to this known transmission threat. Some staff members arrived to work with mild, non-fever symptoms and indicated they were unsure whether they should work. A misunderstanding of symptoms and transmissibility was amplified by the Home's inadequate employee screening process described above. The Home did not have a dedicated screening contact or phone number and the screening desk was frequently left vacated. Thus, without proper education on COVID-19, staff members were unsure of whether their

⁷⁸ <https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html>

⁷⁹ Johansson MA, Quandelacy TM, Kada S, et al. SARS-CoV-2 Transmission From People Without COVID-19 Symptoms. *JAMA Netw Open.* 2021;4(1):e2035057. doi:10.1001/jamanetworkopen.2020.35057

symptoms permitted them to work, and the Home did not provide needed oversight, or an effective screening process.

The IDPH observed non-compliance with masking and social distancing at the Home during its November 12, 2020 onsite visit. Indeed, two weeks into the outbreak, the IDPH noted laxity in masking and social distancing during break periods resulting in opportunities for transmission among staff. The IDPH's visit was at the height of the outbreak.⁸⁰ This concerning disregard of safety and accountability was bolstered by the Home's communication, training, and education failures. The Home's lack of education was a contributing factor to non-compliance during the outbreak.

Like the Home's failure to formulate an outbreak plan, training and communication were inadequate due to a failure to improve upon initial planning and protocols. The Home's initial operation for communicating directives and training staff—including daily administrator, supervisor, and department meetings and dedicated bulletin boards and binders for policies—provided the appropriate framework for effective communication. However, the Home did not critically evaluate the effectiveness and execution of this framework throughout the pandemic. As a result of this communication failure, staff lacked the necessary education leading to policy unawareness and non-compliance. As evidenced by employees gathering without masks in certain areas and PPE noncompliance, the Home's Management Team failed to foster a workplace culture that valued safety and personal responsibility. This culture is partly a product of the Management Team's failure to create a COVID-19 task force or committee within the Home. There were also undefined responsibilities and insufficient accountability within the Management Team, which resulted in insufficient direction throughout the Home.

Notably, the Home's communication, training and education failures are not relevant only to COVID-19. Even as the health community continues to better understand and manage COVID-19, the threat of similarly dangerous infections is constant at long-term care facilities. As a result, these fundamental failures must be corrected as part of a more comprehensive infection control plan within the Home.

⁸⁰ Although some initial news reports indicated that a number of LaSalle Home employees who tested positive for COVID-19 were at the same off-site Halloween party, see, e.g., (CHRIS COFFEY/NBC5 CHICAGO; <https://www.nbcchicago.com/news/local/investigations-underway-after-28-veterans-die-in-coronavirus-outbreak-at-illinois-va-home/2383007/>), our investigation did not uncover any evidence suggesting that a Halloween party was a material contributor to the COVID-19 outbreak at the Home.

h. Challenges with Interpersonal Dynamics

Communication and training issues were made more difficult by relationship dynamics among staff, department supervisors, and the Management Team within the Home. Communication and interpersonal issues between staff and supervisors, placed the Home in a difficult position to implement COVID-19 policies. Many staff members were critical of the Home's Management Team and department supervisors in the months leading up to the outbreak. Several staff members indicated that the Home's Management Team did not understand and appreciate staff members' daily responsibilities and were not receptive to staff's proposed policy changes. Supervisors were also frustrated with the staff noncompliance described above.

Staff was particularly critical of Ms. Mehlbrech's disengagement throughout the pandemic. She was rarely seen at the Home and often remained in her office. Ms. Mehlbrech did not hold any meetings with nurses. Ms. Mehlbrech's interim replacement, Anthony Vaughn, noted that after joining the Home's administration, one staff member informed him, "I'm glad you're here, because I haven't talked to Angela in six months." In addition to issues with staff, Ms. Mehlbrech did not always have a productive working relationship with other members of the Management Team.

Department supervisors were also criticized for their lack of engagement and communication throughout the pandemic. One supervisor was criticized for providing inconsistent or incorrect PPE policies. The same supervisor was often observed not complying with the Home's procedures and protocols. Another supervisor, who has since been replaced, was described as detached throughout the pandemic and never provided the department's staff with any information or instruction concerning COVID-19.

Supervisors were also critical of certain staff members, noting that it remains a constant struggle to ensure staff's compliance with policies and procedures. But some supervisors reported feeling limited in their disciplinary options and further stated they are sometimes reluctant to impose discipline on staff for PPE compliance for fear that staff members may retaliate against them.

Staff and supervisors' attempted enforcement of policies and procedures appear to be obstructed by the Home's reporting structure. According to staff, when staff members seek to hold supervisors accountable for violating the Home's policies and procedures, they have two options: (1) inform a supervisor or (2) inform the Home's union representative. In addition, a supervisor must consider each disciplinary action with the fear of retaliation from the non-compliant staff member. Neither the Home nor IDVA have an internal affairs officer.

B. Observations and Concerns Outside of the Home

The Home's inadequate COVID-19 response was also caused by corresponding failures in IDVA leadership at the executive leadership level. These issues included the consolidation of too many responsibilities in one individual, the failure to delegate and assign clear responsibilities, the failure to learn from outbreaks at other long-term care facilities—including other Illinois Veterans' Homes, the failure to effectively communicate, and the failure to identify, seek, or accept external resources.

1. The IDVA Executive Structure

The IDVA is an executive agency under the jurisdiction of the Governor.⁸¹ Besides managing Veterans' Homes, the IDVA offers two other services through field offices around the state: (1) it provides Veterans assistance with obtaining federal and state Veteran benefits, and (2) it partners with other agencies and non-profit organizations to help Illinois Veterans with their education, mental health, housing, and employment.

The IDVA's structure is somewhat unclear in terms of roles and responsibilities, due in part to several vacancies in the organization. Under the Director, there is an Assistant Director position, and a Senior Home Administrator position that is currently vacant. According to the organizational chart, the Chief of Staff oversees ten positions, including the Field Services Manager, and reports directly to the Director. A Human Resource Manager, a Chief Internal Auditor, and Chief General Counsel, among others, also directly report to the Director.

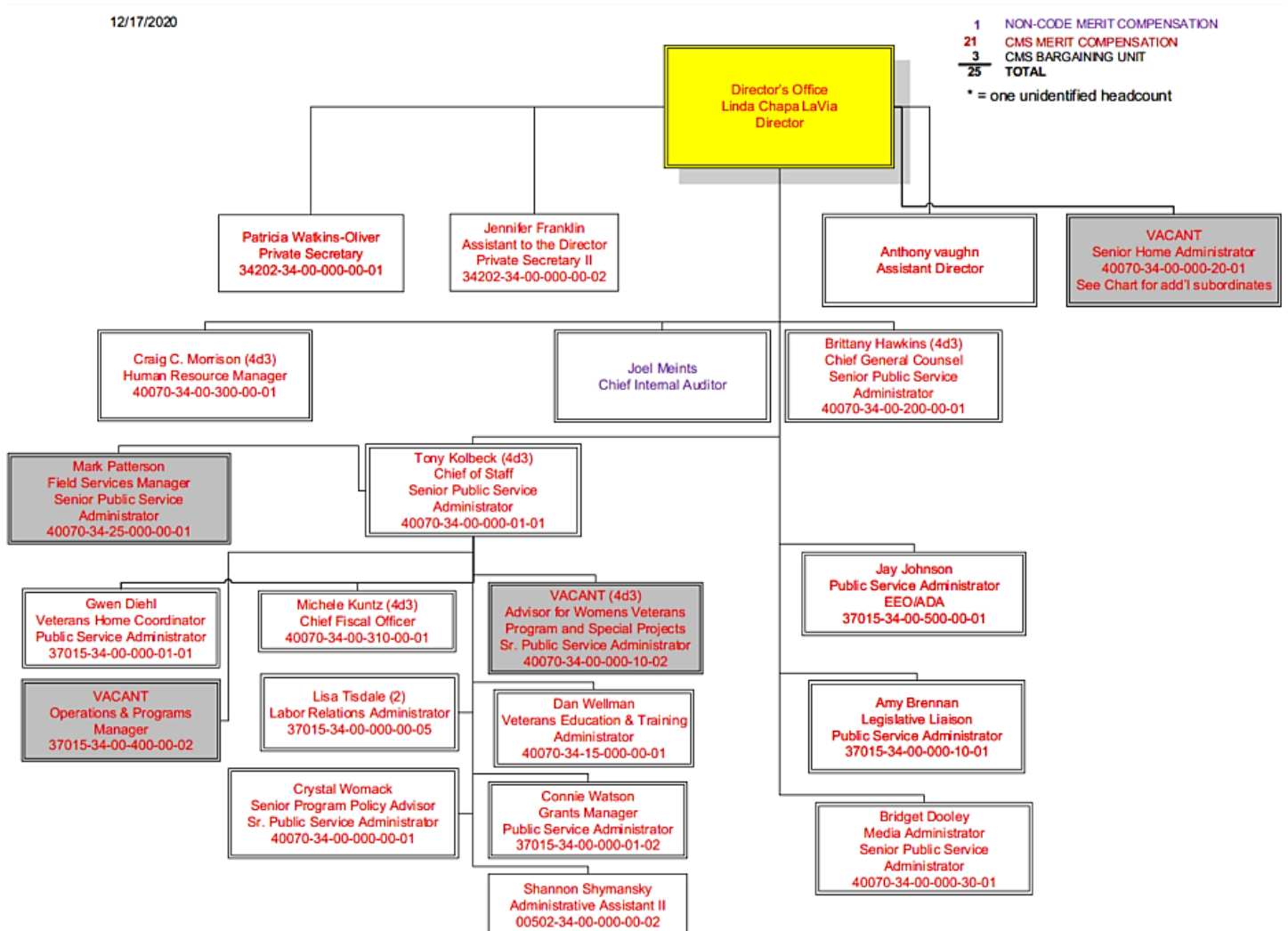
In January 2019, Governor Pritzker appointed Ms. Chapa LaVia as the IDVA's Acting Director. Mr. Kolbeck served as her Chief of Staff and Anthony Vaughn served as her Assistant Director.

Several witnesses noted that Ms. Chapa LaVia was not a hands-on or engaged day-to-day Director and that Mr. Kolbeck managed the agency. Mr. Kolbeck stated that he "was generally making decisions for the IDVA" and handled its day-to-day operations. Mr. Vaughn confirmed Mr. Kolbeck's involvement, observing that it was as if Ms. Chapa LaVia had "abdicated" her authority to Mr. Kolbeck. Mr. Kolbeck described his directives as ultimately being on behalf of the Director, which provided him similar control and authority over the Homes' operations. Indeed, the organization structure offers little oversight over the Chief of Staff or Assistant Director positions, other than the Director herself, and no reporting relationships to the Assistant Director (except for a

⁸¹ <https://www2.illinois.gov/veterans/about-us/Pages/default.aspx>

secretary). Responsibilities are not evenly distributed, and there are few, if any, checks on decision-making. Managing the Veterans' Homes requires someone at the executive level of IDVA to have the medical understanding to provide meaningful leadership. The Senior Homes Administrator position would ideally meet that need, but it has been left vacant for approximately two years—leaving others, like Mr. Kolbeck, who was effectively functioning as Chief of Staff, Director, and Senior Homes Administrator, to try to fill in the gap.

As of December 17, 2020, IDVA's chain of command was as follows; no one in that senior chain of command had any long-term care experience:



The Chief of Staff's specific position within the organization's hierarchy is unclear in the chart above, which was confirmed by Mr. Kolbeck and Mr. Vaughn. The job description includes:

- overseeing “all coordination on Veterans’ Home policies and procedures,”
- “formulating policy on Agency programs and benefits,”
- “continual analysis of organizational functions and programs, making recommendations in problem areas,”
- implementing new IDVA initiatives and programs,
- integrating and coordinating all management planning functions,
- providing guidance for regulatory impact,
- conducting studies on IDVA programs and benefits,
- developing summary reports for the Director’s use at the Governor’s cabinet meetings, IDVA staff meetings, and legislative hearings,
- supervising and counseling staff,
- approving time off,
- recommending and issuing discipline,
- representing the Director and the Department at the state and federal level, and
- any “other duties as required or assigned.”⁸²

At the time of the outbreak, Mr. Kolbeck was also covering the duties of the Senior Home Administrator, since that position had been vacant for nearly two years. The Senior Home Administrator role was created in 2013, when the IDVA determined that it needed someone at the executive level who could oversee day-to-day operations at the Homes, be a primary IDVA contact for the Homes, and work toward standardizing policies and procedures across the Homes. The most recent Senior Home Administrator had been an administrator at one of the Homes. However, the position has been vacant since that Administrator retired in 2019.

Mr. Kolbeck stated that the Senior Homes Administrator position requires approval from the Governor’s Office, so while the IDVA conducted several rounds of interviews and selected a candidate in late 2019, Mr. Kolbeck stated the Governor’s Office did not approve that candidate.

⁸² Illinois Department of Central Management Services, Form No. CMS-104, Position Description for Position Number 40070-34-00-000-01-01, Chief of Staff of the IL Department of Veterans’ Affairs (Aug. 28, 2020).

The IDVA eventually reposted the position, but this process was deferred because Mr. Kolbeck did not believe he had time to conduct interviews during the pandemic. In addition, Mr. Kolbeck’s stated his philosophy regarding filling this role has been that a vacancy is better than having the wrong person. Mr. Kolbeck acknowledged that it “absolutely” would have been beneficial to have a Senior Homes Administrator with a clinical background during the pandemic, but it was not a priority to IDVA officials at the time. Ultimately, Mr. Kolbeck could have delegated this hiring process to others, such as the Human Resources Director, but elected not to do so.

As a practical matter, this meant that Mr. Kolbeck, who does not have experience in long-term care, infection control procedures, or medicine in general, was the de facto Senior Homes Administrator when the pandemic started. Anthony Vaughn, the Assistant Director, managed the other arms of the IDVA. It also meant that policy changes suggested in the 2019 Tetra Tech audit,⁸³ which would have been handled by the Senior Homes Administrator, went unaddressed. Indeed, Mr. Kolbeck noted that the changes suggested in the audit, especially those related to policy-making, were expected to be handled by the Senior Homes Administrator. He stated that without a Senior Homes Administrator, the policies and other changes suggested by the audit were not implemented.

The overlap of positions seemed to be a running theme among management both within the Home and at the IDVA—too many vacancies in management have meant that executive officers, administrators, supervisors, and other managers have been expected to cover two or even three positions at once. The coverage of vacant positions makes it difficult to effectively meet the increased demands created by the temporarily consolidated roles, leaving administrators and other managers with too many responsibilities to effectively lead.

In addition, while both state and federal guidelines mandate that each Home have an “advisory physician”⁸⁴ or “medical director,”⁸⁵ it does not appear that the IDVA consulted these individuals in managing the Homes, or provided these individuals with any meaningful role in COVID-19 or other infection control policymaking.

⁸³ 2019 Tetra Tech Audit:

<https://bloximages.chicago2.vip.townnews.com/thesouthern.com/content/tncms/assets/v3/editorial/e/5a/e5aeded6-c54b-565a-971a-690dd4f2dd23/5cfc1b4323e61.pdf.pdf>

⁸⁴ <https://www.ilga.gov/commission/jcar/admincode/077/077003400B13000R.html> (Section 340.1300 Facility Policies)

⁸⁵ 38 CFR 51.210, 340.1300

2. Internal IDVA Communication

Communication between the central IDVA office and the Homes was often unproductive, and expectations were undefined. The IDVA assumed that each Home would develop its own COVID-19 policies, but it failed to communicate this expectation to the Homes or and failed to provide guidance, deadlines, or resources for implementation. This lack of guidance persisted in the face of an outbreak at the Manteno Home in mid-2020, as well as the 2019 report that instructed IDVA to standardize policies across its four Homes. IDVA failed to respond to these direct and indirect calls for change.

This was not for want of opportunity. Early in the pandemic, around March 2020, the IDVA began holding daily internal calls related to COVID-19. Mr. Kolbeck led the meetings, which were also attended by Ms. Chapa LaVia, Mr. Vaughn, the Homes' Administrators, and, at the Administrators' discretion, their Director of Nursing or Infection Control Nurse. At these meetings, the Homes' Administrators would discuss any positive test results, provide updates on other events of note at each Home, and address any questions or concerns. Sometime over the summer, the calls were reduced from daily to three times a week, on Monday, Wednesday, and Friday. Mr. Kolbeck repeatedly informed the group that they could contact him at any time and gave them the phone numbers to both his state and personal phones. He often acted as the middleman in communicating with other agencies. As both the Chief of Staff and as the de facto Senior Homes Administrator, Mr. Kolbeck had significant influence over the Homes' operations.

Mr. Kolbeck was the point of contact with IDPH, although that role would have been filled by the Senior Homes Administrator if IDVA had hired one. He provided daily reports to IDVA leaders and to IDPH in the form of an elongated email that was described by some as difficult to understand. It is unclear if anyone at IDVA or IDPH was required to analyze the data, and the form of the email made any meaningful analysis impractical, especially for individuals already responding to developing and uncertain issues during the pandemic.

Mr. Kolbeck stated that from the onset of the pandemic in March 2020 until December 2020, no one from the IDVA visually inspected the Homes in person, by video, or otherwise. This informal policy was not written, but IDVA officials believed the risks outweighed the benefits because they were not medical professionals. However, they failed to use their resources to send individuals who *were* qualified to inspect the Home for its COVID-19 response practices. Instead, IDVA officials relied on the Monday, Wednesday, and Friday calls to understand what was happening at the Homes, and ultimately put substantial onus on the Homes' Administrators. As Mr.

Kolbeck stated: “at the end of the day, the Home Administrator is in charge of that home . . . they’re responsible for their facility,” further noting that “it’s the Administrator’s license on the wall”—not anyone on the Leadership Team. This was echoed by Assistant Director Anthony Vaughn, who noted that decisions about what happened at each Home were ultimately left up to that Home’s Administrator. The only time Mr. Kolbeck eventually went in person to the Home during the pandemic and prior to the outbreak was to terminate Ms. Mehlbrech on or around the beginning of December, 2020.

The Leadership Team was not only physically absent, they also were not providing frontline staff with cohesive directives or guidance related to COVID-19. Mr. Kolbeck explained that he could not stop staff from eating lunch together, though he admitted that Homes’ Administrators answer to him. While Mr. Kolbeck could not physically require staff to comply with social distancing and PPE requirements, he also took no steps to ensure staff was being effectively educated on best practices, nor did he create a culture of safety and compliance among all employees. Thus, staff was not seeing leadership outside of the Home, or any consequences for noncompliance with social distancing practices. No one at IDVA was specifically tasked with monitoring changes in CDC recommendations or analyzing the responses of other nursing homes with COVID-19 outbreaks. At a time of crisis, no one at IDVA was taking ownership of the situation, let alone teaching, supervising, or inspiring employees across the Homes. This is despite clear guidance available from the CDC and CMS on COVID-19 prevention and control in nursing homes by the summer of 2020, and clear guidance from the VA regulations about required infection control practices.⁸⁶

Even if it was not actively looking for information on best infection control practices from the CDC, the IDVA could have learned from the COVID-19 outbreak that occurred in the Manteno Veterans’ Home in mid-2020. In particular, IDVA could have made or at least overseen changes in its communications and operations to prevent similar outbreaks in the three other IDVA Homes. Despite the events at the Manteno Veterans’ Home, recommendations from the CDC, and regulations from IDPH governing nursing homes in general,⁸⁷ the Home had few or no formal written policies specific to COVID-19 before the outbreak in 2020. IDVA could have required its Homes to develop COVID-19 policies, supervised and managed the process of COVID-19 policy development, and required a qualified individual to vet or approve these policies. Instead, the IDVA

⁸⁶ CDC Reports, *supra*, and 38 CFR 51.190

⁸⁷ Ill. Adm. Code 300.

expected the four Homes to prepare specific guidance for staff, keep track of CDC recommendations, and create their own plans, all independently of one another.

This lack of leadership, coupled with Mr. Kolbeck's significant oversight, created gaps in the Home's infection control protocols. For example, according to Mr. Kolbeck IDVA would not "get into the weeds" of how infected Veterans might be moved from one location to another, but expected the Homes to independently develop and follow an outbreak plan. Mr. Kolbeck stated his role was to give direction and guidance when questions were asked. At the same time, Mr. Kolbeck apparently expected the Homes to run policy changes through him. While he stated that the Homes do not "absolutely have to" seek his approval for new policies, this was inconsistent with the experience of at least one member of the Management Team at the Home, who had tried to change a policy but had been informed that it would require IDVA approval.

The Home received mixed messaging: could it really implement its own policies, or did it need to run policies by Mr. Kolbeck? Were they supposed to have a plan already in place, or would further guidance be coming from the Leadership Team? Mr. Kolbeck expected the Homes to implement policies and manage the day-to-day operations, while at the same time, expecting the Homes to submit policies for his approval and providing the Homes with communications from other agencies. This confusing state of affairs left the Home's staff uncertain and unprepared to manage the pandemic's varying circumstances.

Funneling all proposed policies to Mr. Kolbeck was also problematic because Mr. Kolbeck does not have a medical background. He often did not understand or was not aware of best infection control practices. For example, before the outbreak, Mr. Kolbeck incorrectly believed that the guidance was to test staff once a week until there was a positive Veteran or staff member, and to test Veterans every two weeks. This remained unchanged in the face of increasing community incidences of COVID-19. Similarly, Mr. Kolbeck acknowledged that he did not recognize that the positive results at the Home were a real problem until November 9th or 10th, even though the Home already had more than 20 cases on November 3. The same was true for Mr. Vaughn, who said that he did not appreciate the numbers until November 13, 2020, when Mr. Kolbeck prepared his usual email report in a spreadsheet for the first time, rather than in narrative text. By November 9th, the Home had more than 60 positive cases. By November 13, 10 Veterans had died. Given this data, Mr. Kolbeck's delayed reaction was inexcusable and contributed to the prolonged nature of the outbreak.

3. The Response to the Outbreak

From the beginning, the Management and Leadership Teams were slow to recognize that there was a problem and slow to ask for assistance. On October 31, 2020, Ms. Mehlbrech called Mr. Kolbeck to report that the Home had a positive Veteran. Overnight, the Home received additional positive results. Mr. Kolbeck emailed Dr. Counard at IDPH the next day, detailing the initial positive results that had been received that day and the steps taken at the Home and did not request assistance. Ms. Mehlbrech reported the initial positive test to the VA on November 2, 2020, and similarly did not request assistance.

The IDVA continued its daily calls during the outbreak. According to Mr. Vaughn, Ms. Mehlbrech never expressed a request for more workers or communicated the severity of the Home's outbreak in the daily calls in November. One employee of the Home admitted that "no one even considered calling IDVA or IDPH." Mr. Kolbeck continued to report numbers to IDPH and the VA. He said he assumed that IDPH would reach out if it thought there was a problem. IDPH, on the other hand, expected the IDVA to identify if it had a problem and to use IDPH as a resource. According to witnesses, the IDPH and the VA generally only visit facilities in response to complaints or a specific request for assistance. Neither Mr. Kolbeck nor Ms. Mehlbrech received any guidance about when the Home could or needed to escalate its response and seek additional resources.

On Saturday, November 7, Mr. Kolbeck emailed the IDPH lab director and Dr. Counard informing them of a significant outbreak and that additional PCR tests were being delivered over the weekend. Again, no request for assistance was made. That Monday, November 9th, the Home had more than 60 positive cases. Dr. Counard, IDPH infection control staff, and the IDVA Leadership Team had a virtual meeting in what Mr. Kolbeck described as a touch base on IDVA Homes. Later that day, Mr. Kolbeck emailed Dr. Counard to request that IDPH conduct an onsite consultation at the Home to assist with infection control. Unbeknownst to Mr. Kolbeck, the VA had also reached out to Ms. Mehlbrech that day and offered assistance. After attempts to reach Ms. Mehlbrech, an offer was made to arrange an onsite consultation. The VA had asked Ms. Mehlbrech about staffing needs, and she made no request for assistance at that time. Ms. Mehlbrech and Mr. Kolbeck did not communicate about these requests to each other and were unaware that the other had set up an onsite visit.

According to Mr. Kolbeck, he received a call from the Deputy Governor in early November, who coordinated the delivery of rapid COVID-19 tests to the Home. To Mr. Kolbeck's knowledge,

the BinaxNOW rapid COVID-19 tests were unavailable sooner than early November. However, the federal government purchased the first 150 million Abbott BinaxNOW diagnostic tests on August 27, 2020, for distribution to governors across the United States.⁸⁸ The company began to distribute millions of tests in September 2020, ramping up to 50 million tests a month at the beginning of October—well before the outbreak.⁸⁹ For example, Veterans’ Homes in Missouri received their first shipment of the BinaxNOW test on October 2, 2020.⁹⁰ While it is unclear at what point the Home *could* have received the BinaxNow tests in Illinois, the Leadership Team did not appear to be monitoring available resources or strategies taken by other facilities.

On November 11, infection control staff from IDPH contacted Ms. Mehlbrech and Mr. Mize to review their responses to the outbreak. IDPH infection control staff reported to Dr. Counard at IDPH and Mr. Kolbeck at IDVA that the Home’s current processes were “sound,” that Mr. Mize “was able to clearly articulate procedures for separating residents,” and that the Home had made some helpful adjustments in policies.⁹¹ Mr. Mize also reported that he “feels they are doing okay and doesn’t feel the need for someone to visit.”⁹² Later the same day, however, the Home had 12 more positive tests.⁹³

On November 12, IDPH infection control staff performed an onsite inspection. The same day, Amelia Bumsted, a board-certified, infection-control nurse practitioner from the VA, performed the VA’s onsite consultation. She suggested immediate corrective actions and then submitted a report on November 16.⁹⁴

By November 13, 10 Veterans had died. Significant resources were waiting and available to assist the Home if individuals on the Management or Leadership Teams would have asked. Mr. Kolbeck was even uniquely positioned to receive help from other agencies. He had worked with the Director and Assistant Director of the Illinois Emergency Management Agency (“IEMA”) for ten

⁸⁸ <https://www.hhs.gov/about/news/2020/10/25/states-begin-detailing-specific-use-150-million-binaxnow-covid-19-tests-distributed-trump-administration.html>

⁸⁹ <https://abbott.mediaroom.com/2020-08-26-Abbotts-Fast-5-15-Minute-Easy-to-Use-COVID-19-Antigen-Test-Receives-FDA-Emergency-Use-Authorization-Mobile-App-Displays-Test-Results-to-Help-Our-Return-to-Daily-Life-Ramping-Production-to-50-Million-Tests-a-Month>

⁹⁰ <https://governor.mo.gov/press-releases/archive/governor-parson-orders-external-review-missouri-veterans-homes-regarding>

⁹¹ Nov. 11, 2020 Email from Karen Trimmerger to Dr. Counard and Mr. Kolbeck.

⁹² Nov. 11, 2020 Email from Karen Trimmerger to Dr. Counard and Mr. Kolbeck.

⁹³ Nov. 11, 2020 Email from Mr. Kolbeck to Dr. Counard.

⁹⁴ <https://www2.illinois.gov/veterans/Documents/11-24-20%20LaSalle%20Reports%20Release2.pdf>

years in his prior roles in government. The IEMA coordinates the State's response to and recovery from emergencies by activating, deploying, and employing State resources.⁹⁵ However, Mr. Kolbeck never reached out to IEMA for help with the outbreak at the Home. Quite the reverse: IEMA personnel, according to Mr. Kolbeck, recognized the emerging situation and called Mr. Kolbeck in early November to ask if IDVA needed any assistance. Even at that point, Mr. Kolbeck declined, saying that by the time IEMA could mobilize (which Mr. Kolbeck assumed without confirmation from IEMA would be approximately five days), IDVA would be on the other side of the crisis. Furthermore, Mr. Kolbeck felt that the assistance would be meaningless because they could not provide nursing staff.

Mr. Kolbeck's failure to appreciate the significance of the circumstances and the resources required prevented the Home from accessing them—even though these needed resources were readily available. IEMA persisted, and eventually, on December 10, 2020 (a month after the outbreak and IEMA's initial willingness to assist), the Illinois National Guard arrived at the Home to assist with screening employees, administering tests and tracking testing data, and making sure that PPE was worn properly.⁹⁶ This help allowed nurses to focus on Veterans' care.⁹⁷ The National Guard provided valuable assistance for nearly four months—clearly, their help was needed.

While federal resources were not as immediately available, they were similarly untapped by the Management and Leadership Teams. The VA's VISN 12 has a liaison that works with the LaSalle and Manteno Homes. At one point, VISN 12 informed IDVA it could help with pandemic staffing and PPE resources once State resources were used up. According to Mr. Kolbeck, VISN 12's position on this changed at some point during the pandemic, but no one reported ever seeking this kind of federal assistance.

Information flowed to Mr. Kolbeck and from Mr. Kolbeck, who acted as a gatekeeper for the Home with other agencies. However, Mr. Kolbeck did not believe there was a problem at the Home until November 9, when the outbreak was already significant and increasing. No one at IDVA, including Mr. Kolbeck, was meaningfully tracking data from week to week. The Leadership Team did not appear to have appreciably learned from the outbreak that had already occurred in Manteno, which had shown them how significant a single Veteran infection can be and how quickly

⁹⁵ <https://www2.illinois.gov/iema/About/Pages/default.aspx>

⁹⁶ https://qctimes.com/news/state-and-regional/govt-and-politics/national-guard-sent-to-help-staff-at-lasalle-two-other-veterans-homes/article_84372bc2-136d-5f73-a22d-61ed026c68eb.html

⁹⁷ <https://www.nprillinois.org/post/national-guard-staff-sent-lasalle-quincy-veterans-homes-after-outbreaks>

it can spread. Instead, the Leadership Team was apparently relying on IDPH to let them know when they needed to sound the alarm bells, when the Leadership Team should have appreciated what was happening in real time to sound those bells themselves.

Once the Home had the resources and leadership it needed—first from IDPH, and later from IEMA, the National Guard, and Acting Administrator Anthony Vaughn and Acting Director of Nursing Danielle Vanko—the outbreak was controlled.⁹⁸

V. RECOMMENDATIONS

We make the following recommendations to help prevent a future outbreak of this severity at the Home.

A. Root Cause: Inadequate Policies, Education and Training

1. Corrective Action: Create centralized policies and develop outbreak drills and stress tests

While the Home had a general infection control policy before the pandemic, it made no changes to this policy to account for COVID-19, and did not create a standalone COVID-19 infection control policy. The Home failed to adapt its policies as the pandemic developed and did not execute and educate staff on prevailing COVID-19 directives. This was despite receiving audit guidance that this was a problem in 2019 and despite a COVID-19 outbreak that occurred several months prior in IDVA's Manteno Veterans' Home. The IDVA's purpose is to provide oversight for the Homes, not to leave the Homes to their own devices because "it's the Administrator's license on the wall" and not IDVA's—especially when the Homes' Management Teams have full-time roles managing the Home's day-to-day needs.

IDVA should work with the Homes to create centralized policies. IDVA and the Homes should continually revisit their guidance on testing Veterans and staff and on PPE usage standards, as new information becomes available or testing guidance from the CDC evolves. For example, under current CDC recommendations, a Home's testing strategy should escalate and deescalate as the community prevalence of COVID-19 in the area increases and decreases.

It is not apparent that the Home's general infection control policy was followed. There was a deficiency in written policy and active training. There was an apparent lack of centralized written

⁹⁸ Since November, IDPH has visited the Home seven times in response to complaints. The Home required corrective actions in its initial visit but has required no corrective actions since.

policies that staff could reference to be assured that the most current procedures were being followed. An electronic policy handbook available to all staff would provide an efficient way for management to update and staff to stay apprised of the Home's operative policies and procedures.

The IDVA and the Home should develop immediate response checklists that can be executed by any member of the Home's Management Team if the Home receives a report of a COVID-19 positive staff and/or resident. In developing the immediate response checklist, at a minimum, the IDVA and the Home must consider and address: (1) additional PPE protocols which address when an elevation of PPE is necessary and under what circumstances, (2) isolation/quarantine decisions, (3) testing protocols, (4) spot cleaning and other environmental hygiene considerations, (5) notification of all relevant stakeholders including staff and Veterans' families; and (6) standardized contact tracing and documentation.

In addition, because infections affect communities in different ways, the Home and IDVA should emphasize more regular monitoring of community infection data. Evidence suggests that the responsibility of monitoring COVID-19's effect on the surrounding community fell on the Home's Administrator. However, the extent and detail of this review process were unclear. A more structured approach should consider, at a minimum: the community positivity rates; the case status of other IDVA Homes; whether there is adequate staffing; whether there is access to adequate testing; and whether there is access to adequate PPE for staff.

The Home would also benefit from a more expansive and functional training program that includes drills and demonstrations of the policies. For example, like a fire drill, scheduled exercises of various outbreak procedures would both serve as an education to staff and a stress test of the policies. Had testing or drills been in place at the Home, the various policy inefficiencies the outbreak revealed may have been identified and remedied.

2. Corrective Action: Educate staff on the importance of quality infection control for any infection

Certain non-compliance with established infection control principles was attributable to a lack of education. As noted above, some staff members arrived to work with symptoms unsure whether they should report to work. The Home also reused some forms of PPE across multiple Veterans' rooms in contradiction with basic infection control protocol. By November 2020, these incidents were avoidable had staff been properly educated on infection control and on COVID-19 in particular.

While COVID-19 presented a unique, developing situation, the Home and IDVA struggled to appreciate the importance of tailoring their general infection control response to COVID-19. Staff should be educated on the importance of ongoing education for any future infections and develop an understanding that different infections require different responses. For example, the Quincy Home experienced a separate infection of Legionnaire’s Disease in December 2020, which co-existed with COVID-19 cases that were appearing in that Home. Staff should understand that quality infection control must be adapted to the infection at hand.

This kind of training is important to combat any tendencies for defeatism among staff. If staff understand what other long-term care facilities are doing and understand that specific protocols can effectively combat specific infections—COVID-19 or otherwise—they are likely to remain more vigilant about complying with basic infection control measures. Leadership and Management teams should understand and model the same behavior.

3. Corrective Action: Integrate the standards for long-term care facilities, at least in part, into the Veterans’ Home Code

The Veterans’ Homes are subject to one chapter of the Illinois Administrative Code, while other long-term care facilities are subject to another. During the pandemic, other long-term care facilities received helpful instructions and guidance in the form of emergency rules. The Veterans’ Home Code, on the other hand, received no meaningful emergency rule. The State should consider incorporating many of the standards and controls of the Long-Term Care Code into the Veterans’ Home Code so that Veterans’ Homes are expected to provide the same quality of care and meet the same standards as long-term care facilities, as the data reflects that three out of the four Veterans’ Homes in Illinois experienced major COVID-19 outbreaks. While less under the State’s control, the VA certification process has similar gaps in oversight and does not hold Veterans to the same standards as nursing homes regulated by CMS.

4. Corrective Action: Develop an infection control task force or committee within the Home

The Management Team’s responsibilities during the outbreak were undefined leaving certain duties unattended and causing staff uncertainty on infection control policies and procedures. Failure at the Management Team level affected policy development, training, and communication with staff concerning management, prevention, and control of COVID-19. The creation of an infection control task force or committee within the Home that includes management, supervisors, and staff

would help create universal infection control policies and procedures with consideration for all Home departments. It would help prevent the situation that occurred during the Home's outbreak, where there was a lack of clarity as to who was responsible for which duties and tasks. It would also minimize the opportunity for any gaps in the Home's response, ensuring, for example, that basic procedures like contact tracing were being effectively implemented.

Development of this committee would promote communication and accountability throughout the Home by establishing clear responsibilities for infection control both within the Management Team and amongst staff and supervisors. The committee could meet regularly and discuss ongoing COVID-19 management and prospective infection control issues. This committee would also benefit from incorporating related external perspectives. Thus, the infection control task force or committee could coordinate with similar nursing homes or long-term care facilities in the surrounding area to remain apprised of community considerations and practices.

B. Root Cause: Lack of clarity regarding inter-agency reporting and responsibilities

1. Corrective Action: Establish and clearly communicate thresholds for when IDPH visits the Home

Mr. Kolbeck and the Leadership Team assumed that because they were reporting data to IDPH that IDPH would let them know when numbers at any of the Veterans' Homes were a cause for concern. The Management and Leadership Teams at the Home, as well as individuals we interviewed at IDPH, struggled to identify who was responsible for what duties, and at what point. To avoid this "bystander effect," where each agency assumes the other is responsible, there should be clear thresholds understood by both IDPH and IDVA about when IDPH will escalate its involvement. This could involve a formal request for assistance by IDVA, but there should be a procedure in place, and some event that triggers this response regardless of whether it is requested. A clearer understanding of when IDPH will provide additional infection-related assistance will benefit both the Home and the IDVA as a whole.

C. Root Cause: Poor staff and management relations and accountability

1. Corrective Action: Provide a suitable independent outlet for escalating internal complaints

Certain difficulties are always expected among line staff and management in any workplace. However, the tension between frontline staff and management within the Home was especially

apparent from the interviews and has resulted in a less productive and accountable work environment. Notably, staff and management expressed concerns with the current recourse provided for complaints made within the Home. Staff reported they are limited to internal reporting to supervisors or seeking help from a union representative. Supervisors currently fear that disciplining staff will result in retaliation and false reports. IDVA should engage with the appropriate stakeholders to ensure that there is a suitable outlet to escalate and independently and objectively address both supervisor and employee complaints and concerns.

D. Root Cause: Overworked and clinically inexperienced leadership:

1. Corrective Action: Create temporary positions or consultancies to ensure essential positions do not remain unfilled

The Senior Homes Administrator is a critical position for the IDVA's effective management of the Homes. While the IDVA wants to find a good fit for the position, it cannot leave the position open indefinitely. Because the Senior Homes Administrator is the only position at the IDVA that requires experience in a long-term care setting, filling it should be a priority. IDVA cannot effectively lead the Homes if those making top-level decisions lack long-term care experience or are not being advised, at a high level, by people with such experience. Until the Senior Homes Administrator position is filled, whether through a temporary or emergency hire, a short-term personal service contract, or procurement of a consultant, the IDVA should take steps to ensure that a qualified, clinically-experienced individual is involved in decision-making.

2. Corrective Action: Require one Veterans Advisory Council member to be appointed by IDPH

Currently, the Veterans Advisory Council is made up of several individuals appointed by legislators, Veterans organizations, some State officials, and some State agencies. The Council would benefit from also including at least one member with clinical or long-term-care experience who can advise the IDVA on matters of importance to the Homes. An appointment by IDPH, for example, might give the Council the clinically experienced liaison it needs for meaningful oversight on decisions being made for the Homes.

E. Root Cause: Failure to adopt recommendations of the 2019 health and safety audit:

1. Corrective Action: Adopt the recommendations of the audit and succeeding interagency memo as soon as possible.

The outbreak at the Home could not have come as a surprise to the health and safety auditors who evaluated the Veterans' Homes in 2019 and recommended that the Homes implement a standardized policy structure to ensure the health and safety of Veterans and staff at the Homes. IDVA, though, failed to take the corrective actions required. The IDVA should make this a priority, and it should take immediate steps to adopt the interagency memo dated March 9, 2021, which incorporates the recommendations made in 2019 and adds additional recommendations: reorganize infection prevention as a standardized, coordinated effort across the organization; expand system capacities for infection prevention, better educate infection preventionists and prepare them to be interdisciplinary team members; strengthen staff-wide training; monitor adherence to policy and procedure and promote active, shared staff participation; and engage top management directly with frontline staff. Another audit should be scheduled within one year, with annual or otherwise regular audits to ensure the Homes are compliant and prepared.

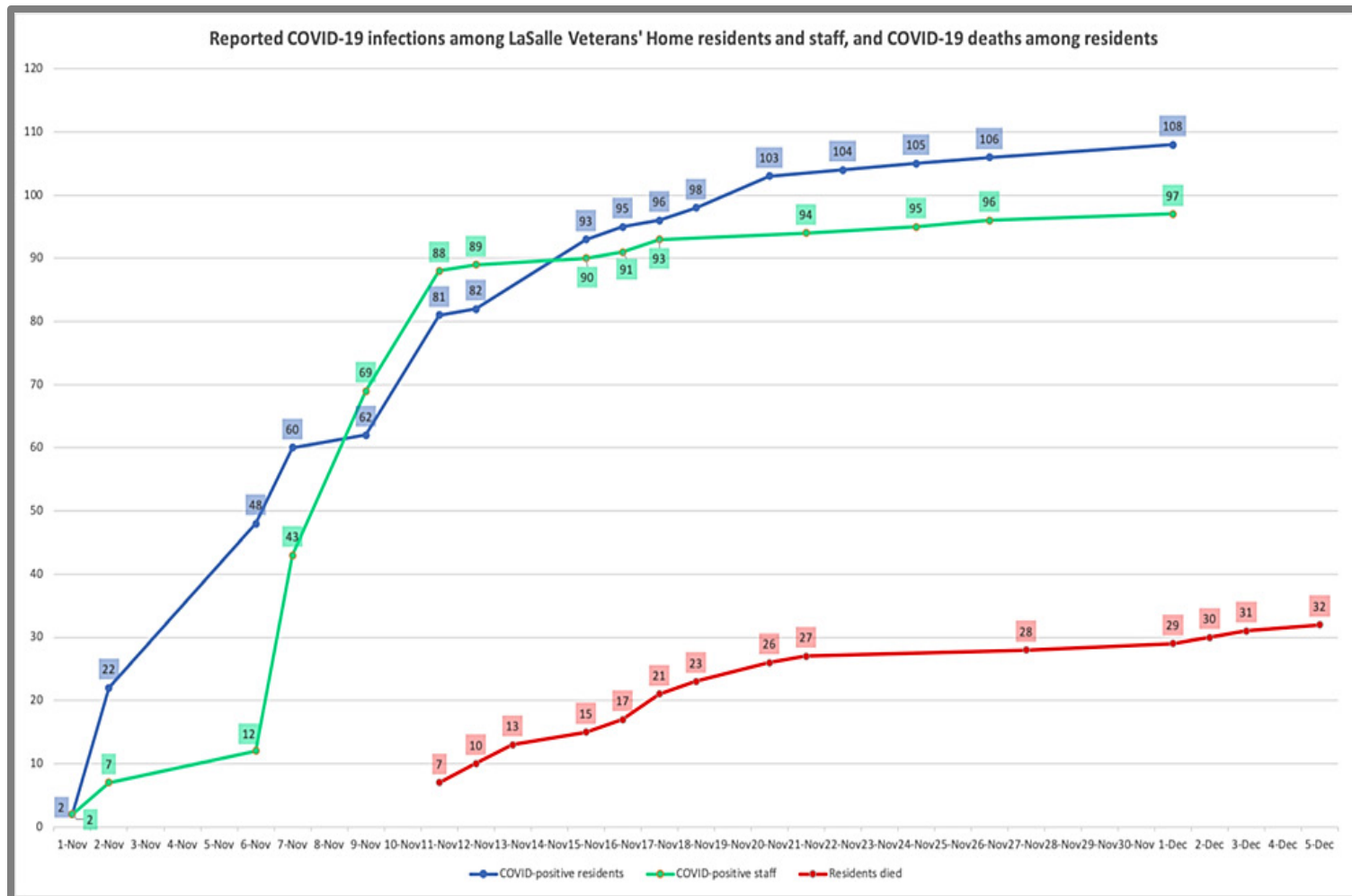
VI. CONCLUSION

While the availability of vaccines and the increasing acceptance of vaccinations have greatly helped, COVID-19 continues to present unique challenges to long-term care facilities, which require significant support from management and leadership to provide procedures consistent with public health guidance and general infection control principles. As detailed above, failures in the Home and IDVA's preparation and response to COVID-19 contributed to the scope of the outbreak. And, to reiterate, although this report identified a number of deficiencies within the Home and IDVA, it is important to note the staff's dedication and care for Veterans amid the pandemic's demanding conditions. We acknowledge that this was a challenging period for everyone involved and stress that the staff's genuine care for the Veterans was apparent in our investigation. Nevertheless, the importance of well-developed infection control procedures within long-term care facilities cannot be overstated. Inadequate leadership and structure within the Home and IDVA resulted in the Home's failure to adequately meet the increased expectations caused by the pandemic.

We hope this report serves as an opportunity for the Home and IDVA to reevaluate their organizational structure in an effort to improve accountability within the Home's management and

IDVA leadership. While discussed in the context of COVID-19, we note that these recommendations are not limited to COVID-19 control and management. The fundamental principles highlighted in this report are necessary for any effective infection control response. Indeed, the above findings and recommendations are intended to provide an improved framework from which the Home may more appropriately manage and appreciate any infectious disease threatening Veterans and staff. We hope that these recommendations will aid in improved procedures and policies being developed and employed to better meet the goal of all involved: ensuring that Veterans receive the high-quality care they deserve.

VII. APPENDIX A.



VIII. APPENDIX B.

Given the nature of COVID-19’s highly contagious, asymptomatic transmission, an outbreak is considered to be two or more resident or staff cases. According to COVID-19 outbreak data obtained from IDPH’s website, as of March 31, 2021, only 33 other homes had numbers comparable to the Home, that is, had more than 200 staff and resident cases (13 facilities), more than 30 deaths (8 facilities), or both (12 facilities).

Facility Name	Total Cases	Total Deaths	County
Illinois Veterans Home Quincy	305	27	Adams
Warren G Murray Developmental Center	263	1	Clinton
Albany Care	206	1	Cook
Avantara Park Ridge	202	32	Cook
City View Multi Care Center	249	15	Cook
Elevate Care Chicago North	176	34	Cook
Fairmont Care	151	32	Cook
Generations at Regency	211	41	Cook
Glenview Terrace	210	36	Cook
Harmony Healthcare and Rehab	158	32	Cook
Ludeman Developmental Center	395	9	Cook
Mosaic of Lakeshore	135	32	Cook
Niles Nursing and Rehab Center	250	54	Cook
Norridge Gardens	210	57	Cook
Peterson Park Health Care	259	36	Cook
Symphony at 87th	217	35	Cook
Symphony at Midway	236	27	Cook
Symphony of Lincoln Park	225	34	Cook
Symphony of Morgan Park	227	28	Cook
Symphony of South Shore	230	36	Cook
DuPage Care Center	201	10	DuPage
Manorcare Hinsdale	215	46	DuPage
Oakbrook Care	172	34	DuPage
St. Patrick’s Residence Nursing and Rehabilitation	230	16	DuPage
Tower Hill Healthcare Center	192	31	Kankakee
Samuel H. Shapiro Developmental Center	230	1	Kankakee
Marigold	111	31	Knox
Avantara Long Grove	258	34	Lake
Bryan Manor	216	7	Marion
Hope Creek	227	26	Rock Island
Four Fountains	119	33	St. Clair
Aperion Wilmington	205	12	Will
Meadowbrook Manor of Bolingbrook	260	46	Will

While an in-depth comparison of the conditions at each facility in Illinois is beyond the scope of this investigation, and understanding that facilities obviously vary in the number of residents and staff, it appears that the majority of Illinois facilities controlled the spread of COVID-19 more effectively than the Home under similar environmental constraints and with similar community positivity rates.