| COVID-19 OUTBREAK |

MISSOURI VETERANS HOMES

An Independent Investigation
Conducted for the Missouri Veterans Commission
November 16, 2020

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INTRODUCTION

The Missouri Veterans Commission ("MVC"), a division of the Department of Public Safety ("DPS"), operates seven Veterans Homes, five Veterans Cemeteries, and the Veterans Service Program. The MVC is committed to honoring and serving Missouri's Veterans whose dedication and sacrifices have preserved our state, our nation, and our freedoms.

The MVC is a state commission established in part to assist Veterans in accessing available state and federal benefits. The MVC's mission is "to serve Veterans as the FIRST CHOICE in Skilled Nursing Care; BEST CHOICE in Securing Benefits; and PROVEN CHOICE in a Dignified Resting Place." The commitment of the Commission to honoring and serving Missouri's Veterans is reflected in its vision "[t]o Provide High Quality, Compassionate Care for Veterans; Seamlessly Integrated with the Veteran Community; Emphasizing a Culture of Transparency and Excellence." Its core values are "Integrity First; Service before Self; Excellence in all We Do."[1]

The MVC manages seven long-term care facilities or "Homes" providing 1,238 beds for Veterans in need of skilled nursing services. These Homes are located across Missouri in Cameron, Cape Girardeau, Mexico, Mount Vernon, St. James, St. Louis, and Warrensburg (collectively, "Homes"). The Homes provide residential care and services including physician care; physical, speech, occupational and recreational therapy; medications; maintenance, environmental and social services; dietary specialists; and specialized programs for dementia care.

Locations of Missouri Veterans Homes throughout Missouri:

In September 2020, the Homes experienced a prolonged outbreak of COVID-19.[2] As of November 13, 2020, there were 103 COVID-19 related deaths among Veterans living in the Homes.[3]

The MVC retained Armstrong Teasdale LLP ("Armstrong Teasdale") to conduct an independent investigation into the cause of and response to this outbreak with the goal of preventing further Veteran illnesses and deaths. In conducting this investigation, Armstrong Teasdale assessed each individual Home as well as MVC Headquarters. This investigation included (1) analyzing COVID-19 related data and trends in the Homes, in the communities in which the Homes are located, and in the State; (2) assessing leadership and management's preparations for and responses to the outbreak; (3) reviewing communication strategies and protocols between the Homes, the MVC, and other State programs; and (4) analyzing the existence of and compliance with policies (including testing, mask wearing, etc.); (5) the appropriate use and management of isolation and quarantine spaces in each Home; (6) compliance with and consistent application of Centers for Disease Control and Prevention ("CDC") and U.S. Department of Veterans Affairs ("VA") guidelines for long-term care facilities in preventing and responding to COVID-19 and any additional tasks deemed appropriate to understanding the root cause of the outbreak.

This independent investigation identified lapses and deficiencies at multiple levels throughout the Homes and MVC's hierarchy, lapses which contributed to the outbreak of COVID-19 throughout six of the seven Homes. Categorically, the lapses can be described as (1) failure to recognize and appreciate the existence of a problem at the first sign of an outbreak; (2) failure to plan for the outbreak; and (3) failure to properly respond to the outbreak. The specifics of each failure are set forth in detail in the body of this report as are the proposed recommendations to ensure an outbreak of COVID-19 (or any other virus) and preventable illnesses and deaths do not occur in the future.

At the outset, we would like to make clear that while our investigation identified several failures and deficiencies, the MVC clearly and genuinely cares for the Veterans and is working diligently in this stressful and rapidly changing situation to keep safe the men and woman who have kept them safe.

EXECUTIVE SUMMARY

Armstrong Teasdale's independent investigation revealed that while Missouri Veterans Homes' administrators and staff genuinely care for the Veterans, three major lapses contributed to the COVID-19 outbreak in the Homes this fall: (1) failure to recognize and appreciate the problem at the first sign of an outbreak; (2) failure to plan for the outbreak; and (3) failure to properly respond to the outbreak.

A. Failure to Recognize the Outbreak

MVC Headquarters failed to recognize and appreciate the impact of even one positive case of COVID-19, despite a number of experts, like the Missouri State Epidemiologist and the Missouri Medicaid Director, defining a COVID-19 outbreak in a residential setting as a *single* positive case. This meant that MVC leadership did not change tactics to aggressively contain the first positive cases, nor did they reach out to external partners for assistance. Instead, they treated the initial cases as something that could be overcome using the same directives, policies, and internal resources that had been employed prior to the positive case.

This lack of understanding was not due to a lack of information. Homes' staff provided data to Headquarters via reports, calls, and meetings on an ongoing, nearly real-time basis. MVC Headquarters simply lacked the ability to engage in meaningful analysis of this data. They should have recognized the presence of a COVID-19 outbreak in the Cape Girardeau Home by September 2, 2020 (when the Home reported a jump from one positive Veteran to three positive Veterans within a 72 hour period, and a jump from five positive staff members to seven positive staff members within a two week period), but even as cases increased, MVC Headquarters failed to appreciate the need to move quickly to isolate positive patients. This also impacted their communication with external stakeholders, in that MVC Headquarters did not identify specific issues or concerns related to the outbreak. For example, in weekly briefings to DPS, the MVC provided little data about the outbreak, other than its impact on staffing vacancies—missing a critical opportunity early on to engage outside agencies and resources.

Perhaps most significantly, the MVC failed to fully engage with the Fusion Cell. The Fusion Cell is part of Missouri's collective response to COVID-19 and is meant to be a single point of information for all Missouri agencies. According to a press release issued by the Governor of the

State of Missouri: "The state's cross-governmental COVID-19 Fusion Cell helped coordinate development of the dashboards, which include data from the Missouri Department of Health and Senior Services, the Department of Economic Development, the Department of Social Services, and the Department of Elementary and Secondary Education, among others."[4] It is led by the Missouri Chief Operating Officer ("COO"), the Missouri Medicaid Director, and an outside consulting company. A morning Fusion Cell meeting currently occurs four days a week for one-and-a-half-hours. Typically, 100-250 individuals attend these meetings representing personnel from various Missouri agencies, commissions, and outside stakeholders like hospital associations. While MVC Headquarters attended the Fusion Cell meetings and provided information regarding positive test results among staff and Veterans, they failed to raise concerns to the Fusion Cell about the state of the outbreak in the Homes. When the MVC Headquarters disclosed the number of COVID-19 positive staff and Veterans at a September 10, 2020 meeting, no one from the Fusion Cell asked any questions or requested any follow up on the data that was presented.

The Fusion Cell, the Office of the Governor, and the Office of Administration, along with the leaders from Department of Social Services ("DSS"), Department of Health and Senior Services ("DHSS"), and DPS have since provided to the MVC a number of resources, including rapid antigen tests, access to a visual analytics platform to better review and analyze positivity rates, testing statistics and other metrics, as well as other support. Going forward, the MVC should establish a more direct line of communication with the Fusion Cell. This should include a report of more specific data and a mechanism to report any concerns in order to draw on the collective expertise of Fusion Cell leaders. In addition, external stakeholders, like those who lead the Fusion Cell, must ensure there are better mechanisms in place to ensure data from the MVC and other commissions and agencies are not only reviewed but analyzed.

The need for more meaningful engagement from external stakeholders is especially important given the structure of MVC and its position under DPS. As noted above, MVC is a division of DPS, a Missouri agency which oversees a number of other entities. Yet, DPS has little to no oversight over the MVC or its Headquarters staff. MVC is merely housed under DPS for budgeting purposes. The MVC only administratively reports to DPS, where DPS acts as a type of holding company. This is evident in the fact that DPS has no authority to hire or fire the MVC Executive Director. Instead, that authority is vested in the MVC Commissioners who serve as unpaid volunteers. The Commissioners have only limited oversight of the MVC's day to day activities and no authority to direct Headquarters or Homes' staff. In sum, the current structure

provides MVC with little oversight or direct access to resources. The combination of poor accountability measures and failure to escalate information about the state of the outbreak is evidence of ineffective communication between the MVC, DPS, and other stakeholders.

B. Failure to Plan for an Extensive Outbreak

While the novelty of COVID-19 makes long-term strategic planning difficult, MVC Headquarters demonstrated an absence of leadership in failing to appropriately plan for a severe and prolonged COVID-19 outbreak. Headquarters should have known by the beginning of summer 2020—well before the fall outbreak—that COVID-19 spreads covertly through asymptomatic carriers and is difficult to control in a residential setting like a nursing home. But despite several months to prepare for a predicted fall surge in COVID-19 cases, MVC Headquarters did not develop any comprehensive outbreak plan. As a result, they did not have an opportunity to vet the plan with outside agencies or other long-term care facilities, or test the plan to identify areas of needed improvement. The lack of a comprehensive outbreak plan led to confusion and inefficiencies, and it almost certainly contributed to the inability to contain the spread of COVID-19 once it was introduced into the Homes.

As early as February 2020, MVC Headquarters could have relied on publicly-available guidelines, templates, and checklists published by the CDC. They also could have looked to open source material regarding outbreaks that had already occurred in congregate care settings in other parts of the country, including in Missouri. The investigation revealed that around March and April, MVC Headquarters studied and learned from an outbreak in Kirkland, Washington, but they did not study any additional outbreaks, even as occurrences multiplied across the country. No one at the MVC Headquarters took the initiative to gather this information and develop a comprehensive plan.

The MVC Headquarters did provide some guidance to the Homes in the form of directives, but these directives were reactionary, haphazard, and often conflicted with each other. The directives addressed only discrete aspects of care and COVID-19 management and in some instances were inconsistent with guidelines from the CDC and VA or infection control best practices. They were also issued frequently, with little insight as to how staff might learn of or implement them. Staff found it difficult to keep up with the constant updates and changes, and most did not have access to any compilation of the directives they were supposed to be following. The

lack of policies and frequently-changing directives made it difficult to educate, let alone train staff in how they should provide hands-on care and services in the Homes.

This lack of preparation was compounded by the fact that the MVC did not have a current, comprehensive manual for infection prevention policy and procedure generally. An infection prevention policy and procedure manual is required by VA and CDC guidelines. This manual would have included an outbreak management plan or emergency management plan for infections generally, and it would have provided the Homes baseline guidance regarding isolation, quarantine, and universal precautions.

While the MVC developed a general pandemic plan in March, there was no evidence that this plan was updated, reviewed, used, or tailored for use during the COVID-19 pandemic. The MVC should have prepared and printed a comprehensive COVID-19 plan and made multiple copies accessible to staff in each Home.

C. Failure to Respond to the Outbreak

Without an appreciation for the problem or a comprehensive plan in place, the MVC's response to the outbreak was inadequate. In particular, the Homes had significant issues related to testing, cross-contamination, and staffing.

The timing of test results facilitated the spread of COVID-19. In August 2020, the Homes implemented routine nasopharyngeal PCR testing of all Veterans and staff twice a week. PCR tests take anywhere from 24 to 48 hours to process. This is significant because approximately sixty percent of individuals who are COVID-19 positive are either pre- or asymptomatic at the time they are tested.[5] This meant that while awaiting test results, infectious staff and Veterans interacted with one another, some without any personal protective equipment ("PPE"). Asymptomatic Veterans and some symptomatic Veterans were not quarantined pending the results and moved freely among the Homes, dined together, interacted with each other, and remained lodged with their roommates. Asymptomatic staff continued to work, engage with Veterans, and take breaks with other staff members pending test results.

Beginning in October, and with the assistance of the Fusion Cell and the Office of the Governor, Veterans now undergo rapid antigen testing on the days of the week they do not receive PCR testing. Rapid test results are available in approximately 15 minutes, and allow the Homes to send infected staff home sooner, isolate infected Veterans immediately, and more rapidly quarantine

exposed Veterans. While the rapid test can have a high rate of false negatives, and this perceived unreliability contributed to some mistrust of the results initially, use of the rapid tests in conjunction with the routine PCR tests has had a positive impact on managing the outbreak, because it allows for faster diagnosis, faster isolation, faster quarantine, and reduced spread. Other changes to the Homes' practices include increased monitoring of Veterans' vital signs to every four hours, in order to identify changes in a Veteran's condition for earlier medical intervention. This practice should be standardized across the Homes.

In addition to testing issues, improper quarantine and isolation procedures contributed to the spread and cross-contamination of COVID-19 within the Homes. Initially, most of the isolation and quarantine spaces only had between one and four beds, and little consideration had been given to how expansion would occur, if or when necessary. Neither MVC Headquarters nor the Homes' administrative leadership was prepared for the rapid spread of the virus, and at least one isolation area was filled with fifty patients in one week. This required frequent re-location of Veterans among the scarce quarantine and isolation beds, and sometimes led to the hectic co-mingling of COVID-19 positive Veterans with otherwise uninfected Veterans.

A delay in closing common spaces also contributed to cross-contamination and the spread of COVID-19 within the Homes. In the early days of the outbreak, Veterans were allowed to move freely about the Homes. Many did so without wearing masks, even while exhibiting COVID-19 symptoms. Veterans have since been confined to their own units or rooms, and common spaces like dining rooms have been closed. Most of the Homes have prohibited meal carts from being brought onto the units. Instead, the carts are left at the entryway to the unit and nursing staff distribute the meals on disposable plates and with disposable utensils.

However, several Veterans still do not wear masks or practice social distancing. Due to the layout of the homes, several Veterans have roommates and share shower and toilet facilities. For Veterans in special care units with impairments like dementia or Alzheimer's disease, compliance with masking, social distancing, or hand hygiene cannot be expected. Due to the unique nature of these Veterans' medical conditions, they are unable to comply with mitigation strategies such as masking, social distancing, hand hygiene, or directives to stay in their rooms. The underlying nature of these conditions renders it incredibly difficult to contain and mitigate COVID-19 once it is present in a special care unit. The special care units are locked down, but staff working in these areas must be particularly vigilant.

In many Homes, staff movement has contributed to cross-contamination. At the onset of the outbreak, staff typically were not assigned to work in a dedicated unit, but rotated across all units. In two Homes, surges of cases were tied to COVID-19 positive staff who had moved throughout the entire facility. While the Homes are now trying to dedicate staff to one particular unit, staffing shortages have climbed, it is particularly difficult to assign dietary and environmental services staff to a dedicated unit, and many staff continue to serve multiple roles in the Homes. These staffing shortages could have been prevented, or at least mitigated. Prior to the outbreak, the MVC Headquarters failed to make a contingency plan to address potential staffing shortages, and it waited to coordinate with the VA until the Homes were in the midst of the current staffing crisis. Currently, the VA and personnel from The Missouri Disaster Medical Assistance Team ("DMAT") are providing additional staffing as needed.

However, staff morale is low, and many are overwhelmed by the emotional toll of caring for COVID-19 affected Veterans, the negative media attention, and the added demands of COVID-19 protocols—especially when many of them live in Missouri communities where mask mandates and social distancing are not enforced. The Homes need to provide education about practicing COVID-19 prevention measures when staff are in their own homes and communities, as well as develop consistent policies regarding when staff who have been exposed to COVID-19 may return to work. Staff should feel empowered to collaborate with Headquarters in the development of policies and procedures.

The investigation also identified inconsistencies in the use of PPE and in the initial screening process, which may have contributed to cross-contamination. Staff wore only surgical masks prior to the September outbreak. They had likewise been instructed to use certain forms of PPE for a period of time longer than recommended by the CDC. While the MVC has done an excellent job in procuring PPE, the investigation revealed ongoing non-CDC compliant PPE use in the Homes. These include wearing gowns from COVID-19 areas to non-infected areas, inadequate areas for donning and doffing sterile gowns, a failure to properly clean medical devices between uses, and inconsistencies in how staff are screened to enter the Homes. For instance, some Homes allow self-screening of staff and others allow employees to congregate without social distancing while awaiting rapid screening results. These issues could have been prevented if the Homes had dedicated infection prevention to staff.

Finally, although the frequency of cleaning the Homes increased after the outbreak, disinfectant products were not being used according to the manufacturer's recommendations.

Specifically, staff was only letting the products sit for 1 minute, when the products must sit for 10 minutes to be effective against viruses, including COVID-19. Thus, while the Homes were clean, they were not disinfected.

SCOPE AND APPROACH TO THE INVESTIGATION

Our independent external investigation and subsequent reports were completed in response to the State of Missouri's Emergency Request for Quote No. 30034902100586 and Contract Number CS210586001 (collectively the "Emergency RFQ"), which set forth the general parameters and requirements for the investigation. Pursuant to the Emergency RFQ, on October 12, 2020, the MVC retained Armstrong Teasdale to investigate the prolonged COVID-19 outbreaks at its Veterans Homes. The MVC tasked Armstrong Teasdale with conducting a corrective action investigation that specifically examined: (1) possible lapses in the prevention of COVID-19; (2) response and containment of COVID-19; and (3) any lapse of reporting and broader communication and recommending corrective action.[1] The investigation included:

- Assessing the operations of each individual Home as well as MVC Headquarters;
- Analyzing COVID-19 related data and trends in each Home, the communities in which the Homes are located, and in the State;
- Assessing leadership and management's preparations for and responses to the outbreak;
- Assessing communication and reporting strategies and protocols between the Homes, the MVC, and other State programs;
- Analyzing the existence of and compliance with policies, the appropriate use and management of isolation and quarantine spaces, and consistency with published guidelines for long-term care facilities in preventing and responding to COVID-19; and
- Any additional tasks deemed appropriate to understanding the root cause of the outbreak.

In addressing these questions and preparing this report, we focused on the period of recent COVID-19 outbreaks at the Homes - September and October 2020. As relevant context and as necessary to address the scope of the investigation requested by the MVC, however, this report

[1] Although the MVC retained Armstrong Teasdale for this investigation, we have conducted this investigation independently from any State government or MVC employees. No redactions or revisions to this report were made by any individual outside of Armstrong Teasdale.

examines events and facts predating the September/October COVID-19 outbreak. The investigation means and methods were developed and selected by us based on our professional judgement and experience, with the direction and guidance in particular areas of the MVC. This report is not a comprehensive historical review of the Homes' operations; instead, we studied the facts and issues as necessary to analyze the specific issues posed by the MVC.

Armstrong Teasdale conducted this investigation, in part, by interviewing individuals (via video conferencing so as to protect the Veterans, staff, and Homes from further COVID-19 exposure) and by analyzing documents. While we did not have the authority to compel any testimony or the production of any documents, most individuals we contacted cooperated in being interviewed and providing requested documentation. We did not agree to conduct any interviews on an anonymous basis. Accordingly, we included the names of important individuals within the body of our report and also identified other individuals by their roles or titles.

In the course of this rapid investigation, between October 15 and November 10, 2020, Armstrong Teasdale interviewed a total of 174 individuals, analyzed more than 900 documents, directed Pathway Health, Inc. ("Pathway Health") to conduct on-site audits of each Home, and created a hotline for families and Veterans to share information and concerns. Based on upon the initial results of the investigation, Armstrong Teasdale issued early recommendations to the MVC intended to induce immediate action to reduce the spread of COVID-19 in the Homes. More specifically, the Armstrong Teasdale team interviewed 99 individuals, from MVC Headquarters, Homes' staff, Missouri state employees, and Veterans. The interviews of Homes' staff included personnel from all levels of each Home's operations - administrators, infection control personnel, nurses, medical directors, certified nursing assistants, social workers, housekeeping, dietary, and environmental services and interview of Veterans from each Home. We also interviewed MVC Headquarters personnel, members of the State COVID-19 Fusion Cell ("Fusion Cell"), the Director of DPS, and the State Epidemiologist.

This report, along with portions of the summary 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. Unless otherwise indicated, the interviews referred to in our reports took place between October 15, 2020 and November 10, 2020.

To supplement our investigation, the Emergency RFQ required the utilization of a subject matter expert in the areas of long-term care: "clinical management, prevention and control of

infectious disease, geriatric medical care and treatment of infectious disease, management and communications." At the direction of the MVC, a specific third-party, Pathway Health was selected as the qualifying subject matter expert in accordance with the terms of the Emergency RFQ. At the suggestion of Armstrong Teasdale, Pathway conducted an on-site audit of each Home donning full PPE and followed all necessary safety protocols. Their findings provided further context to the observations and conclusions gleaned from Armstrong Teasdale's interviews and document review.

In the course of conducting this investigation, we identified Veterans' family members as an essential element of our inquiry. Based on the initial reports we received from various family members, we recommend the creation of a telephone hotline. MVC adopted the recommendation in accordance with the additional consulting services contained in Exhibit F to Contract Number CS210586001. Accordingly, a hotline was established and was open from October 29 through November 4, 2020 in order to collect and screen the various reports and inputs from the Veteran's family members. At the recommendation of Armstrong Teasdale, MVC issued a press release publicizing the hotline. In total, through this hotline, Armstrong Teasdale attorneys spoke to 75 individuals, including spouses and children of Veterans in the Homes, Veterans, volunteers, and a nurse.

Pursuant to the Emergency RFQ, we had 30 days to complete our investigation. On November 10, 2020, Amendment No. 1 to Contract Number CS210586001 was executed, thereby extending the contract period through November 16, 2020. The amendment was based on newly disclosed information in the final days of our investigation.

The overall emergent nature of the investigation and reports only allowed for certain investigatory methods and procedures to be employed, in order to comply with the needs of the MVC in quickly addressing this critical life-threatening situation. Given the emergency procurement requirements and truncated response timeline, we were required to rely on open source information as well as the materials provided directly by the MVC and the various Homes' Administrators. While independent verification efforts were taken for all critical documents and information, every fact and statement could not be independently verified through external sources.

The Armstrong Teasdale team participating in this investigation consisted of attorneys Brian Kaveney, Timothy Gearin, David Ott, Maureen Bryan, Ida Shafaie, Jared Walsh, Jason Stavely, Melanie Tamsky, Angela Kennedy, Mikayla Travers, Colleen Kinsey, Jake Kohut and Mark Ohlms, as well as paralegal Christopher McDonald and administrative assistant Peggy Zimmerman.

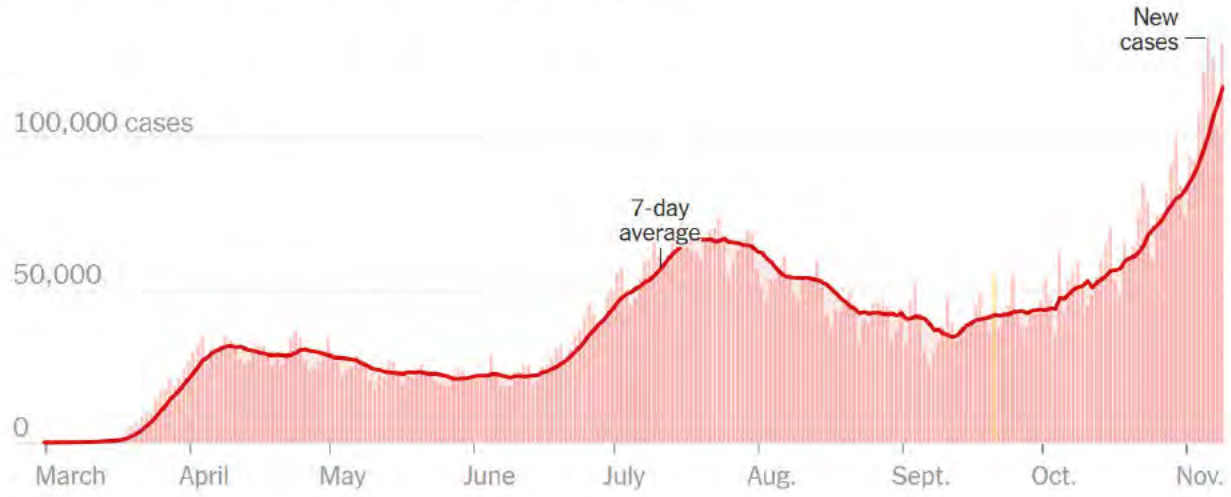
I. COVID-19

A. COVID-19 Outbreak Timeline and Current Data

On March 13, 2020, President Donald Trump declared a national emergency concerning COVID-19, a novel virus discovered in Wuhan, China in December 2019 ("COVID-19").[6] Per the President's proclamation, 1,645 people from 47 states had been infected with COVID-19 as of March 12.[7] By April 2, the CDC had reported 213,144 COVID-19 total cases and 4,513 deaths nationwide.[8]

The CDC reports that as of November 13, 2020, there have been 10,314,254 total COVID-19 cases in the United States and 241,069 COVID-19 related deaths,[9] with an overall positivity rate of 7%.[10] According to the New York Times database, the sharp upward trajectory of daily new COVID-19 cases continues:[11]

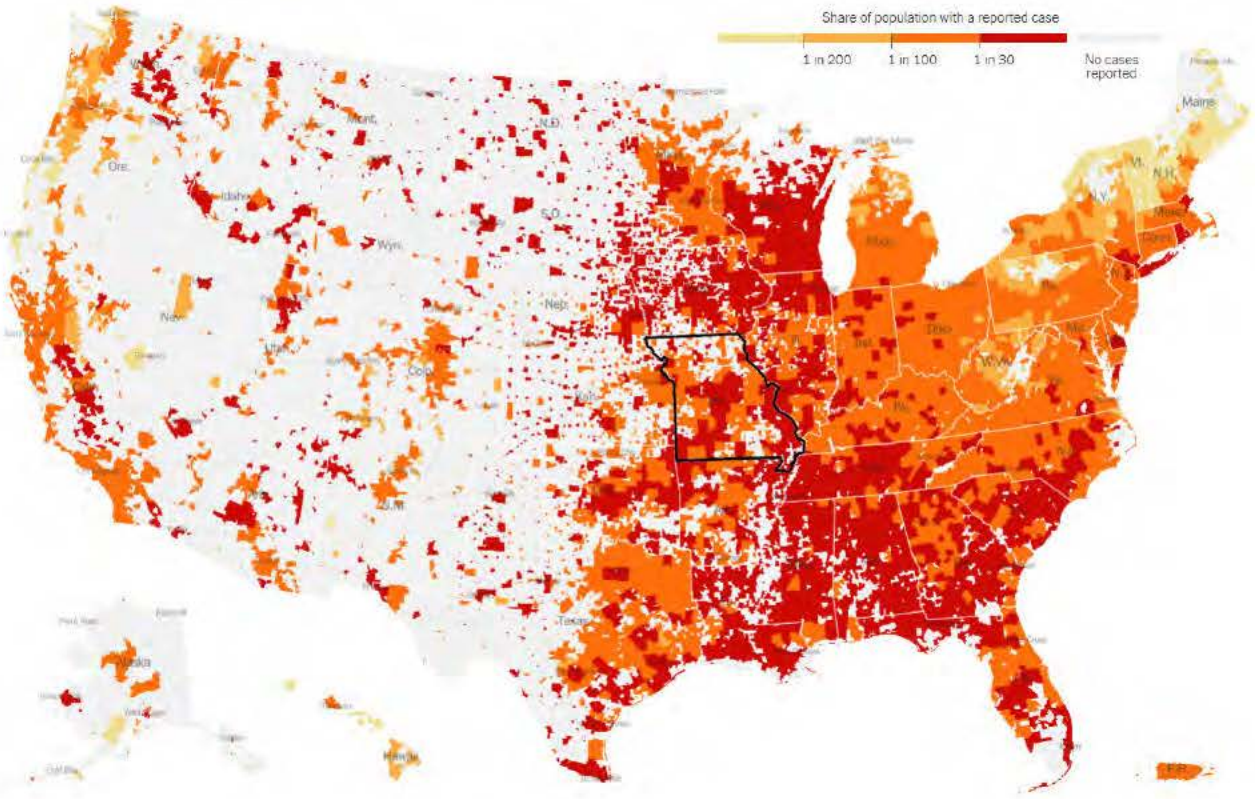
New reported cases by day in the United States



The above graphic demonstrates the trajectory of the COVID-19 virus since March with three obvious surges in cases. The third surge, in which the outbreaks leading to this investigation occurred, has yet to crest and is already of greater severity than those that preceded it.

No region in the United States has been spared from the invasion of COVID-19. The heat map below demonstrates the share of the population with a reported COVID-19 case in each state as of November 10, 2020[12] and provides context overall for the Homes' performance on a national

level. Missouri is among the hardest hit states with respect to the share of its population that has contracted COVID-19.



B. COVID-19 in Missouri

1. Timeline

The first positive COVID-19 case in Missouri was announced on March 7, 2020.[13] Six days later, on March 13, 2020, Governor Michael Parson signed an Executive Order declaring a state of emergency in Missouri in response to COVID-19.[14] Missouri's first COVID-19 death was announced on March 18, 2020.[15] On March 21, 2020, the Director of DHSS ordered state-wide social distancing, stating all Missourians "shall avoid social gatherings of more than ten people."[16]

On April 3, 2020, Governor Parson issued a state-wide "stay home" order stating: (1) individuals shall avoid leaving their homes or places of residence; (2) individuals shall avoid social gatherings of more than ten people; (3) all public and charter schools must remain closed for the

duration of the Order; (4) non-essential businesses must adhere to social distancing limitations; and (5) businesses providing essential services may operate with limited capacity.[17]

The "stay home" order was lifted in two phases as part of the "Show Me Strong Recovery Plan." Phase 1 was implemented on May 4, 2020 and continued through June 15, 2020. During this Phase, (1) citizens were allowed to re-engage in economic and social activities but with adherence to social distancing requirements, including maintaining six feet of space between individuals in most cases; (2) there were no limitations on social gatherings as long as necessary precautions were taken and six feet of distance could be maintained between individuals and/or families; and (3) all business could open provided social distancing guidelines were followed.[18]

On June 16, 2020, Phase 2 of the "Show Me Strong Recovery Plan" was implemented, which removed the state-wide health order and lifted state-wide restrictions. However, local officials were given the authority to erect further rules, regulations, or ordinances.[19] While Missouri is currently one of seventeen states without a state-wide mask mandate,[20] seventeen Missouri counties have implemented policies requiring masks. Additionally, the Missouri DHSS has provided guidance concerning masks and recommends Missourians wear masks in public settings where social distancing measures are difficult to maintain.[21]

2. Data

As of November 16, 2020, Missouri has had 249,403 total reported cases of COVID-19 and a total 3,463 deaths.[22]

The above graphic depicts Missouri's daily rate of new COVID-19 cases. As demonstrated, and as consistent with the national trend, Missouri has experienced a consistent rise in COVID-19

cases in recent months. Daily new COVID-19 cases in Missouri have increased from a 7-day average of 1,386 new cases per day on August 1, 2020 to a 7-day average of 4,949 new cases per day on November 14, 2020.[23]

When analyzing the impact of COVID-19, account must be taken not only of the number of COVID-19 infections but also the cumulative percentage of positive PCR tests or "positivity rate." According to the Johns Hopkins Bloomberg School of Public Health, the positivity rate is a relevant indicator for decisions pertaining to tightening or relaxation of infection-control measures:

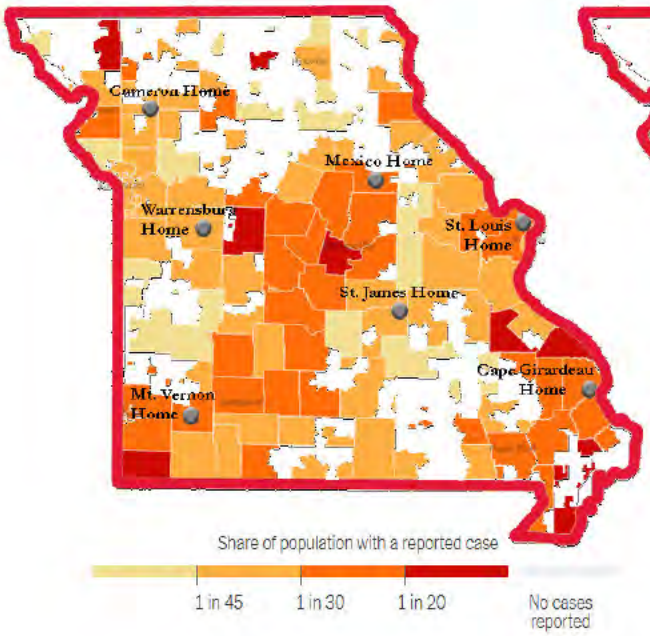
> "A higher percent positive suggests higher transmission and that there are likely more people with coronavirus in the community who haven't been tested yet.... a high percent positive can indicate it may be a good time to add restrictions to slow the spread of disease"[24]

According to the World Health Organization, the threshold for a high positivity rate is 5%.[25] Missouri's positivity rate has increased from 6% in June, to 8% in August, 10% in September, 11% in October, and 12% currently.[26]

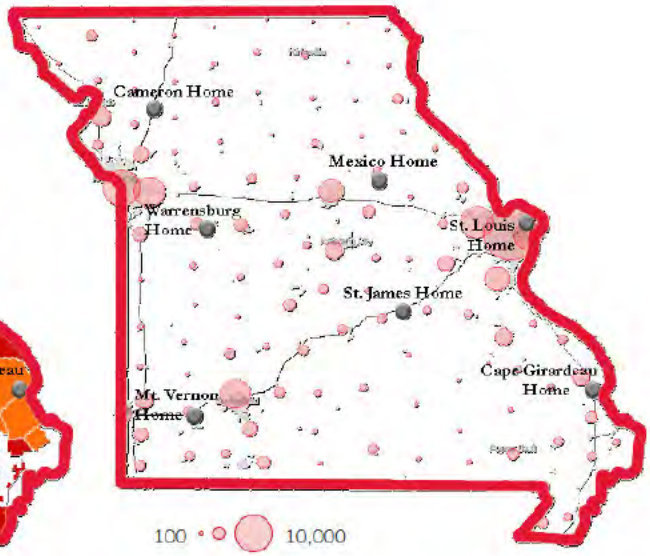
In addition to examining state-wide metrics, there are regional differences with respect to the number of positive COVID-19 cases, the share of population infected with COVID-19 (i.e., number of cases per number of people), and the death rates.[27] The below heat maps demonstrate the pandemic severity in the areas of each of the seven MVC Veterans Homes. The positive cases by share of population map (left) shows the areas of the State which have known positive cases in 1-out-of-20 people (red), 1-out-of-30 people (dark orange), 1-out-of-45 people (light orange), or fewer (yellow and white).

The total positive cases map (right) visually represents the actual number of reported cases in that area, without regard to the density of the population. In more sparsely populated communities, the per capita case rate may be high (shown in red or orange to the left), but the actual number of cases may appear relatively few (smaller circles to the right).

Positive Cases by Share of Population:



Total Positive Cases:



Taken together, these maps portray the local intensity of the COVID-19 spread as well as the cumulative COVID-19 cases in the area of each Home. In context, these maps demonstrate that the number of COVID-19 cases and the prevalence of COVID-19 in a given area do not necessarily correlate to a specific Home's outcome or the onset of an outbreak. For example, St. Louis has the largest number of COVID-19 cases and a significant prevalence of COVID-19 in its community. However, the St. Louis Veterans Home had zero COVID-19 positive Veterans within the Home until recently and still has a lower number of cases than smaller communities with a lower percentage of positive cases. Compare the St. Louis Home to the St. James and Cameron Homes – both are in communities with smaller numbers of COVID-19 cases and less prevalence of COVID-19, but these Homes have had 60 and 83 COVID-19 positive Veterans, respectively.

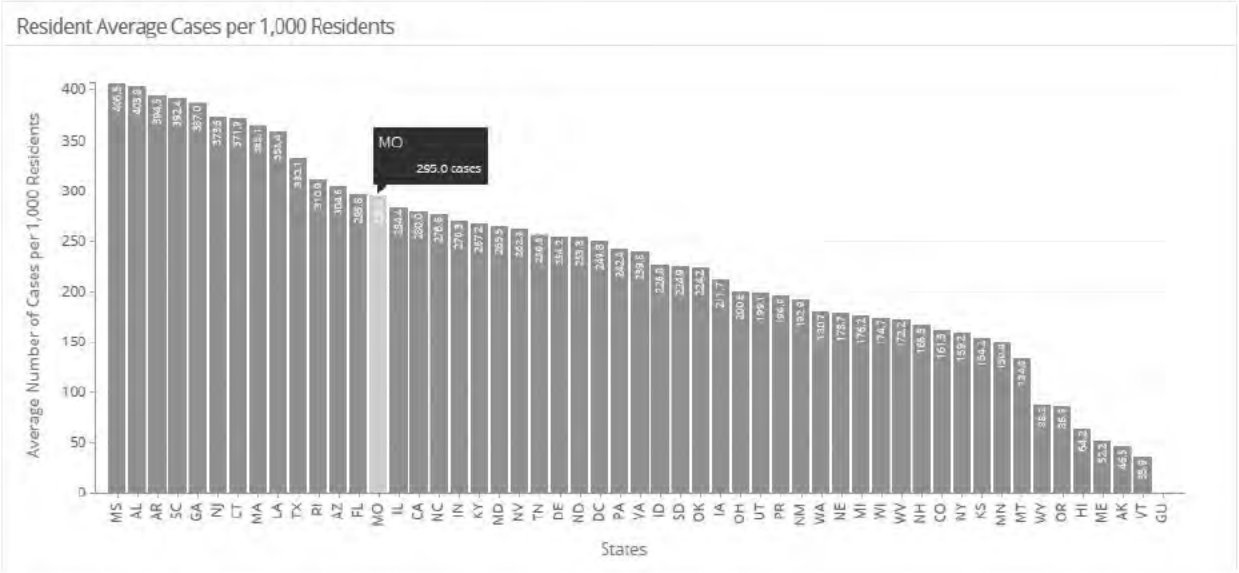
Finally, in a national comparison, Missouri ranks 18th highest in total COVID-19 case count and 23rd highest in deaths.[28] Missouri's positivity rate range is similar to all of its bordering states, except Nebraska, which has experienced a slightly higher positivity rate.[29]

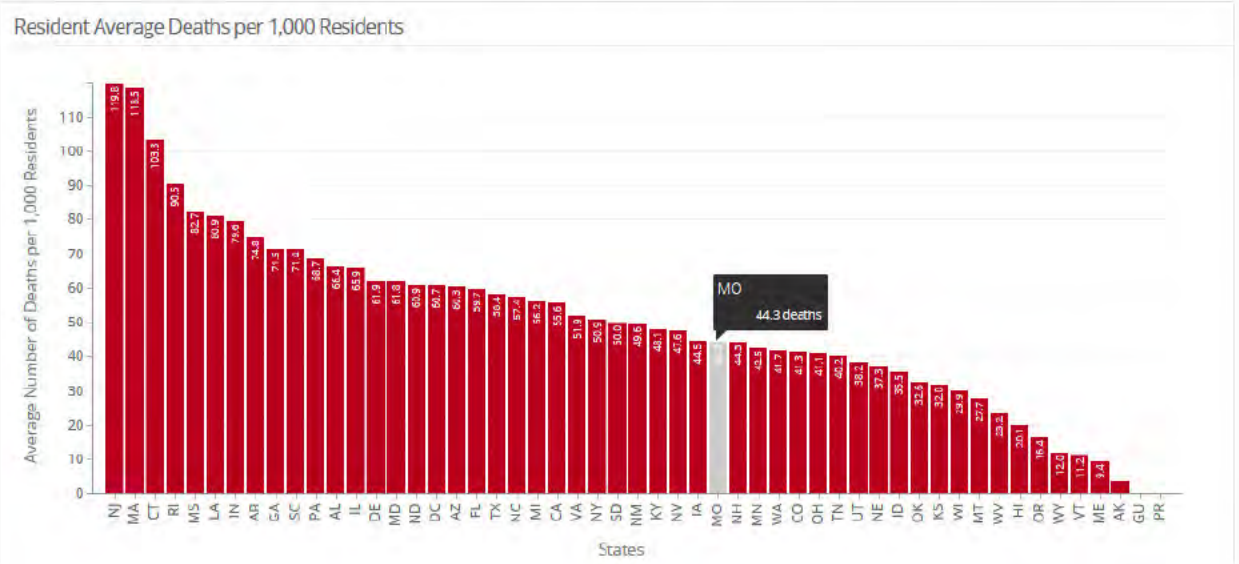
C. COVID-19 in Nursing Homes

Nationally, as of November 1, 2020 (the most current publicly accessible data), 294,438 residents of federally licensed nursing homes had tested positive for COVID-19 and 65,446 had died as a result.[30] Within VA Homes overall, as of November 13, 2020, there have been 86,304 cumulative COVID-19 cases with 4,254 known related deaths.[31]

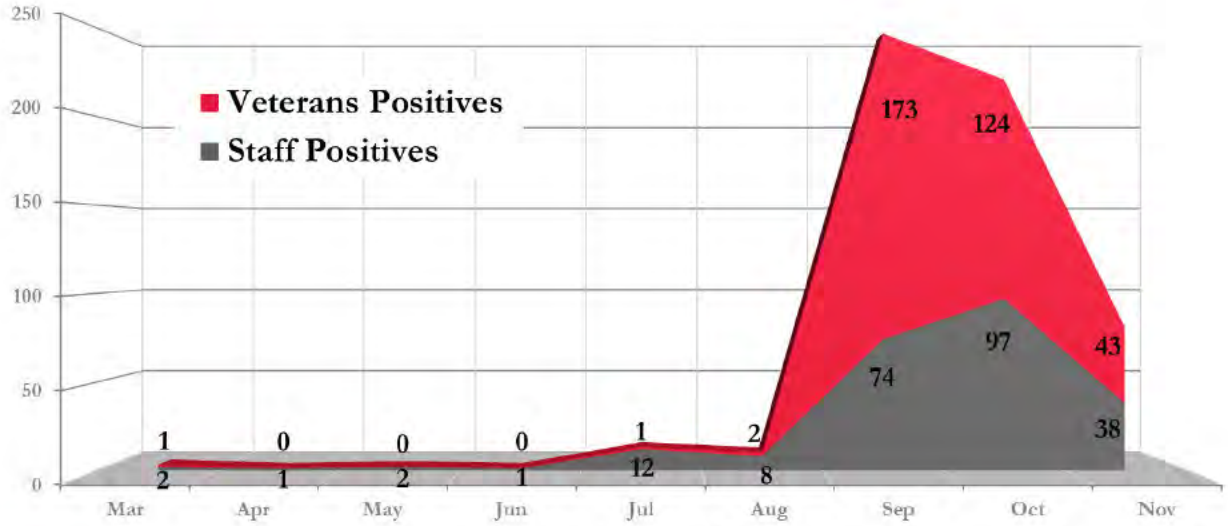
In Missouri, as of November 1, 2020 (the most current publicly accessible data), 10,008 nursing home residents had tested positive for COVID-19 and 1,511 had died as a result.[32] Statistically, in Missouri, nursing home residents comprise 4.26% of the total number of COVID-19 cases in the State but account for 43.9% of the total deaths.

The below graphics demonstrate that Missouri's COVID-19 nursing home positivity rate is comparable to other nursing homes nationally and its COVID-19 related nursing home death rate is lower than the national average.[33] Stated another way, these national rankings suggest that Missouri is slightly above average at reducing the death rate, but is slightly below average at preventing spread among residents.





Comparatively, within VA Homes as of November 16, 2020, in Missouri, there have been 3,314 cumulative COVID-19 cases with 149 known deaths.[34] The below figure graphically illustates the timing and severity of the current COVID-19 outbeak in the Missouri Veterans Homes as a unit.



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Veterans Positives	1	0	0	0	1	2	173	124	43
Staff Positives	2	1	2	1	12	8	74	97	38

As of November 13, 2020, 342 Veterans at the Missouri Veterans Homes have tested positive for COVID-19 and 103 have died as a result.[35] Comparatively, these statistics reveal the Missouri Veterans Homes have experienced a greater percentage of deaths-to-cases than both the State and national averages, as the below figures demonstrate:

Missouri Veterans Homes Confirmed COVID-19

- Cases: 342
- Deaths: 103

United States Residents Confirmed COVID-19

- Cases: 294,438
- Deaths: 65,446

Missouri Residents Confirmed COVID-19

- Cases: 10,008
- Deaths: 1,511

Cameron Home

- Cases: 83
- Deaths: 34

Cape Girardeau Home

- Cases: 96
- Deaths: 29

Mexico Home

- Cases: 21
- Deaths: 2

Mt. Vernon Home

- Cases: 41
- Deaths 9

St. James Home

- Cases: 60
- Deaths: 21

St. Louis Home

- Cases: 15
- Deaths: 1* (*Recent Outbreak)

Warrensburg Home

- Cases: 26
- Deaths: 7

*As of November 13, 2020

II. BACKGROUND: THE MISSOURI VETERANS HOMES

A. Organization and Duties

Missouri has provided care to Veterans in some form since 1896 when the State Federal Soldier's Home was established.[36] Today, the seven Missouri Veterans Homes are managed by the MVC, a state agency established by legislature and governed by Chapter 42, RSMo. The MVC operates three core programs: the Veterans Service Program, the Veterans Homes Program, and the Veterans Cemeteries Program.[37] The MVC aids Veterans, their dependents, and legal representatives by providing information regarding their rights as Veterans and assistance in accessing the benefits available through state and federal government.[38] The MVC serves more than 458,000 Veterans and through its operation these programs.[39] The MVC's duties are enumerated by statute and include assisting Veterans in obtaining benefits earned following service.[40]

The MVC is composed of nine members.[41] Two are members of the Senate with one appointed by the President Pro Tem of the Senate and one appointed by the Senate Minority Floor Leader. Two are members of the House of Representatives with one appointed by the Speaker of the House of Representatives and one appointed by the House Minority Floor Leader.[42] These four members serve a two-year term or until a successor is appointed. These members may be reappointed to the Commission.[43] Preference must be given to current or former members of the military and their spouses, parents, and children.[44]

The remaining five members consist of Veterans appointed by the Governor, with the advice and consent of the Senate, for a four-year term.[45] The MVC members are not compensated for their services, but may be reimbursed from funds appropriated therefor for actual and necessary expenses incurred in the performance of their duties.[46]

Currently, the MVC's members are Senator Jill Schupp, Senator Wayne Wallingford, Representative Steven Lynch, Representative Robert Sauls, Dr. John Buckner, Dr. Jose Dominguez, Meredith Knopp, Tim Noonan, and Tim Smith.[47]

The MVC is also required to have an Executive Director as its "Chief Administrative Officer."[48] The Executive Director is "in charge of the staff of the commission and responsible for execution of the duties vested in the commission."[49] The Executive Director is appointed by the nine MVC commissioners and must have served in military forces of the United States.[50] The Executive Director is not required to have a medical or nursing background nor any prior

experience operating or managing long-term care facilities. The Executive Director's compensation is fixed by the MVC as provided by law.[51]

In July 2020, COL. Paul Kirchhoff was appointed Executive Director of the MVC.[52] His predecessor, Col. Grace Link, resigned effective May 31, 2020, after accepting a position with the VA.[53]

B. Veterans Homes

Pursuant to RSMo. § 42.100, the MVC is required to maintain "facilities for the care of Veterans who require institutional health care services as shall be funded by appropriations of the general assembly." The MVC manages 1,238 beds with more than 500 employees across its seven Veterans Homes, which are located in Cameron, Cape Girardeau, Mexico, Mount Vernon, St. James, St. Louis, and Warrensburg.[54] In addition to residential services, the Veterans Homes provide physician care; physical, speech, occupational and recreational therapy; medications; cosmetology; maintenance, environmental and social services; dietary specialists; and specialized programming for dementia care.[55]

C. Rules and Regulations Applicable to the MVC Homes

Missouri Veterans Homes are exempt from the licensing requirements for state residential care facilities located in Missouri.[56] Missouri law requires the MVC to make all rules regulating the necessary management of the Homes, including sanitary standards and funding.[57] Missouri law requires the Missouri Veterans Homes to participate in the per diem grant program administered by the VA.[58] To receive the per diem, the Missouri Veterans Homes must meet the VA standards set forth at 38 C.F.R. § 51.100, *et seq.* These VA regulations require the Homes to meet several safety standards and outline the facility, staffing, and service requirements applicable to state-sponsored Veterans Homes. More specifically, these standards require Missouri Veterans Homes to protect the health and safety of Veterans, personnel, and the public by providing "[a] safe, clean, comfortable, and homelike environment" that has "a sanitary, orderly, and comfortable interior." [59] Additionally, these regulations require the Homes to establish a Resident Council to bring concerns to the facility's management team.[60]

To ensure Veteran safety, the regulations also require the Homes to "establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection" as follows:

> **(a) Infection control program.** The facility management must establish an infection control program under which it—
>
> (1) Investigates, controls, and prevents infections in the facility;
>
> (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
>
> (3) Maintains a record of incidents and corrective actions related to infections.
>
> **(b) Preventing 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.

38 C.F.R. § 51.190(a-b)

In addition to the VA per diem grant, funding is also provided pursuant to Missouri statute and constitutional amendments [61] as well as from appropriations of the General Assembly.[62] The Veterans Commission Capital Improvement Trust Fund, established by statute, is administered by the Missouri Treasurer and may be used solely, upon appropriation, for purposes provided by statute including, *inter alia*, the construction, maintenance, renovation, equipment, and operational needs of the Veterans Homes and cemeteries and administration of the MVC.[63]

A financial summary of DPS as included in Missouri's 2020 Executive Budget outlines the MVC's 2018 fiscal year expenditure, 2019 fiscal year appropriation, and the Governor's recommended budgeting for the 2020 fiscal year:[64]

DEPARTMENT OF PUBLIC SAFETY
MISSOURI VETERANS' COMMISSION

FINANCIAL SUMMARY

	FY 2018 EXPENDITURE	FY 2019 APPROPRIATION	FY 2020 GOVERNOR RECOMMENDS
Administration and Service to Veterans	$ 5,433,862	$ 6,140,682	$ 6,253,192
Veterans' Service Officer Program	1,421,212	1,600,000	1,600,000
Veterans' Homes	78,082,538	82,337,426	87,303,298
World War I Memorial	103,650	150,000	150,000
TOTAL	**$ 85,041,262**	**$ 90,228,108**	**$ 95,306,490**
PERSONAL SERVICE			
General Revenue Fund	194,784	0	0
Veterans Commission Capital Improvement Trust Fund	4,066,774	4,690,718	4,804,034
Missouri Veterans' Homes Fund	54,139,787	58,003,035	59,519,600
EXPENSE AND EQUIPMENT			
Veterans Commission Capital Improvement Trust Fund	1,174,776	1,456,213	4,904,714
Missouri Veterans' Homes Fund	23,878,503	24,254,330	24,254,330
Veterans' Trust Fund	61,776	73,812	73,812
World War I Memorial Trust Fund	103,650	150,000	150,000
PROGRAM SPECIFIC DISTRIBUTION			
Veterans Commission Capital Improvement Trust Fund	1,421,212	1,600,000	1,600,000
TOTAL			
General Revenue Fund	194,784	0	0
Veterans Commission Capital Improvement Trust Fund	6,662,762	7,746,931	11,308,748
Missouri Veterans' Homes Fund	78,018,290	82,257,365	83,773,930
Veterans' Trust Fund	61,776	73,812	73,812
World War I Memorial Trust Fund	103,650	150,000	150,000
Total Full-time Equivalent Employees	**1,797.10**	**1,753.69**	**1,753.69**
General Revenue Fund	5.22	0.00	0.00
Other Funds	1,791.88	1,753.69	1,753.69

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

While the Homes' facilities are exempt from the licensing requirements for state residential care facilities located in Missouri, the Homes are nevertheless obligated to ensure the safety and well-being of Veterans in the Homes, which includes the obligation to follow applicable state and federal guidance aimed at reducing the spread of COVID-19.State and federal agencies, including the CDC, Centers for Medicare and Medicaid Services ("CMS"), and DHSS have issued guidance to long-term care and skilled nursing facilities aimed at limiting and preventing the transmission of COVID-19.

E. Centers for Disease Control and Prevention

Since February 2020, the CDC has consistently published guidelines directed at preventing the spread of COVID-19 infections. While the Homes are not required to comply with CDC guidelines, universally each of them strives to do so and have used the CDC guidelines in responding to the COVID-19 pandemic. The guidelines pertinent to our investigation are identified herein, have not been substantially altered since being issued, and remain in effect.

1. Guidance Issued April 29, 2020

The CDC published its initial guidelines specific to nursing homes and long-term care facilities on April 29, 2020.[65] These guidelines recommend that facilities identify a location for a specific COVID-19 care unit and create a contingency staffing plan to implement when residents or healthcare personnel with COVID-19 are identified in the facilities.[66]

The CDC also recommends facilities take the following steps, among others, in preparing for COVID-19 infections at a facility:

> Physically separating the COVID-19 unit from rooms or units housing residents who have not been confirmed to have COVID-19.
>
> Assigning dedicated healthcare professionals to work only on the COVID-19 care unit, including at least the primary nursing assistants and nurses assigned to care for the residents, and restricting access of ancillary personnel (e.g., dietary).
>
> Ensuring health care providers practice source control measures and social distancing in common areas.
>
> Utilizing signage at the entrance to the COVID-19 care unit instructing healthcare personnel to wear eye protection and an N95 or higher-level respirator (or face mask if respirator is not available) at all times while on the unit.
>
> Requiring gowns and gloves to be worn when entering a resident's room.
>
> Ensuring healthcare personnel are trained on infection prevention measures, including the use of and steps to properly put on and remove recommended personal protective equipment ("PPE").
>
> Implementing strategies to optimize PPE supply in the event of a shortage, including considering extended use of respirators, eye protection, and gowns, to the extent necessary.
>
> Creating a plan for managing new admissions and readmissions of residents whose COVID-19 status is unknown, including by placing these individuals in a separate observation to be monitored for evidence of COVID-19.[67]

Infections among Staff Members: Upon discovery of personnel with a suspected case of COVID-19, facilities should identify which residents received direct care from, and which personnel had unprotected exposure to, the COVID-19 infected personnel in the 48 hours prior to the individual's onset of symptoms.[68] Additionally, residents who were cared for by the infected individual should be restricted to their rooms with care being provided utilizing all recommended COVID-19 PPE until it is determined whether the resident is infected with COVID-19. If the resident tests positive for COVID-19, the resident should be cared for utilizing full PPE until 14 days after last exposure to the individual infected with COVID-19.[69] CDC guidance further directs facilities to consider testing asymptomatic residents and personnel who were exposed to the individual infected with COVID-19.[2]

Infections among Residents: Upon discovery of a resident with a confirmed COVID-19 infection, facilities should isolate the resident in a dedicated COVID-19 care unit and care for the resident using all recommended PPE.[70] Residents with a suspected COVID-19 infection or exposure to a COVID-19 infected person should be quarantined and monitored unless the residents remain asymptomatic and/or test negative for COVID-19 14 days after their last exposure.[71]

The CDC directs long-term care facilities to take the following additional steps in the event a resident tests positive for COVID-19:

> Consider temporarily halting admissions to the facility, at least until the extent of transmission can be clarified and interventions can be implemented.
>
> Increase monitoring of ill residents, including assessing symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, at least 3 times daily to identify and quickly manage serious infections.
>
> Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms.
>
> Counsel all residents to restrict themselves to their room to the extent possible.
>
> Use all recommended COVID-19 PPE when caring for any resident on affected units (or facility-wide if cases are widespread), this includes symptomatic and asymptomatic residents.

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[2] The PPE recommended by CDC guidance when caring for an individual with a suspected or confirmed case of COVID-19 include (1) respirator or facemask; (2) eye protection; (3) gloves; and (4) gowns. See https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html

> If PPE supply is limited, implement strategies to optimize PPE supply, which might include extended use of respirators, facemasks, and eye protection and limiting gown use to high-contact care activities and those where splashes and sprays are anticipated.
>
> Notify personnel, residents, and families and reinforce basic infection control practices within the facility (e.g., hand hygiene, PPE use, environmental cleaning)."[72]

In addition to these steps, the CDC addressed testing: "If testing capacity allows, use of facility-wide testing following identification of newly identified SARS-CoV-2 infected residents or [healthcare personnel] could be particularly important. Facility-wide testing can help identify asymptomatic or pre-symptomatic residents with COVID-19 to guide movement into COVID-19 designated spaces."[73]

2. Memory Care Guidance Issued May 11, 2020

On May 11, 2020, the CDC issued specific infection prevention and control guidelines for memory care units[74] (each Home has a memory care unit). Recognizing infection prevention strategies to mitigate the spread of COVID-19 "are especially challenging to implement in dedicated memory care units where numerous residents with cognitive impairment reside together," the CDC recommends long-term care facilities with memory care consider the following recommendations:

> Routines are very important for residents with dementia. Try to keep their environment and routines as consistent as possible while still reminding and assisting with frequent hand hygiene, social distancing, and use of cloth face coverings (if tolerated). Cloth face coverings should not be used for anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
>
> Dedicate personnel to work only on memory care units when possible and try to keep staffing consistent. Limit personnel on the unit to only those essential for care.
>
> Continue to provide structured activities, which may need to occur in the resident's room or be scheduled at staggered times throughout the day to maintain social distancing.
>
> Provide safe ways for residents to continue to be active, such as personnel walking with individual residents around the unit or outside.
>
> Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel.
>
> Frequently clean often-touched surfaces in the memory care unit, especially in hallways and common areas where residents and staff spend a lot of time.

Continue to ensure access to necessary medical care, and to emergency services if needed and if in alignment with resident goals of care.[75]

Given the unique challenges with restricting residents in a memory care unit to their rooms, all personnel on the unit should utilize eye protection and N95 respirators (to the extent available).[76]

Further, while moving infected residents to a designated COVID-19 care unit can help decrease the risk of exposure, the CDC acknowledged that moving residents with cognitive impairment to new locations within a facility "may cause disorientation, anger, and agitation."[3] Accordingly, facilities "may determine that it is safer to maintain care of residents with COVID-19 on the memory unit with dedicated personnel."[77]

3. Testing Guidance Issued May 18, 2020

On May 18, 2020, the CDC issued the following considerations, among others, regarding COVID-19 testing protocols for residents and personnel:

Bystanders should not be present for specimen collection.

Swabbing of multiple individuals should not be performed in the same room at the same time unless swabbing stations are greater than 6 feet apart.

When testing is taking place in succession in a single room, consider the use of portable HEPA filters to increase air exchanges and to expedite removing infectious particles and minimize the amount of time healthcare personnel spend in the room.

Consider whether self-collection is appropriate, including whether the tested individuals can correctly self-swab in a way that avoids contamination.

Healthcare personnel in the room should wear N95 respirators and eye protection, and the individual responsible for specimen collection should wear gloves and a gown (gloves should be changed and hand hygiene performed between each person swabbed).

Surfaces within 6 feet of where specimen collection was performed should be cleaned and disinfected using an EPA-registered disinfectant if visibly soiled and at least hourly.

Terminal cleaning and disinfection of all surfaces and equipment in the specimen collection area should take place at the end of each day.[78]

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[3] The CDC explained that if residents with COVID-19 are moved from the memory care unit, the facility should (1) provide information about the move to residents and be prepared to repeat that information as appropriate; (2) prepare personnel on the receiving unit about the habits and schedule of the person with dementia and try to duplicate it as much as possible; and (3) move familiar objects into the space before introducing the new space to the resident.

4. Long-Term Care Facilities June 25, 2020 Infection Prevention Guidance

The CDC issued its most recent guidance on the subject of COVID-19 transmission in nursing homes and long-term care facilities on June 25, 2020.[79] The CDC stated, "[g]iven 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 and other pathogens, including multidrug-resistant organisms (e.g., Carbapenemase-producing organisms, Candida auris)." [80] For that reason, a strong infection prevention and control ("IPC") program is critical to protect residents and healthcare personnel. Accordingly, the CDC directed nursing home and long-term care communities to implement the following "core practices," practices which should remain in place even as facilities resume normal activities:

> Assign one or more individuals with training in infection control to provide on-site management of the IPC program.
>
> Report COVID-19 cases, facility staffing, and supply information to the National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module weekly.
>
> Educate residents, healthcare personnel, and visitors about COVID-19, current precautions being taken in the facility, and actions they should take to protect themselves.
>
> Implement source control measures, including ensuring healthcare personnel wear a facemask at all times when they are in the facility, residents wear a cloth face covering or facemask (if tolerated) whenever they leave their room, and visitors wear a cloth face covering while in the facility.
>
> Have a plan for visitor restrictions, including by facilitating and encouraging virtual methods for visitation and screening visitors prior to entering the facility.
>
> Create a plan for testing residents and healthcare personnel for COVID-19, including expanded viral testing of all residents if there is an outbreak in the facility (i.e., a new COVID-19 infection in any healthcare personnel or resident) and repeat testing to ensure there are no new infections among residents.[81]
>
> Evaluate and manage healthcare personnel, including asking staff to regularly monitor themselves for fever and symptoms for COVID-19, screening all healthcare personnel at the beginning of their shift for fever and symptoms of COVID-19 and developing plans to mitigate staffing shortages from illness or absenteeism.

Provide supplies necessary to adhere to recommended infection prevention and control practices, including ensuring sufficient hand hygiene supplies, respiratory hygiene and cough etiquette, PPE, and environmental cleaning and disinfection.

Identify space that could be dedicated to monitor and care for residents with COVID-19.

Evaluate and manage residents with symptoms of COVID-19, including (1) asking residents to report if they feel feverish or have symptoms consistent with COVID-19; (2) actively monitoring all residents at least three times daily for fever and symptoms consistent with COVID-19; and (3) transporting residents to another facility if the resident requires a higher level of care or the facility cannot fully implement all recommended infection control precautions.[82]

In addition to these "core practices," and in conjunction with state and local guidance, the CDC recommends additional strategies depending on the facility's reopening status, including: (1) implementing aggressive social distancing measures and remaining at least 6 feet apart from others by cancelling communal dining and group activities and reminding residents and healthcare personnel to practice social distancing; (2) implementing visitor restrictions by prohibiting all visitation to the facilities except for certain compassionate care reasons and end-of-life situations; and (3) restricting non-essential healthcare personnel and volunteers from entering the building.[83]

5. Return-to-Work Criteria Updated August 10, 2020

The CDC's most current guidance allows personnel to return to work following a COVID-19 infection under the following circumstances: [84]

Healthcare personnel with mild to moderate illness who are not severely immunocompromised may return to work following:

- At least 10 days have passed since symptoms first appeared; and
- At least 24 hours have passed since last fever without the use of fever-reducing medications; and
- Symptoms (e.g., cough, shortness of breath) have improved.

Healthcare personnel with severe to critical illness or who are severely immunocompromised, in consultation with infection control experts, may return to work following:

- At least 10 days and up to 20 days have passed since symptoms first appeared; and

- At least 24 hours have passed since last fever without the use of fever-reducing medications; and
- Symptoms (e.g., cough, shortness of breath) have improved.

Healthcare personnel who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.

Healthcare personnel who are severely immunocompromised but who were asymptomatic throughout their infection may return to work when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.[85]

Alternatively, a test-based strategy may be used which permits healthcare personnel to return to work when: (1) the fever (if any) is resolved without the use of fever-reducing medications; (2) symptoms (if any) have improved; and (3) results are negative from at least two consecutive respiratory specimens collected at least 24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect COVID-19.[86]

F. Missouri Department of Health and Senior Services

While the Homes are not required to meet the licensing standards applicable to Missouri long-term care facilities, DHSS guidance is relevant to long-term care facilities located within Missouri and is something with which the Homes strive to comply. DHSS guidance, issued on August 31, 2020, details criteria the State deems necessary for reducing the transmission of COVID-19 in long-term care facilities. Specifically, DHSS guidance addresses the following topics: (1) administrative actions, (2) reporting and notification requirements, (3) PPE, (4) testing, (5) physical environment, (6) visitor management, (7) resident management, (8) considerations for special populations, (9) staff management, and (10) environmental management.[87] Essentially, DHSS guidance echoes that promulgated by the CDC as set forth above and, therefore, is not repeated herein.

G. Centers for Medicare and Medicaid Services

Because the Homes do not receive Medicare funding, they are not required to comply with CMS directives.

III. FACT FINDING

The investigation included interviews with 99 individuals including MVC Headquarters personnel, staff from each Home, external stakeholders, plus an additional 75 family members, Veterans, and volunteers between October 15 and November 10, 2020. As more specifically set forth in the above *Scope and Approach to the Investigation* of this Report, we interviewed personnel from all levels of each Home's operations, MVC staff, the State Epidemiologist, and members of the state Fusion Cell. A chart detailing the identities of all individuals interviewed and the dates of each interview is attached as Appendix A. Additionally; we reviewed and analyzed approximately 920 documents. A chart detailing each of the documents reviewed and analyzed is attached as Appendix D.

As previously stated, as directed by the MVC, our team worked with Pathway, a professional management and consulting organization serving clients in the long-term care and post-acute care industry,[88] to audit the operations of each Home. Pathway's expertise and findings provided valuable context and insight to the observations and conclusions gleaned from Armstrong Teasdale's interviews and document review. The reports Pathway generated pertinent to each Home are attached as Appendix E1 to E14.

Finally, through the call-in hotline, we spoke to 75 family members, Veterans, volunteers, and nurses between October 29 and November 4, 2020. A chart detailing these specifics of these interviews is attached as Appendix B.

The interviews, document review, and on-site visits revealed failures, deficiencies, and opportunities for improvement throughout the hierarchy of the Homes and the MVC in the areas of communications regarding, preparations for, and responses to the COVID-19 outbreak. These failures, deficiencies, and opportunities for improvement were evident across the entire team tasked with caring for the Veterans, at both organization and individual levels. The following sections contain a comprehensive overview of each Home and include the following categories:

Subject Categories of Home Sections:
1. Summary of Observations and Concerns;
2. Structure of the Home;
3. COVID-19 Preparation;

Subject Categories of Home Sections:
4. Outbreak and Timeline;
5. Response to Outbreak;
i. Quarantine and Isolation;
ii. Visitors;
iii. Screening and Testing;
iv. Training;
v. PPE and Additional Procedural Changes;
vi. Staffing;
vii. Communication;
viii. Impact on Veterans; and
6. Regional Considerations.

1. Pathway's On-Site Home Visits

As this chart lists, Pathway consultants visited each Home between October 26 and October 30, 2020.

Missouri Veterans Home	Dates of On-Site Review
Cameron Home	October 26 – 27, 2020
Cape Girardeau Home	October 28 – 29, 2020
Mexico Home	October 30, 2020
Mount Vernon Home	October 26 – 27, 2020
St. James Home	October 28 – 29, 2020
St. Louis Home	October 28 – 29, 2020
Warrensburg Home	October 28 – 29, 2020

Pathway's specific findings relative to each Home are summarized in the Report sections pertinent to each Home. Overall, however, Pathway identified several common strengths and weaknesses throughout the on-site audits.

Universally, Pathway found the front-line staff at each Home, the people running the Homes and actually caring for the Veterans, are fully dedicated and committed to the needs of the Veterans. The staff genuinely cares for the Veterans and is doing their best to diligently and compassionately tend to the Veterans in these stressful and rapidly changing circumstances. Further, the Homes' leadership teams were cooperative and informative throughout the process.[89] Pathway observed instances of positive leadership and collaboration of personnel at the Homes, including the Homes' empowerment of staff to take necessary action to protect the Veteran population.[90]

On the other hand, Pathway observed several common concerns and issues throughout their on-site audits. These include a lack of clear lines of communication between the Homes' leadership and the direct care staff with respect to infection prevention and mitigation guidance.[91] Each Home lacks a comprehensive COVID-19 preparedness and response plan. While the Homes utilize COVID-19 related directives promulgated by MVC, the Homes (and MVC) lack formal infection control and prevention policies at a generic level as well as specific to COVID-19.[92] Further, the directives themselves do not constitute a comprehensive and considered plan but rather are reactionary and haphazard, issued in a piecemeal fashion, often contradicting each other, do not comply with the CDC or VA guidelines set forth in the body of this Report, and do not comport with "best practices" related to infection control. As a result, the Homes are unable to adequately train and educate the staff. In turn, the staff act inconsistently among each other and inconsistent with relevant VA and CDC guidelines as well as best infection control practices.[93]

Further, the Homes (and MVC) lack current, comprehensive, and consistent infection prevention and control policies and procedures as required by the VA and CDC guidelines cited herein.[94] While some infection control policies exist on an electronic database at each Home, many staff, including one nursing manager, were unable to access the database on which the policies and procedures reside.[95] Pathway's on-site audits also identified that front-line staff at the Homes are not aware of infection control and COVID-19 policies and procedures.

Additional concerns Pathway identified include: (1) failure to follow CDC guidelines regarding use of common spaces and implementation of social distancing by both Veterans and staff; (2) symptom screening and COVID-19 testing of Veterans and staff which was non-compliant with CDC guidance; (3) improper and inconsistent use and optimization of PPE; (4) inconsistent,

improper, and untimely use of and movement of Veterans among quarantine and isolation units; (5) failure to assign dedicated staff to the quarantine and isolation units; (6) infection prevention nurses have other duties and are unable to devote the necessary time to infection prevention; (7) improper use of disinfecting agents by environmental services staff; and (8) an overall lack of planning for the COVID-19 outbreak.96 [4]

While Pathway was impressed by the dedication of staff and the cooperation of the Homes' leadership teams, Pathway's observations and concerns were consistent with the concerns our investigation identified.

[4] These concerns are raised in addition to several other Home-specific concerns identified in the following sections applicable to each Home.

A. Cameron Home

1. Summary of Observations and Concerns

There are many positive practices performed at the Cameron Home. Additionally, Pathway encountered cooperative and informative leadership at the Cameron Home throughout Pathway's visit and Pathway observed that the Cameron Home's staff is dedicated to the needs of the Veterans they serve. However, as noted above, several concerns were identified and observed during the interviews and Pathway visit, including the Cameron Home's (1) failure to plan for sufficient isolation and quarantine units that could be utilized in an outbreak; (2) failure to separate Veterans with suspected or confirmed COVID-19 cases from the Veteran population; (3) failure to appropriately quarantine Veterans who temporarily leave the Cameron Home; (4) failure to implement an effective response plan and communicate changes in protocols in a uniform and effective manner; (5) failure to implement testing and screening in a way to avoid the risk of COVID-19 transmission; and (6) failure to follow appropriate guidelines for storing and re-using PPE.

2. Structure of the Cameron Home

The Cameron Home located at 1111 Euclid, in Cameron, Missouri 64429 opened in 2000. While it has the capacity to be home to 200 Veterans, the Home currently serves 132 Veterans. The Cameron Home is divided into four communities of approximately 50 Veterans each separated by fire walls.[97] The Cameron Home communities are Apple Grove (A-Unit), Briar View (B-Unit), Cherry Hill (C-Unit), and Dover's Point (D-Unit).[98]

3. COVID-19 Preparation

The Cameron Home implemented contagion prevention and mitigation procedures in March 2020, when Clinton County experienced its first case of COVID-19.[99] According to Daniel Leff, the Director of Social Work for Cameron Home, "it was a swift and conservative response." While some families complained the measures were strict, he said "we need to continue to be stringent."[100]

The Cameron Home has been locked down since early March 2020. Veterans were originally asked to remain in their rooms and the doors allowing the Veterans' access from one community to

another were closed. 101 Veterans leaving their rooms were instructed to wear a face mask and practice social distancing.102

While the Cameron Home allowed outdoor visitations prior to this outbreak, no visitors have been permitted indoors since March.103 Cameron Home's lock-down also applied to outside service providers and delivery personnel. Supplies delivered to the Home were temporarily quarantined.104 The Cameron Home held town hall meetings at least once per month in the chapel or dining area where staff can be socially distanced, and the Cameron Home prohibited large group events or activities with more than 10 individuals.105

Also in March, the Cameron Home required staff members to wear surgical masks in the Home at all times. Staff members also underwent a COVID-19 screening process before being allowed to work and underwent PPE instruction and training.106 The Cameron Home commenced nasopharyngeal or PCR testing on May 27, and since on or about July, such testing has been required for all staff and Veterans twice per week, on Mondays and Thursdays. Staff members must participate in the scheduled testing even if they are not scheduled to work on the day of testing.107

During spring and summer, the Cameron Home received guidance from the MVC which essentially echoed recommendations from the CDC and DHSS.108 Additionally, the Administrator, Assistant Administrator, and Director of Nursing participated in daily calls with MVC's Headquarters (initially including Col. Grace Link and Home Director Joan Elwing), during which the call participants discussed the COVID-19 pandemic and identified strategies for limiting the spread of COVID-19.109

In preparation for COVID-19 infections, the Cameron Home converted a portion of its Apple Grove community into isolation and quarantine areas to be used for Veterans with a suspected or confirmed case of COVID-19.110 The eight-bed isolation and eight-bed quarantine areas were completed by April 1, and the isolation and quarantine areas include a station at which to don and doff PPE.111 The isolation area was equipped to limit the spread of COVID-19 and incorporated an extra air handler to bring air pressure down and prevent filtration of the air from reaching other areas of the Apple Grove community.112

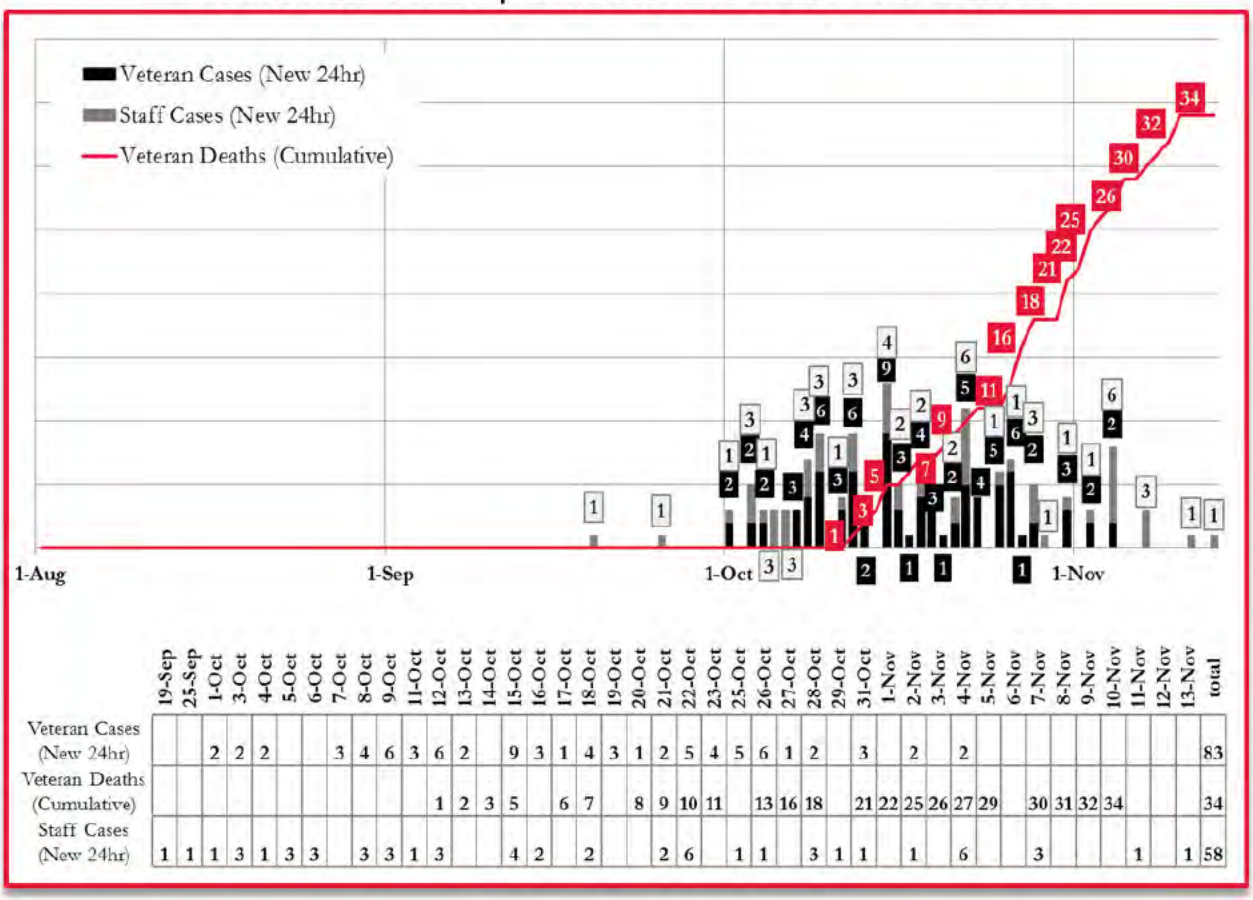
4. Outbreak and Timeline

The first COVID-19 positive case at the Cameron Home was of a staff member on September 19, 2020.113 This staff member was on vacation at the time of infection and did not

return to work until permitted by CDC guidance.[114] A second staff member tested positive on September 25, 2020.[115]

The first Veterans testing positive at the Cameron Home included two Veterans who tested positive during September 29 – October 1, 2020.[116] Commencing September 29, 2020, the Cameron Home experienced the following positive tests for COVID-19 among Veterans and staff members:[117]

Cameron Home | Timeline of Cases and Deaths



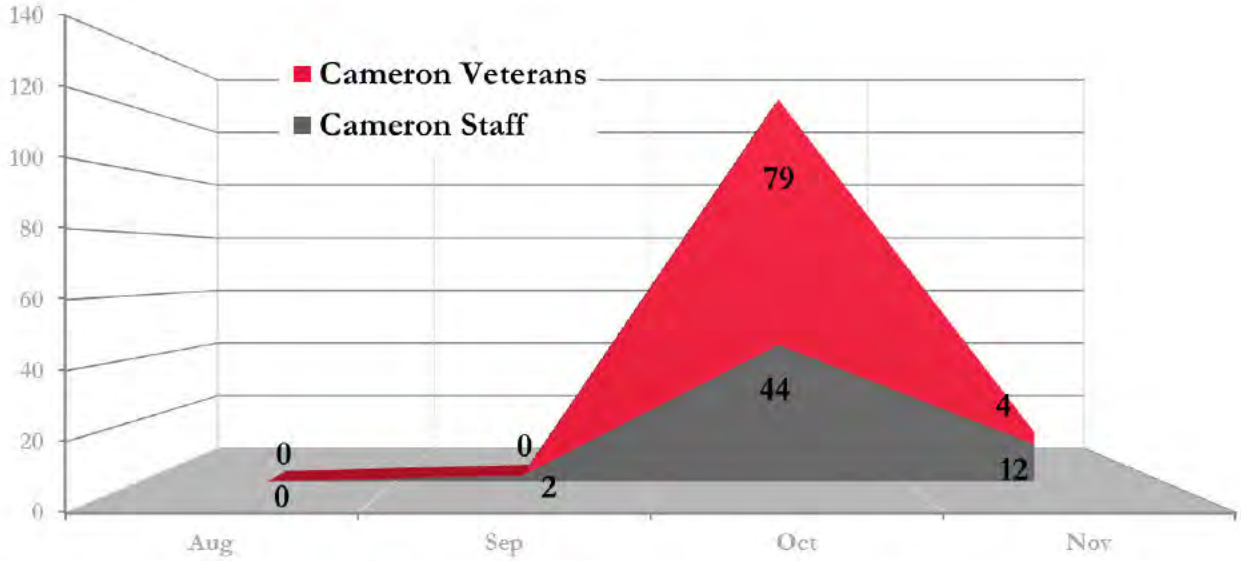
	19-Sep	25-Sep	1-Oct	3-Oct	4-Oct	5-Oct	6-Oct	7-Oct	8-Oct	9-Oct	11-Oct	12-Oct	13-Oct	14-Oct	15-Oct	16-Oct	17-Oct	18-Oct	19-Oct	20-Oct	21-Oct	22-Oct	23-Oct	25-Oct	26-Oct	27-Oct	28-Oct	29-Oct	31-Oct	1-Nov	2-Nov	3-Nov	4-Nov	5-Nov	6-Nov	7-Nov	8-Nov	9-Nov	10-Nov	11-Nov	12-Nov	13-Nov	total
Veteran Cases (New 24hr)			2	2	2			3	4	6	3	6	2		9	3	1	4	3	1	2	5	4	5	6	1	2		3		2		2									83
Veteran Deaths (Cumulative)												1	2	3	5		6	7		8	9	10	11		13	16	18		21	22	25	26	27	29		30	31	32	34				34
Staff Cases (New 24hr)	1	1	1	3	1	3	3		3	3	1	3			4	2		2			2	6		1	1		3	1	1		1		6			3			1		1	58

As illustrated above, the recent outbreak at the Cameron Home commenced during the period of September 29 through October 1, when a Veteran residing in the Cherry Hill community tested positive following the Veteran's return from a hospital visit.[118] Following the Veteran's positive PCR test for COVID-19, the Veteran and his roommate were immediately transferred outdoors and to the isolation and quarantine area in the Apple Grove community, where the Veteran who tested positive was taken to an isolation unit and the Veteran's roommate was

transferred to the quarantine area for testing and further observation.[119] During this time, [redacted] also tested positive for COVID-19.[120]

At the notification of the first Veteran cases, all Veterans were quarantined to their communities and Veterans were no longer permitted to voluntarily travel between the Veteran communities.[121] Notably, the Briar View community, which continues to house approximately 35 to 40 Veterans, has not experienced a single case of a resident testing positive for COVID-19.[122]

The following chart provides an illustration of the Veterans and staff members testing positive for COVID-19 to date, with the Veterans experiencing an infection rate nearly double that of the staff:



	Aug	Sep	Oct	Nov
Cameron Veterans	0	0	79	4
Cameron Staff	0	2	44	12

5. Response to Outbreak

As one family member described that "once COVID got into the Home, it was like all hell broke loose, quite frankly."[123]

i. Quarantine and Isolation

The isolation and quarantine areas are comprised of two wings, with each area walled off with plastic walls and magnetic closures.[124] A Veteran is transferred to isolation if the Veteran tests

positive for COVID-19.[125] Veterans are released from isolation after 20 days with no or improved symptoms and the receipt of a negative rapid test and a negative PCR test.[126] If a Veteran is quarantined but not transferred to isolation, the Veteran is released after 14 days if the Veteran has no symptoms and receives a negative PCR test.[127] When a Veteran tests positive, he or she is transferred to the Apple Grove community by wheelchair with an N95 respirator to the external door for the Apple Grove community to avoid travel through the Home.[128] If the Veteran has a roommate, the roommate is quarantined while the Veteran awaits test results.[129] The Home does not allow new admissions, resulting in a drop of the Veterans served from 200 to approximately 132.[130]

Veterans in isolation and quarantine require extra care.[131] Due to the unique circumstances posed by placing Veterans in quarantine and isolation for their safety and the safety of their fellow Veterans, Veterans in isolation and quarantine require someone to bring them their mail and extra clothing from their original room.[132] The Director of Social Work, Daniel Leff, explained that he visits quarantine and isolation to check on the Veterans, facilitate communication with their families, and arrange telehealth visits with health care providers and counselors.[133] Mr. Leff confirmed that when he visits isolation and quarantine areas, he dons full PPE in the unit.[134] Staff members are not permitted to access other communities of the Cameron Home after the staff members in the isolation unit that day.[135]

While the Cameron Home had prepared the separate isolation and quarantine areas used for the first two Veterans who tested positive for COVID-19, the COVID-19 cases among Veterans quickly climbed and the isolation area was insufficient to care for the number of infected Veterans.[136] Therefore, the Cameron Home utilized the entire Apple Grove community to isolate residents testing positive for COVID-19 because Apple Grove was experiencing the highest rate of infection among Veterans.[137] While the Cameron Home recommended Veterans transfer out of the Apple Grove community and into another community if the Veterans have not tested positive for COVID-19, some Veterans refused and remained in the isolated Apple Grove community.[138] To accommodate quarantine needs, the Cameron Home converted a portion of the Briar View community into a new quarantine area.[139] Following the outbreak commencing on October 1, all staff are now required to wear gowns, gloves, respirators, and face shields in each community.[140] After visiting each room, staff is required to change their gowns, gloves and wipe their face shields.[141] The originally-planned isolation and quarantine areas were better equipped to limit the spread of COVID-19 than the Apple Grove and Briar View communities.[142] As noted above, the

planned isolation area incorporated an extra air handler to bring air pressure down and prevent filtration of the air from reaching other areas of the community.[143]

While visitors have not been allowed inside the Home, family members have been permitted to visit Veterans in critical condition subject to complying with temperature checks, screening surveys, and PPE requirements.[144] The MVC has also approved certain vendors (skilled therapy and one part-time barber) to enter the Cameron Home, subject to the same entry screening and PPE requirements as staff.[145]

The implementation of rapid antigen testing on or about October 6, 2020, has allowed the Cameron Home to identify and isolate cases more effectively.[146] However, residents are not always transferred to isolation immediately upon receiving a confirmed positive COVID-19 test. The Cameron Home's Staff Development Director, Monica Bonderer, recalled that on or about October 12, 2020, she personally tested two Veterans in Dover's Point (the memory care unit).[147] Those two Veterans tested positive but were not moved to the isolation unit until the following day, at which time three more residents in the Dover's Point community tested positive.[148] Four more residents in the Dover's Point community subsequently tested positive.[149] Ms. Bonderer questioned the decision not to move the first two positive residents, but the Administrator, David Hibler, informed Ms. Bonder that the decision to transfer the Veterans was "not her call," citing the residents' need for memory care in Dover's Point.[150] Ms. Bonderer expressed concern because she knows Veterans receiving special services in Dover's Point seldom stay in their rooms, and she believes this contributed to the outbreak in Dover's Point.[151] All Veterans in Dover's Point thereafter tested positive for COVID-19 and were moved to isolation.[152]

ii. Visitors

As explained above, the Cameron Home ceased indoor visitations in March 2020. However, the Cameron Home did arrange for outdoor visits, including socially-distanced face-to-face visits and hand-holding visits.[153] Family members submitted to temperature checks, screening surveys, and agreed to maintain distance from their Veteran as conditions for family visits.[154] In order to keep Veterans engaged, the Cameron Home's social workers have engaged in increased phone calls and video calls to Veterans' families.[155] Despite restrictions on indoor visits, the Cameron Home was cited in August for having let volunteers into the building to work the staff checkin-area.[156] In addition, at least one family member was discovered roaming the Home without a chaperone and

was not visiting for end-of-life reasons.[157] The Cameron Home ceased all further family visits effective September 30, 2020.[158]

Notably, Mr. Leff recently drove a Veteran to a radiology appointment in Kansas City because there was no available driver, and neither the Veteran nor Mr. Leff were asked to quarantine or self-isolate following the appointment.[159]

iii. Screening and Testing

Prior to the COVID-19 outbreak commencing October 1, 2020, employees were tested for COVID-19 weekly or bi-weekly.[160] The Cameron Home began utilizing PCR tests to test for COVID twice per week after June 2020.[161] All staff were tested on Mondays and Thursdays, even if the staff members were not scheduled to work that day.[162] PCR tests were also administered to patients on those same days.[163] Starting October 6, 2020, the Cameron Home implemented daily rapid testing on the days that the Cameron Home does not conduct PCR testing.[164]

At the time of the first two positive cases, the Cameron Home was conducting PCR testing twice a week on Tuesdays and Fridays.[165] However, on October 6, 2020, the Cameron Home received the shipment of rapid tests and implemented daily rapid testing immediately.[166] The Cameron Home's specialty care unit, Dover's Point, began experiencing positive cases of COVID-19 on or about October 15, 2020.[167] The fourth community, Briar View, had not had any positive COVID-19 cases among the Veterans at the time the Cameron Home's staff was interviewed.[168]

When staff members arrive, they are given a surgical mask and instructed to use hand sanitizer.[169] Staff members are provided surgical masks at the start of the day, but if staff members go to any unit, the staff member must wear respirator, gown, and face shield.[170] Staff members are permitted to utilize the same N95 respirator throughout the day; however, each time a staff member cares for a new Veteran the staff member is required to don new PPE.[171]

Laura Clark, the Cameron Home Personnel Manager, explained that employees must clock in at the administration area in the hallway.[172] When employees arrive, the employees are required to put on a mask and hand sanitizer and then walk through the hallway to clock in.[173] The employees then engage in testing and symptom screening in the entrance to the Home and wait in that area for the results of their tests for 10 to 15 minutes.[174] This process results in congestion and crowding in the testing area.[175] Ms. Clark recommended that the Home move the clock-in area to prevent congestion and crowding, and to avoid COVID-19-postive staff members from congregating and

moving through the Home; however, she was informed that the Cameron Home does not have the resources to make this change.[176] Pathway confirmed during its on-site visit that the process of screening at the entry to the Cameron Home was not consistent with CDC guidance aimed at promoting social distancing.[177]

The Cameron Home has made additional efforts to actively test and identify cases of COVID-19. Nursing staff have begun checking all residents' temperatures and oxygen levels once per shift, and in the isolation units, the residents undergo full vital sign checks every shift.[178] If the nursing staff observes any signs or symptoms of COVID in a resident, the staff is directed to advise the Charge Nurse, who will contact the Medical Director for further instruction and administer a rapid test.[179] According to the Director of Nursing, Mr. Becker: "I think the reporting internally is going well. I don't think there's any breakdown there. It's not just with COVID[-19]; supervisors and managers are great about keeping me informed about anybody who had to be moved for any reason."[180]

Staff members who test positive are currently required to remain home for 10 days and until the staff member is symptom free for 24 hours.[181] Previously, employees could not return for 14 days.[182] No employees are excused from the testing requirement.[183] However, Ms. Clark explained that due to low staffing levels, employees have been permitted to work in isolation after testing positive for COVID-19 on an as-needed basis.[184]

iv. Training

Since March 2020, Staff Development Coordinator Monica Bonderer has spent additional time training on infection control.[185] However, Ms. Bonderer explained that COVID-19 was poorly understood early in the pandemic and most practices followed during the spring and summer were only routine practices for infection control (e.g., washing hands, covering coughs).[186] Ms. Bonderer explained that since the outbreak commencing October 1st, the Cameron Home has "really hit hard" prevention and containment strategies.[187] Ms. Bonderer currently conducts infection control rounds to ensure staff wear PPE correctly, wash their hands, sanitize equipment and surfaces, secure cleaning supply carts, follow isolation and handle food safely, don/use/doff PPE correctly, and remain in assigned work areas.[188] Ms. Bonderer performs these rounds twice every day, and she follows a checklist.[189] Bonderer conducts COVID-19-related safety training by utilizing guidance from the CDC and information passed down by MVC Headquarters.[190] Ms. Bonderer explained

that she communicates with Homes Director Joan Elwing, and Headquarters staff Joyce Polacek, and Medina Drapin to address concerns relating to training.[191]

Since the pandemic began in March 2020, Ms. Bonderer has held several COVID-specific trainings, including trainings on lockdown procedures, pre-shift screenings, and PPE.[192] In August, Ms. Bonderer conducted training on random testing, call-ins for potential exposures, screening of outside visitors, hand-washing techniques, mask usage, and equipment sanitization.[193] In September, Ms. Bonderer held a "Stop the Spread" training using information from the CDC, teaching staff on practices such as not appearing for work when they are sick, monitoring Veterans for signs and symptoms of COVID-19 daily, cleaning hands and sanitizing all equipment and high-touch surfaces, and properly donning and doffing procedures with PPE.[194] In October, Ms. Bonderer presented a video from DMAT regarding screening procedures, and she also conducted a training on donning/doffing PPE.[195] There are posters and literature throughout the Cameron Home on COVID-related topics, such as hygiene and sanitization, PPE usage, and recognizing the differences between signs and symptoms of flu, cold, strep throat, COVID-19, and seasonal allergies.[196] Staff confirmed that Ms. Bonderer was very thorough on the trainings for these topics.[197]

v. PPE and Additional Procedural Changes

Assistant Administrator Stephanie Whitney confirmed that the Cameron Home has always had sufficient levels of PPE.[198] Ms. Whitney recalled that at one point, protective gowns used in isolation were limited on sizes, but the MVC was able to supply the protective equipment needed.[199] While the Cameron Home initially wore surgical masks, to prevent the spread of COVID-19, Cameron Home's staff were fitted for N95 respirators, and the staff commenced wearing N95 respirators during late September 2020.[200] Staff are instructed to use N95 respirators for up to 30 days.[201] According to the Cameron Home's Medical Director, Dr. Frederick Kiehl, the Cameron Home experienced a "mask evolution" in which all staff members have been required to wear N95 respirators since late September 2020.[202] However, staff members are required to re-use respirators, spraying the respirators with disinfectant at the end of the day and placing the respirator in a bag overnight.[203] Pathway confirmed that the storage and re-use of PPE was not consistent with CDC guidance.[204] Employees working in the isolation and quarantine units are required to wear a Tyvek suit, in addition to the full PPE.[205]

Mr. Ed Becker, Director of Nursing, explained that he has encountered some PPE noncompliance among staff.[206] Mr. Becker explained that he trains and educates his staff on the importance of compliance and noting that compliance is very good inside the Cameron Home.[207] Mr. Becker confirmed that there are 10-15 Veterans who refuse to wear masks.[208] He also conveyed that he received calls from Veterans' families when the families see a Cameron Home employee not wearing masks in public, and he has re-educated members of his staff if the individual employee is not identified.[209] According to Mr. Becker, "[w]e preach it and preach it and preach it."[210] Mr. Becker acknowledged that some staff members believe COVID-19 is a hoax or exaggerated, and some have complained about PCR testing as a violation of their rights.[211]

Similarly, Laura Clark, Personnel Manager, confirmed that the Cameron Home has had the necessary PPE throughout the pandemic.[212] Ms. Clark explained that charge nurses and unit managers are assigned to each community to ensure that employees are following PPE requirements.[213] To date, no employees have been disciplined for failure to follow PPE rules, and only a handful of warnings have been given relating to the failure to properly wear face masks.[214]

Lloyd Heckman, the Director of Environmental services, explained that his cleaning and laundry staff of 22-25 employees has increased the intensity and frequency of cleaning.[215] While Veteran rooms were infrequently inspected for cleanliness before the pandemic, Mr. Heckman now personally checks one or two rooms each day to ensure that his staff is properly cleaning rooms.[216] Mr. Heckman provides his staff with the inspection checklist, so they know what needs to be done to satisfy his review.[217] In addition to more frequent inspections, the level of cleaning by Mr. Heckman's staff has also increased. Before the pandemic, a room was given a "deep clean" once a month; that same level of cleaning is now required daily.[218] Similarly, before the pandemic, Mr. Heckman would disinfect common areas once a day; however, staff now disinfects common and high touch areas twice daily.[219]

For laundry, primary changes to the Cameron Home have involved dedicating one washer and dryer set to isolation materials, and outsourcing the laundry of everything but Veterans' personal clothes (e.g., towels, sheets, etc.) to a nearby prison for cleaning at the MVC's suggestion.[220] This activity has been helpful in freeing up staff and has worked well for the Cameron Home.[221] However, Mr. Heckman explained that he often receives supplies without explanation or vague instructions from the MVC on processes.[222] For example, the MVC sent a disinfectant to the Cameron Home; however, the MVC failed to include instruction on the use for the product.[223] Mr.

Heckman stated that he would like someone at the MVC to be dedicated to environmental services, as he is not familiar with who to contact at the MVC with questions.[224]

In addition to the procedures implemented and explained above, the Cameron Home implemented further changes to prevent the transmission of COVID-19. For example, Valerie Dredge, Food Services Manager, confirmed that prior to the pandemic, staff would regularly interact with Veterans in the dining areas.[225] However, once the Cameron Home had its first positive Veteran case, the Cameron Home closed the dining room and served Veterans meals in their rooms.[226] For approximately ten days, food service staff visiting Veterans' rooms wore full PPE; however, when two food service staff members received positive COVID-19 test results after being tested for COVID-19 on October 6, 2020, Ms. Dredge requested that her staff no longer enter into the rooms to take food orders.[227] The Cameron Home administration "agreed wholeheartedly" with her in this decision.[228] Now, each unit has its own "hot box" where meals are kept warm for up to three hours.[229] The hot boxes are rolled to each unit with a drink cart (with single-servings to avoid cross-contamination) and a speed cart (for trays), and the meals are removed and placed onto the plastic trays to be served to the residents.[230] The meals are provided to Veterans on paper plates and bowls, and the utensils are plastic so they can be thrown away.[231] The nursing staff receives the meals at the entrance to each community and distributes meals to Veterans in hinged containers.[232] After meal service, the plastic trays and metal utensils for the few Veterans who require metal utensils are washed in the dishwasher twice.[233] The carts and hot boxes are "bleached out" any time they leave the kitchen, both prior to them leaving the kitchen, prior to them leaving the units, and prior to them coming back in the kitchen.[234]

Since the start of the pandemic, the Cameron Home has held town hall meetings at least once per month in the chapel or dining area where staff can be socially distanced.[235] The Cameron Home prohibits large group events or activities with more than 10 individuals.[236]

vi. Staffing

The Cameron Home employs approximately 230 staff members, including approximately 14 LPNs, 16 RNs, 80 CNAs, and 14 CMTs.[237] After the first Veteran's positive test, the Cameron Home had several members of the staff resign.[238] As noted above, the Cameron Home worked to limit the use of staff between isolation and the other communities; however, staffing needs made that practice difficult.[239] Nurses transitioned to 12-hour shifts and emergency staffing was

implemented to ensure appropriate staffing. The Home also rearranged the break room to promote social distancing; however, staff members continue to occupy the same space during breaks, including the indoor break room and outdoor patio used for staff members to take smoke breaks.[240]

Staffing has been challenging due to staff members testing positive, resigning, and/or requesting not be sent into the quarantine and isolation units.[241] These staffing concerns contribute to long shifts for nursing staff and reduced compliance with PPE, sanitization, and isolation protocols.[242] The Cameron Home currently has nine (9) open nursing positions and 23 open CNA positions.[243] Staffing shortages require "mandates," where staff can be required to continue working after their shift ends, up to 16 hours total.[244] Further, staffing shortages often force nursing staff to work across units in a single shift, which Mr. Becker believes may have contributed to the outbreak in the Home.[245] However, while staff members are needed to interact with both the isolation and quarantine areas, as well as the general Veteran population, staff members never work in another unit after working in the isolation unit.[246]

Once staff enter the isolation unit for the day, they should not permitted to reenter the general population.[247] The staff are expected to remain in the isolation unit all day and exit a side door outside when the shift ends.[248] During Pathway's on-site visit, Pathway observed that maintaining a dedicated staff to the quarantine and isolation units was not a consistent practice.[249]

Ms. Clark explained that many employees are experiencing anxiety while using PPE and employees have expressed concerns with appearing for work due to the employees' needs to care for family members and the risk posed to the family members.[250] Ms. Clark explained that many of the employees who are experiencing anxiety are long-time employees who care for Veterans every day.[251] Ms. Clark confirmed that some care providers have established such strong bonds with Veterans that it is taking an emotional toll on those employees who are assisting Veterans fighting COVID-19 infections.[252]

vii. Communication

Communication was an area of concern identified by Pathway during the on-site visit. Pathway confirmed witness accounts that there is no consistent general infection prevention and control policies and procedures or COVID-19 specific policies and procedures implemented at the Cameron Home.[253] Similarly, Pathway confirmed during its visit that there is no evidence of a written pandemic response plan, and front line staff informed Pathway that the staff was not aware

of infection control and COVID-19-specific policies.[254] Additionally, Pathway observed that COVID-19 guidance was not reflected in signage throughout the Cameron Home.[255] Pathway noted that communication regarding COVID-19 guidance flowed from the MVC Headquarters to the Cameron Home's administration; however, Pathway was unable to determine the flow of communication to the care staff and how staff members were updated on new guidance.[256] While directives are utilized and transmitted to staff in emails and during town hall meetings, Pathway noted that the content received from MVC Headquarters was not uniformly conveyed to Cameron Home's staff members.[257]

However, Dr. Kiehl noted that in addition to the daily calls between the Administrators and the MVC, Dr. Kiehl and all medical directors meet by telephone every Wednesdays night to discuss new guidelines, new findings and the status of each of the Homes.[258] Dr. Kiehl noted that members of the MVC join those calls and that it is encouraging for the "team" to be behind them.[259]

viii. Impact on Veterans

[redacted] explained that he had several opinions about COVID-19 concerns in the Cameron Home, which he has made known to Cameron Home's staff.[260] [redacted] is concerned that he and his fellow Veterans are not receiving information from the Cameron Home's Administrators.[261] [redacted] explained that nurses pass information to him, but the nurses inform [redacted] that they have been instructed not to tell him anything.[262] [redacted] and his family have contacted the MVC, DHSS, and Governor Parson's office several times with their complaints.[263] However, [redacted] is generally supportive of the care he and his fellow Veterans have received at the Home and the restrictions in place to prevent the spread of COVID-19 among the Veterans.[264] His main concerns were the lack of rapid tests early in the process, staff working in multiple units on a single shift, and lack of information being provided to Veterans.[265]

6. Regional Considerations

The individuals interviewed did not know how COVID-19 first entered the Cameron Home. Dr. Kiehl believes the outbreak was due to the opening of area schools, the state "loosening up" mask mandates, the opening of the race car track nearby, and the lack of mask wearing in the community.[266] Dr. Kiehl believes the most effective tool to limit COVID-19 transmission has been the rapid testing and the use of N95 respirators.[267] Assistant Administrator Stephanie Whitney also

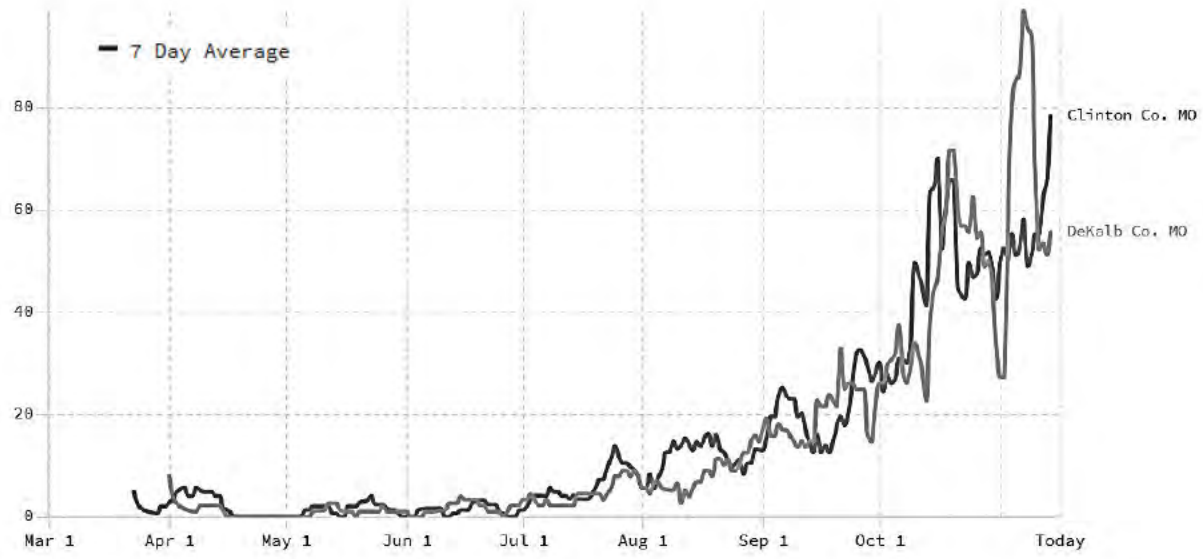
noted the increased COVID-19 cases in the community and explained that many staff members now have children who have returned to school.268

As of the November 16, 2020, Clinton County has had 735 cases and 38 deaths and attributed to COVID-19.269 Clinton County does not currently have a mask mandate. Per an August 6 Clinton County Public Health Emergency Order, school districts within Clinton County are open but must develop and implement a COVID-19 policy to mitigate the risk of contagion among faculty, staff, and students. These policies "shall include mandatory masking of all students, faculty, and staff except during outdoor activities, physical conditioning, consuming food or beverages, when seeing the mouth is essential for learning or communicating."

As of the November 16, 2020, DeKalb County has had 452 cases and 9 deaths attributed to COVID-19 to date270. DeKalb County does not currently have a mask mandate. School districts in DeKalb County have reopened for in-person instruction. Students, however, had the option to request virtual instruction for the fall semester. At least one school district in DeKalb County is operating solely with in-person instruction (See Maysville R-1 School District).

The following illustrates the course of positive cases over time in Clinton and DeKalb counties up to November 16, 2020.271 This rise in the number of cases within the surrounding community resulted in a rise within the Home.

CASES PER 100K POPULATION IN CLINTON CO. MO AND DEKALB CO. MO



B. Cape Girardeau Home

1. Summary of Observations and Concerns

The Cape Girardeau Home is led by experienced staff who are clearly devoted to the care of Veterans. Like other Homes, however, there are some areas of concern and room for improvement. The Cape Girardeau Home demonstrated issues with: (1) frequent movement of Veterans following the outbreak of positive tests; (2) unclear plans and protocols for Veterans exhibiting symptoms, and (3) appropriately addressing staff members' self-reported symptoms.

Staff members and Veterans appear to comply with PPE protocol now, and most staff stated that the Cape Girardeau Home now has sufficient supplies.[272] Communication within the Cape Girardeau Home appears sufficient and staff feels supported by their Administrators: "They are always checking on our Veterans and sharing every piece of information they get with their management team and their staff in general. . . . they're doing everything they can."[273] But particular departments and staff members may benefit from increased communication and clarity from Headquarters.

2. Structure of the Cape Girardeau Home

The Cape Girardeau Home is located at 2400 Veterans Memorial Dr., Cape Girardeau, Cape Girardeau County, Missouri, opened in 1990. It can accommodate 150 Veterans across its three wings: A-100, B-200 and C-300.[274] There are 24 private rooms in the Cape Girardeau Home, but the majority of rooms are doubles.[275]

The Cape Girardeau Home's occupancy has gradually decreased since the beginning of the pandemic. In March, 142 Veterans resided in the Home which decreased to 138 Veterans in April, 133 Veterans in May, 126 Veterans in June, 124 Veterans in July, 119 Veterans in August, and 102 Veterans in September.[276] Much of this decline was due to the mandate to allow no new admissions.

To increase the Veteran census, MVC Headquarters allowed the Cape Girardeau Home to admit new Veterans on a case-by-case basis.[277] However, due to a Veteran testing positive for COVID-19 on August 25, the Cape Girardeau Home is no longer admitting new Veterans.[278] The last new admission occurred on August 21.[279] As of October 26, 2020, 88 Veterans currently reside at the Cape Girardeau Home.[280]

3. COVID-19 Preparation

On March 7, 2020, MVC Headquarters directed the Cape Girardeau Home's Administrator to lockdown the Home.281 In response to policies and directives from Headquarters, on March 8, the Cape Girardeau Home began preparing quarantine and isolation areas as well as staff education modules.282

Early in the pandemic, Headquarters issued directives to the Homes relative to COVID-19. However, the Cape Girardeau Home did not rely solely on those directives but also considered VA regulations, CDC and Missouri DHSS guidelines.283 Headquarters sent the directives to the Cape Girardeau Home's Administrator, rather than directly to the Staff Development Coordinator and Infection Control Nurse.284

In March, the Home's Infection Control Nurse implemented COVID-19 policies, which she revised as necessary when new guidance was issued.285 In turn, the Staff Development Coordinator ensured the staff was educated on the policies.286 Education methods included face-to-face instruction, handouts, demonstrations, videos, and specific instruction on donning, doffing and hand washing.287 All staff members—even those who do not interact with Veterans—were trained regarding appropriate PPE use, hand hygiene, and the COVID-19 policies.288 Specific training included handwashing, signs and symptoms of COVID-19, prevention of COVID-19, when to stay home from work, social distancing, cleaning surfaces, face mask use, plans for isolation areas, stress and coping training, and donning and doffing PPE.289 This training was conducted on a weekly basis beginning on March 5 and still occurs at least once a week.290

Beginning March 8, no visitors, family, volunteers, or vendors were allowed in the Cape Girardeau Home. Veterans were required to wear a mask when leaving their rooms, and the dining room operated at a limited capacity (i.e., 20-25 Veterans at a time) with social distancing (i.e., one Veteran per table and all Veterans six feet apart).291 Veterans were educated on the importance of increased hand hygiene and proper sanitization measures.292 One Veteran noted that though the training was "helpful" it was "not very detailed."293 During this initial period, the staff's morning screening included a temperature check and filling out a questionnaire form.294

One department was particularly proactive at the beginning of the pandemic. The Food Services Department quickly began using single-serving disposable dishware, treys, and food and drink containers (e.g., juice cartons) for sanitary and safety purposes.295 The Cape Girardeau Home made some of these changes independent from any suggestion by Headquarters.296

Initially, Headquarters held meetings twice a day including weekends.[297] During the calls, Homes Director, Joan Elwing, provided updates and guidance to the Administrators and any department leaders who attended the meetings.[298] Many of the meetings focused on plans for an outbreak and how to implement changes.[299] Some meeting attendees expressed frustration with the frequency of policy changes and inconsistencies in the instruction, including the amount of time to quarantine staff.[300]

4. Outbreak and Timeline[301]

On July 16, 2020, an employee reported that her July 12 PCR test was positive for COVID-19. Later that same day, a second employee notified the Cape Girardeau Home that she also tested positive. That afternoon, the Cape Girardeau Home informed all Veterans' families, Veterans, and staff that two employees had tested positive. Veterans' were quarantined to their rooms and vital sign checks, including temperatures and oxygen saturations, were increased to every four hours. In turn, the Cape Girardeau Home determined three employees had been in close contact with the positive employees and all three were required to quarantine. The Cape Girardeau Home informed the VA, DHSS, local health department, and its Headquarters of these developments. The next day, all staff and Veterans were tested.

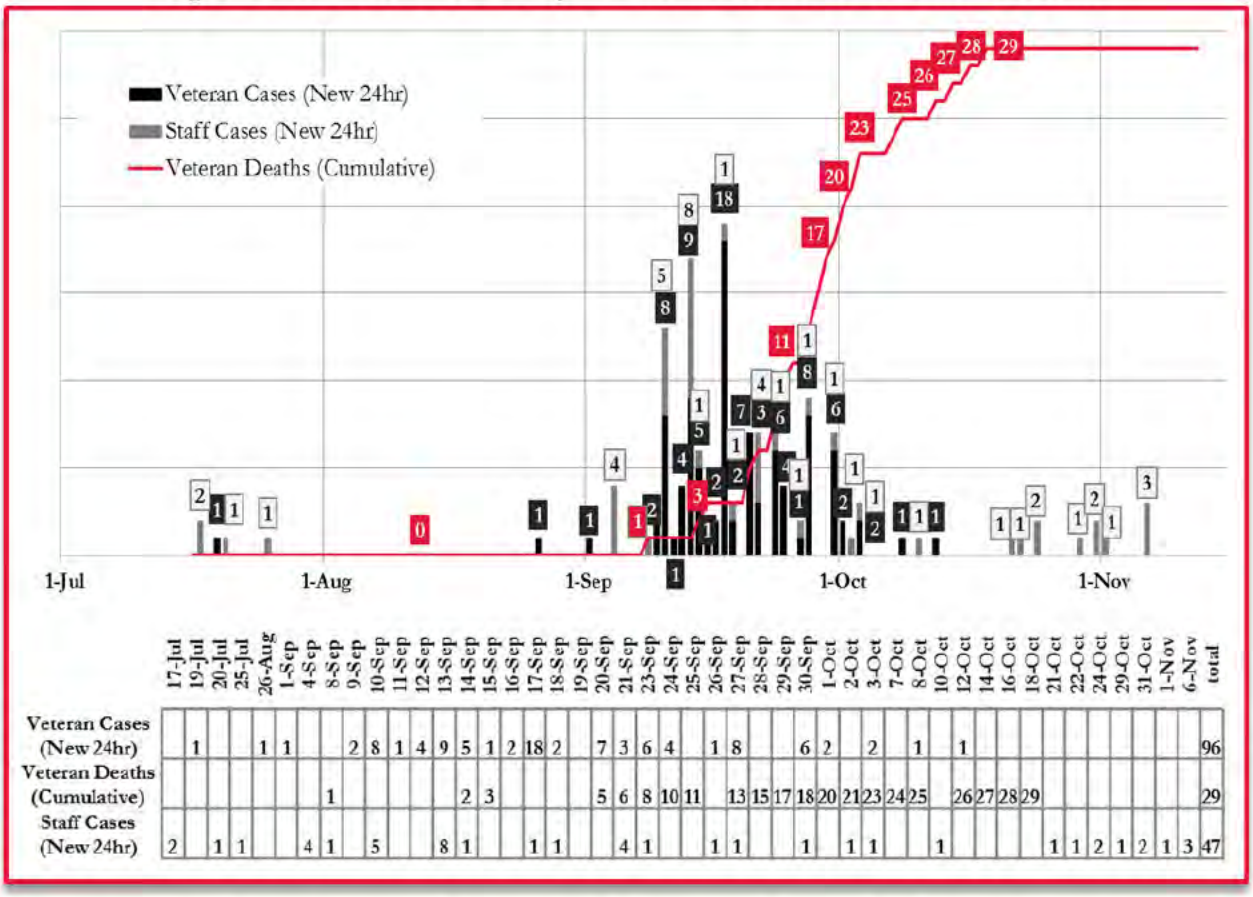
On July 18, the Cape Girardeau Home's first Veteran tested positive. The Veteran was transported to the emergency department for a repeat test and, when he returned to the Home the next day, he was immediately taken to the isolation area. This Veteran's roommate was also immediately moved to the quarantine area. Again, Headquarters, DHSS, and VA were notified of these developments.

The next day, a laundry worker's COVID-19 tests returned positive. The employee was removed from the building immediately and the employee's workspace was deep cleaned. Two additional laundry staff were deemed to have been in close contact with the infected employee and were quarantined.

An outbreak of positive tests among Veterans began on September 9.[302] From September 6 to September 12, twelve Veterans in the A-Wing tested positive for COVID-19.[303] From September 13 to September 19, fourteen Veterans in the A-Wing tested positive for COVID-19.[304] From September 20 to September 26, three Veterans in the A-Wing tested positive for COVID-19.[305] As of November 13, 2020, the Cape Girardeau Home has had at least 96 Veterans and 47 staff

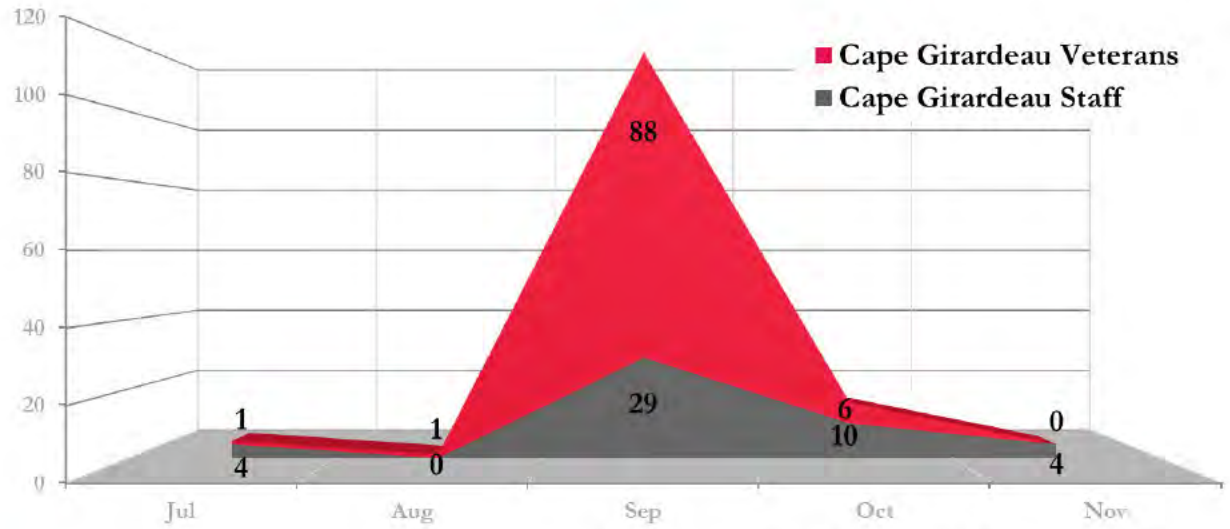
members test positive for COVID-19; there have been 29 Veterans die due to COVID-19.[306] The following figure visually represents the intensity of the outbreak and subsequent sharp rise in deaths:

Cape Girardeau Home | Timeline of Cases and Deaths



	17-Jul	19-Jul	20-Jul	25-Jul	26-Aug	1-Sep	4-Sep	8-Sep	9-Sep	10-Sep	11-Sep	12-Sep	13-Sep	14-Sep	15-Sep	16-Sep	17-Sep	18-Sep	19-Sep	20-Sep	21-Sep	23-Sep	24-Sep	25-Sep	26-Sep	27-Sep	28-Sep	29-Sep	30-Sep	1-Oct	2-Oct	3-Oct	7-Oct	8-Oct	10-Oct	12-Oct	14-Oct	16-Oct	18-Oct	21-Oct	22-Oct	24-Oct	29-Oct	31-Oct	1-Nov	6-Nov	total
Veteran Cases (New 24hr)		1			1	1			2	8	1	4	9	5	1	2	18	2		7	3	6	4		1	8			6	2		2		1		1										96
Veteran Deaths (Cumulative)								1						2	3					5	6	8	10	11		13	15	17	18	20	21	23	24	25		26	27	28	29								29
Staff Cases (New 24hr)	2		1	1			4	1		5			8	1			1	1			4	1			1	1			1		1	1			1				1	1	2	1	2	1	3	47

The next figure illustrates the timing and severity of the outbreak of positive cases in the Home. In this figure, it is clear that the Veterans experienced an infection rate more than twice that of the staff:



	Jul	Aug	Sep	Oct	Nov
Cape Girardeau Veterans	1	1	88	6	0
Cape Girardeau Staff	4	0	29	10	4

5. Response to Outbreak

i. Quarantine and Isolation

Originally, the isolation area was designed to accommodate four beds. It was located in the Annex Hallway, a previously unused area separate from the rest of the Cape Girardeau Home.[307] Air scrubbers, negative pressure tubes, and UV lights were installed in the isolation area.[308]

In September, when the Cape Girardeau Home experienced an increase in positive Veteran cases, the isolation unit was quickly at capacity. The Home then created an isolation unit in the Annex Hallway leading to C-100, which had 17 beds.[309] This unit isolation unit also quickly filled to capacity. As COVID-19 cases among Veterans continued to rise, the Cape Girardeau Home added an isolation hall to each wing and created a quarantine hall on the C wing.[310]

Due to limited space, the Cape Girardeau Home has quarantined Veterans in the same room as non-quarantined Veterans on occasion.[311] All quarantined Veterans are currently residing on the A-200 unit, with two Veterans to a room.[312]

As a result of insufficient isolation and quarantine beds, Veterans were frequently relocated, which staff described as "chaotic," "hectic" and "stressful."[313] As an example, one Veteran with a fever was moved to a non-isolation hall while awaiting his PCR test result.[314] During this wait, the hall in which he originally lived was converted to an isolation hall.[315] The Veteran's PCR test

returned positive for COVID-19 two days later and he was then relocated to yet another isolation hall.316 Rather than quarantine this Veteran in his room until his results returned (at which time he already would have been in the newly converted isolation unit), the Cape Girardeau Home moved this Veteran with symptoms twice within a short period.317

Frequent movement of Veterans like this was common practice. It was not uncommon for the Cape Girardeau Home to relocate a Veteran four times in less than a month. Staff expressed confusion as to what the plan was for the Veterans.318 Some staff raised these concerns with supervisors, but no changes were ultimately implemented.319

Additionally, Veterans with fevers were permitted to leave their rooms and halls.320 These same Veterans shortly thereafter received positive COVID-19 test results.321 Staff members expressed concern about allowing symptomatic Veterans free access to roam halls/units and the failure to restrict these Veterans to their rooms.322 Staff members were unsure why temperatures were even checked if the Cape Girardeau Home was just going to allow Veterans to roam around the halls regardless of high temperatures.323 Expressing frustration with this practice, one staff member stated, "After one person got sick in the unit, it just spread like wildfire."324

The Cape Girardeau Home's isolation unit is now sealed with zippered plastic walls, and one can only enter through an exterior door. The isolation unit has a pressure system and air cleaning system.325 At the time of the Administrator's interview, there were seven Veterans in the isolation unit.326 Positive Veterans are now isolated for twenty days and are released from isolation only after symptoms onset and a negative rapid test is confirmed. The Medical Director determines when a Veteran may leave isolation.327

Unless leaving to use the bathroom, all Veterans are now quarantined to their rooms for most daily activities—including meals.328 Veterans are allowed to leave their rooms for walks outside.329 Despite the policy to limit Veterans predominantly to their rooms, Pathway observed Veterans in all common areas during its onsite review.330

ii. Visitors

The visitation process has also changed since the outbreak.331 No outside visitors have been permitted inside the Cape Girardeau Home since March (other than for end-of-life visitations).332 Window visits, front porch visits, and virtual visits were encouraged.333 Since the September outbreak, porch visits have been discontinued but window visits and virtual visits are ongoing.334

From June to early August, families were able to sign up for thirty-minute front porch visits with Veterans.[335] The Cape Girardeau Home set up tables about ten feet apart (one for family and one for Veteran), screened the visitors, required hand washing/sanitizing, and provided surgical masks. Two families could visit at a time (sitting at 4 separate tables) and a ten-minute sanitization period was used between visits.[336] Families were virtually always compliant.[337] One Veteran did complain that due to the mask and distance, he could not hear his family during these visits, but the front porch visits were generally considered a positive experience by staff.[338] Pathway confirmed the Cape Girardeau Home's outdoor visitation protocols complied with CDC guidance.[339]

Veterans do not leave the Cape Girardeau Home unless it is an emergency and the Medical Director approves the Veteran's reason for leaving.[340] Veterans use telehealth for routine doctor visits to limit outside exposure.[341] When Veterans are required to visit a hospital in-person, they are quarantined for 14 days upon return with their vital signs checked every four hours.[342]

iii. Screening and Testing

Currently, when staff enters the Cape Girardeau Home, they complete a questionnaire and their temperature is checked.[343] On Mondays and Thursday, a PCR test is performed with results returned in 24-48 hours.[344] Every other day of the week, staff undergo a rapid antigen test. (This process began on October 3.) On rapid test days, staff await their results in the Chapel, socially distanced, until cleared with a negative result.[345] If a staff member tests positive on either test, the staff member is immediately sent home.[346] Staff may return to work after ten days and if he/she has been fever free for 24 hours.[347] Symptoms must also improve, but staff is permitted to return with a mild cough because the cough can linger for months.[348]

Veterans are tested with the same frequency and in the same manner as the staff. [349] Veterans are not informed when they test negative. One Veteran described the results process as "no news is good news."[350] In addition, Veterans are not informed if someone tests positive.[351]

Generally, it is the Home's policy that, if a staff member exhibits any COVID-19 related symptoms, he/she are PCR tested and sent home until the test results come back.[352] Despite this policy, some staff worked in close proximity with Veterans even after self-reporting symptoms. More specifically, in September, more than one CNA self-reported symptoms to a supervisor and stated they were not feeling well.[353] Because they did not have a fever, their supervisors asked them to continue working and did not send them home.[354] These staff members had undergone PCR

testing but the results were still pending.[355] When results were returned a couple days later, tests for the CNAs that had self-reported symptoms—but continued to work—returned positive.[356] CNAs assist Veterans with activities of daily living including grooming, toileting, showering, checking vital signs, eating etc.[357] As such, CNA's are in frequent and close contact with the Veterans.[358] Thus, the Cape Girardeau Home permitted self-reported symptoms to work directly with Veterans while tests results were pending and shortly after confirmed that the CNAs in fact were positive. The CNAs have expressed frustration with how the Cape Girardeau Home has handled continuing to work with self-reported symptoms.[359]

iv. Training

MVC Headquarters issues directives typically once a week.[360] The Staff Development Coordinator then provides training sessions and educational meetings relative to these directives.[361] The Staff Development Coordinator also conducts independent research from sources she considers reputable (e.g., CDC, Cape Girardeau County Health Department, Headquarters' policies) and trains the staff on those she deems pertinent.[362] Additionally, individual department coordinators provide training that is unique to each department (e.g., proper cleaning, laundry, food service protocols).[363]

Staff members are still trained regularly regarding COVID-19 measures. In-person training is provided in the Chapel with frequent enough presentations to ensure social distancing.[364] Each time a staff member attends an education session, the staff member must sign an attendance sheet which the Staff Development Coordinator maintains.[365]

In addition to in-person training, signs are hanging throughout the Cape Girardeau Home instructing on the proper PPE use. CDC-approved videos play in the area where staff await their daily rapid test results.[366] Pathway found an "overwhelming" amount of signage, which presented inconsistent procedures and sequencing for donning and doffing PPE.[367]

v. PPE and Additional Procedural Changes

No concerns were expressed regarding the amount and types of PPE currently available in the Cape Girardeau Home. While there were almost no complaints concerning sufficient supplies, ordering PPE from the State was described as difficult because the ordering manager "has to go through many hoops."[368]

Veterans and staff wore surgical masks until September 8. Following a directive and supply from Headquarters, staff began wearing disposable N95 respirators. Some staff members expressed frustration with how long it took to obtain the N95 respirators.[369]

The staff wear PPE throughout the Cape Girardeau Home, including N95 respirators (provided and worn daily), gowns, and gloves.[370] The isolation unit has its own supplies and equipment (e.g., cleaning supplies, linens, etc.) which remain in the unit to prevent unnecessary movement of potentially contaminated supplies throughout the Cape Girardeau Home.[371]

Before September, Veterans could go into hallways and canteen without a mask. Masks were only required if the Veteran went to the lobby. Currently, Veterans are required to wear masks when outside their room. Veterans have been "pretty good" about wearing masks, and will comply if requested by staff.[372]

When surgical masks were initially required, many staff members were observed keeping the masks under their noses. Headquarters does allow the Home to send non-compliant employees home without pay.[373] The Cape Girardeau Home has not had to do so yet.[374]

Staff and Veterans are largely compliant with PPE protocol as of the time of this report.[375] Pathway did, however, observe two staff members in a closed office without mask compliance.[376] Pathway also observed varying and inconsistent gown use.[377]

vi. Staffing

Staffing has been a challenge for the Cape Girardeau Home. Staffing was a noted issue in the social services department (i.e., only three staff members in department) and the custodial department (i.e., three of 18 spots currently unfilled).[378] The Cape Girardeau Home has worked to add staffing during the pandemic, hiring at least 25 employees since March.[379] In early September, the Cape Girardeau Home's Administrator requested additional staffing from Headquarters and the VA began providing support staff.[380]

As much as possible, the Cape Girardeau Home tries to limit staff moving among units. The isolation caregivers typically stay in the isolation unit for their entire shift. [381] However, there are some staff members who move between the quarantine hall, the isolation hall, and the general areas throughout the day.[382]

vii. Communication

Headquarters Staff indicated there has been good communication from administration, which provides daily updates.[383] The department directors have daily morning meetings in which they discuss the COVID-19 status in the Cape Girardeau Home.[384] There are also monthly meetings with the Administrator and the department heads during which they discuss any updates in COVID-19 policies.[385] Some staff are overwhelmed by the amount and evolving nature of the information provided, which one staff member noted "seems to change daily."[386] As reported by the other Homes, Headquarters has calls with the Homes' administrators on Mondays, Wednesdays, and Fridays.[387]

While there is generally adequate communication within the Cape Girardeau Home, it is unclear whether Headquarters is responsive to individual departments' concerns and needs.[388] The Cape Girardeau Home did not have much control over what to do to prepare for COVID; instead, they were required to get permission from Headquarters before they could do anything.[389] This requirement led to delays in implementing some policies.[390] Cape Girardeau staff members further suggested Headquarters develop more individualized plans, policies, and procedures specific to each Home.[391] Individuality regarding the specific needs of each Home and the community in which it is based are not reflected in the universal plans and directives provided by Headquarters.

viii. Impact on Veterans

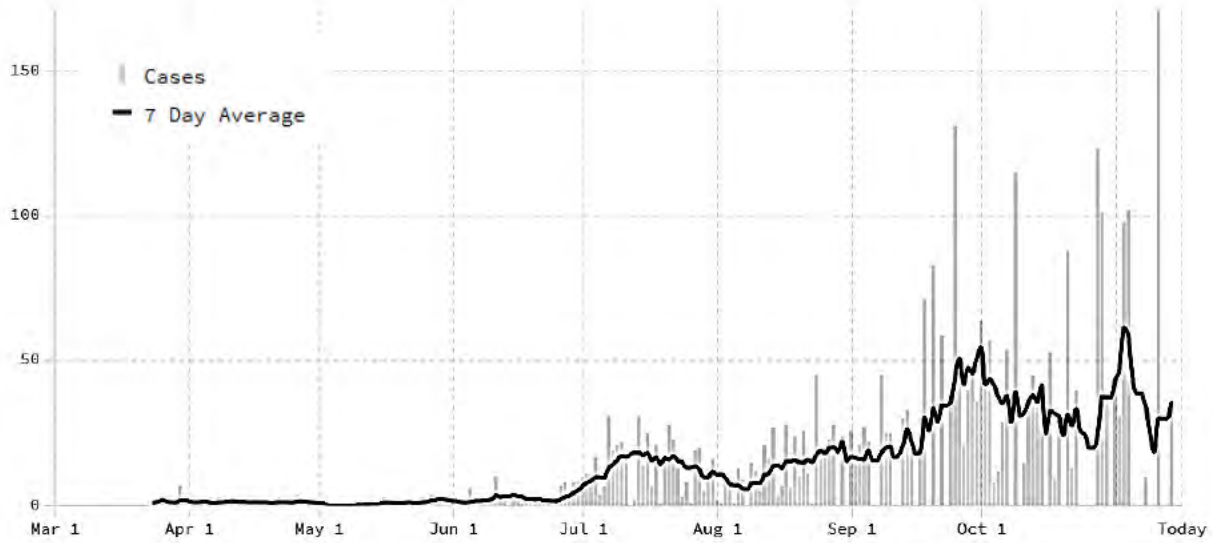
The pandemic and outbreak have had a dramatic effect on the Veterans' mental state and well-being.[392] The Director of Social Services noted a definite decline in mood, increased depressive symptoms, and increased sadness and hopelessness.[393] There has also been an effect on the Veterans' physical health and sleeping habits (e.g., some sleeping too much, while others not getting enough sleep).[394] One staff member suggested increased communication with Veterans concerning testing and the status of the Cape Girardeau Home may also help Veterans feel more invested in the implemented safety efforts and procedures.[395]

6. Regional Considerations

As of the morning of November 16, 2020, Cape Girardeau County has had 3,961 cases and 60 deaths attributed to COVID-19.[396] The following illustrates the course of positive cases over

time in Cape Girardeau County up to November 16, 2020.[397] This rise in the number of cases within the surrounding community resulted in a rise within the Home.

CASES IN CAPE GIRARDEAU CO. MO



Cape Girardeau County initiated a mask mandate in July 2020, which remains in effect as of the time of this report. On October 27, 2020, the Board of Trustees of the Cape Girardeau County Health Center extended the mask mandate indefinitely until one of three conditions is met: (1) the Viral Lab Test Positivity Rate for Cape Girardeau County is below 5 percent for a two-week period and the rolling 14-day case count of new COVID-19 cases is below 200 for a 2-week period; (2) a COVID-19 vaccine becomes widely available to the general public; and (3) a highly effective, relatively low-cost COVID-19 therapeutic treatment becomes widely available.[398]

The mask mandate requires everyone older than nine years of age to wear masks in public places within the county unless they have an overriding health condition prohibiting mask use.[399] Despite this mandate, one staff member opined the community has not complied with the county's order. For example, he observed less than half of the shoppers wearing a mask during his recent visit to a Cape Girardeau Lowe's.[400] Though the community businesses have signs requiring masks, compliance does not appear enforced.[401]

Some staff members attribute the increase in the Home's positive cases to the increased positive cases in the Cape Girardeau community.[402] Others pointed to a recent highly attended rodeo in the area, school openings, and concerts. Attendance at these events has resulted in increased exposure for the Cape Girardeau Home's staff.[403]

Headquarters implemented a rule requiring any staff member seek approval from human resources and Headquarters before attending an outside event.[404] However, some staff members suspect that this policy was not followed by staff and events were attended without permission.[405]

C. Mexico Home

1. Summary of Observations and Concerns

The Mexico Home has had generally good outcomes prior to COVID-19 and continues to manage the pandemic successfully. The Home did not experience any positive cases among Veterans until October 25, 2020. There remain some concerns and areas for improvement notably: (1) the lack of formal infection control policies; (2) inconsistency in screenings; and (3) communication issues between the Mexico Home and Headquarters. For instance, Veterans' temperatures are monitored, but symptoms screening are not completed as a part of that process. Communication from Headquarters is constant but directives change frequently, creating issues among the staff and Veterans.

2. Structure of the Mexico Home

The Mexico Home is located at 1 Veterans Drive Mexico, MO 65265, and has 150 beds divided evenly into three floors. Each floor is subdivided into ten-bed "modules."[406] Most rooms are semi-private with a privacy curtain separating two roommates.[407] A bathroom is shared by four Veterans, between two adjoined semi-private rooms.[408] The second floor of the Home contains the secured dementia-care unit. The Veterans are housed two to a room, with only a few having private rooms.[409] The census numbers are currently less than 115, as staff adjusted to add a quarantine unit and a separate isolation space.[410] The average monthly mortality rate is roughly 2-5 Veterans per month, though it may currently be higher as Veterans are depressed and struggling with the isolation.[411]

3. COVID-19 Preparation

On March 7, 2020, the Director of Nursing received a call from the Administrator indicating the Home would enter lockdown the next day. [412] A meeting occurred on March 8 where supervisors developed policies, systems, and practices to decrease the spread of COVID-19.[413] The Mexico Home had a COVID-19 Project Management Plan in place since before March, which was essentially an emergency response plan for COVID-19.[414] The plan was reviewed and updated frequently over the following months.[415] The Mexico Home took the initiative to create its own set

of policies and procedures with staff noting that "… the leadership team at Mexico has assembled the 'COVID Bible,' a large collection of resources available in a central location."[416]

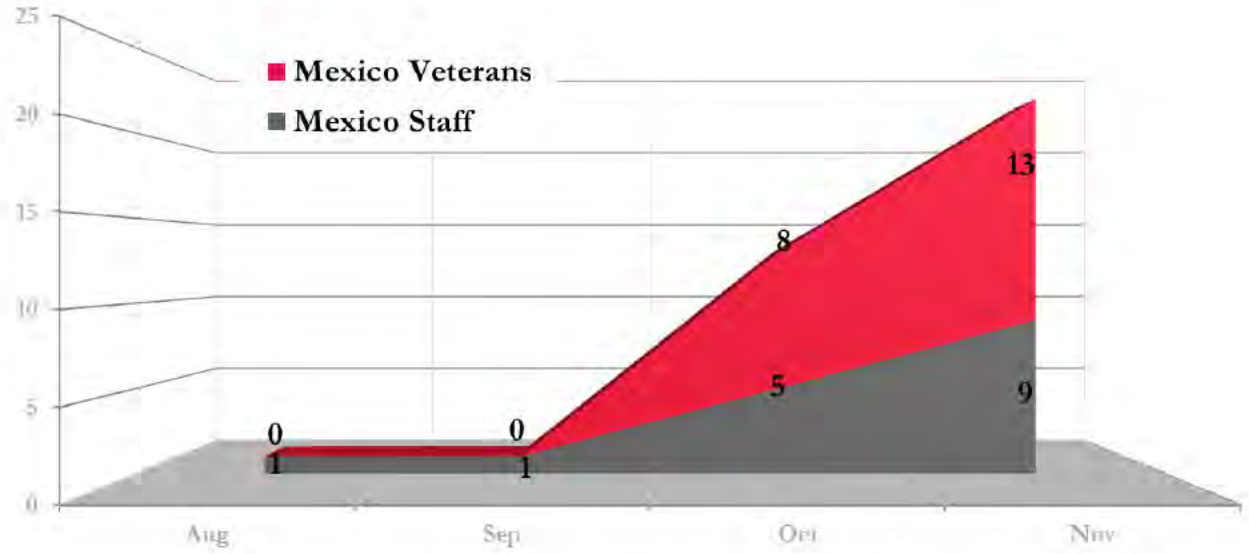
Large gatherings were prohibited and dining was limited with social distancing features, but the Veterans still had free reign of the Home in March.[417] When there were positive staff members, everyone was restricted to their units, including being served meals on paper plates in the units instead of the central location.[418]

The Mexico Home has an Infection Control Lead who is responsible for Veterans' vaccinations, outcome surveillance, analysis and mapping for Veteran infections, identification of new infections and actions taken.[419] There have been approximately 15 new Veterans admitted to the Mexico Home since March.[420]

4. Outbreak and Timeline

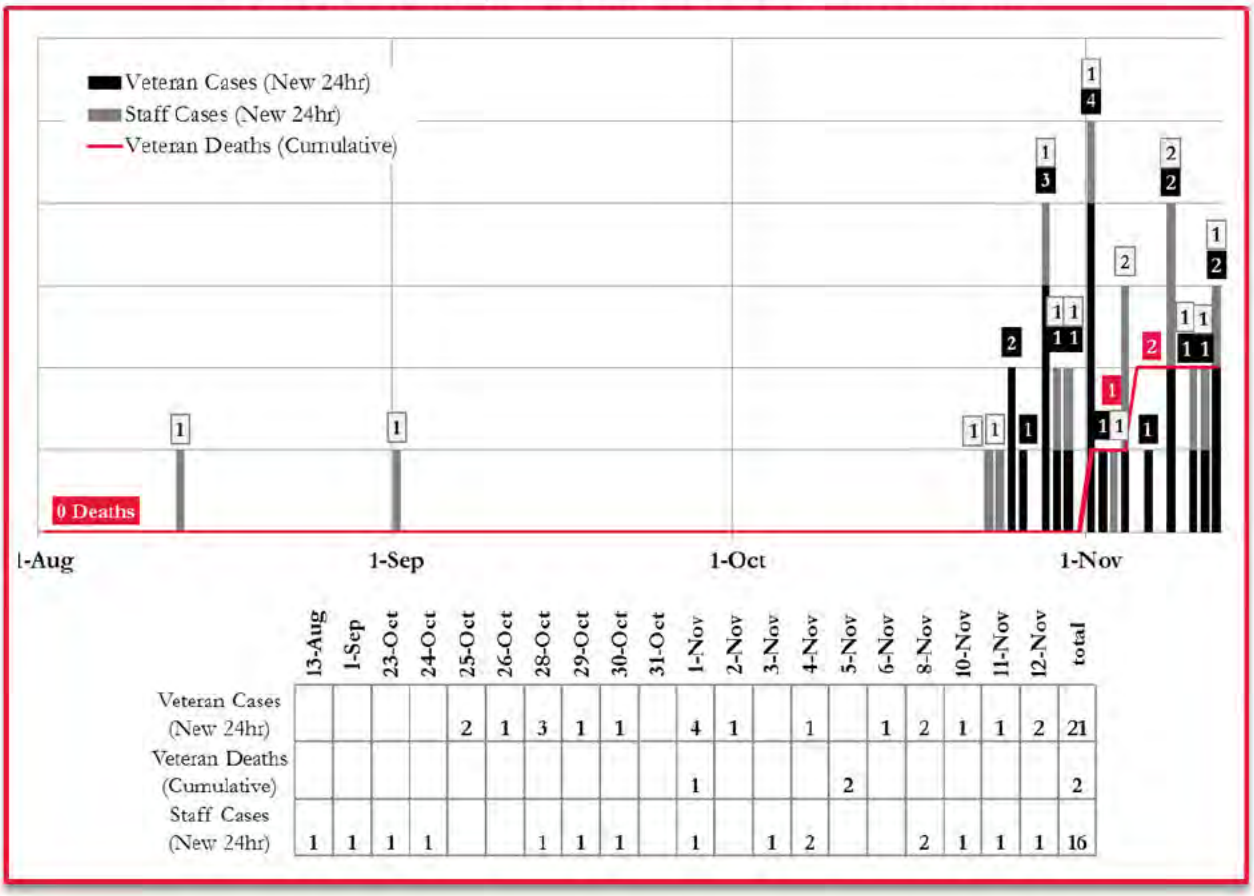
The first positive case was in July when a staff member on the night shift called stating her mother was positive for COVID-19.[421] The staff member was tested immediately as well as all other staff and Veterans.[422] The staff member quarantined in her home, and testing did not reveal further spread within the Home.[423] As of November 12, 2020, 17 staff were quarantined at home, and there were 20 active Veteran COVID-19 cases with 2 Veteran deaths.[424] Those with COVID-19 are in the isolation unit.[425]

The following figures illustrate the relatively delayed outbreak at the Mexico Home as well as their successful early mitigation of spread from August and September positive staff cases. However, while the Home has experienced just two COVID-19 related deaths to date, it is important to note that the outbreak is recent and ongoing. A higher death rate may result in the future.



	Aug	Sep	Oct	Nov
Mexico Veterans	0	0	8	13
Mexico Staff	1	1	5	9

Mexico Home | Timeline of Cases and Deaths



	13-Aug	1-Sep	23-Oct	24-Oct	25-Oct	26-Oct	28-Oct	29-Oct	30-Oct	31-Oct	1-Nov	2-Nov	3-Nov	4-Nov	5-Nov	6-Nov	8-Nov	10-Nov	11-Nov	12-Nov	total
Veteran Cases (New 24hr)					2	1	3	1	1		4	1		1		1	2	1	1	2	21
Veteran Deaths (Cumulative)											1				2						2
Staff Cases (New 24hr)	1	1	1	1			1	1	1		1		1	2			2	1	1	1	16

5. Response to Outbreak

i. Quarantine and Isolation

When directed to institute a quarantine and isolation area, the Mexico Home set up a quarantine area for suspected but confirmed cases of COVID-19 and a separate isolation unit for confirmed positive cases.[426] The isolation unit is set up with air scrubber, negative pressure, UV lights, its own equipment and supplies, and separate magnetic plastic walls.[427] The Mexico Home does not utilize the quarantine unit for symptomatic patients.[428] Rather, Veterans quarantine to their room and do not move to the quarantine area.[429] Staff are required to use PPE and cleaning supplies located on a door caddy outside the Veteran's room.[430] If a Veteran tests positive and has a roommate, staff will test both roommates and conduct increased monitoring.[431]

The isolation area has 6 – 8 beds and is on the 3rd floor. The isolation space was later increased to 10 beds and is on the 1st floor. There is a separate entrance, and the area remains sealed and locked.[432] Upon entry into the clean room, staff don PPE, enter the ante room which, along with the isolation area, shares scrubbers and negative pressure tubes.[433] Staff then enter through a plastic doorway closed by magnets and is part of the plastic wall enclosing the isolation area.[434] When leaving isolation, staff enter the ante room, sanitize gloved hands, remove face shield or goggles along with all other PPE and sanitize again.[435] After entering isolation, a staff member is not allowed to return to the general population area.[436] Veterans are kept in quarantine for fourteen days per a directive from Headquarters.[437]

ii. Visitors

The Mexico Home had implemented family visitation during the pandemic, where Veterans sat more than six feet away from their family member and with all wearing masks.[438] The restrictions for these visits were strictly enforced at the Mexico Home.[439] The Home did not implement a hand holding station and held off on doing so given the recent outbreaks across various Homes.[440] Veterans' families are allowed into the Home only for end-of-life scenarios.[441]

iii. Screening and Testing

Midway through the pandemic, the Mexico Home implemented "random" or sentinel testing—this is how the first two staff member positives were recorded even though they were asymptomatic.[442] Rapid testing now occurs daily for staff and Veterans. PCR testing is completed twice per week for staff and Veterans and is used to confirm positive results from the rapid testing.[443] Some staff quit following the mandatory testing, stating that testing infringes on their rights.[444] Veterans have complained as well, but are permitted to refuse testing.[445]

Every person entering the building is screened with a self-reporting questionnaire which is immediately reviewed.[446] A rapid test is conducted on every person that enters the building. Once a negative test result is confirmed, the visitor is instructed to perform hand hygiene and provided an N95 respirator for the day.[447] Every shift a COVID-19 assessment is completed on Veterans.[448] However, symptoms screening is not completed for Veterans as would be expected per best practice guidelines.[449] The COVID-19 assessment does not list all of the symptoms of COVID-19, but staff members are aware of the current symptom list and appropriately screen for all symptoms.[450]

PPE requirements changed from March through October. From March to mid-April, staff members were allowed to wear homemade cloth masks.[451] Staff members were then directed that homemade masks were not permitted, and disposable surgical masks became required in areas with Veterans or in groups greater than 10.[452]

iv. Training

The Staff Development Coordinator conducts training through the use of educational tools on signs and symptoms, use of PPE, donning and doffing, and general COVID-19 information. Training is conducted using videos, demonstrations, return demonstrations, communication board, one-on-one education, emails, posters, and pamphlets.[453] House supervisors police the units to ensure compliance among the staff, who undergo constant re-education.[454] The Staff Development Coordinator also reviews all the staff medical screening forms for staff and families.[455] The Environmental Specialist trains her staff and the nurses on chemical kill times so they understand the products used.[456]

v. PPE and Additional Procedural Changes

With the exception of those in isolation, quarantine, or undergoing aerosolizing procedures, the staff only wore surgical masks and standard universal PPE prior to any Veterans testing positive in the Mexico Home.[457] All staff members now wear N95 respirators, while Veterans wear surgical masks.[458] Staff members were assigned a mask, which was fitted for each individual. The masks are discarded after forty hours of wear and disinfected as necessary during this period.[459] After being disinfected, masks are stored in a paper bag for 24 hours or until the next shift.[460] Most N95 respirators do not last forty hours.[461] Gowns are issued at the beginning of each shift for each nursing assistant.[462] Nursing assistants' are provided a separate gown for each Veteran they are assigned to cover that day.[463] A different gown is worn for each room; the nursing assistant hangs the gown on the door outside each Veteran's room and reuses it throughout the shift.[464] PPE and cleaning supplies are available on a door caddy outside the rooms of quarantined Veterans so that staff can don PPE prior to entering the quarantined room.[465] Staff members have been informed of the importance of wearing PPE by Home Administrators: "they assure us that if we wear PPE correctly, we will not catch it."[466]

In addition to the procedures implemented and explained above, the Mexico Home implemented further changes to prevent the transmission of COVID-19. For example, the Mexico Home implemented additional screening measures for staff members that traveled. First, staff members must state if they have been out of the Mexico area before each shift.[467] Before traveling, a staff member must have Headquarters approve the travel.[468] If a staff member travels to a designated COVID-19 "hot spot," that staff member cannot return to the Mexico Home until he or she quarantines for 14 days.[469]

vi. Staffing

The HR Specialist noted significant increases in overtime in the last couple of months. Prior to COVID-19, there was hardly any overtime worked, but in the last couple of weeks there have been over 100 hours of overtime each week.[470]

vii. Communication

For dissemination of guidance from Headquarters, the Administrator set up a shortcut on every computer in the Home that accesses the collection of policies applicable to the Home. The

Home also relies on the Staff Development Director who engages in education efforts for the staff. Part of the current communication plan involves a daily weekday phone call between the Mexico Home and Headquarters' leadership.[471] Ms. Edwards, the Administrator, is complimentary of Headquarters' communication with the Mexico Home and believes Headquarters responded to the pandemic from the very beginning, proactively creating COVID-19 policies. When asked about reporting positive tests, Ms. Edwards said that Headquarters was clear that "if you have a positive test, you better be calling and texting until it's acknowledged by someone up at HQ."[472]

During the calls, the Homes discuss all relevant COVID-19 information.[473] The Assistant Administrator relies on the unit manager or charge nurse to collect information from the floor and report it to the Chief Nurse, who then forwards the information to the Mexico administration.[474]

Mrs. Edwards also noted that the Mexico Home provides roughly 40 categories of information concerning all aspects of its COVID-19 response (including suspected and positive cases) every day in spreadsheets it is required to submit to Headquarters.[475]

Internally, there were morning meetings with the unit managers and interdisciplinary teams. During these meetings, the Home discussed any changes in the Mexico Home within the past 24 hours, and managers discuss guidance and policy changes received from Headquarters. When asked about the burdens of collecting various policies, directives and guidance, Ms. Edwards stated: "We are complying with all reporting requirements but frankly, I would want the public to know that we are taking care of people, and that they are not just numbers to us. They are our family."[476]

The Staff Development Coordinator did express frustration at the constant change in directives, particularly related to testing, because she would share the information with staff or Veterans and it would be different the next day.[477] She felt the frequent change in directives demonstrated Headquarters' uncertainty and further compromised Administrators' ability to effectively communicate the changes to the Mexico Home.[478]

viii. Impact on Veterans

The restrictions have been hard on Veterans' overall mental health and morale. The Mexico Home acknowledges an increase in depression and complaints.[479] Veterans will say: "I don't care if I get COVID, I would rather die of COVID than loneliness."[480] They compare the lockdown to being in prison.[481] The Home has seen an increase in deaths that are not related to COVID-19 in the Mexico Home, which may be due to loneliness and depression.[482] On occasion staff will ease up

on restriction and permit Veterans additional access to the Home: "Depression is such a heavy thing right now because they're having to stay in their rooms, if they want to get out and stretch their legs for two minutes, we're going to let them, as long as it's one at a time and they have their mask on. If they want to go get a cookie, we're going to let them."[483]

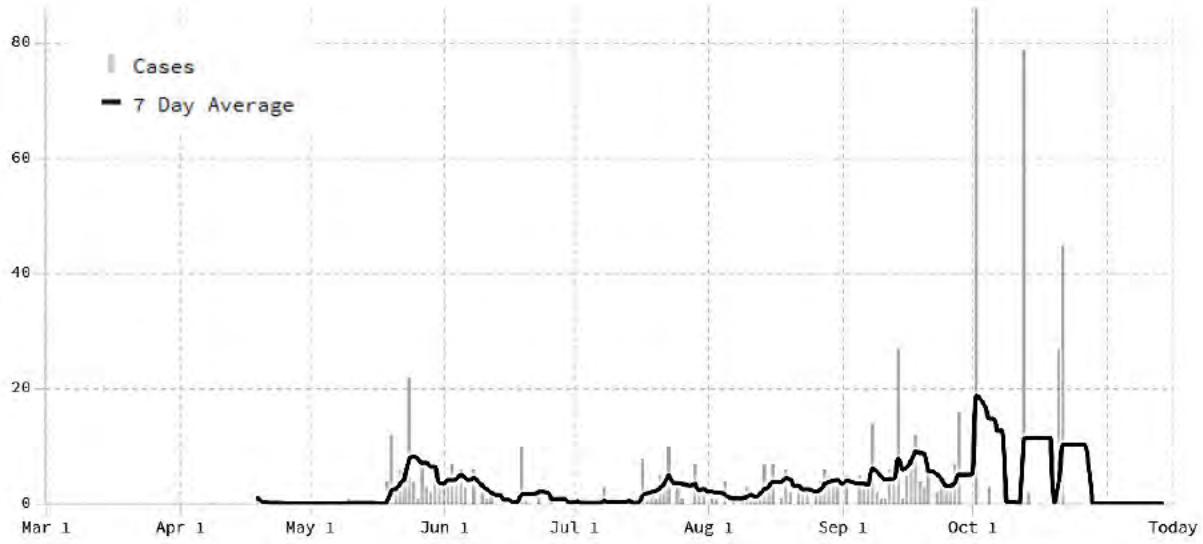
One of the Clinical Case Workers observed increases in Veteran depression due to the lack of in-person family visits.[484] To help Veterans with the decreased personal interaction, the Mexico Home facilitated and encouraged families' virtual visitations with Veterans. [485]

[redacted], the President of the Resident Council, painted a very positive picture of the Mexico Home. He repeatedly stressed four key factors to his high praise: (1) consistent staffing, with the same CNAs and nurses assigned to the same module; (2) a culture among the staff of treating the residents like family; (3) heavy emphasis on sanitizing all common surfaces; and (4) excellent food.[486]

6. Regional Considerations

As of the morning of November 16, 2020, Audrain County has had 896 cases and 11 deaths attributed to COVID-19.[487] The following image illustrates the course of positive cases over time in Audrain County as of November 16, 2020.[488] This reletively late rise in the number of cases within the surrounding community has resulted in a similarly late rise within the Home.

CASES IN AUDRAIN CO. MO



Other health care facilities in the Mexico area have experienced an outbreak COVID cases and deaths. On September 3, 2020, the Audrain County Health Department confirmed 42 active

COVID-19 cases at the Tri-County Care Center.[489] The first death related to the facility occurred at the Harry S. Truman Memorial Veterans' Hospital after the patient was transferred from the Tri-County Care Center.[490] Less than two weeks later, another patient from the Tri-County Care Center died due to COVID-19.[491] The county death toll increased to three later in September when another Tri-County Care Center patient died.[492]

Audrain County does not currently have a mask mandate and school districts have reopened for in-person instruction. The option for a virtual education program was available to all students that registered for the online learning program.

D. Mount Vernon Home

1. Summary of Observations and Concerns

The Mount Vernon Home has instituted many positive practices – at the time the Mount Vernon Home's staff was interviewed, the outbreak was currently contained to the isolation unit. The Mount Vernon Home has not had any positive tests in the general population for the past thirty days.[493]

There are, however, concerns regarding the practices of the Mount Vernon Home that may have contributed to the spread of COVID-19 amongst its Veterans and staff: (1) there is no evidence of general infection prevention and control policies and procedures; (2) education on procedures is not in compliance with COVID-19 guidance, including hand hygiene; and (3) communication and directives from Headquarters change frequently, creating confusion and inconsistent practices.

The Mount Vernon Home's Administrator believes that earlier access to testing may have helped quickly identify positive staff.[494] The lack of formal infection control policies and procedures was apparent during Pathway's site visit in which a charge nurse indicated that the 3-4 pages of undated COVID-19-specific guidance was the only hard copy of the policies and procedures.[495] Moreover, the procedures are not in accordance with the most updated guidance.[496] Signage for donning and doffing, proper PPE usage, and hand hygiene is not in line with current CDC guidance.[497] Cleaning and disinfecting for equipment reuse and PPE reuse is not in accordance with current guidance[498] PPE is not consistently and appropriately used.[499] Communication between Headquarters and the Mount Vernon Home could also be improved, as directives from Headquarters frequently change, creating extra work and confusion among the staff.[500] For instance, the Home might receive guidance to push information to staff, and then learn later the guidance had changed.[501] If some change is implemented mid-shift, the environmental services staff may stop their regular tasks to go handle that, even if it makes some units shorthanded or some usual cleaning tasks left incomplete.[502]

Headquarters did not prepare or anticipate an outbreak and develop a plan; instead, it relied solely on the State's guidance on influenza.[503] As a result of this reactionary approach, one staff member noted it felt like the staff was "flying by the seat of their pants."[504]

2. Structure of the Mount Vernon Home

The Veterans' Home is located at 1600 S Hickory St, Mount Vernon, MO 65712. The Mount Vernon Home has 200 beds with four different neighborhoods, each holding 50 beds.[505] The Home has both private and semi-private rooms.[506] Each neighborhood is organized based on the level of care necessary to serve the Veteran population.[507] Employees are assigned a neighborhood but some float between neighborhoods.[508]

The Mount Vernon Home has experienced a sharp decline in residency:[509] The total census has decreased from 187 to 115.[510] There have only been a few admissions to the Mount Vernon Home in August, and admissions ceased when a COVID-19 case was identified in September.[511] The Mount Vernon Home had admissions of new residents on the following dates: June 3-5; June 24; June 25; August 25-26; September 11.[512]

While there have been no new cases identified, at the time of the interviews with Mount Vernon Home's staff, there are approximately eight Veterans and three staff members that are positive for COVID-19.[513] There have been nine COVID-19 related deaths at the Mount Vernon Home.[514]

3. COVID-19 Preparation

Access to the building was immediately limited to essential staff only, as well as necessary medical vendors.[515] Quarantine was originally set up with 12 beds and located in the special care unit because it had the lowest census.[516] Veterans moved to these single occupancy isolation rooms and are under contact and droplet transmission-based precautions in addition to the standard precautions used with all other Veterans.[517] The single occupancy unit was also where all cases were initially confined.[518] The Director of Nursing identified one or more private rooms on each of the four wings to be used as isolation rooms for Veterans with presumptive COVID-19 symptoms or confirmed COVID-19 diagnosis.[519] PPE door hangers and vital sign equipment are placed outside the Veterans' door for staff to use prior to entering.[520]

At the beginning of the pandemic, the Mount Vernon Home was instructed to begin training staff on proper PPE including donning and doffing, fit testing for N95 respirators and full face respirators.[521] Training also included learning the procedures following a Veterans' death and the procedure for items jointly used by staff and Veterans.[522] Following the first staff positive cases, Veterans were locked down in their respective neighborhoods.[523]

4. Outbreak and Timeline

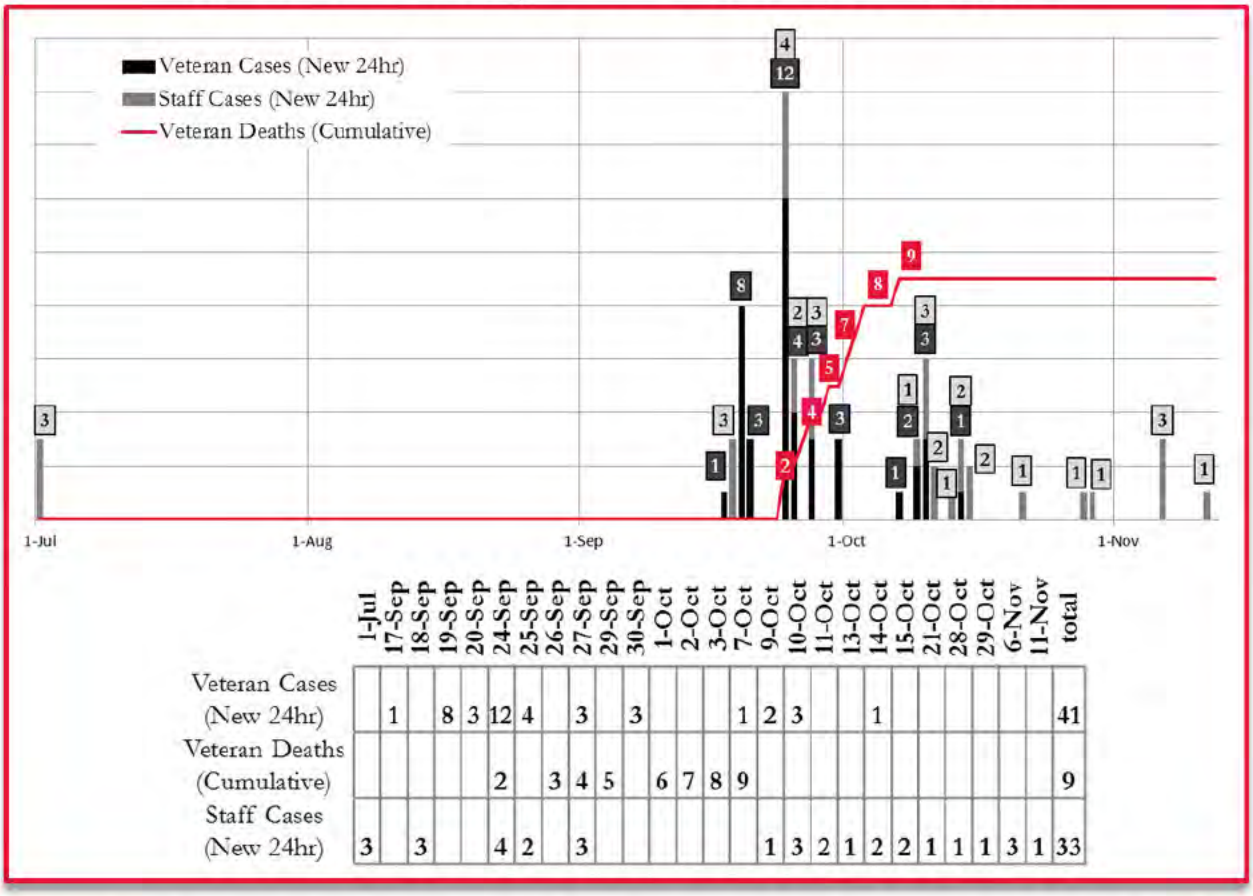
In July 2020, three employees tested positive for COVID-19.[524] The first was positive following a vacation, but that employee did not re-enter the Home.[525] The second was in [redacted] with minimal Veteran interaction, and the third was in maintenance.[526] The three quarantined at home.[527]

The first Veteran tested positive on September 15, 2020.[528] This Veteran lived on the special care unit.[529] However, maintaining social distancing in the special care unit is challenging because the Veterans' conditions make monitoring and directive compliance difficult.[530] In fact, Veterans in the dementia unit were never confined or restricted to their rooms, and it would be impossible to enforce this confinement.[531] The only way to keep dementia patients from wandering among the rooms is to dedicate a nurse or CNA for one-on-one care to ensure the Veteran does not leave his or her room.[532] The Mount Vernon Home's staffing levels do not allow this for every Veteran that needs room restriction.[533]

On September 24, 2020, 12 more Veterans tested positive and the Mount Vernon Home experienced an exponential increase in positive cases for COVID-19. [534] There have been nine deaths among COVID-19 positive Veterans; those Veterans had been on hospice or had had multiple co-morbidities.[535] Currently, The Mount Vernon Home has one active Veteran COVID-19 case.[536]

The following figure illustrates the positive cases and cumulative deaths over the course of the outbreak:

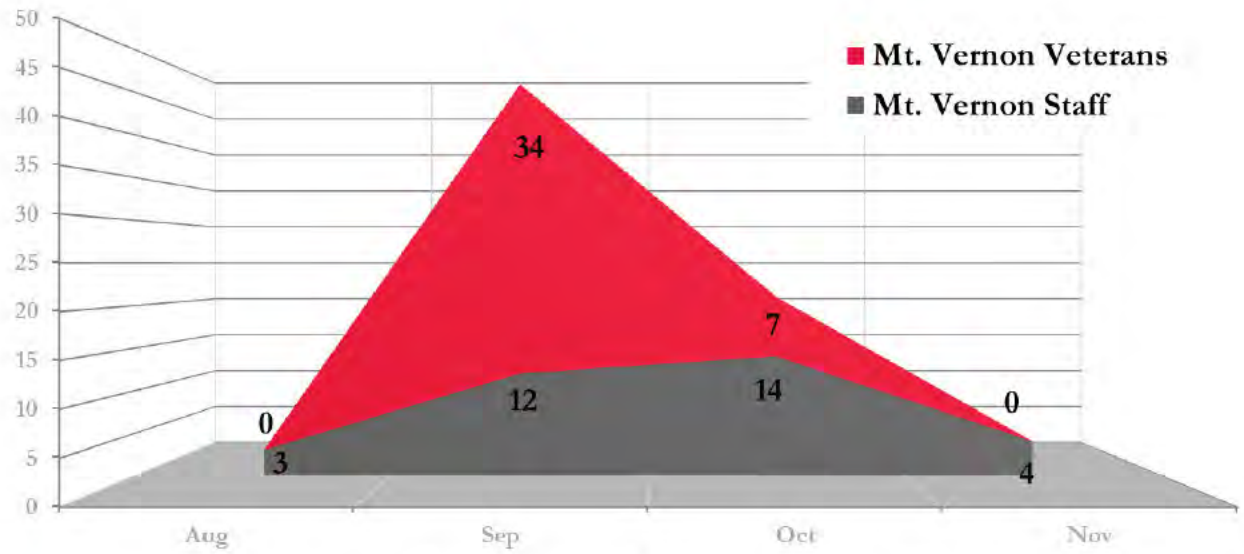
Mt. Vernon Home | Timeline of Cases and Deaths



	1-Jul	17-Sep	18-Sep	19-Sep	20-Sep	24-Sep	25-Sep	26-Sep	27-Sep	29-Sep	30-Sep	1-Oct	2-Oct	3-Oct	7-Oct	9-Oct	10-Oct	11-Oct	13-Oct	14-Oct	15-Oct	21-Oct	28-Oct	29-Oct	6-Nov	11-Nov	total
Veteran Cases (New 24hr)		1		8	3	12	4		3		3				1	2	3			1							41
Veteran Deaths (Cumulative)						2		3	4	5		6	7	8	9												9
Staff Cases (New 24hr)	3		3			4	2		3							1	3	2	1	2	2	1	1	1	3	1	33

One of the staff members who tested positive was an asymptomatic restorative aid that had floated off one unit and had worked with other members in two other units.[537] As a result, there were clusters of positive cases in those units as well.[538] The Administrator and Director of Nursing believe the likely source of the outbreak was two staff members who were working in the affected unit.[539] Additional cases were found on this unit and linked to restorative staff who tested positive and worked with residents who were also positive but did not live on the affected unit.[540]

The next figure also represents the positive cases over time for the Veterans and staff. However, this visualization of the outbreak clarifies the pattern and burden of each group. The Veterans experienced a sudden and dramatic increase in positive cases as the staff positive case rate followed a comparatively shallower rise:



	Aug	Sep	Oct	Nov
Mt. Vernon Veterans	0	34	7	0
Mt. Vernon Staff	3	12	14	4

5. Response to Outbreak

i. Quarantine and Isolation

All Veterans are quarantined to their room, including those who return from hospital visits and those displaying symptoms and awaiting results.[541] PPE is kept on door hangers and vital sign equipment is placed outside the Veterans' door for staff members.[542] Because of the number of positive COVID-19 tests, Mount Vernon leadership staff created a COVID-19 positive area of the building on Wing D.[543] Wing D is used by both COVID positive Veterans and Veterans experiencing symptoms while awaiting PCR test results.[544]

During the onsite visit by Pathway, procedures related to moving Veterans were not clearly understood by staff. Precaution practice for a Veteran who shows symptoms could not be clearly articulated by all nursing staff.[545] While a Veteran who tests positive is taken to the COVID-19 unit, it was unclear what precautions would be taken for the Veteran's roommate.[546] Staff do not consistently follow current quarantine and isolation guidance.[547] Issues with bed placement are not quickly addressed because they are first referred to the Medical Director who offers mitigations strategies.[548]

ii. Visitors

The Mount Vernon Home previously permitted outdoor visits, hand holding visits, and closed window visits.[549] The outdoor visits followed CDC guidelines for staff and Veteran screening, visitor restrictions, and Veteran communal dining and activities limitations.[550] The hand holding visits and closed window visits ceased once staff and Veterans tested positive.[551]

iii. Screening and Testing

Staff members are screened at the beginning of each shift.[552] The daily screening and check-in process includes a questionnaire, hand hygiene, surgical masking, and temperature check.[553] The check-in staff reviews the questionnaire and contacts the shift supervisor if there are any answers warranting further attention.[554] The staff screening and testing area is located at the front entrance. During off hours, Nursing Supervisors are summoned to this same locked area.[555] If employees exhibit COVID-19 symptoms, the Administrator and the Director of Nursing evaluate whether the employee's symptoms pose a transmission threat and decide whether the employee may work.[556] At the beginning of fall 2020, many employees were experiencing allergy symptoms, making it difficult to determine whether the symptoms prohibited the employee to work.[557] Given the similarity between certain allergic reactions and COVID-19 symptoms, The Mount Vernon Home sent most employees experiencing allergy symptoms home.[558]

Prior to positive cases in the Mount Vernon Home, testing was a random selection of Veterans and staff using PCR tests.[559] It varied from 1-2 times per week and tested approximately 40% of the population.[560] Once a case was identified in early September, daily rapid tests were implemented.[561] Currently the Mount Vernon Home is undergoing five days of rapid testing and two days of PCR testing.[562] Positive results are reported to Headquarters by phone, logged on an Excel report for Headquarters, and provided to DHSS, the local health department, and the VA.[563] Staff members who test positive are required to remain home for ten days and until symptoms have been reduced.[564] If the staff member continues to test positive, the staff member is permitted to continue working as long as the staff member does not have symptoms consistent with COVID-19.[565] However, if the employee remains symptomatic, the HR Director contacts the employee each day to check on the employee's status and directs the employee to see the employee's physician after 20 days if the employee continues to experience symptoms.[566] Employees who return to work are not tested again for ninety days.[567]

Veterans are screened every four hours by taking temperatures and O2 saturation levels. A temperature between 99-100.4 degrees is reportable and that Veteran is monitored.[568] If the O2 level drops below 90%, the Veteran receives a follow-up assessment.[569] Veterans testing positive for COVID-19 are monitored in similar fashion with a full respiratory system assessment added each time.[570] Pulse, blood pressure, and respirations are not checked during these four-hour checks, only monthly.[571]

iv. Training

At the beginning of the pandemic, the Mount Vernon Home was instructed to begin training staff on PPE, including early fit testing for N95 respirators and full-face respirators.[572] Headquarters drives policy and directive on these issues, typically consistent with CDC and DHSS guidance.[573]

The Staff Development Coordinator has encountered some PPE noncompliance. Her role is to conduct "re-educations" where the employee receives instruction on proper procedures. The Staff Development Coordinator cannot issue discipline, and believes it is difficult for managers to issue discipline due to progressive policies.[574] Some discipline must be approved with the Mount Vernon Home's and Headquarters' Human Resources departments before being issued. Despite constant education, the Mount Vernon Home's Administrator noticed issues of "slack masking," which she described as staff wearing or pulling their surgical masks below their nose. Employees were not disciplined, but received instruction on how to properly wear masks.[575] Some staff also fail to seal their N95 respirator properly around the chin.[576] Overall, the Mount Vernon Home seemingly struggles with balancing compliance and discipline due to the fear that discipline may create staffing shortages.[577]

v. PPE and Additional Procedural Changes

After screening, staff working the three non-COVID-19 wings report to their assigned wing to don additional PPE.[578] All direct care staff are wearing N95 respirators, face shields, and gowns on the wings.[579] Foot coverings are added for the staff assigned to the COVID-19 unit.[580] Staff working the COVID-19 wing exit the building and immediately drive to a parking lot in the back of the building.[581] They enter through an exterior door and don additional PPE before entering through a zippered door.[582] PPE usage continues to be in contingency mode in that PPE (other

than gloves) are used for multiple Veterans and/or for multiple days.[583] CNAs frequently remove masks to talk to Veterans because it is difficult for them to hear them.[584]

Prior to September 15, 2020, Mount Vernon followed CDC guidelines for nursing facilities in that surgical masks were worn by all staff and social distancing measures and frequent hand hygiene were in place for both staff and Veterans.[585] Staff members were fit tested for N95 respirators.[586] At one point, the Staff Development Coordinator overheard Joan Elwing say that N95 respirators must be worn until they fall apart.[587] Recently, the Mount Vernon Home switched to soft N95 respirators and staff members were told they should wear them for 40 hours.[588] Masks are kept in paper bags until the next shift. [589] Despite this instruction, the Staff Development Coordinator believes they should be disposed of more regularly because the masks degrade.[590] In addition, some staff cannot wear the soft N95 respirators and must wear the hard variety for fit reasons.[591]

There have been some issues with PPE compliance at the Mount Vernon Home. During Pathway's onsite visit, it observed a CNA passing meal trays without performing hand hygiene between rooms and entering a droplet precaution room with a meal tray, no gloves and no hand hygiene.[592] A CNA was also observed removing meal trays from room with no hand hygiene performed before or after donning and doffing of gloves.[593] Pathway also observed a number of staff utilizing PPE improperly.[594] Gowns were not properly secured while on the unit or in Veteran rooms, either at the top tie or waist tie.[595] As staff exit certain Veterans' room, they must walk down a hall to get to trash where they can remove their PPE.[596] Hand hygiene was not completed following donning and doffing. Hand hygiene should also be used if any adjustments are made to face shields or masks.[597]

vi. Staffing

While the Mount Vernon Home has a designated Infection Control Nurse, the person in that position was on [redacted] during August and September.[598] The Director of Nursing filled in that role, and now that she is working again, she is not involved in the Headquarters meetings related to COVID-19 activities and responses.[599] She is also not routinely maintaining the line lists as expected per standards of practice.[600]

The Home is experiencing a staffing shortage of nurses that was present even before the pandemic. Due to additional nursing and CNA support from the VA, the Mount Vernon Home has

not needed to utilize staff who test positive for COVID-19.[601] Staffing levels are manageable, but recruitment is difficult due to several large hospitals in the area.[602] Staff members feel stressed by the negative social and media issues regarding COVID-19 cases in the Missouri Veterans Homes.[603] The Environmental Services Manager stated that her department is overwhelmed by its understaffing.[604]

A staff member self-reported COVID-19 symptoms in September but stated she was asked to continue working, which she suspected was attributed to low staffing.[605] She worked that day—the next day she felt worse and stayed home, and when her test returned the following day she had tested positive.[606] Thus, she worked for one day with noted symptoms and tested positive shortly later.

vii. Communication

Information was passed to and from the Mount Vernon Home through daily calls with the MVC Headquarters. At the Mount Vernon Home, any department leader can participate in the calls, which communicate "information on COVID in the state, what DHSS has been reporting, how things are going in those areas, the department gives a brief, then each one of the Homes gives a brief on PPE, census (i.e., how many Veterans are in the building, how many are going out to hospital), testing positive to COVID, employees, positive cases, how many have tested positive, where are they in their stage."[607] The HR Director expressed that it is difficult to continually update staff with changes to practices recommended by the CDC.[608]

The staff has tried to keep families updated on the developments in the Mount Vernon Home: "At first – when we went on lockdown we called every single family member. From that point forward we maintained calling every single family member, every single week—at least—to let them know how their person was doing and what was happening. If there was a change – we called – we always called about any changes and calling at least once a week and how they are faring. And we would offer – facetime/zoom whatever medium was easiest for them instead of a telephone call."[609]

viii. Impact on Veterans

Veterans' morale and mood have suffered from the isolation caused by the implemented safety policies and procedures. It has also been difficult to keep staff optimistic and motivated,

particularly given the heightened level of care required by some Veterans due to the Veterans' inability to see their families.[610] Staff members have observed the challenges Veterans are facing:

> "*It's terrible. It's brutal.* They can't see their families, and they are sad and mad. They don't get the support from the families, from Veterans to staff – you can only do so much up lifting they have had enough, they are ready to see their families. People are passing away and they are not going to live forever, people are upset – it has not been an easy seven months. Our hallways are sad, it used to be Veterans sitting around – it was a fun happy place, it is bare now, guys in their rooms it is really hard on them."[611]

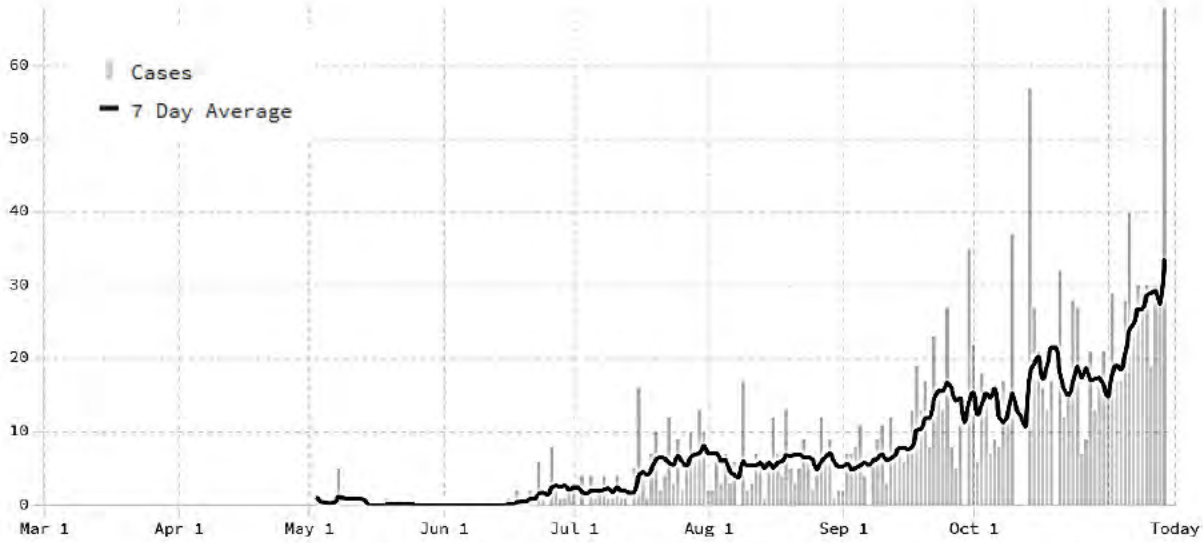
> "The Veterans do not like the staff in the PPE, they do not understand what you are saying, they don't know what you are trying to do – we added stuff for safety but they are like – what – I have no idea who you are to take care of them because they cannot see you or hear you. So we have strip everything away from them, even the closeness of the staff—we have name tag and pictures but not over the gown – *it has been really hard on them*"[612]

6. Regional Considerations

In May, seven residents of an unidentified nursing home—but not the Mount Vernon Home—in Lawrence County tested positive for COVID-19.[613] At that time, those were the first reported cases for the entire county. In July, the county reported its second COVID-19 related death. Fifteen cases were traced to the Lacoba Nursing Center in Monett, Missouri.[614] In the first week of October, Lawrence County reported nine deaths related to COVID-19, bringing the county's death total to fifteen.[615]

As of November 16, 2020, Lawrence County has had 1,585 cases and 32 deaths attributed to COVID-19.[616] The following image illustrates the course of positive cases over time in Lawrence County as of November 16, 2020:[617]

CASES IN LAWRENCE CO. MO



Lawrence County does not currently have a mask mandate. School districts in Lawrence County have reopened for in-person instruction. The option for all-online virtual education program was also available to all students that registered for the online learning program.618

E. St. James Home

1. Summary of Observations and Concerns

The St. James Home's staff is dedicated to the Veterans they serve, doing what they can to make their time in the Home pleasant. While the staff care for the Veterans and do what they can, the onsite observations revealed that the St. James Home can do more in its infection control and prevention efforts, including: (1) following proper PPE and hygiene protocols; (2) re-education and training on infection control procedures; and (3) communication. There were multiple observations noted of staff not disinfecting medical equipment appropriately and subjecting supplies and themselves to cross contamination within the Home. Re-education and training should take place immediately to correct behavior of staff. These topics should include proper hand hygiene, proper PPE use and when it is necessary, proper donning and doffing, as well as general infection control procedures that can help limit the spread of COVID-19 and other viruses. Additionally, improving the communication that comes from Headquarters and making sure that directives are properly disseminated among the staff could improve the Home's efforts to mitigation COVID-19 within its walls.

2. Structure of the St. James Home

The St. James Home is located at 620 N Jefferson St., St. James, Missouri 65559. The Home is divided into "cores" which contain two halls.[619] Each hall typically houses 25 Veterans.[620] The Home has three "cores" — A, B, and C — and each core has two halls, with each hall having three living areas.[621] Each core is closed to the others.[622] This Home can accommodate 150 Veterans.[623] There are currently 96 beds filled.[624] Due to the low census, the St. James Home continued to admit new Veterans until August 25, 2020.[625]

3. COVID-19 Preparation

On March 7, 2020, Headquarters directed the St. James Home's Administrator to enter lockdown, prohibiting all non-essential visitors to the Home.[626] In response to policies and directives from Headquarters, on March 8, the St. James Home began preparing quarantine and isolation areas; both quarantine and isolation were originally set up with eight beds each.[627] Headquarters came to the Home around April and discussed preparations for a potential

outbreak.[628] The Home created a stockpile of additional PPE and designated the Home's old outpatient clinic as the isolation area.[629] The A-Core, A-Hall was eventually designated and prepared as the isolation unit. It has room for 25 Veterans.[630] After the first positive case on September 4, air scrubbers were installed in the isolation area.[631]

Veterans were allowed to leave only for necessary appointments.[632] In March, housekeeping staff began increased cleaning of high-touch surfaces.[633] Veterans were allowed to use the communal dining room, but they were encouraged to socially-distance themselves.[634] Veterans are now restricted to their Home wing within their core.[635]

If a Veteran began exhibiting symptoms but was not positive or awaiting a test, the Veteran remained in their room or moved to a private room if available.[636] Staff were advised the Veteran was exhibiting symptoms and a door hanger would be placed outside with PPE.[637] A Veteran who tests positive on a rapid test is not immediately moved into isolation.[638] Instead, the Veteran is either moved to a single room or quarantined to his room.[639] No one is moved in or out of isolation without consulting the medical director.[640]

The unit housing Veterans with dementia is shutoff from the other floors, has designated staff, and staff from other floors only enter that floor if absolutely necessary.[641] The unit also has its own dining room. These Veterans co-mingle only among themselves.[642]

Since the first positive case on September 4, 2020, housekeeping began using an anti-viral spray, mopping walls, and working in assigned areas (rather than across the whole Home).[643] The St. James Home also hired an outside company to begin cleaning using three different cleaning products.[644] At first, Shift Supervisor Hobson directed the company to clean specific areas, including the rooms of infected or suspected positive Veterans, main hallways, the kitchen (after a kitchen staff member tested positive), and employee break rooms.[645] About two to three weeks ago, this duty was given to the Environmental Services Supervisor Pam Bach.[646]

Ms. Bach noted that there were already increased cleaning measures in the St. James Home in place in March before the lockdown because it was flu season. COVID-19 made them more aware and vigilant but the practices were essentially the same.[647]

Admissions continued to take place.[648] To be admitted to the St. James Home, A Veteran needed to test negative plus complete a fourteen-day quarantine on site in the quarantine area.[649] Staff did not start to wear full PPE until September 9, 2020.[650] Prior to that, staff wore surgical masks.[651]

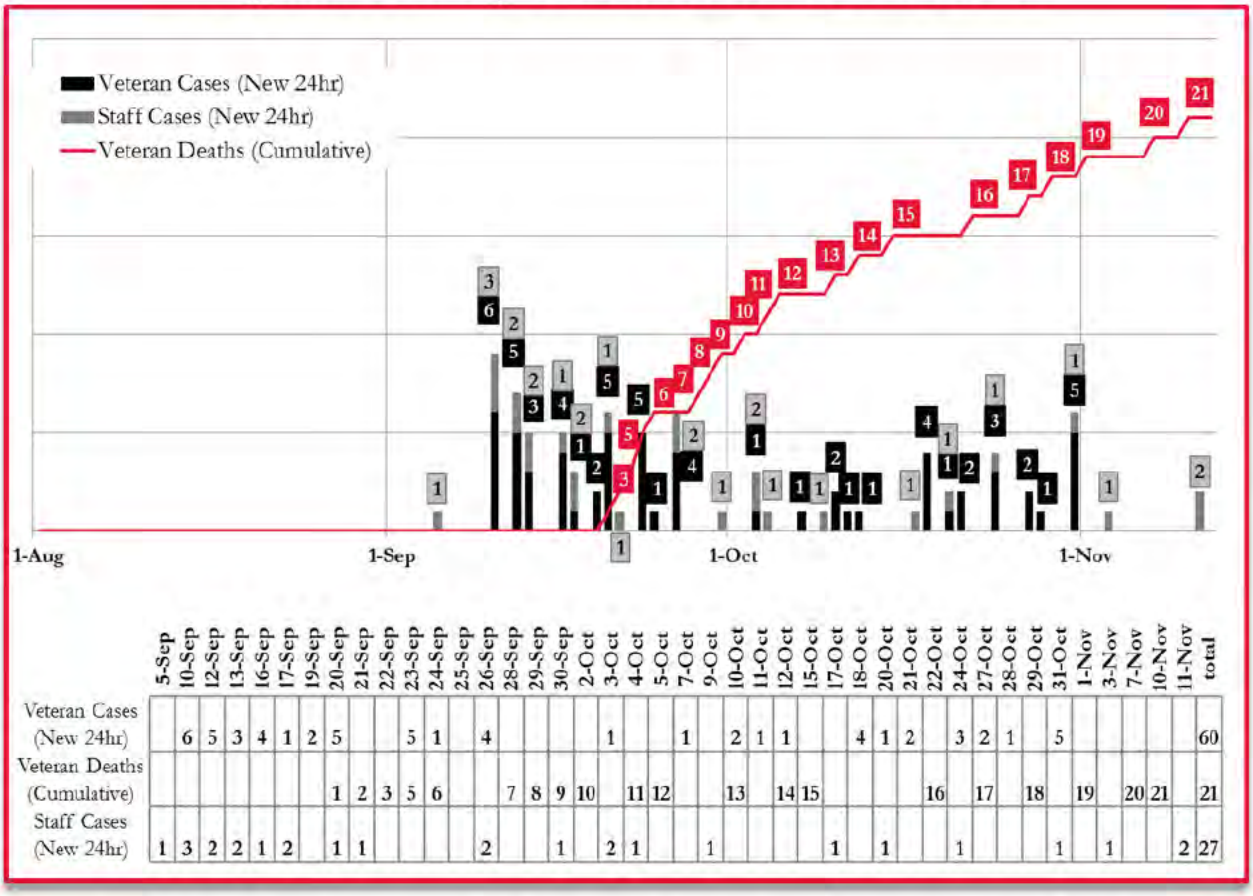
4. Outbreak and Timeline

On September 5, 2020, the St. James Home had its first staff member test positive.[652] The next day, sentinel testing was conducted on all Veterans and staff.[653] Veterans were also given a baseline assessment of vital signs and were to be given the same assessment every four hours.[654] On September 10, 2020, six Veterans and three more staff tested positive.[655] These Veterans were from both A and C Cores.[656]

Cases in the St. James Home grew exponentially—there were twenty more Veterans and eight staff members who tested positive over the next ten days.[657] The Home had its first Veteran death on September 19, 2020.[658] Fourteen more Veterans died between September 21 and October 16, 2020.[659] There are currently 10 active COVID-19 cases of Veterans. In total there have been 21 Veteran deaths at the St. James Home.[660]

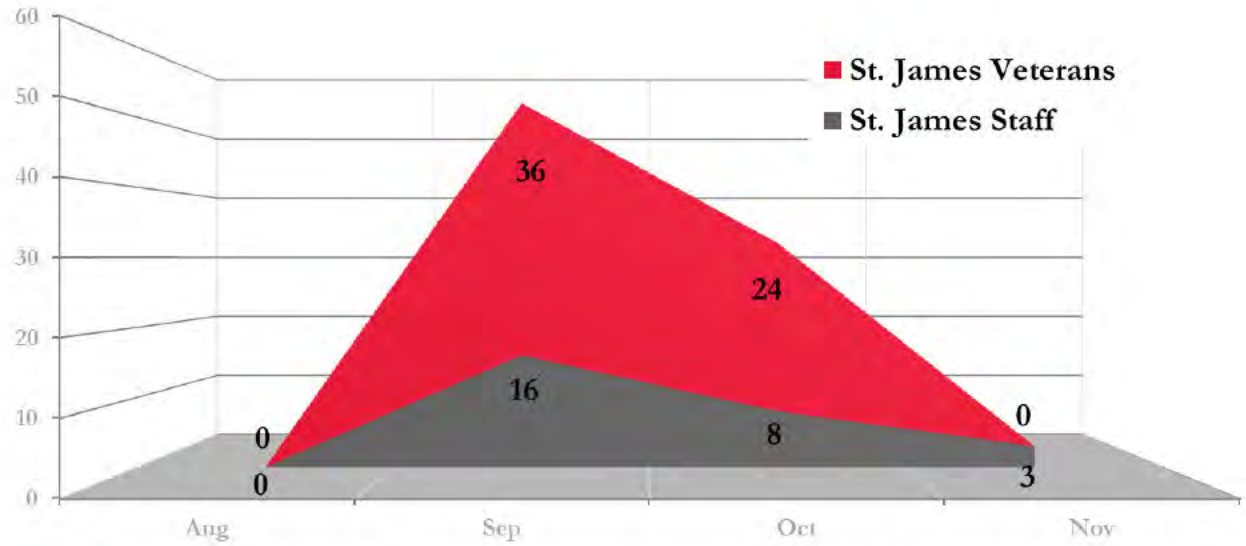
The following figure illustrates the course of the outbreak and suggests a relatively unmitigated rate of spread and high death rate:

St. James Home | Timeline of Cases and Deaths



	5-Sep	10-Sep	12-Sep	13-Sep	16-Sep	17-Sep	19-Sep	20-Sep	21-Sep	22-Sep	23-Sep	24-Sep	25-Sep	26-Sep	28-Sep	29-Sep	30-Sep	2-Oct	3-Oct	4-Oct	5-Oct	7-Oct	9-Oct	10-Oct	11-Oct	12-Oct	15-Oct	17-Oct	18-Oct	20-Oct	21-Oct	22-Oct	24-Oct	27-Oct	28-Oct	29-Oct	31-Oct	1-Nov	3-Nov	7-Nov	10-Nov	11-Nov	total
Veteran Cases (New 24hr)		6	5	3	4	1	2	5			5	1		4					1			1		2	1	1			4	1	2		3	2	1		5						60
Veteran Deaths (Cumulative)								1	2	3	5	6			7	8	9	10		11	12			13		14	15					16		17		18		19		20	21		21
Staff Cases (New 24hr)	1	3	2	2	1	2		1	1					2			1		2	1			1					1		1			1				1		1			2	27

On the following figure, note the duration of the peak with its extensive gradual slope. The absence of a sharp decline at any point in the case rate further suggests an ongoing spread at a relatively unmitigated rate:



	Aug	Sep	Oct	Nov
St. James Veterans	0	36	24	0
St. James Staff	0	16	8	3

As positives increased, the quarantine space was consumed by isolation. [661] There are currently 33 isolation beds with room to expand if needed.[662] The quarantine space was used for Veterans who returned from hospital visits, although not all Veterans were required to quarantine after hospital visits.[663] Some, who went only to the ER, were returned to their room.[664]

Over the course of the outbreak, the St. James Home continued to report positive cases to Headquarters and kept up with the directives issued, including those that affected when staff could return to work following a positive test.[665] Veterans were moved into isolation or quarantine, and staff contacted family members when a Veteran tested positive.[666] There was also constant communication with Headquarters, as the Home complied with the reporting requirements, as well as reporting to DHSS and the local health department.[667]

The Home had its first new admissions since the pandemic in late August.[668] New Veterans were required to quarantine upon arrival. Admissions ceased after the first positive.[669] The last new admission was August 25, 2020.[670]

5. Response to Outbreak

i. Quarantine and Isolation

Currently, there are 33 isolation beds with room to expand if necessary. Because the quarantine area has been taken over by isolation, suspected positive Veterans are quarantined to their rooms.[671] All other Veterans are also encouraged to stay in their rooms and wear masks if they exit, though not all complied and some refused to stay in their rooms.[672] Veterans who test positive can go to a "step down" area if they have been in isolation for 20 days, their symptoms have resolved, they have a negative test, and they are cleared by the medical director.[673] Not all Veterans who were supposed to quarantine in their rooms kept their doors closed per current guidance.[674]

ii. Visitors

The St. James Home did allow outdoor visits with families at least 6 feet apart, masked and no touching during the summer.[675] They did only one session of hand holding.[676] Both activities stopped once staff tested positive.[677]

Families are still permitted to enter the Home to visit Veterans who are actively dying.[678] Prior to the first positive, each Veteran could have two family members and donned a surgical mask, but now families may enter isolation but must don full PPE and sign a waiver.[679]

iii. Screening and Testing

Veterans' temperatures and O2 saturation levels are recorded every 4 hours. The House Supervisor and physician are notified if a Veteran demonstrates any symptoms.[680] Additionally, every shift a COVID-19 assessment is completed.[681] This assessment, however, does not include all known symptoms of COVID-19, although staff are aware the symptom list has grown. Staff indicated that the COVID-19 assessment has not been updated since March 2020.[682]

When staff arrive for a shift, they must go through a screening process before starting the shift.[683] This includes a questionnaire that must be filled out daily that asks questions about potential exposures.[684] When Pathway conducted its onsite observations, the auditor disclosed travel within the U.S. on the questionnaire but was not questioned about it.[685] Temperatures are also recorded.

The St. James Home received PCR tests in the summer and typically obtained results within 24 hours. Originally staff were tested once a month.[686] Veterans were tested next, but later the

directive changed and staff and Veterans were both tested twice a month; then once a week; then twice a week.[687] Rapid tests appeared later and are used five days a week.[688] Staff were allowed to decline testing at first, but the policy has now changed.[689]

If a Veteran exhibits symptoms of COVID-19, he/she is quarantined to their room, even if the Veteran has a roommate.[690] The Veteran is then tested using a rapid test—if that test is positive, the Veteran is moved to isolation for 20 days; if the rapid test is negative, the Veteran stays in quarantine until a PCR test result can be obtained.[691] The roommate will receive both rapid and PCR tests.[692]

Contact tracing is not initiated until after a positive PCR test.[693] The positive staff member fills out a questionnaire that includes questions like the date of their last shift, what cores they visited, person in their homes, and interactions with Veterans/staff without masks or without proper PPE.[694] Most staff remove their masks on breaks or lunch and are social distancing.[695] Once home, Human Resources monitors the employee's condition to determine when they can return to work. Currently, employees need to quarantine at home for at least 10 days from the date of the positive test before returning, have symptom improvement, and be fever free without medicine.[696]

iv. Training

Ms. Hammerschmidt initiated training on the screening process for entering the building on March 13; donning and doffing of PPE at the end of March; dietary training with procedure for delivering trays to isolation; COVID-19 testing education in June; and hand hygiene. There are also continual updates in response to the current COVID-19 situation.[697] The reminders to staff about PPE are constant.[698] There are posters next to every entrance to show how to properly take off or on and videos playing on constant loop.[699]

v. PPE and Additional Procedural Changes

Since switching to full PPE following the first positive cases in the Home, staff change PPE between direct care except mask/eye protection.[700] Dietary staff do not wear full PPE when cooking.[701]

Veterans on the Special Care Unit do not wear masks or maintain social distancing.[702] Staff does not intervene with reminders to wear masks or keep Veterans apart.[703] When staff attempted to mandate that Veterans wear masks on that unit, they experienced an increase in falls.[704]

Headquarters gave permission that masks were not mandatory for Veterans on this unit.[705] Veterans on that unit were observed congregating. During an onsite visit, terminal cleaning of common areas following a meal was not observed.[706]

Pathway noted some deficiencies during their onsite observations. For instance many routine hygiene and disinfectant procedures were not followed. A nursing assistant was observed taking vital signs for two Veterans without sanitizing the machine between use.[707] The machine was then put in the nurses' station without being sanitized.[708] A Pathway representative brought this to the attention of a unit manager who questioned the assistant.[709] She said, "It was clean when I started," and the manager responded, "whatever."[710]

A nursing assistant told the Pathway representative that she used a "1 minute" spray to disinfect shower chairs and vital sign machines.[711] The label on that spray had a 1-minute dwell time for bacteria but a 10-minute dwell time for COVID-19.[712]

A staff member in the hall of the Special Care Unit wore only an N95 respirator but no other PPE.[713] He was returning supplies to the drawers of the cart without cleaning or disinfecting them.[714] He used an electric razor to shave a Veteran's face in the hallway—he did not wear gloves, perform any hygiene before or after, and did not disinfect the razor.[715]

vi. Staffing

Multiple people in the facility stated the Home has had staffing issues for years. In June, the St. James Home had about 18-20 staff vacancies.[716] During the September outbreak, about 15 CNAs quit.[717] Currently the Home has about 44 staff vacancies, 33 of which are CNAs.[718] The Administrator raised concerns with Brad Haggard when she transitioned into her role about the staffing but nothing was done.[719] She also raised these issues with Joan Elwing and in the weekly calls.[720]

Later, when they had positives, staffing became a bigger issue. For instance, staff were needed to check test results and contact families in addition to regular duties. Inadequate staffing also triggers a "mandate system," which requires nursing staff to continue working after their shift ends (up to a total shift length of 16 hours).[721] This makes the staff tired, which forces turnover and affects performance.[722] Staff are also not allowed to have secondary employment.[723] Temporary assistance from the VA and DMAT has been helpful but is not a long-term solution.[724]

vii. Communication

Directives come from Headquarters and points of contact include Homes Director Joan Elwing or Assistant Director Brad Haggard. Some directives are accessible on a Sharedrive, but not all.[725] The Assistant Administrator created her own binder containing documents, emails, etc. She also received a COVID-19 toolkit used by Minnesota but has not seen anything similar issued by Headquarters.[726] The Assistant Administrator did not know if there was an outbreak protocol, has not seen one. There is no online portal or physical booklet for staff to access COVID-related policies.[727]

A shift supervisor identified communication as an issue. She has not received direct information from Headquarters since their visit to the Home in April.[728] There are posters all over the Home with information, which she believes came from Headquarters.[729] While she assumes the Home's Administrator has shared all relevant information, she does not know who to ask for additional guidance. She would "absolutely" like to be kept in the loop.[730]

The Director of Personnel stated they may receive one directive in the morning and another in the afternoon.[731] This is hard on staff and Home leadership. Changes to procedure felt reactive instead of proactive.[732] For example, when the Home first received the rapid tests, they were instructed to inform employees to find a supervisor during the shift to be tested.[733] Then, a few days later, the directive was changed that all employees needed to test at the beginning of their shift.[734] Staff could go home one day and the next day be subject to different directives; the result is a staff member may not know of the change until checking emails the following day.[735]

The Administrator explained that she receives directives from Headquarters generally but few formal written policies. She feels directives can be interpreted differently and that there is a lack of standardization across the board.[736] There is no decision tree or established protocol for threshold conditions that warrant testing.[737] Information is provided to staff through town halls or verbal communication.[738] Sometimes information is presented in the form of written newsletters. Some information is also emailed to staff.[739]

In addition to regular duties, since the pandemic the social workers have been going to the Home on the weekends to call family members for a daily update of all those Veterans in isolation.[740] A family member or other contact is called for each Veteran in isolation daily for an update.[741]

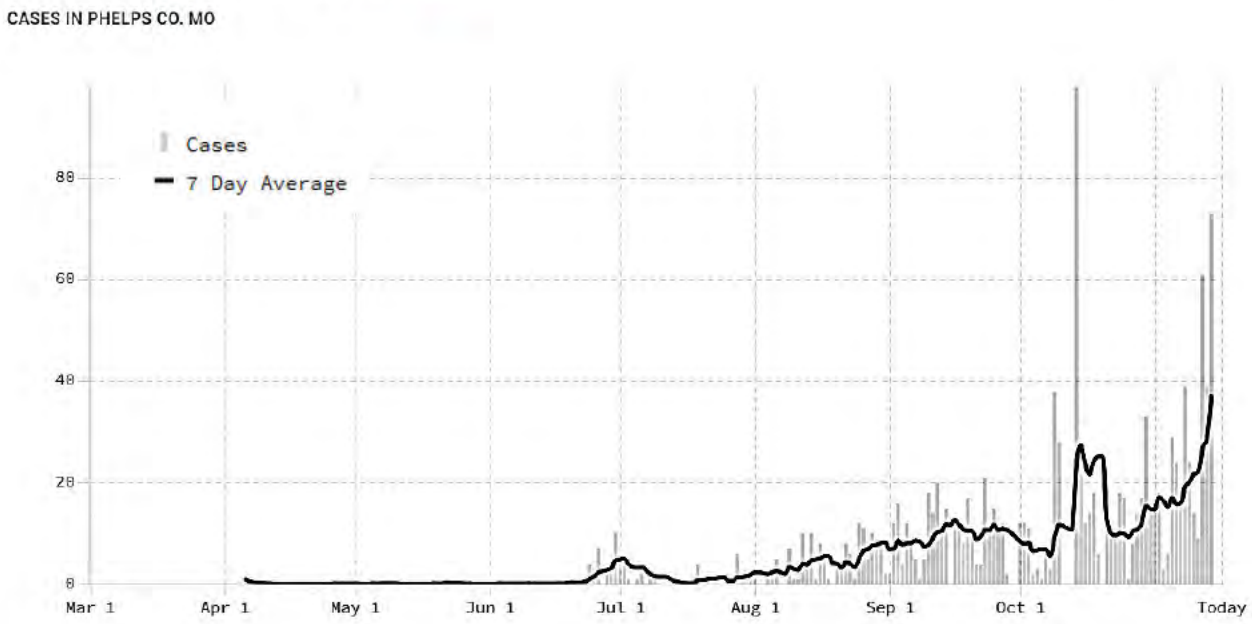
viii. Impact on Veterans

The Medical Director described a significant impact on the Veterans due to the isolation with an increase in depressive and suicidal thoughts.[742] They are all doing their best to keep the Veterans busy and connected to their family. While morale among Veterans has been low, the President of the Resident Council did not believe there was any specific action that could be taken to improve morale.[743]

6. Regional Considerations

In June, the Rolla City Council voted to revise its COVID-19 ordinance to eliminate many of its restrictions on business operations and public events. This included the provision barring visits to nursing homes and long-term care facilities.[744] While the ordinance allowed public visitors to these facilities, they were encouraged to follow DHSS guidelines, including that all visitors and employees should wear a protective mask when engaging with residents within six feet, temperature checks should occur daily, and a health questionnaire should also be conducted upon arrival.

As of November 16, 2020, Phelps County has had 1,287 cases and 34 deaths attributed to COVID-19[745]. The following image illustrates the course of positive cases over time in Phelps County as of November 16, 2020:[746]



Phelps County does not currently have a mask mandate. School districts in Phelps County have reopened for in-person instruction. The option for all-online virtual education program was

also available to all students that registered for the online learning program. Missouri University of Science and Technology located in Rolla, Missouri, returned with a combination of online, in-person and hybrid classes. Missouri S&T students, faculty and staff must wear face coverings in classrooms, labs and other areas when social distancing is not possible.

F. St. Louis Home

1. Summary of Observations and Concerns

Until recently, the St. Louis Home had performed quite well during the pandemic, despite a high number of cases in the surrounding area. The majority of individuals interviewed agreed that the St. Louis Home and MVC have worked effectively to prevent COVID-19 infections. Director of Nursing, Monica Halsey explained that she believes the success of the St. Louis Home is attributable to the strict guidelines staff and Veterans follow, and the Home's decision not to relax guidelines prematurely.[747] Nevertheless, like other Homes, St. Louis can improve its overall mitigation and containment strategies. Based on the interviews and Pathway site visit, the St. Louis Home has some deficiencies, including the (1) failure to implement an effective response plan and communicate changes in protocols in a uniform and effective manner; (2) failure to implement social distancing consistently; and (3) failure to ensure compliance with recommended standards concerning the use, re-use, and storage of PPE.

2. Structure of the St. Louis Home

The St. Louis Home, located at 10600 Lewis & Clark Blvd, St. Louis, MO 63136, is home to approximately 140 Veterans, who live in six communities of approximately equal size separated by fire walls.[748] The St. Louis Home is a 188-bed facility. The St. Louis Home could previously accommodate up to 300 Veterans; however, "the St. Louis Home is in the process of complying with the national Veteran Home model of providing all single-resident rooms, complete with private bathrooms," and the St. Louis Home was in the process of "slowly reducing its Veteran population through normal attrition before systematic renovation begins" in advance of the pandemic.[749] The St. Louis Home is supported by the STL Veterans Home Assistance League, referred to as the STLVHAL, which provides financial support for recreation and activities that enhance the quality of life of the Veterans who have served.[750]

Most Veterans at the St. Louis Home have individual rooms; however, six (6) rooms currently house two Veterans each.[751] The Veterans in shared rooms were chosen based upon their low risk for severe complications resulting from COVID-19.[752] The St. Louis Home categorizes the level of care required for Veterans as follows: 1) independent; minimal amount of care; medication monitoring, mild assistance (approximately 31 Veterans); 2) more moderate level of care (approximately 51 Veterans); and 3) significant care requiring continuous assistance (approximately

51 Veterans).[753] Two of the six Veteran communities are specialty units aimed at serving Veterans who have dementia and similar conditions.[754]

3. COVID-19 Preparation

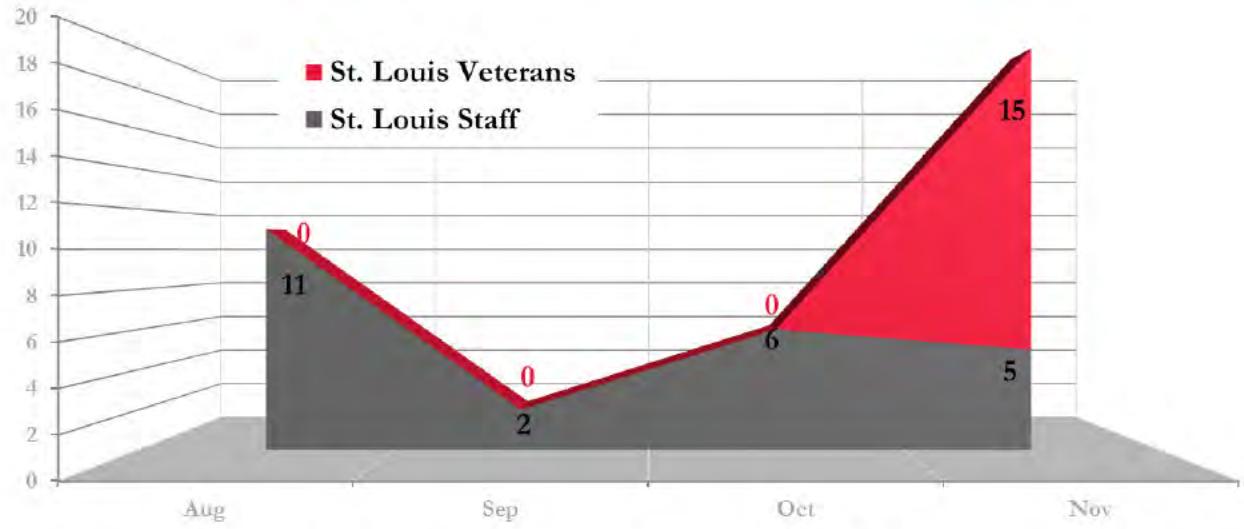
The St. Louis Home aggressively prepared for concerns regarding COVID-19. The last admission of a Veteran to the St. Louis Home took place March 3, 2020.[755] On March 7, 2020, Col. Grace Link informed the St. Louis Home's leadership that the St. Louis Home would close to all visitors effective March 8, 2020 and implement a 14-day quarantine.[756] On March 8, 2020, staff from MVC Headquarters met at the St. Louis Home with the Home's leadership team to discuss how to prepare the Home for COVID-19 concerns.[757] During March 7-8, 2020, the St. Louis Home began plans to construct isolation and quarantine areas, education modules and enacted other changes, including sequestering units and precautionary measures due to the increase in COVID-19 rates in the St. Louis area.[758] The St. Louis Home was the first long-term care/nursing home in the St. Louis area to "lock down" and prohibit visitors.[759] During March 2020, the MVC advised the St. Louis Home to designate a staff member to take on the role of infection prevention.[760] At that time, the Assistant Director of Nursing, Jennifer Neisler, transitioned her duties to focus on infection prevention, and she trained for that responsibility by attending webinars relating to COVID-19 and infectious diseases.[761]

Buffy Huffman, the Assistant Administrator, confirmed that the St. Louis Home implemented some changes differently than other Homes due to the unique circumstances at the St. Louis Home. Ms. Huffman explained that due to low morale of Veterans, the St. Louis Home provides dining to residents in buffet-style containers that are delivered at one end of each community.[762] The Veterans can individually visit the buffet-style display to retrieve meals or instead have the meals delivered to them by nursing staff.[763] Prior to March, meals would be served in the dining room.[764] In March, the St. Louis Home attempted staggered community dining, but once Veterans were on "lockdown" in their own communities, food service was delivered.[765]However, by the time the trays were delivered to the residents, the food was cold.[766] Therefore food service began utilizing chaffing dishes where food on each unit was arranged like a buffet.[767] This new system has helped make the food more appetizing for the Veterans.[768]

4. Outbreak and Timeline

At time we interviewed St. Louis Home's staff, there were no known cases of a Veteran becoming infected with COVID-19 at the St. Louis Home.[769] One Veteran who resided in the St. Louis Home contracted COVID-19 during April 2020; however, that Veteran was actively engaged in activities at the St. Louis Home, including assisting with [redacted], participating on the Veteran's Council, and [redacted] many residents.[770] The Veteran was admitted to the hospital and tested negative for COVID-19.[771] However, the Veteran experienced shortness of breath and the hospital moved him to the COVID-19 area.[772] After staying in the hospital for a few days, the Veteran tested positive for COVID-19 and experienced symptoms consistent with COVID-19, and he was transferred to the local Veterans Hospital where he passed.[773] The St. Louis Home does not believe the Veteran contracted COVID-19 while at the Home.[774] Until November 6, 2020, the St. Louis Home had not had any Veterans infected with COVID-19 since April 2020.[775]

The following figure illustrates the outbreak and spread of COVID-19 among staff and the successful prevention of spread to the Veterans, who had zero cases contracted within the Home until November 6, 2020:

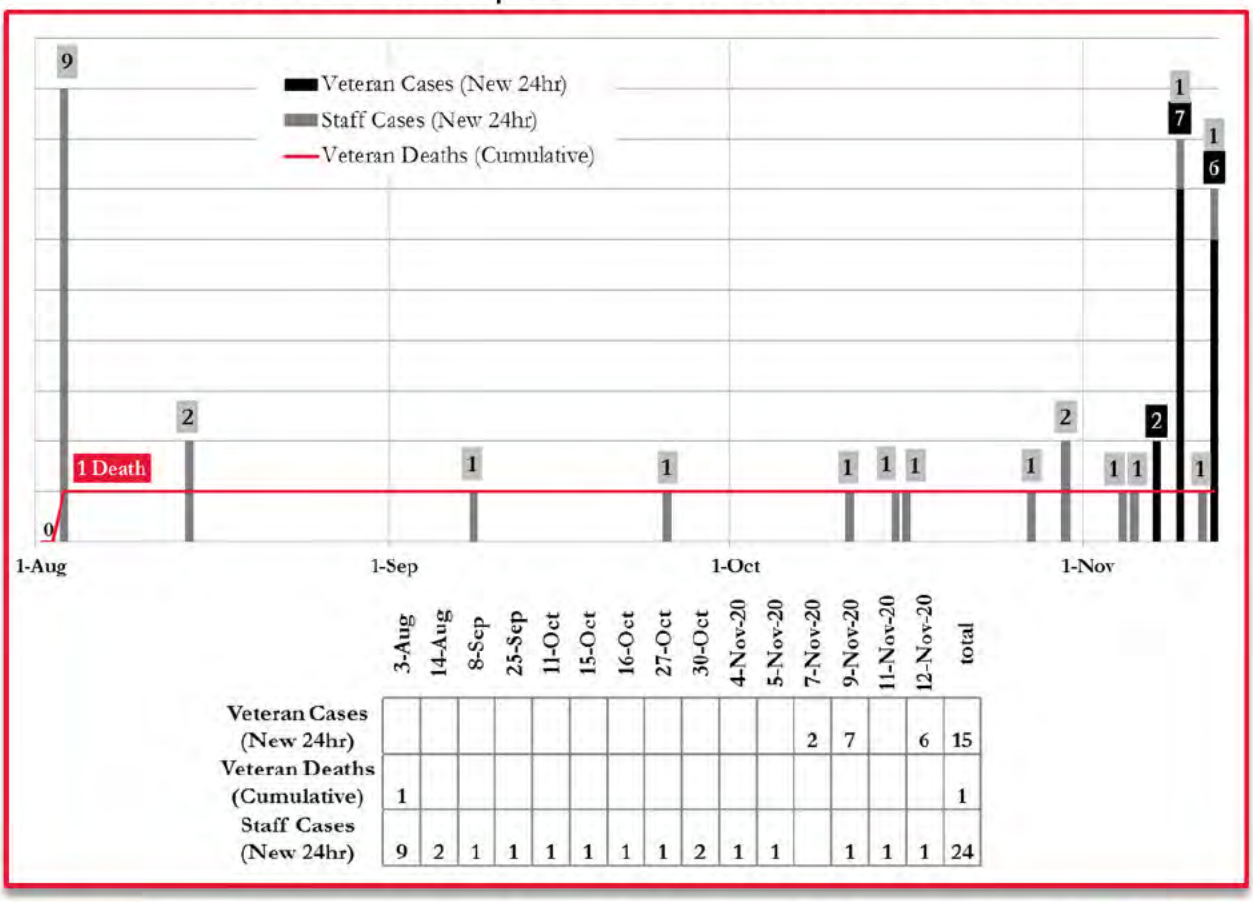


	Aug	Sep	Oct	Nov
St. Louis Veterans	0	0	0	15
St. Louis Staff	11	2	6	5

The St. Louis Home had prevented COVID-19 infections among its Veterans despite the fact that 21 employees had tested positive for COVID-19 between March 2020 and November 6,

2020.[776] The following timeline illustrates the occasional positive staff members without a corresponding patient positive or change in cumulate deaths:

St. Louis Home | Timeline of Cases and Deaths



	3-Aug	14-Aug	8-Sep	25-Sep	11-Oct	15-Oct	16-Oct	27-Oct	30-Oct	4-Nov-20	5-Nov-20	7-Nov-20	9-Nov-20	11-Nov-20	12-Nov-20	total
Veteran Cases (New 24hr)												2	7		6	15
Veteran Deaths (Cumulative)	1															1
Staff Cases (New 24hr)	9	2	1	1	1	1	1	1	2	1	1		1	1	1	24

Of the now 24 infected staff members, 19 have recovered and returned to work.[777] St. Louis Home's staff is instructed that if they have symptoms or are exposed to COVID-19, they are instructed to call before they appear for work.[778] If a staff member travels, the staff member must notify human resources for approval and the staff member may be required to quarantine for 14 days before returning to work.[779] However, if the staff member tests positive for COVID-19, the staff member is currently required to stay home and quarantine for 10 days until the staff member is symptom free for 24 hours.[780] Note, CDC guidance previously recommended that staff members stay home for 14 days following a positive COVID-19 test, and leadership at the St. Louis Home have been uncomfortable with the reduction in time to 10 days, leading the Assistant Director of Nursing, Jennifer Neisler, to remark that the St. Louis Home may apply a longer period of time than

10 days for an employee's return to work[5], and that Ms. Neisler expects the MVC would "back her" on that decision.781

5. Response to Outbreak

i. Quarantine and Isolation

The St. Louis Home has a designated isolation unit that was prepared in March 2020. The area designated for isolation is enclosed by zippered plastic walls, has air scrubbers and negative pressure tubes.782 The St. Louis Home has also prepared a separate area with a separate entrance from the outside for quarantine purposes.783 The two areas share the same ventilation system but they have their own scrubbers and negative pressure systems.784 The St. Louis Home's plan is to utilize separate staff for the isolation and quarantine areas.785 There have been no positive COVID-19 cases among Veterans and these areas have not been used.

During late summer 2020, the St. Louis Home had an infection survey performed by the Veterans' Administration.786 The Veterans' Administration determined that the concrete floors in the quarantine area needed to be covered with laminate because the porous floor could transfer COVID-19.787 Until the work in the quarantine area is completed, residents who are required to quarantine are restricted to their rooms for 14 days.788 Veterans go to quarantine if have a hospital admission or suspected exposure to COVID-19.789 Staff members wear full PPE to treat Veterans who are on quarantine, and Veterans are not released from quarantine unless the Veterans receive a negative COVID-19 test and exhibit no symptoms consistent with COVID-19.790 St. Louis Home's staff have been fitted for reusable N95 respirators, and each nursing staff member has three N95 respirators available as needed.791

Veterans not in quarantine or isolation are restricted to their communities; however, the Veterans are permitted to sit in common areas outside their rooms while dining and are only permitted to take off facemasks while eating.792 Veteran and President of the Veterans' Council [redacted] explained that Veterans remain able to walk in their communities, and the St. Louis Home continues to host Bingo and horse races in the hallways to maintain Veteran morale.793 During Pathway's visit, however, Pathway observed that social distancing is not always followed

[5] Dr. Imdad and Ms. Halsey similarly confirmed that the St. Louis Home enforces the 14-day quarantine period for staff members who tested positive.

during these group activities, including the participation of up to six Veterans at a single table without masks, resulting in the use of common areas inconsistent with CDC guidance.[794]

ii. Visitors

When the St. Louis Home first locked down, no outside visitors, vendors, or food was permitted.[795] The policy has relaxed, and the St. Louis Home has permitted outdoor face-to-face visits socially distanced for 30 minutes pursuant to CDC guidance since July 4, 2020.[796] These outdoor visits take place in the presences of a social worker to ensure compliance with social distancing and PPE standards.[797] If a Veteran becomes too close to a family member, both the Veteran and family member are rapid tested and the Veteran is directed to quarantine for 14 days.[798] However, staff members have noticed an increase in moodiness and depression among the Veterans since they have been confined to their units.[799] Some Veterans do not understand why, if there are no positive cases, they cannot be in the dining or community rooms.[800]

iii. Screening and Testing

Testing at the St. Louis Home commenced in May 2020.[801] Even though both staff and Veteran tests were repeatedly negative, the St. Louis Home continued to test weekly for safety purposes and included COVID-19 testing as part of the pre-employment process.[802] Veterans' symptoms and vitals are also checked every four hours; however, Pathway observed that full COVID-19 symptom screening was not completed during the Veteran monitoring process during Pathway's visit.[803]

The Home utilizes COVID-19 testing five days a week.[804] Rapid tests are used three days a week and the PCR tests are used twice per week on Tuesdays and Fridays.[805] Initially, some staff expressed concern about coming into work due to the risk of transmitting COVID-19.[806] When testing was introduced, staff could refuse to take the COVID-19 test; however, staff who refuse to test are now sent home without pay until they agree to testing.[807] [redacted] confirmed that he believes testing helps ease some concerns and fears about COVID-19.[808]

Currently, when staff appear for work, they are directed to enter through a side front door, complete a symptom screening form, have their temperature checked, take a COVID-19 test, and sit in the dining room with an N95 respirator socially distanced to wait on the results of the COVID-19

test.809 Individuals working in isolation or quarantine are directed to the separate entrances for those units.810

iv. Training

The St. Louis Home utilizes CDC and DHSS guidance, which are updated on a continuous basis.811 According to Ms. Huffman, the MVC has been open to communications and has relayed CDC and DHSS updates.812 The St. Louis Home's Staff Development Coordinator is responsible for training and education of staff, and she conducts trainings on the floor to avoid placing too many people in one room.813 Topics of training include abuse and neglect, hand hygiene, infection control, Veterans' rights, and dementia care.814 The staff attends meetings in the dining room as needed, and COVID-19 town halls are conducted once per month.815 Every week, the St. Louis Home issues a newsletter to bring staff up-to-date on the most recent changes.816 The Veteran's Council also meets bi-monthly and the Administrator and Assistant Administrator perform group walks to each of the six units to address questions and needs.817 According to the St. Louis Home's Medical Director, Dr. Riffat Imdad[6], one of the most important practices at the St. Louis Home is educating and re-educating the staff on hand hygiene, PPE use, and how to stay safe outside of the Home while social distancing.818 Additional training to the nursing staff is provided by Ms. Neisler in town hall meetings, pamphlets, e-mail and video, depending on the content of the training.819 Staff members also receive training from their unit manager, and staff members must sign a roster to ensure that the staff's training is recorded.820 Director of Nursing Monica Halsey confirmed that in educating staff members, the St. Louis Home reiterates that if staff members do not protect themselves, they could kill someone they love by exposing them to the virus.821

v. PPE and Additional Procedural Changes

At this time, the St. Louis Home utilizes mask and gloves for PPE.822 Gloves are changed after meeting with each Veteran.823 Staff does not wear a gown or other forms of PPE unless there is a suspected or confirmed case of COVID-19 at the St. Louis Home.824 The Home has appropriate and adequate amounts of PPE.825 While St. Louis Home's staff observes current PPE standards, Ms. Neisler confirmed that there is "room for improvement with compliance."826

[6] Dr. Imdad speaks to staff frequently to offer encouragement and support, and Dr. Imdad reiterates to his staff that their compliance with these practices is working.

Pathway similarly observed multiple violations of PPE best-practices with respect to the use, re-use, and storage of PPE.827 Ms. Neisler expressed concern that as the pandemic continues, Veterans and staff members will experience greater difficulty in complying with PPE requirements over time.828

vi. Staffing

The St. Louis Home seeks to maintain the following staffing levels per 40 Veterans: four certified nursing assistants, one medical technician, one registered nurse or licensed practical nurse, and one unit manager on each unit.829 Ms. Lornette Harris, Human Resources Manager, identified staffing as a concern on a moving-forward basis.830 Ms. Harris confirmed that the St. Louis Home is short-handed and if more employees take medical leave, the staff shortages will worsen.831 Morale has been low among nurses and CNAs.832Also, while the Home is prepared for a Veteran outbreak, the designated staff for the isolation unit will no longer be available to work with the remainder of the Home, and the Home will not be in the best position if there is an outbreak among Veterans.833 Currently, the St. Louis Home serves approximately 18 Veterans per CNA, which is difficult to manage.834

vii. Communication

Assistant Administrator Buffy Huffman confirmed the Home has always had the resources needed to address concerns relating to COVID-19, and Huffman believes MVC and the other Administrators have been very supportive and effective throughout the pandemic.835 However, other staff members at the St. Louis Home have expressed concern with the way information is relayed to them from the MVC. Ms. Jackie Jackson, the Staff Development Coordinator, identified communication as an area of concern.836 She believes that the communication from Headquarters is being sent to the Administrators, but that once the information is received by the Administrator, it could be disbursed more efficiently.837 Ms. Jackson stated that she hears things by word of mouth, but does not rely on that information unless she hears it from the Administrator.838 This is a very important issue to Ms. Jackson, as the changes in directives need to be relayed to all staff quickly.839 For example, Ms. Jackson noted that there were no preliminary communications to staff in March 2020 prior to the order prohibiting all visitors.840 Ms. Harris also noted that communication could be improved, especially in regard to training and education of new staff.841

Pathway's site visit confirmed these concerns with respect to communication. Pathway noted that the St. Louis Home enforced limited general infection prevention and control policies and

procedures, and that the St. Louis Home showed no evidence of COVID-19 specific policies and procedures.[842] Pathway confirmed that front line staff indicated they were not aware of infection control and COVID-19 policies and procedures, and that the policies and procedures that were available were outdated.[843] Consistent with Pathway's observations of the other Homes, Pathway noted that communications regarding COVID-19 flow from the MVC to the administration at the St. Louis Home; however, Pathway was unable to identify how the communications regarding updated guidance flow from St. Louis administration to the direct care staff.[844]

viii. Impact on Veterans

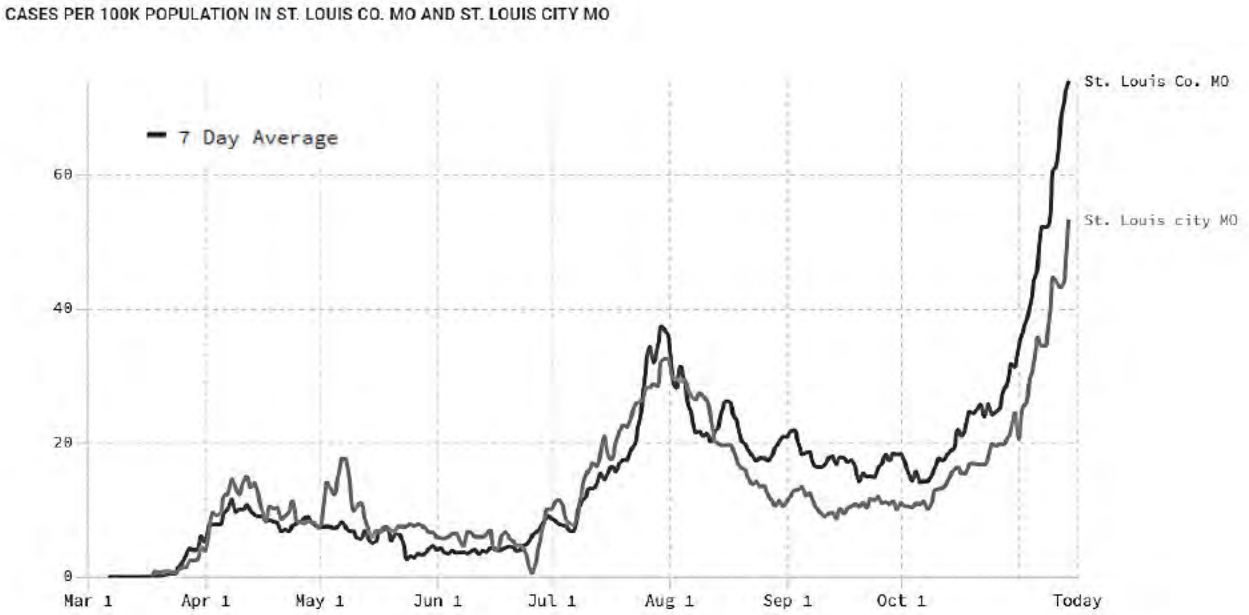
[redacted] explained that it has become more difficult to resolve Veteran complaints due to changes prompted in response to COVID-19 and that he believes the Home requires additional staff.[845] [redacted] also mentioned that some Veterans have difficulty understanding why they remain confined to their units when they are told there are no positive cases.[846] [redacted] reiterated that these precautions are "for the best," but noted that the lockdown has been very difficult on many of the residents and that the winter weather will make these circumstances even more difficult.[847] Ms. Huffman similarly explained the importance of family visits and that face-to-face visits have been very helpful to improving Veteran morale.[848] Huffman explained that there were four occasions during outdoor visits requiring Veterans to quarantine afterward, including one circumstance during which a Veteran snuck over a fence around the St. Louis Home to meet his spouse, and another circumstance during which a Veteran's spouse met the Veteran at a dialysis center to try and visit prior to or following the Veteran's procedures.[849] These circumstances demonstrate the importance of family interactions to the Veteran population.

[redacted] conveyed that to his knowledge, the Veterans' families have been "pretty happy" and understand the need for precautions and testing.[850] According to [redacted]: "I think they are doing the best that they can do right now."[851]

6. Regional Considerations

As of November 16, 2020, St. Louis County has had 40,982 cases and 914 deaths attributed to COVID-19 to date. St. Louis City has had 10,713 cases and 230 deaths attributed to COVID-19 to date.[852] The following images illustrate the course of positive cases over time in St.

Louis County as well as a comparison of positive cases in St. Louis County and St. Louis City, as of November 16, 2020:[853]



On July 1, 2020, St. Louis City and St. Louis County issued orders requiring masks starting July 3, 2020. These orders remain in effect as of the time of this report. Reopening plans for public schools in the St. Louis area vary by district. Some schools are operating entirely online or with hybrid learning, while other districts have full in-person schooling. Saint Louis University and University of Missouri—St. Louis returned for the fall semester with hybrid and online courses.

Dr. Imdad believes the Homes in rural areas are suffering at a higher rate of COVID-19 infections because individuals in those areas do not wear masks regularly.[854] Dr. Imdad believes the staff members unknowingly may come in contact with a person who is positive for COVID-19 and bring it in to the Home.[855]

G. Warrensburg Home

1. Summary of Observations and Concerns

The Warrensburg Home currently demonstrates "a strong culture of safety."[856] Indeed, Pathway acknowledged staff followed proper infection control procedures, its units were clean, and were well-informed concerning the status of the Home.[857] While procedures and operations appear well established at the Warrensburg Home, some previous and current policies remain areas of concern. As an example, rapid tests are still not administered every day — even on days when PCR tests are administered. Rapid testing every day would provide faster results and prevent staff members from working on a day without any testing result.[858]

Communication with Headquarters also presents potential issues. Some staff members characterized Headquarters as reactive, rather than proactive.[859] The Warrensburg Home and/or Headquarters did not have any plans or policies in place for various situations. There is no policy for getting Veterans back into the general population upon recovery.[860] One staff member suggested Headquarters make a COVID-19 policy or procedure manual that could be followed and updated as necessary rather than endless, changing directives.[861] Such guidance would aid uniformity amongst the Homes' with particular procedures instead of each Home interpreting different emails, directives and texts to maintain compliance with the Headquarters directives.[862]

2. Structure of the Warrensburg Home

The Warrensburg Home located at 1300 Veterans Road, Warrensburg, Missouri has approximately 175 rooms with the capacity for 200 Veterans.[863] The Home currently has approximately 146 Veteran Veterans and more than 250 staff members.[864] There are four units with two halls located in each unit.[865] The rooms are both private and semi-private (i.e., shared room with divider and shared bathroom).[866] The VA reported no deficiencies at the Warrensburg Home following its August regulatory compliance survey.[867]

3. COVID-19 Preparation

The Warrensburg Home has had consistent communication with the MVC Headquarters since the pandemic began.[868] Administrators participated in regular conference calls with Headquarters where Homes shared information with each other concerning the pandemic

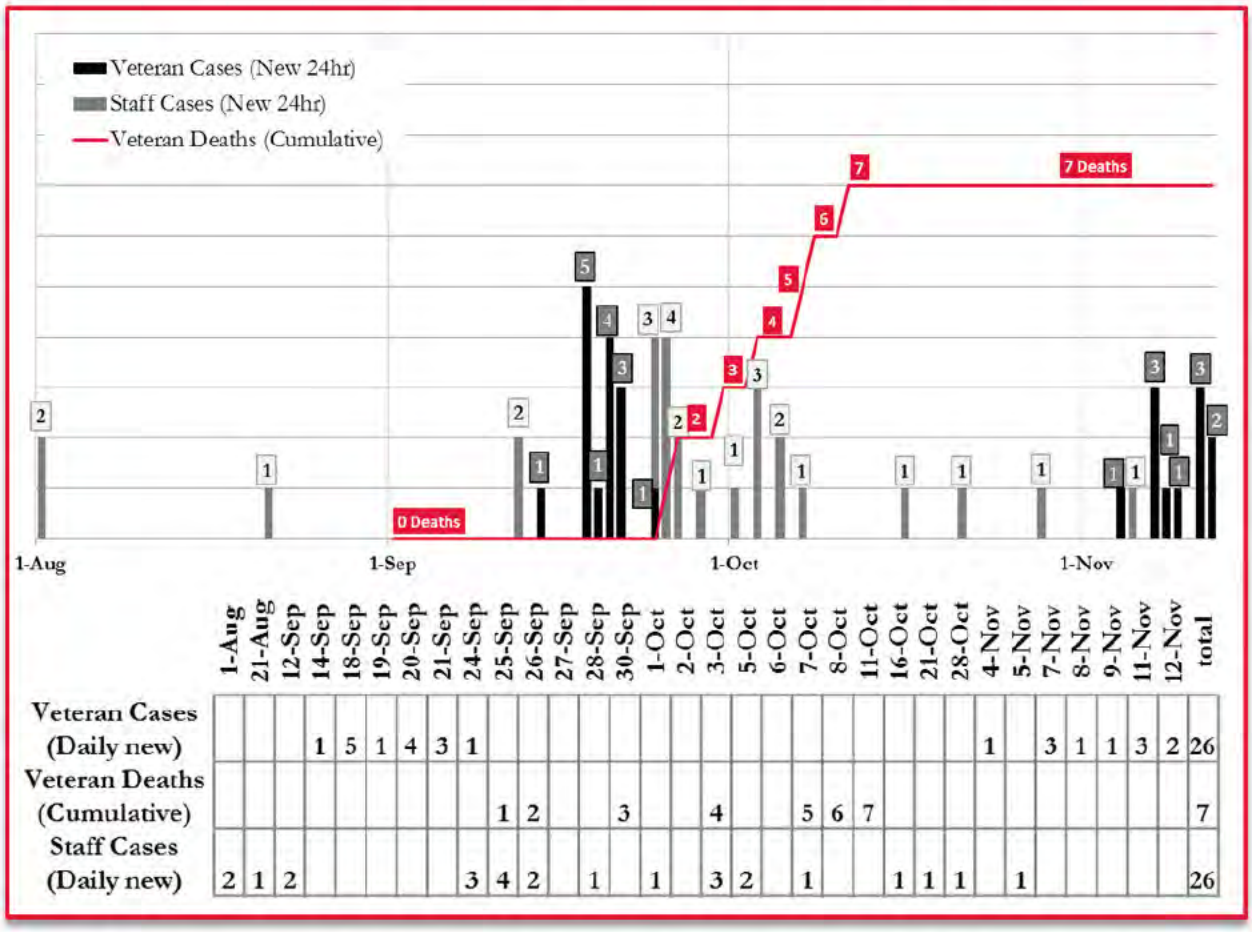
response.[869] The Administrator received emails with guidance from Headquarters, which was implemented at the Warrensburg Home beginning in April or May.[870] The Warrensburg Home's initial steps included: (1) creating isolation and quarantine areas; (2) acquiring and stocking PPE, food and water; (3) restricting outside visitors; (4) minimizing the Veterans' time outside the Home; and (4) communicating all of this information to Veterans, employees, Veterans' families.[871] All Veterans' visits outside the Home were suspended in March or April, unless necessary for a medical appointment.[872] Staff members were also required to wear PPE and have temperature screenings before beginning a shift during this period.[873]

Initial COVID-19 guidance and protocols were communicated to staff through training sessions, regular meetings, public announcements, emails, electronic bulletin boards, and posters throughout the Home.[874] The Warrensburg Home's administration monitored the community infection rate in the county and provided updates via its public announcement system.[875] During the first few months of the pandemic, Veterans were allowed to freely move around the Warrensburg Home and no mask mandate was implemented for the Veterans.[876] Some Veterans chose to wear masks, but not many.[877]

4. Outbreak and Timeline

The Home has had 26 positive cases among Veterans with 7 associated deaths and 26 positive cases among staff.[878] The following figure illustrates the course of those positive cases and deaths:

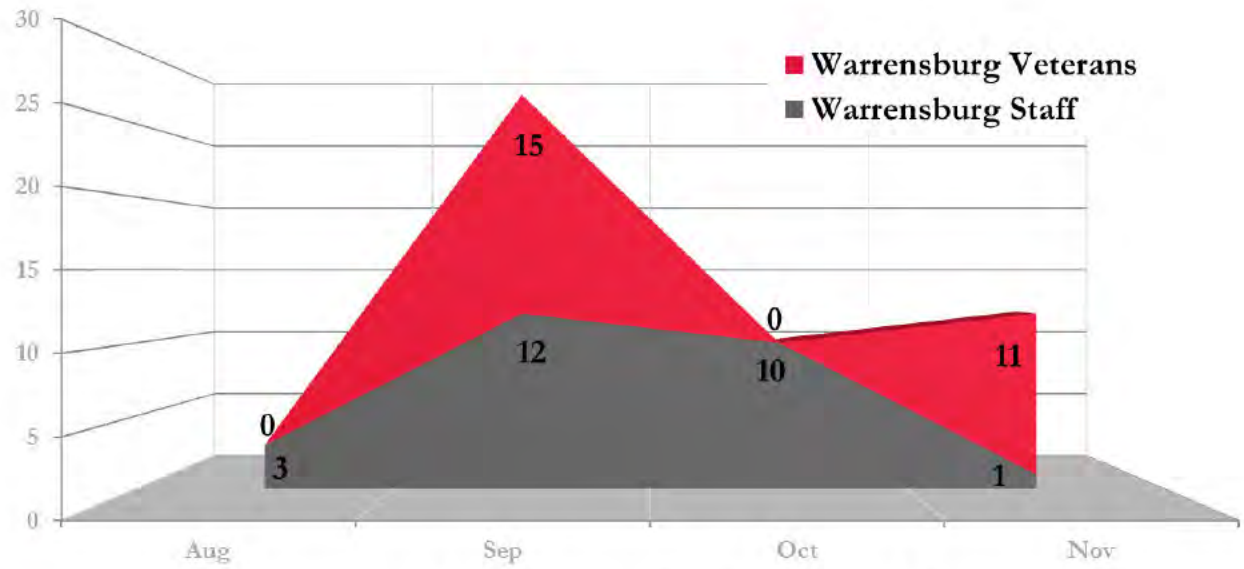
Warrensburg Home | Timeline of Cases and Deaths



	1-Aug	21-Aug	12-Sep	14-Sep	18-Sep	19-Sep	20-Sep	21-Sep	24-Sep	25-Sep	26-Sep	27-Sep	28-Sep	30-Sep	1-Oct	2-Oct	3-Oct	5-Oct	6-Oct	7-Oct	8-Oct	11-Oct	16-Oct	21-Oct	28-Oct	4-Nov	5-Nov	7-Nov	8-Nov	9-Nov	11-Nov	12-Nov	total
Veteran Cases (Daily new)				1	5	1	4	3	1																	1		3	1	1	3	2	26
Veteran Deaths (Cumulative)										1	2			3			4			5	6	7											7
Staff Cases (Daily new)	2	1	2						3	4	2		1		1		3	2		1			1	1	1		1						26

The most recent outbreak occurred after one Veteran tested positive following an October 5 PCR test, and several more tested positive following an October 8 PCR test.[879] The Warrensburg Home reached a peak of nine actively positive Veterans and about five actively positive staff members.[880] Seven Veterans have died from COVID-19.[881] In addition, a few Veterans died from COVID-19 at a hospital within the prior month, but there was no outbreak of positive cases at that time.[882] All of the positive cases in the current outbreak were limited to the special care unit (D-100 hall). These cases may be traced back to a Veteran in the D-100 hall of the memory care unit that had an appointment outside the Home; at about the same time, a staff member tested positive within that hall as well.[883]

The following figure illustrates the timing of the outbreak and the mitigation of spread following the peak infection in September:



	Aug	Sep	Oct	Nov
Warrensburg Veterans	0	15	0	11
Warrensburg Staff	3	12	10	1

The most recent outbreak originated in the special care unit (D Unit).[884] The first positive case was a staff member that worked in the D-200 hall of the unit.[885] The other half of the unit was immediately locked down. Since then, all positive cases were limited to the D-Wing, and all but one case were in D-200. (The D-100 hall only had one positive case.) Of the 25 beds in the D-unit, 15 became positive; the other ten remain negative. The outbreak in the D-Unit was suspected to be caused by dementia patients moving freely around the hall due to the inability to restrict dementia patients to their rooms.[886]

5. Response to Outbreak

i. Quarantine and Isolation

Currently, the Warrensburg Home has converted one of the special care units into an isolation and quarantine space with 21 beds for isolation and the other side for quarantine.[887] Nursing staff that works in the isolation unit remain in the unit throughout their shifts, and cannot reenter the general area.[888] Some staff members, however, will enter the isolation unit during the day.[889] For example, if a quarantined Veteran requires help from the social work department, a social worker will enter the isolation unit to assess the problem.[890] In these instances, the staff member will wear full PPE including an N95 respirator, face shield, gown, and gloves.[891] When

leaving the quarantine area, the staff member must change PPE, changes clothes, and sanitize before going to work in another unit on the same day.[892] Housekeeping does not enter the isolation unit; the nurses who work in that unit have their own housekeeping cart and supplies.[893]

ii. Visitors

The Home has had very few visitors.[894] A paper log of all visitors since March is kept with each visitor's temperature logged.[895] Family members could only visit if a Veteran was dying, and were required to go through full screening, wear all PPE, and remain in the Veteran's room.[896] Since April, the Warrensburg Home has heard many complaints from Veterans and their families relating to access and visits.[897] The Warrensburg Home is aware of some families complaining to the MVC and Governor's Office regarding visitation restrictions.[898]

iii. Screening and Testing

Prior to the outbreak, in addition to temperature screening, the Warrensburg Home also performed a PCR test on staff one a week with results received 24-48 hours later.[899] For the past few months, the Home administered PCR tests on Mondays and Thursdays for all staff (even if is the staff is "off" that day).[900] Testing is mandatory for all employees.[901] For the past two weeks, staff has also received rapid tests before beginning their shift.[902] Staff members arrive, complete a questionnaire, wash hands, and don PPE. Staff members then continue to the check-in table for a temperature check, and then proceed to the chapel where a rapid antigen test is performed. Before being cleared to proceed to the work area, staff must wait with proper social distancing in the chapel for their results.[903] If a staff member tests positive, he or she must leave the Warrensburg Home through an external door of the chapel.[904] Pathway's observations of the Home confirmed that the screening process was "well managed" with the screening area properly separated from other activities and Veterans, and the flow of employees allowed for appropriate social distancing.[905]Notably, though, when staff members receive PCR testing they are not rapid tested.[906] Thus, staff works Monday and Wednesdays without any same-day test results.

Veterans are also PCR tested on Mondays and Thursdays.[907] If a Veteran is showing symptoms, a rapid antigen test is performed.[908] Staff has been trained to immediately transfer a positive patient through an outside door, around the building, and into the isolation unit.[909] The area is then cleaned by industrial cleaners in hazmat suits.[910]

Veterans who test positive must remain in isolation for at least twenty days and must test negative before leaving isolation.911 Results are reported to DHSS, the county health department, and the Kansas City VA hospital.912 If a Veteran tests positive, they are moved to isolation immediately.913 If the Veteran is suspected positive, the Veteran may quarantine in a private room without moving units and is only moved once confirmed positive.914 The Warrensburg Home also tests Veterans' temperatures every four hours.915 There are currently three or four Veterans in quarantine, and only one Veteran in isolation.916

The Director of Nursing conducts contact tracing following a positive test. 917 She contacts the Veteran (or staff member) to retrace their steps, identify anyone who may have been in contact with that person, and continues until all possible exposures are identified.918 Contact tracing information is sent to Headquarters, where any further contact tracing is conducted.919

iv. Training

The Warrensburg Home received many directives from Headquarters about COVID-19, but no actual "policies" or guidance on the implementation the directives.920 Headquarters did not provide training, context, or explanation for the directives; instead, the information was given with the implied instruction to "provide this [to staff]; get it done."921 Moreover, Headquarters did not track or ensure compliance of any COVID-19 procedures.922 While training at the Warrensburg Home has previously been done via one-on-one instruction, social distancing protocols have made this infeasible.923 As a result, most COVID-19 training has been conducted via binders that can be wiped down or PowerPoint presentation.924 Specifically, COVID-19 training has included educating staff on any updates from Headquarters (e.g., new way to enter building, a new form to fill out and teaching those who man the desk what they need to look for, etc.), proper PPE usage, proper don/doff procedures, infection prevention measures, cleaning and sanitization, isolation and quarantine protocol, and unique department training.925 Staff members have been receptive to Headquarters' information: "Everything [Headquarters] told us to do, we have educated and performed."926

v. PPE and Additional Procedural Changes

Staff members were initially required to wear just cloth masks.927 A few days later, the Warrensburg Home required surgical masks for all employees, and COVID-19 positive Veterans

were required to wear N95 respirators.928 Currently, all staff members are required to wear a surgical mask in common areas, N95 respirators in patient care areas, a gown in all common areas and patient care areas, face shield in all patient care areas, and gloves.929 Some staff is under the impression that N95 respirators should be worn for up to 40 hours.930 To prolong a mask's use for 40 hours, masks are sometimes sprayed with virex and put in a paper bag to dry overnight.931 The Warrensburg Home no longer suggests to its staff that a mask may be worn for up to 40 hours. Yet, even though the Warrensburg Home has sufficient supplies for daily masks, some staff members still reuse masks over consecutive shifts.932 Staff has also been observed having problems complying with the face shields and gown requirements, which are hard to wear and become uncomfortable on a 12-hour shift.933 Additionally, staff has been observed failing to properly social distance and wear masks during breaks.934

Veterans are encouraged to wear surgical masks.935 Despite this encouragement, Veterans are not wearing masks or staying physically distant from each other.936 One staff member has observed fewer than 50 percent of the Veterans on the B-unit complying with the mask recommendation.937 This lack of compliance was also observed by Pathway, which noted that 10 Veterans on the memory care unit were not wearing face covering.938 In the isolation and quarantine unit, staff wears front-zipping Tyvek suits and shoe covers.939 Most recently, the Warrensburg Home ordered new face shields (i.e., flexible goggles) that are less prone to fogging.940

In addition to PPE, The Warrensburg Home now has a firm lockdown plan following a positive COVID-19 test: If two or more Veterans test positive for COVID-19, all Veterans are confined to their rooms.941 This plan has been enacted at least three times since the pandemic began.942 Veterans are currently going on weeks of confinement to their rooms.943 In addition, all common areas are now closed until there is not a single positive result amongst Veterans or staff for 28 days.944 When the common areas reopen, Veterans and staff must observe safe social distancing.945 All meals are currently brought to Veterans in their rooms.946 To compensate for these restrictions, the Home offers more counseling, facilitated video visits with families, and increased one-on-one visits with care staff and recreation staff.947

One staff member expressed concern that the Warrensburg Home was not prepared for another outbreak.948 Specifically, the staff member is unsure the Warrensburg Home is equipped to coordinate and manage another isolation unit because so much effort (e.g., nurses working seven days a week or thirteen days in a row) went into the initial isolation unit and problems still persisted.949

vi. Staffing

There has been a staffing shortage with 30-45 CNA positions and five licensed nurse positions still open.[950] The Warrensburg Home was already having difficulties before the outbreak, but the staffing issue has only worsened.[951] When fully staffed, the Warrensburg Home includes 236 positions, but there are currently only 200 staff members.[952] Even factoring in fewer Veterans currently residing at the Warrensburg Home, staffing is still down about 15 members.[953] There were specific concerns that the Warrensburg Home does not have an adequate nursing staff, which has required Administrators and supervisors to fill in as nurses.[954]

vii. Communication

The Administrator is supportive of Headquarters' guidance and communication throughout the pandemic, stating they have done a "remarkable job."[955] The Assistant Administrator is similarly supportive of Headquarters: "The HQ is doing an exceptional job doing the best they can – I feel fortunate working for this agency through this. We have been proactive and have the resources to provide the PPE we need so we can be safe for us and the Veterans."[956]

Still, inconsistent communication from Headquarters has been a frustration for staff members. For example, on occasion, Headquarters provided a directive in the morning, and then later that same day issued a new directive already revising the instruction.[957] In other instances, the Warrensburg Home received inconsistent messages from Headquarters on the same topics.[958]

Communication between the Warrensburg Home and Veterans' families, however, can be improved. Families are frustrated with the visitation restrictions, and this is likely exacerbated by poor communication. A better system for communicating information to families would be helpful for trust and transparency.

The social work department is primarily responsible for communicating information to families, but their role has expanded since the pandemic to include various tasks that Veterans or their families can no longer perform.[959] Because their role has expanded, the social work department has been limited in their ability to relay time-intensive information related to COVID-19.[960]

viii. Impact on Veterans

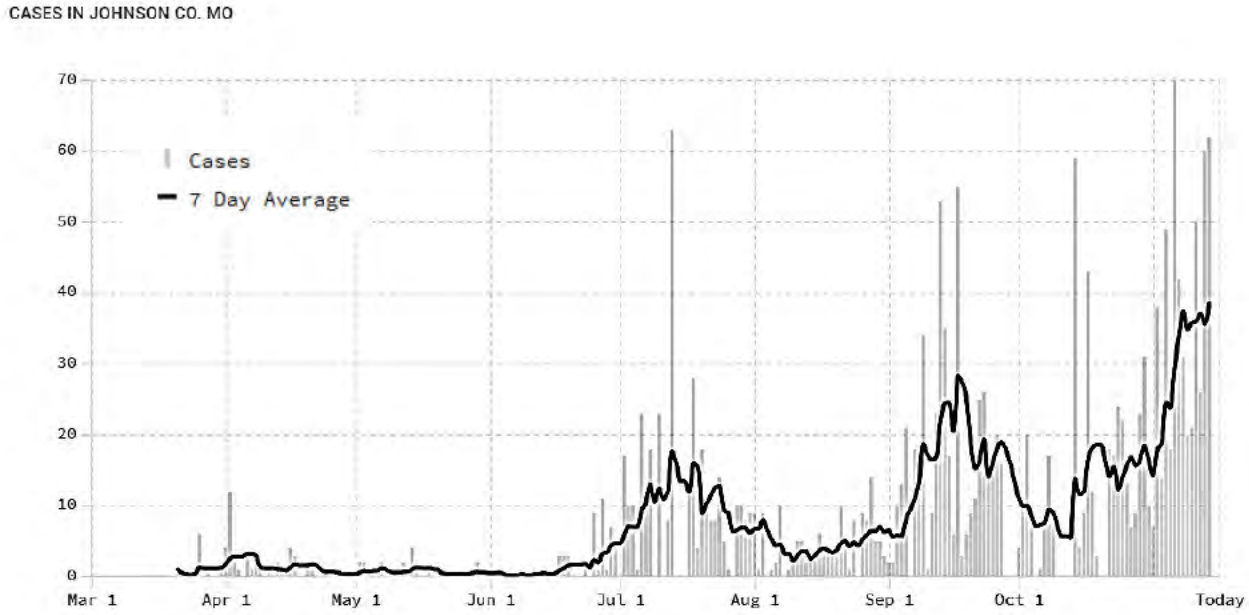
The Warrensburg Home's Director of Social Services noted that the pandemic and COVID-19 procedures have had a notable negative effect on the Veterans.[961] One Veteran at the Warrensburg Home described COVID-19 as "the worst thing I've seen in my days."[962] Veterans have indicated to staff that they have no sense of socialization as they no longer visit with their families in person or interact with the Warrensburg community. As a result, Veterans have exhibited mixed emotions at town halls and during their virtual family visits.[963]

A Veteran and President of Resident Council, [redacted], noted that the overall morale and mood among residents was "just okay."[964] Despite these obvious challenges, [redacted] stated he had not heard many serious complaints from other Veterans.[965] [redacted] also noted that staff members were working hard to continue their care for Veterans, but understaffing of CNAs has been difficult and diminished the Veterans' interaction with CNAs.[966] Because some Veterans interact only with CNAs, this reduced communication caused by understaffing has further isolated some Veterans.[967]

6. Regional Considerations

Some believe that the outbreak at the Warrensburg Home was merely a reflection of the community: "We have a state and community that did not have a mask mandate—and then we have the university, bringing people from all over for the country. Whether it was a staff member or it was a Veteran that was exposed, I think the community numbers didn't help."[968]

As of November 16, 2020, Johnson County has had 2,075 cases and 11 deaths attributed to COVID-19 to date.[969] The following image illustrates the course of positive cases over time in Johnson County as of November 16, 2020.[970] The second local surge in cases, as seen below during the month of September, within the surrounding community resulted in a rise within the Home.



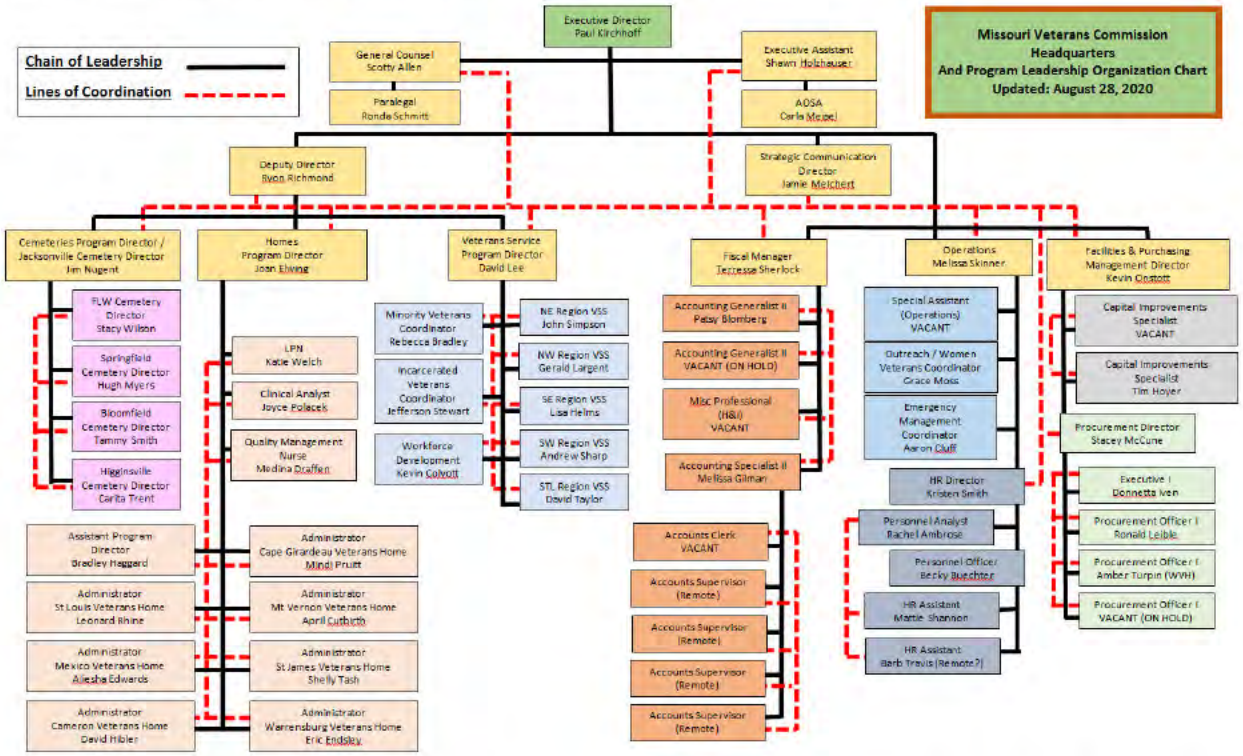
Johnson County Community Health Services Board of Trustees issued a mask mandate in July 2020. The county did not extend the mandate and the order expired on September 14. Following a rise in COVID-19 cases in the Johnson County, the county Health Officer and Community Health service Board of Trustees reissued the mask mandate effective October 12. This reissued mandate remains in effect as of the time of this report.

School districts in Johnson County have reopened for in-person instruction. The option for all-online virtual education program was also available to all students that registered for the online learning program. University of Central Missouri began its fall semester on August 17, 2020, with both in-person, online, and hybrid courses. Wearing face coverings consistent with the CDC guidelines is required inside all classrooms and public buildings on campus.

H. MVC Headquarters

1. MVC Headquarters Organization and Relevant Background

The MVC Headquarters, located in Jefferson City, Missouri, is the command center for the key leadership who oversee the three statutory missions of the Commission. Functionally the Headquarters staff is broken down into two primary sections with an administrative arm (composed of the Communications Director, the Facilities and Purchasing Director, the HIPAA Compliance Officer, and Fiscal Manager) and an operational arm (composed of the Program Director of Homes, the Veterans Services Program Director, and the Cemeteries Program Director). A diagram of the chain of command and lines of coordination is found below.



Each Home Administrator is supported, directly and indirectly, by a number of Headquarters staff. Their direct chain of command flows up from any given Home Administrator to the Director of Homes Joan Elwing, then to the Deputy Director Ryon Richmond, and finally to the Executive Director, currently COL. (Ret.) Paul Kirchhoff.

The MVC is led by an Executive Director whose minimum qualifications, powers, and duties are specifically set by Missouri statute.971 While the statute requires the Executive Director to "have served in military forces of the United States and have been honorably discharged therefrom," there

is no requirement that the Executive Director (or any of the senior Headquarters staff) have any experience in long-term care management, cemetery services, or in coordinating Veteran services. The current Deputy Director, Executive Director, and Director of Operations did not have any prior experience in the specific missions of the MVC prior to joining the organization. 972

From April 2018 to May 31, 2020, the MVC was led by Col. (Ret.) Grace Link, who holds the distinction as the first woman service member to head the agency.973 During our interviews with the Headquarters' staff and the individual Home Administrators, Col. Link was credited with relentlessly driving the initial pandemic preparation efforts during the incredibly fluid period in late February and early March. Part of her success was driven by the relationships she built both across Missouri governmental agencies but also across national peer organizations related to long-term care facilities.974 The early aggressive efforts, specifically focused on preparing the individual Homes for the coming pandemic risk, bought the MVC critical time.

During Col. Link's tenure as the Executive Director, she recruited COL. Kirchhoff, the current Executive Director of the MVC, to join her staff as a special assistant. COL. Kirchhoff and Col. Grace Link had a prior working relationship through their shared service with the National Guard. Prior to joining the MVC, COL. Kirchhoff served as the Director of the Missouri Emergency Response Commission under Missouri's State Emergency Management Agency. He served 33 years of combined enlisted and commissioned military service, both on active duty with the U.S. Army and with the Missouri Army National Guard. His distinguished military career includes multiple combat deployments and multiple leadership positions including posting as the Brigade Administrative Officer, Battalion Operations Officer, Battalion Commander, and Regimental Commander.

While working as the special assistant for the MVC, he engaged in a variety of tasks including running daily meetings, collating and analyzing data concerning COVID-19 from DHSS and the Fusion Cell, conducting investigations, and reviewing and revising policies and producers that were unrelated to COVID-19.975 Because COL. Kirchhoff joined the MVC well before the start of the pandemic, he obtained firsthand knowledge of the MVC's programs, initial preparation for COVID-19, the difficulties the Homes encountered in that process, and what efforts still needed to be revised or finalized.976

2. Proactive Steps by the MVC Headquarters Led to Early Success

At the end of February 2020, faced with mounting evidence of the life threatening risk COVID-19 posed to the Veterans requiring long-term care, the MVC mobilized to prepare the Homes for the impending pandemic. Nearly every aspect of the delivery of care to Veterans was evaluated and adjusted in order to protect the men and women in the Homes. Throughout the month of March alone, the MVC staff took a number of steps in order to provide the Veterans and staff the best possible protection from the virus.977 The following is just a small non-exhaustive sample of the proactive steps Headquarters staff quickly undertook in less than 30 days:

March 2, 2020: Issued guidance placing a hold on new admissions to the Homes in order to limit the potential vectors for COVID-19 transmission into the Veteran community. Obtained accurate counts of all home supplies, including essential items and PPE. Located and acquired two weeks of additional PPE supplies.

March 3, 2020: Developed a daily tracking spreadsheet for the collection of critical information from the Homes. Transmitted CDC posters with guidance for posting around the Homes.

March 5, 2020: Developed a prescription drug shortage plan.

March 7, 2020: Ensured the delivery of additional essential basic supplies to bridge the Homes in case of shortages. Implemented restrictions on external vendors entering the Home.

March 8, 2020: Banned all visitors from entering the Home (except in end of life situations). Issued guidance to Homes on set up for staff screening check points. Developed virtual communication guidance to facilitate family/Veteran communication.

March 10, 2020: Implemented quarantine and isolation directive.

March 11, 2020: Refined staffing guidance on sick leave and administrative leave to address COVID-19 specific issues.

March 14, 2020: Issued guidance canceling all communal dining and group activity.

March 15, 2020: Issued educational materials for all Veterans about COVID-19.

March 16, 2020: Developed staffing plans to accommodate the closure of schools.

March 17, 2020: Developed a plan to address the logistics in shifting from a centralized mess facility to feeding all residents in their rooms with prepared meals.

March 18, 2020: Continued implementation of cross training for staff within the Homes to account for potential shortages.

March 19, 2020: Developed guidance for safely handling laundry within the Homes.

March 22, 2020: Developed additional limitations and safety precautions to those Home employees that engaged in secondary employment.

March 23, 2020: Refined Veteran screening and quarantine criteria for Veterans returning from in-patient hospital stays.

March 26, 2020: Issued guidance requiring staffing shortfall plans to be submitted for each Home and implementing 12 hours shifts for the isolation areas.

March 27, 2020: Implemented new directive for Veteran care and equipment usage related to a COVID-19 positive Veteran. Addressed security concerns for the supplies of PPE to ensure adequate supplies are protected in each Home.

March 28, 2020: Collected additional data for a dashboard created by Melissa Skinner.

March 31, 2020: Adjusted guidance regarding how Homes should handle positive Veterans returning to the Home after a hospital stay.978

The above list demonstrates the volume and complexity of issues the Headquarters and Homes were dealing with on a day-to-day basis during the early days of the pandemic. Everything from securing PPE supplies, limiting visitors to the Homes, addressing multiple different staffing issues, tackling the logistical issues of feeding Veterans in their rooms, and preparing for potential shortages of staples such as food, water, and even prescription drugs were addressed in a short amount of time.

Even decisions easily made for other private and public entities at the time, such as whether to shut the doors to outside visitors, presented a complicated nuanced balance between risk and the need for quality care. For example, the MVC are visited on a daily or weekly basis by lab technicians to draw blood for medical tests, x-ray technicians to capture imagines related to skeletal issues or pneumonia concerns, beauticians and barbers to assist in grooming the Veterans, clergy to minister to the Veterans, podiatrists to address the frequent issues Veterans have with their feet, physical and occupational therapists to assist Veterans in maintaining their current levels of independence, and even the repair personnel and service technicians needed to keep the major facility equipment operational.979

To address these issues Headquarters pulled every lever available at the time. The current Director of Operations, Melissa Skinner, described the planning efforts as follows: "In March and April we were ramping up our preparation efforts. We procured as much PPE as humanly possible. We had our staff going to auto repair stores to buy face masks and hand sanitizer since they were

some of the last locations that had any supply. We provided each Home with the CDC's long-term care checklist[980] and then spent hours on the phone in the war room with each Home going over their preparation efforts. We would ask, 'what are you doing about isolation? What is your plan for PPE? What is your burn rate? What is the plan for staffing?"[981]

During this same initial window, the MVC Headquarters implemented daily conference calls with the Homes to ensure a good flow of information between and among the various stakeholders. The daily group conference calls between the Homes and the MVC Headquarters team started on March 5, 2020. At first the participants discussed the number of Veterans in the Homes and monitoring the situation with influenza, which was a large concern at the time.[982] These calls were initially twice a day, held at 8:30 a.m. and 2:30 a.m., including on the weekend.[983] Each Home was afforded the opportunity to provide information on how the Home was doing.[984] Gradually the calls were reduced in frequency, now down to the current schedule of three times a week on Monday, Wednesday, and Friday in the afternoon. During these calls all of the Headquarters leadership participates, along with each Administrator and/or Assistant Administrator, and any relevant departments from within each Home.

The calls were a key method of communication between the Homes and Headquarters. During the Headquarters meetings, typically lead by the Executive Director, the Deputy Director, or the Emergency Management Coordinator, participants discussed a variety of topics including developments with COVID-19, changes in guidance, and other developments from each Director.[985] The discussion would then progress to each Home Administrator providing an update on any developments at the Homes. If the Homes had any staff or Veterans test positive for COVID-19 since the last call, the Homes provided that information during the meeting.[986] If a Home had specific issues that needed to be discussed, including any additional requests for assistance on any issue that was applicable to the individual Home, the Headquarters staff member leading the call would typically respond with "we can talk about that off line."[987] The appropriate personnel from Headquarters would then follow up with the specific Home to address any issues raised on the call. [988]

Concerning the Executive Director's participation with these daily conference calls, the Assistant Administrator for the Mexico Home reported that "[Col.] Grace Link participated every day on the calls and [COL.] Paul Kirchhoff was always on the calls. I cannot even think of a time when he wasn't on a call I participated in, maybe one time, but that is it."[989] The calls started with a roll call and at a minimum the following Headquarters staff participated in the daily calls: the

General Counsel, the Executive Assistant, the Communication Director, the Deputy Director, the Cemeteries Program Director, the Director of Homes, the Director of Veteran Services, the Fiscal Manger, the Director of Operation, the Director of Facilities and Purchasing, the Clinical Analyst Nurse, the Quality Management Nurse, and the Director of Human Resources. One Assistant Administrator jokingly noted, between Headquarters and the Homes, we must have had a hundred people on the call."[990] Early on, the operational tempo and work environment at the MVC Headquarters adjusted to meet the increased demands on the team. The Headquarters staff shifted to a more collaborative work model, bringing their laptops and material to a centralized conference room dubbed the "war room." The early collaborative efforts were described as follows: "Every day we would get together at HQ and we would go around the table to discuss what we are working on. We would spitball ideas. The meeting was never rushed in that we always tried to think through everything and make good decisions. There was really good collaboration happening around the table."[991]

One Home Assistant Administrator described the early preparation efforts by the Headquarters as follows: "I thought at first we were jumping the gun and being over reactive. We closed our building down right away which seemed unnecessary at the time and were communicating every day with HQ twice a day every day. On the daily calls HQ would provide us with an update on the all of this information from the CDC about the spread of the virus and we would then started going over what was working and not working at other Homes. For a good long while we went a long time without any cases [of COVID-19]."[992]

The efforts by the Headquarters and the Home's staff paid early dividends as evident by the fact that, with the exception of one positive Veteran in St. Louis in April (the origins of that case remain undetermined), no Homes reported any positive cases until the late summer.[993] The initial positive cases in April, July, and August were successfully identified and contained within each Home without causing a prolonged, facility-wide outbreak.[994] Over that same period, other long-term care facilities experienced multiple outbreaks with tragic results.[995] For example, in the St. Louis area during this same period, long-term care facilities were reporting double digits deaths associated with acute COVID-19 outbreaks.[996] The cause of those outbreaks is not within the purview of this report and there is little value in drawing a direct comparison with the circumstances faced by those facilities. However, in an environment where other long-term care facilities experienced multiple outbreaks, the nearly six month record of the MVC without a significant outbreak of cases, serves as at least some anecdotal evidence that MVC Headquarters staff and the

Homes were taking appropriate steps to protect the Veterans and staff for an early infection. At a minimum, it also serves as evidence that the front line staff members (i.e., the nurses, the restorative aids, the CNAs, the custodial staff, the food services staff, the maintenance staff, and the housekeeping staff) were dedicated to the Veterans they served and dedicated to each other. It bears repeating that the men and women who serve our Veterans during these incredibly difficult times should be commended for their dedication to duty.

The other major benefit of the early aggressive decisions by Col. Link and the Headquarters leadership is that it bought the MVC more time for additional testing methods to be developed and more time to develop and implement formal policies and procedures related to Covid-19.

Unfortunately, Headquarters failed to capitalize on its early successes. Specifically, in August and September, when the community positivity rates started to climb and sentinel testing showed the number of positive staff members increasing in a relatively short period of time, the Homes found themselves with basically the same guidance from Headquarters that was provided back in March and April. When early indicators of trouble within the Homes became known during the last week of August into the first week of September–despite advances in the available data concerning how the virus spreads through asymptomatic carriers, how other Homes were preparing for an outbreak, and even advances in the available testing and PPE supplies — the Headquarters found itself unprepared for the outbreak that was already underway. The Headquarters leadership believed they were taking all prudent actions at the time to protect the Veterans. In reality, the failures to properly appreciate the changing circumstances of the pandemic from March until September and the failure to develop and stress-test an outbreak protocol, resulted in poor results.

3. Turnover in MVC Headquarters Leadership Contributed to the Gap in Planning

The MVC Headquarters' experienced significant turnover and disruptions during the critical early summer months. The Executive Director, Col. Link, resigned from her position on May 31, 2020 to assume a position with the VA.997 In her place Ryon Richmond served as the interim director from June 1, 2020 until July 16, 2020 when COL. Kirchhoff was selected to fill the Executive Director role.998 During this same period, the prior Director of Homes was replaced by Joan Elwing.999 Before assuming the role as the Director of Homes, Joan Elwing was the MVC Headquarters' Quality Management Nurse, a position that also had to be back-filled with her promotion.1000 Once COL. Kirchhoff assumed command of the MVC on July 16, 2020, he

implemented additional personnel changes by altering the role of Melissa Skinner from the HIPAA Compliance Officer to what is now called the Director of Operations.1001 Melissa Skinner has been with the MVC as a member of the Headquarters staff for over eight years.1002 COL. Kirchhoff felt Melissa Skinner had valuable institutional knowledge having served the MVC for several years.1003 He also recognized a need to have someone responsible for follow-through.1004 In particular, he felt Melissa Skinner could help follow through on some of the initial actions set into motion by Col. Link.1005

From the perspective of the Home Administrators, they went through six different leaders at Headquarters within a four month period. Because of their prior experience as Home Administrators, Joan Elwing and Bradley Haggard quickly assumed their roles and opened lines of communication with each Home. Specifically, the Administrators and Assistant Administrators would frequently call either Elwing or Haggard to address any questions or concerns, to seek specific guidance on operational questions, and anytime the Homes received a complaint from a family member of a Veteran.1006 As Elwing noted "at this point, I probably spend 75% of my time communicating with the Home Administrators. We also have a group text set up between me, Brad, and the Quality Management Nurse, Melinda Draffen."

While some of the disruptions should have been mitigated by the fact that the new leaders were promoted from within the MVC Headquarters, our review indicates that the leadership shuffle likely contributed to a lack of accountability for strategic planning. For example during multiple interviews with the MVC Headquarters senior leadership, we posed the following three questions:

> (1) Who was specifically responsible for analyzing the data submitted by the Homes and analyzing the community positivity rates in order to make adjustments to the Homes operations?
>
> (2) Who was responsible for developing and stress testing an outbreak plan?
>
> (3) Who was responsible for securing additional resources to assist the Homes in preparing for and dealing with an outbreak?

The answers we received varied in form but the general response we received from each person was that they were *all* working on each of these issues.1007 There is an old military saying that described that exact circumstance, i.e., "when everyone is responsible, no one is responsible." COL. Kirchhoff acknowledged that the MVC felt they had implemented a successful approach and as a result, did not fully engage in contingency planning or the identification of resources until the outbreak occurred.1008 During our interviews with the Headquarters senior leadership, not a single

person indicated that they were either assigned primary responsibility or took ownership for developing and implementing COVID-19 policies and procedures.[1009]

Without unity of command and clearly defined responsibilities related to the COVID-19 response, no one owned any of these three key areas and they fell through the gaps. While there is no doubt that everyone was working hard to get the Veterans safely through the pandemic (especially Joan Elwing, who received praise from nearly every Home's Administrative staff) without proper command and control, the MVC Headquarters was simply not as effective as it should have been. The turnover and lack of clearly defined ownership was further compounded by problems in the Missouri Veterans Commission's data collection and analysis methods.

4. The Complexity of the MVC's Communication and Monitoring Strategy Concealed the Developing Outbreak

Starting on March 3, 2020, the MVC Headquarters started pulling in a massive amount of data from the Homes in an effort to better monitor the developing situation on the ground at any given Home.[1010] On any given day, the sevens Veterans Homes were required to assemble anywhere from 50-100 different data points that they then submit to Headquarters.[1011] At first, the information was compiled by the Director of Nursing at each Home. Later, the format was changed such that the information was gathered by various Homes' staff then added to a spreadsheet by the Home Administrator.[1012] The information from each Home was due at a specific time each day which changed over the course of several months.[1013] At first the reports were uploaded in separate excel files for each Homes, into separate folders on a common MVC SharePoint website.[1014] Eventually, the separate spreadsheets were consolidated into a single excel document, with a separate tab for each Home.[1015] Melissa Skinner was primarily responsible for the development and management of the excel spreadsheet.[1016] Because of her command of the reports and the excel documents, one Home Administrator referred to Melissa Skinner as "the Queen of the Spreadsheets."[1017] This same Home Administrator believed Melissa Skinner was responsible for monitoring all of the data the Homes sent up, including the "PPE availability and our burn rate." Melissa Skinner did not agree that she was primarily responsible for monitoring the data coming in from the Homes and instead noted that it was a team effort.[1018]

The information collected in the various spreadsheets includes everything from the number of Veterans in the Homes, to how many are currently hospitalized, to the number of staff members on the payroll, to the levels of PPE (including how many ounces of hand sanitizer the Homes have

on hand), to the number of residents and staff that recently tested positive for COVID-19.[1019] The figure below, is from just one spreadsheet the Homes populate and send on to the MVC Headquarters for analysis. The specific sheet is from the Cape Girardeau tab of the Headquarters' COVID-19 Tracking Report for the period of August 31, 2020 until September 22, 2020. **No single person was required to analyze the data**.[1020] Rather, the data was reviewed by a number of individuals and discussed during the afternoon Homes meetings.[1021] COL. Kirchhoff acknowledged that he did not view the data until the afternoon meetings, where the information was presented on a slide.[1022]

The volume of data that each Home was required to collect and the method that the MVC Headquarters used for monitoring the data, rendered any meaningful analysis impractical without deliberately studying the reports each day. The combination of too much data without anyone specifically assigned to analyze the information meant that the warning signs of the increased risk to the Homes, and even the warning signs that an outbreak was underway were overlooked.

The figure below is a prime example of the difficulties created by the use of these spreadsheets as the primary method of monitoring the developments at the various Homes. Within the chart, it reflects that an active outbreak is currently underway within the Cape Girardeau Home as early as September 2, 2020 (when the Home is reporting a jump from **one positive Veteran to three positive Veterans within a 72 hour period**, and a jump from **five positive staff members to seven positive staff members within a two week period**). Indeed, by September 4, 2020 the Headquarters COVID-19 Report for Cape Girardeau reflected **another** jump from seven positive staff members to eleven positive staff members.[1023] Yet that obvious warning is nearly impossible to quickly determine from the chart as the critical information is buried amongst a sea of other data. COL. Paul Kirchhoff acknowledged the difficulty in viewing the data in a meaningful way.[1024] COL. Kirchhoff noted "in hindsight, I wish we would have acted sooner in the first week of September when the staff positives jumped from two to four cases. [1025]

DAILY COVID REPORT TO HEADQUARTERS (SPREADSHEET)

	A	AV	AW	AX	AY	AZ	BA	BB	BC	BD	BE	BF	BG	BH
1	Date	31-Aug-20	1-Sep-20	2-Sep-20	3-Sep-20	4-Sep-20	5-Sep-20	6-Sep-20	7-Sep-20	8-Sep-20	9-Sep-20	10-Sep-20	11-Sep-20	12-Sep-20
2	Census - In House	119	119	120	120	120	120	120	120	120	119	119	119	
3	Census - Beds Filled	121	121	121	121	121	121	121	121	120	120	120	120	
4	Special Care Unit Census	44	44	44	42	42	42	42	42	42	42	35	35	
5	Staff Actual	203	203	203	203	200	200	200	200	200	198	198	198	
6	Staff Working at Regular Location (include H&I)													
7	Staff Working Remote (last 24 hrs)													
8	Staff Call Ins (last 24 hrs)	2	2	0	6	8	8	8	8	1	1	6	3	
9	Staff on Leave AL/SL/FMLA (last 24 hrs)													
10	Staff on COVID leave (last 24 hrs)													
11	Staff on Leave w/o Pay (last 24 hrs)													
12	PPD (prior 24 hr)	3.4	3.4	3.7	3.2	3.2	3.2	3.2	3.2	3.2	3.2	3.1	3.1	3.1
13	Total Vacancies (last 24 hrs)	6.5	6.5	6.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5	7.5
14	C.N.A.	3.5	3.5	3.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5
15	Licensed Nurses	1	1	1	1	1	1	1	1	1	1	1	1	1
16	Housekeeping/Laundry	1	1	1	1	1	1	1	1	1	1	1	1	1
17	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	0
18	Other	1	1	1	1	1	1	1	1	1	1	1	1	1
19														
20														
21	Outdoor Visits Scheduled for next 24 hrs (Y/N)													
22	Hand Holding Visits Scheduled for next 24 hrs (Y/N)													
23	# Veterans in Quarantine Unit (last 24 hrs)	120	117	117	117	117	117	117	117	117	114	107	107	
24	# Veterans in Isolation Unit (last 24 hrs)	1	2	3	3	3	3	3	3	3	4	12	13	17
25	# Isolation Beds Currently Available													
26	# Veterans **NEW POSITIVE** COVID (last 24 hrs)	0	1	0	0	0	0	0	0	0	2	8	1	4
27	V#A107													
28	# Veterans **ACTIVE COVID IN FACILITY** (include NEW in last 24 hrs)	1	2	3	3	3	3	3	3	3	4	10	12	16
29	# Veteran **Hospitalizations** - COVID Related (last 24 hrs)	1	1	0	0	0	0	0	0	0	0	2	1	1
30	# Veterans **Recovered** from COVID (cumulative)	0	0	0	0	0	0	0	0	0	0	0	0	0
31	# Veteran **Deaths** Related to COVID (cumulative)	0	0	0	0	0	0	0	0	1	1	1	1	1
32	#Veteran COVID Discharge (cumulative)													
33	# Veteran COVID Tests Completed **RANDOM** (last 24 hrs)	0	1	0	0	0	0	0	0	0	0	0	0	0
34	# Veteran COVID Tests Completed **SENTINEL** (last 24 hrs)	0	0	0	120	0	0	0	0	0	120	0	0	118
35	#Veteran COVID Tests Completed **ANTIGEN** (last 24 hrs)	0	0	0	0	0	0	0	0	0	0	0	0	0
36	# Veterans Eligible for PCR testing (last 24 hrs)													
37	# Staff Quarantine at Home	9	9	9	9	9	9	9	9	15	16	18	22	22
38	# Staff **NEW POSITIVE** COVID (last 24 hrs)	0	0	0	0	4	0	0	0	1	0	5	0	0
39	Work Area of NEW Positive Staff (last 24 hrs) S#Awing	0	0	0									0	
40	# Staff **ACTIVE COVID** (include NEW in last 24 hrs)	7	7	7	7	11	11	11	11	12	12	17	17	17
41	# Staff **Hospitalizations** - COVID Related (last 24 hrs)	0	0	0	0	0	0	0	0	0	0	0	0	0
42	# Staff **Recovered** from COVID (cumulative)	0	0	0	0	0	0	0	0	0	3	4	4	4
43	# Staff **Deaths** Related to COVID (cumulative)	0	0	0	0	0	0	0	0	0	0	0	0	0
44	# Staff COVID Tests Completed **RANDOM** (last 24 hrs)	0	6	0	0	0	0	0	0	0	0	0	0	0
45	# Staff COVID Tests Completed **SENTINEL** (last 24 hrs)	0	0	0	191	1	0	0	0	0	194	3	0	188
46	#Staff COVID Tests Completed **ANTIGEN** (last 24 hrs)	0	0	0	0	0	0	0	0	0	0	0	0	0

Dashboard | Cameron | Cape | Mexico | Mt. Vernon | St. James | St. Louis | Warrensburg | Cemetery | VSP | HQ | Definitions

The MVC Headquarters clearly knew the importance of the positivity data and was actively trying to ensure they did not miss anything. To accomplish that goal, aside from the above spreadsheets, they also required the Home Administrators to personally call and/or text multiple individuals at the Headquarters when they had a positive staff member or Veteran.[1026] "We were told that if we had a positive test, we better be on the phone and sending texts until someone [at Headquarters] acknowledged the information."[1027]

Not only were the Homes required to report the data to Headquarters, they were also instructed that any positive test they received from the lab needed to also be reported to three other sources, (1) the Home's local VA Hospital of Jurisdiction, (2) the Home's local health department;

and (3) DHSS.[1028] In turn, members of the Headquarters leadership would take discrete portions of this data and report it to the 1) Fusion Cell; 2) Office of Administration; and 3) the Department of Public Safety.[1029] Typically, the Home Administrator would call or text either Haggard or Elwing, or both, in the event of a staff or Veteran positive or death.[1030] Elwing and Haggard would then report the information to Deputy Director Ryon Richmond either by phone, text, or email.[1031] Richmond would, in turn, notify COL. Kirchhoff.[1032] Through this system, within hours of the Homes receiving the call from the lab, every member of the Homes' chain of command knew when there was a new COVID-19 positive staff or COVID-19 positive Veteran.[1033] Each member of this chain would then hear and see the same information again during the daily MVC conference call with the Homes.[1034]

Although the real-time reporting allowed for information to be transmitted prior to the meetings, requiring the Homes to report every single positive test through personal phone calls, text messages, emails, excel spreadsheets, and during the live discussions on the daily MVC conference call caused a numbing effect on leadership's ability to analyze the information.

The massive data collection and reporting obligations also resulted in another unintended consequence that disrupted operations. Accurately collecting and reporting such a large detailed volume of information imposes a significant personnel burden on the Homes and Headquarters. Multiple interviewees indicated a significant portion of their day was spent in gathering, reporting, and otherwise dealing with new additional administrative paperwork.[1035] Some management staff from the Homes reported having less time in their given work days for critical tasks such as supervision, policy development, training, and even simply walking the halls because of the new administrative burdens.[1036] One Assistant Administrator framed the issue as follows: "How I spend my day has dramatically changed. I now spend probably 75% of my time at my computer messing with spreadsheets and other COVID[-19] related paperwork."[1037] The Headquarters' chosen communication strategy proved to be ineffective at identifying and relaying key information. For example, when the MVC senior leadership was asked to identify the date when they personally realized that the Homes had a significant outbreak on its hands, we received a wide range of dates:

- **"I would say it was the last week of August when we had one positive resident and several positive staff members."**[1038] (Melissa Skinner)
- **"I knew we had a huge problem on September 10 when I saw the Cape and St. James numbers."**[1039] (Joan Elwing)

- In hindsight, describing when he wished he would have acted sooner: **"The first week of September. We had two cases go to four cases and it took off from there."**[1040] (COL. Paul Kirchhoff)

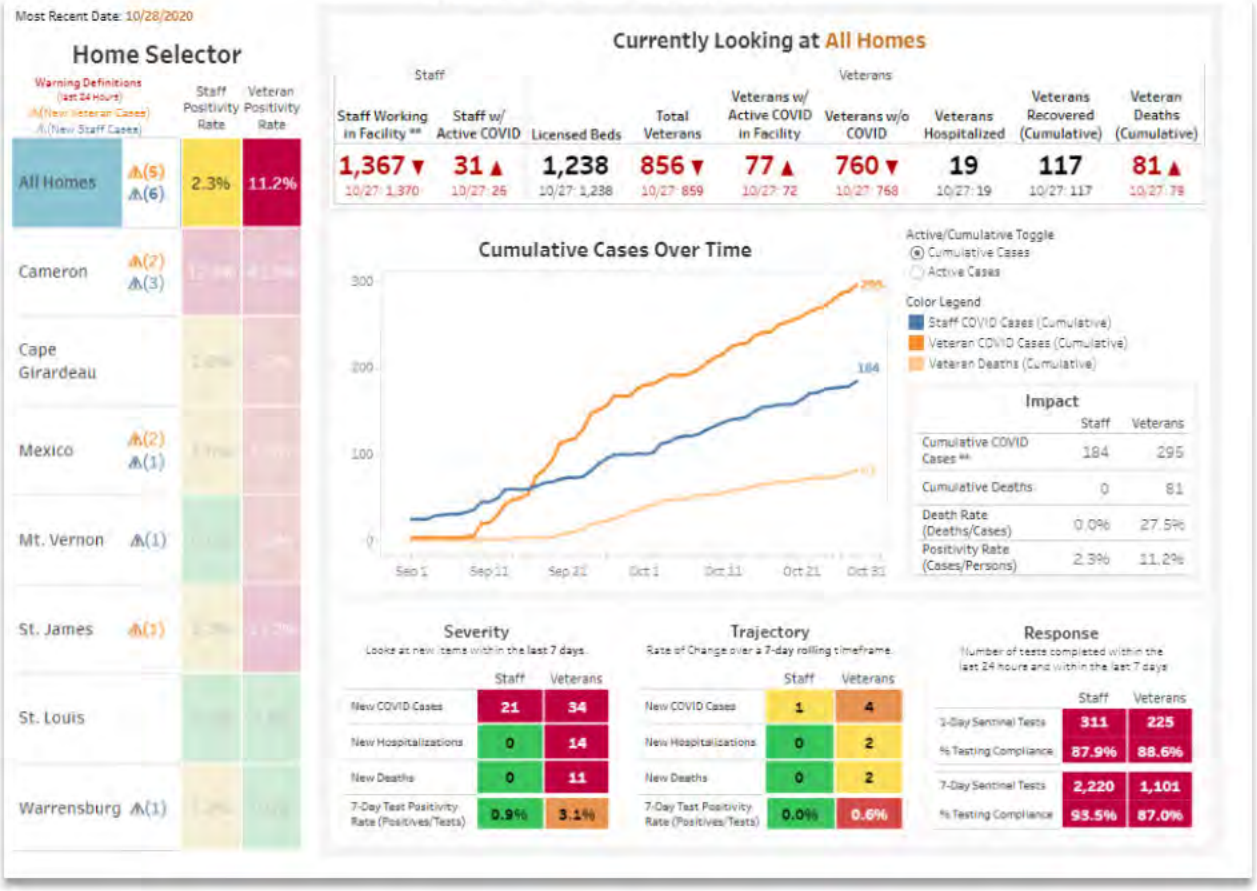
- **"Sometime between September 8 to September 15 is when we knew we had a problem. I am leaning more towards the September 15 date"**[1041] (Ryon Richmond).

There is no doubt that the Executive Director, the Deputy Director, the Director of Homes, and the Director of Operations were all trying to monitor the situation on the ground in the Homes. But their chosen communication strategy led to a failure to identify an outbreak. Joan Elwing summed up the problem when trying to describe the various spreadsheets during an interview:[1042]

> **"We had all of this information, in multiple different forms, but it was really difficult to get a good picture of what was actually going on unless you were studying the spreadsheets on a daily basis."**

In mid-October, the MVC Headquarters recognized the difficulties in using excel spreadsheets as the primary analytical tool and therefore took efforts to craft a dashboard to dramatically improve the monitoring and analysis process.[1043] Below is a screen capture from October 28, 2020. The improvements between the dashboard below and the excel sheet above are self-evident.

DASHBOARD COVID REPORT



5. The MVC failure to develop and stress test an outbreak plan left the Homes in chaos.

By late summer, the advantage secured by Headquarters through its initially aggressive handling of the pandemic preparation had passed. The early successes appear to have caused some level of complacency among the Headquarters leadership. For example after two months of no cases reported among staff or Veterans, multiple Homes reported that their random sentinel testing detected positive staff members, who were otherwise asymptomatic.1044 Luckily the Homes were able to quarantine the staff members from their respective Homes before the virus infected anyone else in the Home.1045

Rather than recognizing these early warning signs, the MVC leadership failed to develop triggers to help identify they were on the verge of an outbreak. MVC should have appreciated the steady increase in the community infection rate, as a warning that the Homes needed to increase

their surveillance and PPE usage. Instead, members of the MVC Headquarters staff took the news as proof that their system was working.[1046]

*** * * "Because things had worked for us for so long, we thought it was all working."[1047] * * ***

Unfortunately for the Veterans within the Homes, the MVC Headquarters never developed an outbreak contingency plan (despite multiple examples of other long-term care facilities facing major intra-facility transmission).[1048] **COL. Kirchhoff admitted that despite their early successes, the MVC Headquarters never developed or distributed an outbreak playbook or even had a meaningful discussion about what constitutes an outbreak.**[1049] COL. Kirchhoff stated that the lack of an outbreak plan meant Headquarters staff spent more time in September developing policies through phone calls and emails on the fly rather than acting proactively to contain the spread.[1050] COL. Kirchhoff noted that the Homes "legitimately felt like policies and procedures changed too often" and that "they would get a policy in place and a week or two weeks later they would change it."[1051]

The Director of Operations described the MVC Headquarters' thought processes on what to do if there was a positive Veteran as follow:

> When we built the isolations in April and March, our census was higher and we had less room to make quarantine and isolation areas. I had those feeling about other Homes having a high number of cases. When I saw in the paper a home with 20 cases, what do you do? The majority of our patients are very ill, what do you do if you have those positive? We focused on trying to separate the Veterans into single occupancy rooms instead of building out large quarantine space. We didn't have the space to do full isolation. Then the goal was to quarantine individuals, so we tried to get them spread out and into their own room to try to keep people as far away as possible. When we did that, it disallowed us from creating a larger isolation space.
>
> Our thought was we would transfer to the hospital if we had a very large outbreak. We created larger isolations units in the facility around the very sick patients. We realized that the isolation units were not going to be transferred. The acuity of the patients – they are very ill and as a skilled nursing facility we are not equipped to treat high acuity levels and the hospitals would not take them.[1052]

Our review indicates Headquarters did not appreciate the gravity of the risks associated with the increase community transmission rates, the impact of the 24-48 hour delay in the then available PCR testing for staff members (which frequently resulted in an caregiver working 1-3 shifts before results returned[1053]), or the scale of the spread that would follow if an asymptomatic but COVID-19 positive staff member came in close contact with multiple residents in multiple units. For instance, COL. Kirchhoff said that although he and others received information about the initial positives in the Cape Girardeau Home, he failed to appreciate that one positive likely meant there were two and two likely meant there were four.[1054] While there was some repeated assertions during our interviews that the Headquarters was requiring the Homes to follow CDC guidance and to comply with a CDC outbreak checklist, there is little evidence that the MVC made the contingency planning a priority.

There was no one at Headquarters specifically tasked to analyze the data submitted by the Homes or even analyze the community positivity rates in order to make adjustments to the Homes operations.[1055] The MVC never developed or stress-tested an outbreak plan.[1056] It is unclear whether the Headquarters followed up on the CDC's long-term care check list to ensure the Homes were still in compliance with the current recommendations.[1057] No one from the MVC expressed any ownership for identifying emergency resources that the Homes could utilize if an outbreak occurred.[1058] For instance, Home Administrators and Headquarters staff did not know the United States Veterans Administration could supply staffing resources in the event of shortages, until the Cape Girardeau outbreak occurred.[1059]

When Cape Girardeau and St. James started reporting higher numbers of staff positives and then the eventual positive residents, the MVC Headquarters leadership was simply caught unprepared despite months of time and plenty of other examples to have learned from across the United States. The result was a mixture of a slow response and poor decision making (though motivated by a good faith effort to try to resolve the situation) brought on by the ensuing chaos and dynamic environment. Furthermore, leadership assumed that because they were dutifully reporting information to the Office of Administration, DHSS, and the Fusion Cell, they would be notified if their numbers were "out of the norm."[1060] Joan Elwing noted, "we were reporting all of this information to various outside agencies, I assumed that they were looking at what we were reporting up every day."[1061] In sum, MVC assumed other agencies were analyzing the data they were reporting.

For example, because the immediate action plan was never developed or tested, there was a significant delay in moving staff to full PPE despite the obvious presence of facility transmission.[1062] "One of the lessons learned from this process is that we should have moved all of the staff to full PPE as soon as we had one positive Veteran."[1063] Similarly, the Homes did not have sufficient isolation space and there was no realistic plan for what to do when the hospitals inevitably discharged patients back to the Homes.[1064] The decision was made to construct new isolation units around the positive patients on their Units, which in turn created additional spread when the Homes moved patients believed to be negative off of the unit into other areas of the Homes that had no positive cases, transplanting the virus into a new section of the Homes.[1065]

The MVC Headquarters and the Homes themselves were not prepared for the reality of a large scale transmission event and in the scramble to get ahead of the virus, they were not following even the referenced CDC checklist. According to Ryon Richmond, "no one could have envisioned the amount of spread or that the isolation space was undersized."[1066] Contrary to this assertion, there were multiple news articles chronicling the problems faced by other Missouri long-term care facilities battling COVID-19 outbreaks, months before the MVC experienced its first positive Veteran.[1067]

The failure to plan for an outbreak caused the MVC Headquarters to become reactive instead of proactive, which further delayed the efforts to secure outside resources, communicate the situation to higher sources, and even to issue solid guidance to the affected Homes. Further compounding the lack of planning, while Col. Link had established a connection with a national association for long-term care, that relationship was left to languish after she departed the MVC.[1068]

6. COVID-19 Fusion Cell

i. Overview

The Missouri COVID-19 Fusion Cell is a source of information for Missouri agencies and commissions to share information related to the COVID-19 pandemic. According to a press release issued by the Governor of the State of Missouri:[1069]

The state's cross-governmental COVID-19 Fusion Cell helped coordinate development of the dashboards, which include data from the Missouri Department of Health and Senior Services, the Department of Economic Development, the Department of Social Services, and the Department of Elementary and Secondary Education, among others.

Participation and attendance in Fusion Cell meetings is not mandatory, but the MVC, along with other commissions and agencies, frequently participated.1070 A general Fusion Cell meeting was originally held five days a week at 9:00 a.m.1071 Approximately 150-200 participants attend these meetings by video.1072 The Fusion Cell is led by Missouri COO Drew Erdmann[7], Missouri Medicaid Director Todd Richardson, and consultants from the McChrystal Group.1073 Director Richardson serves in a coordinator role, making decisions at a tactical level with input from the Governor's cabinet and other department directors.1074 Other individuals, such as DHSS Director, Dr. Randall Williams, attend and present information from time to time.1075 According to Director Richardson, the Fusion Cell "is a process and structure designed to enable the cross department and cross division within department collaboration and coordination on the state's covid response."1076 The purpose is to "give everyone an understanding of what's happening" and the intent is for the Fusion Cell to "identify, enable, and execute the levers of state response."1077

The meetings are currently held four days a week and last approximately an hour and a half.1078 The information shared during the meeting varies. Generally, during the meeting, there is a discussion regarding the positivity and testing rates in Missouri and if applicable, in various counties.1079 There is also discussion of the economy, education, and other sectors influenced by the pandemic.1080 Some agencies and departments are invited to give short presentations. Erdmann and Richardson determine the agenda and strategic initiatives which are discussed.1081 In addition to the general Fusion Cell meeting, various microcells were developed on other more specific topics such as testing and PPE.1082 A morning "management call" is also held at 7:30 a.m. with approximately 60-65 individuals participating.1083 It is unclear whether MVC was invited to join these calls as none of the individuals could say with certainty who was asked to participate; however, Fusion Cell leaders acknowledged that meetings were attended by Director Karsten or her deputy who generally reported on MVC and other agencies housed under DPS.1084 Sarah Steelman, Commissioner for the

[7] Drew Erdmann declined to be interviewed as a part of this investigation. Given we were unable to speak with Mr. Erdmann, we recommend MVC leadership speak with him and/or the appropriate person at the Fusion Cell about the issues discussed herein.

Office of Administration, acknowledged that MVC was represented at the meetings by DPS Director Karsten and her deputy but felt that COL. Kirchhoff or others should have attended, regardless of whether MVC was invited to attend.[1085]

Richmond, Kirchhoff, Skinner and others attended both Fusion Cell and various micro cell meetings.[1086] In addition, Richmond, Haggard, and others were responsible for reporting specific information into the Fusion Cell. Specifically, Richmond reported the number of tests administered and the results for both staff and Veterans daily starting in May to the Fusion Cell through the testing microcell.[1087] According to Richmond, MVC was not directed to report deaths to the Fusion Cell as a part of this process.[1088] The testing and positivity data was sent by Richmond to Mary Menges of DHSS in the form of a PowerPoint slide and went directly to the Fusion Cell.[1089] In June, Menges asked Richmond and others to also provide information as to whether any individuals who tested positive were asymptomatic.[1090] Richmond complied and provided the information.[1091]

Later, Julia LePage of the Department of Mental Health became the point of contact for this process. In September, Richmond and others were asked to discontinue providing the information by PowerPoint.[1092] As a result, the last testing slide was submitted on September 2, 2020.[1093] From that point forward, the same information was entered by the MVC into a SharePoint link that feeds directly into the Fusion Cell.[1094] The information was segregated by Home.[1095] On September 9, LePage asked Richmond and others to provide information on a slide to be presented at the full 9 a.m. Fusion Cell meeting.[1096] The slide, which was presented at the September 10 meeting, shows that that there were 16 staff positives and 17 Veteran positives across all Homes at that time:[1097]

Direct Care Agency Testing "So What"

MVC Spotlight

Impacts

Month	Staff Positives	Veteran Positives
March	2	1
April	1	0
May	2	0
June	1	0
July	12	1
August	8	2
September	16	17
Total	42	21

Through Sep 10

- Box-in Testing began in late March/early April.
- Sentinel testing began in late May.
- Random testing began in July.
- Testing combined with strict protocol have paid dividends in keeping our Veterans and Staff safe.

During that meeting, Richmond reported that the Homes were seeing a rise in positive cases and that he felt the increase was due to an increase in positive cases in the community.[1098] Someone (Richmond could not tell who among the over one hundred participants) remarked they did not think that was the reason for the increase.[1099] **According to Richmond, no one during the meeting asked any questions about the information which was provided.**[1100] Note, at this time, only one death had occurred in the Cape Girardeau Home in the month of September.[1101] MVC continued to provide data through the SharePoint link, listing by Home the number of tests administered and the number of positive results for each day.[1102]

Director Richardson acknowledged that MVC was reporting data since at least May both through the DHSS portal and through the report sent to Menges and LePage.[1103] However, according to Richardson, he does not have a "line of sight" to MVC data as to what was happening at the Home level. When asked who reviews and analyzes the data that MVC and others provided, Richardson stated that the data analyzation "falls on each agency" and that the Fusion Cell does not analyze data provided by the reporting party.[1104] Commissioner Steelman agreed that the Fusion Cell does not analyze data at the agency level but reviews data more globally.[1105] Indeed, Commissioner Steelman noted she has observed other agencies analyze their respective data but is unaware of MVC's attempts to scrutinize the same.[1106]

ii. Involvement by the Fusion Cell with MVC

As noted above, MVC provided information to the Fusion Cell on positive cases from May to present either by PowerPoint or through SharePoint link.[1107] In addition, all Home Administrators reported inputting positive test results for staff and Veterans as well as COVID-19 related deaths into a portal managed by DHSS within 24 hours.[1108] According to Director Crumbliss, it's unclear whether the data entered into the DHSS portal, which includes deaths, is traceable to the MVC.[1109] Although he acknowledged a drop-down menu was added to the portal to help distinguish entries from the MVC as opposed to others, he was unsure of the time frame, noting that it may have occurred in September.[1110] MVC also reported data to the Fusion Cell through a survey managed by Cindy Dixon, the Director of Operational Excellence with the Office of Administration.[1111] However, there are no safeguards to ensure MVC or other agencies fulfill this reporting requirement. Dixon stated that was a "gap" in the process that needs to be closed and that

currently, no one is tasked to monitor the data to ensure it is entered and accurate.[1112] In contrast, Commissioner Steelman, when asked the same question, said the responsibility falls on Dixon.[1113]

Ultimately, the evidence, both from interview and data reviewed, shows MVC was reporting positives test results to the Fusion Cell. Per Ryon Richmond and COL. Kirchhoff, "In accordance with COVID Fusion Cell (CFC) requirements, the Missouri Veterans Commission (MVC) provided regular COVID-19 updates using the directed format and submission method. The chart below provides the detail of these submissions for the month of September."[1114]

MVC Submissions to Fusion Cell in September

September	How Provided	Provided By	Provided To
1	Slide/Email	R. Richmond	Julia LePage/CFC
2	Slide/Email	R. Richmond	Julia LePage/CFC
3	Web/Portal	Richmond/Haggard	Web/Portal/CFC
4	Web/Portal	Richmond/Haggard	Web/Portal/CFC
5			
6			
7			
8	Web/Portal	Richmond/Haggard	Web/Portal/CFC
9	Web/Portal	Richmond/Haggard	Web/Portal/CFC
10	Web/Portal	Richmond/Haggard	Web/Portal/CFC
11	"So What" Brief/Web Portal	Richmond/Haggard	Web/Portal/CFC
12			
13			
14	Web/Portal	Richmond/Haggard	Web/Portal/CFC
15	Web/Portal	Richmond/Haggard	Web/Portal/CFC
16	Web/Portal	Richmond/Haggard	Web/Portal/CFC
17	Web/Portal	Richmond/Haggard	Web/Portal/CFC
18	Web/Portal	Richmond/Haggard	Web/Portal/CFC
19	Web/Portal	Richmond/Haggard	Web/Portal/CFC
20	Web/Portal	Richmond/Haggard	Web/Portal/CFC
21	Web/Portal	Richmond/Haggard	Web/Portal/CFC
22	Web/Portal	Richmond/Haggard	Web/Portal/CFC
23	Web/Portal	Richmond/Haggard	Web/Portal/CFC
24	Web/Portal	Richmond/Haggard	Web/Portal/CFC
25	Web/Portal	Richmond/Haggard	Web/Portal/CFC
26	Web/Portal	Richmond/Haggard	Web/Portal/CFC
27	Web/Portal	Richmond/Haggard	Web/Portal/CFC
28	Web/Portal	Richmond/Haggard	Web/Portal/CFC
29	Web/Portal	Richmond/Haggard	Web/Portal/CFC
30	Web/Portal	Richmond/Haggard	Web/Portal/CFC

There are issues, however, with this process and inconsistencies in reporting among the agencies who report data for congregate care facilities. Kerri Tesreau, of the Department of Mental

Health, is involved in this reporting process.1115 She explained that when testing was first introduced, agencies that operate congregate care facilities, like the Department of Mental Health, Missouri Department of Corrections ("DOC"), and the MVC were asked to reported "surveillance" or sentinel testing results to the testing micro cell, a subgroup of the Fusion Cell.1116 Although the testing supply grew and the number of tests administered increased, the definition of what types of tests needed to be reported into the microcell remained the same.1117 As a result, many agencies, including DOC, only reported sentinel tests but failed to report other tests, such as those administered following the identification of a positive. 1118 At some point (Tesreau could not recall exactly when) the individuals charged with collecting and monitoring the congregate care testing data became aware that agencies were operating under different definitions of sentinel testing and were reporting different data sets.1119 Although there were attempts to clarify what testing data must be reported, this remains an unresolved issue in the testing microcell as of the time of this report.1120

During the period of September 9 through 11, DPS Director Karsten received several general updates from COL. Kirchhoff and others about positives within the Homes.1121 On September 17, a representative from DPS reported during the 7:30 a.m. management meeting that MVC had an increase in positive cases among staff and Veterans.1122 On September 22 and 23, Director Karsten received more updates regarding the Homes, including Veteran deaths, although she believed she was aware of some positives and deaths prior to this time.1123 On September 30, she had a conversation with her Public Information Officer, Mike O'Connell, who informed her the Homes were experiencing a serious outbreak.1124 Director Karsten had been aware of deaths and positives within the MVC Homes prior to this time.1125

On the weekend of September 26, Director Richardson received a call from someone (he does not remember who) identifying a high number of positives and deaths in the Cape Girardeau Home.1126 From there, he reached out to other members of the Fusion Cell, but it does not appear any significant action was taken at that time.1127 According to Richardson no one was "under the illusion that there were no positive cases at MVC" prior to that point and that "people knew there were positive cases at MVC."1128 **He also stated that DHSS defines an "outbreak" as 1 positive resident or staff in the congregate care setting**.1129 From his perspective, however, he felt that until this point, the Fusion Cell was unaware, "of the severity and the amplitude of the outbreak in the Homes"1130 There was no discussion of the MVC during the September 28 or September 29 Fusion Meeting.1131

On Tuesday, September 29, Dr. Randall Williams, Director of DHSS was attending a meeting when his Public Information Officer asked him whether he would take a call from Mike O'Connell, the Communications Director for the State Emergency Management Agency ("SEMA").1132 McConnell asked what is considered a COVID-19 related death. Specifically, McConnell was interested in understanding whether the primary, secondary, or tertiary cause of death has an influence on such a determination.1133 Dr. Williams responded by noting that even if COVID-19 is listed as a tertiary cause, it is still considered a COVID-19 related death.1134 Dr. Williams then asked why the question was being posed and was told that the MVC had 8 deaths at one Home and that the Home had 85 positive cases out of 100 residents.[8] Dr. Williams was shocked and asked for the information to be repeated.1135 After learning this information, Dr. Williams informed Drew Erdmann, Todd Richardson, and others.1136 He also contacted Adam Crumbliss, Director of the Division of Community and Public Health under the Division Health and Senior Services.1137 Crumbliss was unaware of any information up until this point that suggested the Missouri Veterans Homes were experiencing an outbreak.1138

Both Dixon and Commissioner Steelman also became aware of the outbreak sometime in late September after a call from Drew Erdmann.1139 Though they could not recall the dates they were made aware, but expressed surprise at the number of positives deaths.1140 Commissioner Steelman also stated that the Fusion Cell would have recognized even one or two positives prior to this point as a trigger to take action.1141 One account contradicted the reports by Directors Richardson and Crumbliss, Commissioner Steelman, and Dixon. Specifically, Michelle Renkemeyer, Operational Excellence Leader for DSS, reported that the Fusion Cell was well aware of positives and deaths as early as mid-August well into the beginning of September.1142 She explained that DPS reported on the status of MVC during the 7:30 a.m. management meeting and that Drew Erdmann and others were on such calls.1143

On October 1, 2020, COL. Kirchhoff attended a meeting with the Governor and his staff to provide an update on the MVC on a number of matters, including COVID-19.1144 The meeting had been previously scheduled before any information had been transmitted to Dr. Williams or Director Richardson.1145 The next day, the Governor announced an external review of the MVC.1146 In the weeks following this meeting, COL. Kirchhoff and others were asked to present at the Fusion Cell

[8] *Id.* It should be noted that Dr. Williams mentioned it's possible he's misremembering the figures and that it may have been 85 cases across more than one Home. What stood out in his memory was that it was a high number of positives and deaths and that he had no situational awareness prior to this call.

meetings regarding the status of the outbreak at the Homes.1147 COL. Kirchhoff noted that prior to his meeting with the Governor, he had not specifically asked the Fusion Cell for resources. 1148

Following this meeting, the Homes were provided with access to rapid antigen tests which were immediately utilized in the Homes.1149 Director Karsten suggested the MVC use tableau software to view their data.1150 On October 7, Mr. Erdmann reached out to Michelle Renkemeyer and asked that she work with the MVC to prepare a dashboard to better analyze the data MVC was already collecting.1151 Renkemeyer and others worked with Melissa Skinner and COL. Kirchhoff of the MVC beginning Friday, October 9 and through the weekend to establish prototype.1152 The tableau style dashboard went live on October 26.1153

Renkemeyer observed that prior to using the tableau dashboard, MVC did not have a method to meaningfully analyze the data they were collecting.1154 For instance, Renkemeyer noted that had MVC been analyzing trends, they would have seen in early September that something was "not right" given the increase in Veteran positives and steady number of staff positives.1155 She also observed that prior to using tableau, MVC did not have a mechanism in place to accurately calculate the number of staff eligible to be tested.1156 Without such a mechanism, MVC could not ensure strict compliance in staff testing.1157 Renkemeyer also had some concerns about the accuracy of the information being collected and reported.1158 For example, during the process of creating the tableau prototype, Renkemeyer asked for data on testing from Melissa Skinner and Skinner complied.1159 Later, Renkemeyer was provided a wholly different Excel document which had been provided by COL. Kirchhoff to Drew Erdmann, unbeknownst to Skinner.1160 The documents provided by COL. Kirchhoff were presented in a different format and contained different data points.1161

I. Family Interviews

Our investigation sought to understand and evaluate not only the Homes' COVID-19 response, but also the effects of this response on Veteran well-being. We identified family members as an essential voice for this inquiry. Accordingly, on October 29, 2020, the MVC issued a news release in an effort to seek comments from family members of Veterans. The news release is attached as Appendix F. This release was subsequently shared by several Missouri newspapers[1162] and on social media pages.[1163]

By November 4, 2020, the investigation received calls from 75 individuals, including the spouses and children of Veterans in the Homes, three Veterans, volunteers,[9] and a nurse. Many family members expressed how grateful they are that the Homes are taking care of their loved ones, and that the Homes are the best facilities they have ever seen.[1164] They appreciate the "employees' loving care"[1165] and noted the employees are "top notch,"[1166] "have done everything they can do to take care of Veterans,"[1167] that "everyone is wonderful and doing their best,"[1168] and that the "people working there are doing a great job."[1169] The general sentiment among family members is the Homes are doing "the best they can do with the amount of help they have."[1170]

Other family members stated:

> ***"I'm thankful my brother is where he is through this time."***[1171]
>
> ***"They treated him like a hero."***[1172]
>
> ***"The Veterans Home really seems to care about the Veterans."***[1173]
>
> ***"I couldn't ask for a better place for him to be . . . I wish I could go be a resident there with him."***[1174]
>
> ***"He got the best care possible while there."***[1175]
>
> ***"It is a wonderful place for our Veterans."***[1176]
>
> ***"I can't express how grateful I am that these people are there taking care of him when I can't."***[1177]

[9] Several volunteers from the homes' various Veteran Assistance Leagues called with information about their experience before March 2019, but they did not have information related to the homes' response to Covid-19.

Despite the dedication and care of staff, family members expressed concerns about lack of family member access, the Homes' staffing levels, and the combined impact of these factors on the standard of care. Some attributed issues to central decision-makers in Headquarters, stating staff is "just doing what they're told from Jeff City"[1178] and "doing their best to go by the rules,"[1179] while others believe it is "no one's fault in particular"[1180] or see the Governor's visit as the genesis of all of the problems.[1181]

Either way, there is overwhelming consensus that the situation is not getting any better. While each family has unique circumstances and concerns, a number of common themes became apparent from the calls: (1) family members as caregivers; (2) accountability for care; (3) communication with family members; (4) access to other medical care; (5) Veteran well-being; and (6) Veteran autonomy.

1. Family Members as Caregivers

Numerous family members explained that prior to the COVID-19 lockdown they had been instrumental in their loved ones' care. Wives and children described how they visited every day, or at least 3-4 days a week, to perform tasks like feeding the Veterans,[1182] coaxing them into eating and drinking, getting the Veterans out of bed for exercise and mental stimulation,[1183] attending doctor visits,[1184] communicating information to the Veterans about their health care, communicating information to nurses and doctors about the Veterans' health needs, trimming fingernails,[1185] brushing teeth, removing wax build-up from ears to improve hearing,[1186] applying topical medications,[1187] and generally filling the gaps and picking up on any needs for the Veterans' care.

Since the Homes closed their doors in March, family members have not been able to provide this care. Several family members have requested that they be allowed to resume caring for their loved ones in the Homes. They stated they would be willing to be tested, wear PPE, and follow any other requirements. Many wondered why three shifts of staff members are permitted to go in and out of the Homes, but family members are not - with many family members suggesting they stay more isolated from community spread of COVID-19 than staff do. For example, in one Home, a family member talked to an employee who mentioned she had just returned from a vacation to the beach - yet this family member has been staying socially isolated and cancelled all travel plans. She did not understand why the employee was allowed access to her father, while she was not. One spouse wondered if she would have to fill out an application to work at the Home, as that would be the only way she would get to see and care for her husband.

2. Accountability for Care

In addition to providing hands-on care, several family members also explained that prior to the COVID-19 lockdown they had been a "third eye" to make sure the Veterans were happy and being taken care of.1188 But for the last eight months, they have only been able to see the Veterans through windows or from a distance outside. Several observed that their loved ones did not appear well. For example, one family member noted her husband was wearing someone else's clothes. Another Veteran's hair and nails were long and dirty. Several mentioned that their loved ones were sitting in wheelchairs when they were not wheelchair-bound before the lockdown.

Family members are concerned that because they are not able to see their loved ones, they can no longer advocate for their care. While they understand that staff are working overtime, they are still afraid that the standard of care has declined and that many basic care needs are "slipping through the cracks."1189 They try to call the Homes to follow up on doctors' notes or other needs, but they are not certain the communications are being addressed.

Many acknowledged that before the lockdowns, their loved ones were happy and received excellent care—in part because family members could keep an eye on specific issues, such as recurring urinary tract infections1190 or CPAP machine usage.1191 Since the lockdowns, however, these kinds of issues have been overlooked. Many Veterans are also suffering from dehydration and substantial weight loss.1192 Several family members noted their loved ones are not "complainers" or do "not want to bug the nurses"1193 so they do not ask for help.1194 Because of this, family members have to be able to monitor them to make sure their needs are met. One such Veteran lost forty to fifty pounds over the course of a few months due to lack of communal meals and no one ensuring he was eating and drinking.1195 No one informed the family and they only found out when he was sent to the hospital for an unrelated condition.1196 Another Veteran had a foot sore that was left untreated for so long it turned gangrenous and he ultimately passed away.1197 Still another family reported that while their father was in the isolation wing for two weeks, he lost over twenty pounds, his fingernails were not clipped, his hair was not cut, his toenails were so long they curved over the end of his toes, he developed bed sores, and his ears were full of "scum."1198 This family believes that once the Veteran was diagnosed with COVID-19, the Home "just forgot about him."1199

Multiple family members reported that their loved ones' abilities and conditions have deteriorated, from becoming unable to speak or swallow, to cognitive decline from lack of

stimulation or adequate rest, to developing bed sores due to lack of movement. At one extreme, a family member reported their father died of COVID-19 after severe dehydration and several oral sores that inhibited the Veteran's ability to eat and swallow - neither of which the family believed were a complication of COVID-19, but seemed to be attributable to a lack of basic care. Others reportedly noticed their loved ones' cognition was "going downhill"[1200] because they are no longer being stimulated by social interactions or exercise. Most family members with whom we spoke said they are not comfortable that their loved ones are receiving the care they need. As one spouse put it, "when I couldn't be there, I couldn't know how he was being taken care of."[1201]

3. Communication with Family Members

Family members also expressed concerns about a lack of communication regarding their loved ones' care. Several noted that initially, in the Spring of 2020, communication was good and they received fairly regular updates about the Veterans' care and the COVID-19 situation. However, as the months have worn on, communication has become much more limited and much more general, described by one family member as "scripted."[1202] Several family members have not received communication about various health incidents, like falls or infections, until days after the fact. One family member reported that her father has cancer and is dying, but the Home said she cannot see him until a certain number of hours before his expected death. She is receiving no communication about when this might be or how they are predicting this date.

For some families whose loved ones contracted COVID-19, they learned about their loved one's diagnosis by chance. One family was not informed by the Home that their father contracted COVID-19, but only learned about it when their father called and told them a few days later.[1203] Another family only found out about their loved one's diagnosis when they went to a window visit - by that point, their Veteran had been in quarantine for eleven days, yet they had received no notice of either the diagnosis or the move to the isolation unit.[1204] They felt they only "happened to stumble upon it" because they went to the Home for a window visit.[1205] Another family member was told her husband was in isolation but "could never get anybody to tell my why they had him in isolation" when had not tested positive for COVID-19.[1206] She commented that "when you have to rely on the newspaper or the television to get information about your loved one, that's pretty rough."[1207] Yet another family stated their loved one's roommate had been diagnosed with and died

from COVID-19, but they were never informed that their loved one had been in close proximity to someone with the virus.1208

Once a Veteran was diagnosed with COVID-19, several family members reported that communication was non-existent. Many were promised they would get phone calls twice a day regarding their loved ones' condition and progress—only to receive one call in a week's time1209 or less. When families call to get information, they are made to feel like they are a bother and not given any specific information.1210 Family members reportedly have called and left messages, but no one picks up or returns their calls.1211 [10] Family members calling to check on their loved ones, and who had not heard anything for days, reported that "the phone just rang and rang and rang and rang."1212 Several also reported that once their loved ones were moved into isolation or quarantine, they lost all ability to contact the Veterans directly.1213 "If I could have been talking to my dad," one daughter reported, "I would have known just by talking to him on the phone, we would have known he was going downhill."1214

Families tried to believe the lack of communication meant their loved ones were doing alright, but in many instances this was not the case. Some families were notified only once that the Veteran was "gravely ill,"1215 in "really, really bad shape,"1216 or when the Home believed transfer to a hospital was necessary. In these cases, family members had not been informed the Veteran was declining before that point1217 and had "no idea" the Veterans' condition had deteriorated.1218 Families reported not being informed when their loved ones were put on morphine or oxygen.1219 In multiple cases, Veterans' conditions had declined over several days, but the family was not informed until the Home thought the Veteran had less than 24 hours to live.1220 One family member reported that when her father was finally transferred to the hospital, he was "emaciated" and had lost twenty pounds within a month.1221 These families believe if they had received information sooner, they could have taken other steps to ensure their family members received treatment and could have prevented their deaths.

In addition to a lack of communication, other family members reported misinformation. One was told a doctor had seen her husband when no doctors were going into the Home due to the lockdown.1222 One family could not get a straightforward answer about their father's diagnosis and why he had been put in an isolation unit; some nurses said he was negative and others said he was "a

[10] In addition, several family members with loved ones who had passed found it extremely difficult to arrange picking up their belongings, then reported missing belongings, belongings bagged up in trash bags and put on the curb, and receiving other residents' belongings.

little bit positive."[1223] In one case, a daughter could only ever reach a social worker who repeatedly informed her that her dad "was doing better" when in fact her father's condition was steadily worsening.[1224] By the time he was transferred to the hospital, it had been days since he had eaten, had fluids, or taken his medicine, but the Home had not given him an I.V.[1225] The daughter commented, "My dad crawled through the trenches and ended up dying like that?"[1226]

Even for Veterans outside of quarantine or isolation, communication remains a challenge. Many Veterans cannot see or hear well, so phone calls or video chats are not successful.[1227] Others cannot operate a phone well, so they are completely isolated from family.[1228] Window or outdoor distance visits are difficult because the Veterans do not recognize their family members with masks or cannot hear them through the masks or windows.[1229] One spouse noted that at one distance visit, the family next to her only stayed about ten minutes because they could not hear each other.[1230]

Many family members reported that in order to communicate with their loved ones, they have to be right next to them, holding their hands or speaking into their ears.[1231] Because of this, numerous family members have not been able to effectively communicate with their loved ones since March 2020. They are not able to ask the Veterans about their needs or simply connect with them like they have done regularly for decades. Several reported Veterans are forgetting their family members because they have not seen or communicated with them for more than eight months. Others reported Veterans do not understand what is happening and the family members cannot get close enough to explain.

Only a handful of family members stated they had been kept involved and informed throughout this time,[1232] with some identifying specific staff members as a "godsend"[1233] or "go-to people"[1234] in keeping them informed—or trying to, noting these contacts often did not have much more information themselves.

4. Access to Other Medical Care

Because of these communication difficulties, many family members stated their loved ones had either missed doctors' appointments or gone to doctors' appointments without anyone there who could facilitate communication. Several reported that prior to COVID-19 they attended doctors' visits to describe symptoms to the doctors and assist the Veterans in communicating their needs (as well as explain to the Veterans what the doctors were advising). Now, when family members ask if they can attend doctors' appointments for this purpose, they are told if they do, the

Veteran will be put into quarantine upon return to the Home. A nurse who was treating a Veteran reported that when she called the Home to ask about his flu shot, the Home only wanted to know whether his wife had attended the appointment with him.[1235] This Veteran was completely dependent on others, could not answer questions on his own, and his wife was following the same coronavirus precautions as everyone else in the outpatient clinic, yet he was going to be placed in a stricter quarantine simply because his wife had attended the appointment.[1236]

Due to the lockdown, many medical visits are now done over teleconference, which makes communication with the Veterans more difficult. One family member reported that her father had heart issues and was scheduled for a cardiogram, but did a virtual appointment with his cardiologist instead. Her father's speech had gotten worse, so he could not inform the doctor about his condition. Because she was not allowed to be there, she could not inform the doctor that his condition was deteriorating. He died shortly afterward. This family member believes that if her father could have seen his cardiologist in person, or with her assistance, he would have gotten the treatment he needed and would still be alive.

For others, appointments are being put on hold indefinitely. One family member's husband needs new hearing aids and a new electric wheelchair, but he is not allowed to make appointments for either of these needs due to the COVID-19 lockdown. Her husband is therefore not able to hear or be mobile for the foreseeable future. Still others reported missing dental appointments resulting in an inability to chew.[1237] Veterans confined to their rooms are not able to participate in physical therapy, speech therapy, or other activities to help maintain their physical and mental skills.[1238]

5. Veteran Well-being

While one family member reported her Veteran brother was happy the Home was "doing everything to keep him safe,"[1239] an overwhelming number of family members stated the Veterans are isolated, depressed, and upset by the lack of family member access. Family members reported:

> ***"We have each other, he has no one."***[1240]
>
> ***"When he sees us through the window, he bangs on it to try to get out."***[1241]
>
> ***"He told me 'Daughter, I can't take this anymore.'"***[1242]
>
> ***"He suffers from loneliness because he can't see people . . . and he doesn't want to get out of bed."***[1243]

"They aren't dying of coronavirus, they're dying of broken hearts. . . . I got a call back in May and I was told that my dad thought I was dead. He wasn't seeing me on his terms and the way he needs to, so he thinks I am dead."[1244]

"Eight months is too long to keep them away from family."[1245]

"He is dying on the vine, and I've lost eight months of time not knowing how much longer I have any way."[1246]

"Husbands are asking if they are getting divorced since their wives are not there. That is a horrible feeling. The husbands are so distraught because they think the wives don't love or care about them. This is extremely distressing and depressing."[1247]

"A lot of women who lost their husbands didn't know they were going until the husbands were in a coma. . . . So their state of mind when dying is thinking you're abandoned by your wife."[1248]

"My husband is depressed and lonely. . . . I feel like he's in prison, and they feel that way too."[1249]

"These men were in wars, and they come back and they're isolated like a prisoner who has done terrible crimes."[1250]

My husband says "he doesn't know what's going on. . . . he's just fit to be tied."[1251]

"The last three weeks of his life, he was in quarantine, left in a bed, with no communication from us, dying."[1252]

One Veteran reported, "Oh help me. I'm at everybody's liberty to do what they want to. I have a voice."[1253]

Another Veteran reported he goes out to get medicine three times a day, but the rest of the time, he's "sitting in his room looking at four walls."[1254]

One noted that while her husband was still sharp and understood what was happening, "there are so many in there where their wives came every day to help feed them and be with them and all of a sudden, one day, they can't, and those people do not understand."[1255]

A Veteran called to say she "can't get any answers"

A nurse reported that her patient said, "I haven't seen my wife in months. I would rather die than keep living the way I'm living."[1256]

"He's 101 years old, what are you protecting him from? He's dying of loneliness and boredom. He has said several times, just give me my gun."[1257]

"I know they are keeping them safe, but I'm not sure keeping them safe is the way they want to spend the rest of the few years they have left."[1258]

"Every time I call it is the same comment, 'I just wish I could go to sleep and not wake up.' Just worse than being in prison."[1259]

"They are dying of loneliness."[1260]

"I'm at a point where there may be something worse than COVID, and that is losing the mental acuity to enjoy your life."[1261]

One daughter noted that a few months into the lockdown, her father was put on anti-depressants because he was crying so frequently. A Veteran called to say she had been in lockdown for seven weeks and her hair had been washed once. Between that and cold food, she said, "the Veterans are going to start losing it."[1262]

Others highlighted the help of standout staff who were going above and beyond to try to mitigate the effects of eight months of lockdown, including one social worker who helped a Veteran who likes to "tinker" get an old radio to take apart.[1263] But it is apparent that despite these efforts, Veteran morale is low.

6. Veteran Autonomy

Several family members believe that if the Veterans are given a choice, they would choose to accept a greater risk of contracting COVID-19 if it means being allowed to see their family members. Many suggested that if they could take care of the Veterans themselves, they would. Since they cannot, both the families and the Veterans are at the mercy of the Homes. As one wife explained, "I would rather have my husband exposed to COVID[-19] than left with pressure sores."[1264]

Other family members reported their loved ones are trying to modify their wills or take care of financial planning needs, but they cannot meet with the necessary individuals to do so.[1265] One Veteran was not allowed to go to his wife's funeral, even though he tested negative for COVID-19, the family went through an approval process and they waited six weeks for him to be able to attend.[1266]

Family members stated the Homes are making decisions for the Veterans and the Veterans are not being asked what they would like to do. Several family members believe the Veterans are being treated like children or prisoners when they are adults who served their country and should be respected as such. Family members are frustrated, stating the Veterans need to have a say in their own care and the decisions made about their future.

Finally, family members emphasized that even if the Homes are taking good care of the Veterans, eight months is too long to go without seeing your family members. Occasional outdoor or window visits are simply not enough. As one family member concluded, "it really sounds like they were working to keep the virus out of the building, but once it got in, they were unprepared."[1267]

IV. ANALYSIS

COVID-19 has ravaged the nation, infecting more than 10.5 million Americans and contributing to the deaths of more than 242.5 thousand Americans since March.[1268] Missouri has had more than 233.7 thousand COVID-19 cases with more than 3,400 deaths attributable to the virus.[1269] While some states and locales initially managed to avoid large outbreaks of COVID-19 cases in the spring and summer, the current nationwide spread of COVID-19 suggests that may have been more an element of timing or luck than anything else. As the current surge suggests, and as has been predicted by medical and epidemiology experts for months, it was only a matter of time before COVID-19 reached all areas the United States, including Missouri and its municipalities.[1270] However, as medical experts have also explained, with proper planning and precautions, COVID-19 can be isolated and its spread minimized.

Preventing the spread of COVID-19 throughout a population requires appreciation of the virus itself, forethought, diligent planning, education, training, and constant vigilance. This same principle holds true for preventing the spread of COVID-19 through long-term care facilities such as the Missouri Veterans Homes.

Published reports reflect that COVID-19 has affected more than 581,000 people at more than 23,000 long-term care facilities in the United States.[1271] Long-term care facilities in Missouri have not been spared; at least 9,002 Missouri nursing home residents have developed COVID-19 and 1,417 have died as a result.[1272] These statistics demonstrate the reality that even the best preparations and most heightened vigilance cannot eliminate the risk of introducing this virus into long-term care facilities. In other words, simply because COVID-19 made its way into the Missouri Veterans Homes does not in and of itself mean there were errors or lapses.

However, this reality does not render the explosion of COVID-19 throughout the Missouri Veterans Homes in September and October 2020 inevitable. This reality does not excuse a failure to appreciate the nature and course of the virus. It does not excuse a failure to act swiftly and aggressively to isolate the virus nor does it excuse a lack of forethought, conscientious planning, training, education, and vigilance. It does not excuse a failure to have in place a strategic plan to implement basic, long standing, universal infection control principles. It does not excuse a failure of leadership.

At the outset, our investigation revealed that everyone involved in the MVC, from COL. Paul Kirchhoff, Ryon Richmond and Joan Elwing, to the individual Home Administrators, medical and nursing staff, nursing assistants, janitorial and food service staff genuinely care for the Veterans

and are undoubtedly trying to do the best they can in stressful and ever changing conditions. In general, most individuals interviewed willingly participated in the investigation with apparent honesty and out of a seemingly sincere desire to improve the Homes and provide better care for these men and woman who served this country.

Despite the clearly evident best of intentions and the many processes which were in place statewide to address and respond to the COVID-19 pandemic, our independent investigation revealed several failures and opportunities for improvement throughout the Homes' and MVC's hierarchies, which contributed to the explosion of COVID-19 throughout six of the seven Homes in September and October 2020. Summarily, the lapses can be described as (1) failure to recognize and appreciate the existence of a problem at the first sign of an outbreak; (2) failure to plan for the outbreak; and (3) failure to properly respond to the outbreak.

A. Lack of Appreciation and Understanding Resulting in Lack of Communication

Despite a number of resources demonstrating the transmissibility of COVID-19, leadership failed to appreciate the impact of even one positive staff member or Veteran. Because leadership did not appreciate the Homes were experiencing and outbreak, they failed to properly utilize resources and escalate their concerns to other outside agencies.

1. Headquarters Failed to Appreciate the Presence of an Outbreak at the First or Second COVID-19 Cases

Missouri experts like the Missouri State Epidemiologist, Dr. Turabelidze, Adam Crumbliss, Director of the Division of Community and Public Health of DHSS, and Todd Richardson, Missouri Medicaid (Mo HealthNet) Director, all define a COVID-19 outbreak in the congregate case setting as one positive case – either a Veteran or staff member. This definition is more narrow but not inconsistent with the CDC's interim guidance "Managing Investigations during an Outbreak" which recommends defining "outbreak" as, among other definitions, occurring when "two or more contacts are identified as having active COVID-19" or when "[t]wo or ore patients with COVID-19 are discovered to be linked."[1273]

Despite the availability of information narrowly defining an outbreak, leadership treated the first positive cases as if it were something that could be overcome, using the same directives and

policies that had been developed in March of 2020. In doing so, they failed to realize that even one or two positive cases within a single Home meant that there were likely other positive cases yet to be detected. Instead of changing tactics, MVC continued to use the same measures and internal resources instead of reaching out to external partners for assistance. The result of this lack of understanding led to failure at three levels: the human level, the data level, and the Fusion Cell level.

The failure to appreciate the significance of the positives was not due to a lack of information. Rather, Homes Administrators diligently provided information to Headquarters in a variety of forms. For instance, leadership received daily updates in the form of reports, calls, and meetings. Simply put, Homes Administrators and other Homes' staff rose to the occasion and did their part to keep leadership informed of developments on a near constant and almost real-time basis. For example, the Homes contributed to a daily spreadsheet providing information including data such as the number positive Veterans and staff. At that meeting, the data was discussed, but rarely analyzed in a meaningful way, by Headquarters and Homes' staff. Homes Director Elwing and Assistant Director Haggard also reported new positive cases on a daily basis directly to Deputy Director Richmond. In short, our investigation revealed that the information necessary to assess the seriousness of the ensuing outbreak was both accurate and made available to leadership; the failure was in the ability to engage in meaningful analysis.

At a minimum, the MVC leadership, including COL. Kirchhoff and Deputy Director Richmond, should have appreciated the presence of a COVID-19 outbreak by September 2, 2020, and acted immediately to attempt to isolate and contain the spread of COVID-19. Despite this, even with an increase in cases, leadership failed to appreciate the need to move quickly and aggressively to isolate the positive patients. Failure to do so led to rapid explosion of cases inside the Homes and unnecessary Veteran deaths.

The failure to appreciate data and the ensuing outbreak not only impacted leadership's ability to react at the Home level but also the quality of their communication to others. Information provided by leadership often failed to highlight the state of the outbreak for external stakeholders. For example, according to Director Karsten, COL. Kirchhoff's communication in September provided general information but never highlighted any particular issues or concerns. Similarly, on September 10, 2020 Richmond, in writing to Julia LePage of DMH (in her role with the Missouri Fusion Cell related to congregate care facilities) stated "We have had a bit of a spike in positives."

Richmond, Ryon

From: LePage, Julia
Sent: Thursday, September 10, 2020 8:18 AM
To: Richmond, Ryon
Subject: RE: MVC So What

That's what you are testing to catch.....

From: Richmond, Ryon
Sent: Thursday, September 10, 2020 8:17 AM
To: LePage, Julia
Subject: RE: MVC So What

Ok. We have had a bit of a spike in positives.

From: LePage, Julia <Julia.LePage@dmh.mo.gov>
Sent: Thursday, September 10, 2020 8:04 AM
To: Richmond, Ryon <Ryon.Richmond@mvc.dps.mo.gov>
Subject: RE: MVC So What

I'll need to send our portion of the agenda to Ted this evening-can you send me the slide this afternoon? (late afternoon is fine)

Attaching your totals from Aug if helpful; total MVC testing completed numbers that can be added to the Aug 23rd numbers attached. Here is the data I have:
Aug 28: 966 completed of 915 planned
Sept 4: 788 completed of 775 planned
As of today totaled in Sharepoint Sept 10: 1229 completed

In the weekly briefings to DPS, MVC provided little to no context of the outbreak, failing to mention any language or data that would raise concern. The following four document excerpts are from the Weekly Briefings from the month of September:

Missouri Veterans Commission – Weekly Briefing for Week of September 7, 2020:

I. **Upcoming Press Releases/Announcements about Agency Initiatives**
II. **Division Director's Travel Schedule**
III. **30-60 Day Look-Ahead**
IV. **Needed Input**
V. **Programmatic Updates – For Situational Awareness**

UPDATES

- Finance is focused on meeting guidelines for established budget suspense times in order to ensure accurate funding and reimbursements for COVID expenditures.

HOMES

- New COVID positive cases in and around the areas of MVC Veterans Homes requires our continued vigilance both on and off duty.
- Homes continue to monitor and distribute PPE as required in order to continue to meet our staff and Veterans needs during this pandemic time.
- Random and Sentinel COVID testing continues throughout staff and Veteran populations.
- Currently, there are a total of 115 vacant Nursing positions (Down 2 from last week) throughout all 7 homes at this time:
    - Warrensburg, St. James, and Cameron remain as having the most vacancies with a combined total of 70 of the 115 vacant positions. (Down 3 from last week)
        - St Louis Veterans Home has 19 nursing vacancies this week which is the same as last week.
        - Mt Vernon is up to 16 nursing vacancies this week

Missouri Veterans Commission – Weekly Briefing for Week of September 16, 2020:

I. **Upcoming Press Releases/Announcements about Agency Initiatives**
II. **Division Director's Travel Schedule**
III. **30-60 Day Look-Ahead**
IV. **Needed Input**
V. Programmatic Updates – For Situational Awareness

UPDATES

- MVC HQ has 3 positive COVID cases and is currently working remotely.
- Random and Sentinel COVID testing continues at our homes and HQ throughout staff and Veteran populations

HOMES

- Responding to multiple legislative and Governor's office inquiries as to when we will open our homes for family visits even as the population continues to incur more positive COVID cases
- Currently, there are a total of 124 vacant Nursing positions (Up 9 from last week) throughout all 7 homes at this time:
    - Warrensburg, St. James, and Cameron remain as having the most vacancies with a combined total of 73 of the 123 vacant positions. (Up 3 from last week)
        - St Louis Veterans Home has 17 nursing vacancies this week which is down 3 from last week.
        - Mt Vernon is up to 19 nursing vacancies this week which is up 3.
- The Nursing Shortages as stated above compounded with an additional shortage of over 65 individuals out with COVID related concerns puts all of our homes in dire need of assistance
    - Staff are struggling to maintain and feeling the extreme stress of performing duties. We have lost some staff because of this.

Missouri Veterans Commission – Weekly Briefing for Week of September 21, 2020:

I. **Upcoming Press Releases/Announcements about Agency Initiatives**
II. **Division Director's Travel Schedule**
III. **30-60 Day Look-Ahead**
IV. **Needed Input**
V. **Programmatic Updates – For Situational Awareness**

UPDATES

- MVC HQ has multiple COVID cases.
- Random and Sentinel COVID testing continues at our homes and HQ throughout staff and Veteran populations

HOMES

- Responding to multiple new COVID positive cases within the homes involving both staff and Veterans.
    - MVC Homes are expanding Quarantine and Isolation areas in order to accommodate increased numbers requiring separation.
- Currently, there are a total of 131 vacant Nursing positions (Up 7 from last week) throughout all 7 homes at this time:
    - Warrensburg, St. James, and Cameron remain as having the most vacancies with a combined total of 82 of the 123 vacant positions. (Up 9 from last week)
        - St Louis Veterans Home has 17 nursing vacancies this week which is same as last week.
        - Mt Vernon is at 18 nursing vacancies this week which is down 1.
- MVC Homes leaders are working with VA in order to attempt to remedy our nursing Shortages as stated above with augmented nurse staffing.
    - We will not receive all staff requested; however, we hope to gain some assistance in providing our Veterans with the care deserved.

Missouri Veterans Commission – Weekly Briefing for Week of September 28, 2020:

I. **Upcoming Press Releases/Announcements about Agency Initiatives**
II. **Division Director's Travel Schedule**
III. **30-60 Day Look-Ahead**
IV. **Needed Input**
V. **Programmatic Updates – For Situational Awareness**

UPDATES

- MVC HQ, Homes Program, Cemeteries Program, and Veterans Service Program are all conducting COVID-19 testing of all Veterans and staff on a regular basis to reduce staff and Veterans exposure to COVID-19 to as little as possible

HOMES

- Continued response to multiple COVID cases within the homes involving both staff and Veterans.
    - MVC Homes have expanded Quarantine and Isolation areas in order to accommodate increased numbers requiring separation.
- Currently, there are a total of 134 vacant Nursing positions (Up 3 from last week) throughout all 7 homes at this time:
    - Warrensburg, St. James, and Cameron remain as having the most vacancies with a combined total of 86 of the 134 vacant positions. (Up 4 from last week)
        - St Louis Veterans Home has 19 nursing vacancies this week which (Up 2 from last week).
        - Mt Vernon is at 15 nursing vacancies this week which is (Down 3 from last week).
- MVC Homes leaders have been working with VA in order to remedy some of our nursing Shortages as stated above with augmented nurse staffing.
    - We have not received all staff requested at this time; however, we have received some assistance in order to provide our Veterans with the care deserved.

It is clear that the failure to identify and appreciate the nature of the spread of COVID-19 not only led to delayed action within the Homes but thwarted any opportunity to engage outside agencies and resources early on during the outbreak.

2. The Fusion Cell – the MVC Staff Failed to Ask for Assistance

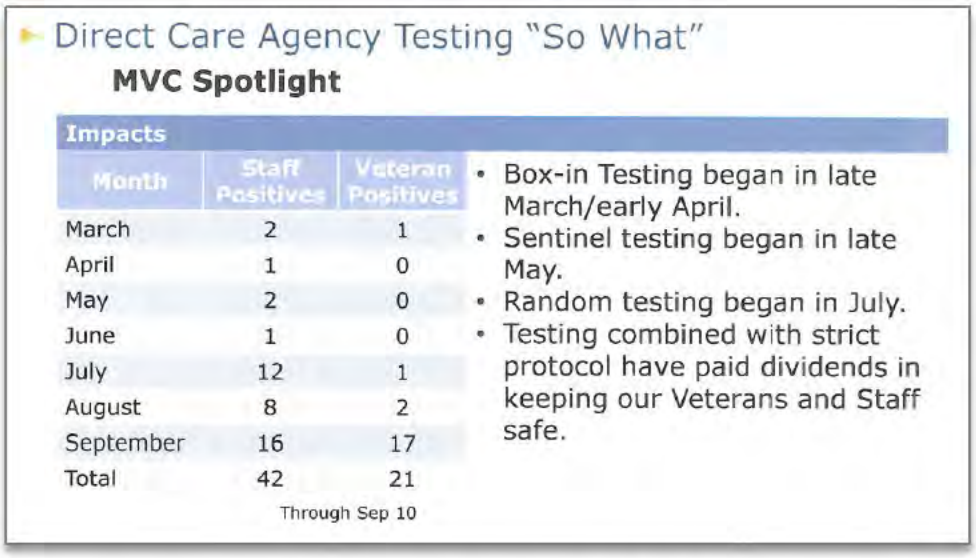
Failure to fully engage with the Missouri COVID-19 Fusion Cell represents a significant missed opportunity. The Fusion Cell is meant to be a single point of information for all Missouri agencies. As a centralized source of data and resources, the Fusion Cell is part of a collective

response to COVID-19 in Missouri. At its core, the Fusion Cell should function to allow the state to develop and distribute plans, resources, and information in a unified manner.

At the helm of the Fusion Cell are Drew Erdman, Missouri COO; Todd Richardson, Missouri Medicaid (Mo HealthNet) Director, and the McChrystal Group, an outside consulting company. In addition to those individuals, other leaders within state government, including those from the education, economic, safety, and medical sectors, are invited to participate and present information. Some non-governmental partners, such as hospital associations and other outside groups are also invited to attend meetings and participate. Fusion Cell meetings take place four days a week at 9am and last one and half hours. Typically, 100-250 individuals attend during any given meeting. Since April, MVC has dutifully participated in the Fusion Cell, attending meetings and providing information when requested. MVC is represented at the Fusion Cell by a number of Headquarters staff, including COL. Kirchhoff, Deputy Director Richmond, Director of Operations Skinner, and others.

Beginning in May of 2020, MVC and others were asked to provide specific statistics related to testing. Richmond began reporting the number of tests administered and the results among both staff and Veterans. He and others from the MVC continued to provide this information through the summer. During the same time, MVC was also reporting positives and deaths to the Missouri Office of Administration which also went straight to the Fusion Cell.[11] In September, Richmond was asked to a give a 5-10 minute presentation on the MVC at the full Fusion Cell meeting. **During the meeting on September 10, he reported an increase in positive cases and displayed, on a PowerPoint slide, a total of 17 Veteran positives and 16 staff positives. Neither Richmond nor others at Headquarters raised any concerns at this meeting. At the same time, no one from the Fusion Cell asked any questions or requested any follow up on the data that was presented.** The following image is the slide presented at the time:

[11] Although there is some debate about the quality of the information provided by MVC to the Fusion Cell, it is undisputed that there was no oversight over the reporting process and that MVC was not notified of any deficiencies in their data or the reporting of such data until October.



The opportunity to ask for assistance did not end with this meeting. Indeed, Headquarters could have engaged the resources of the Fusion Cell early on, even when the first positives were discovered in the Cape Girardeau Home in August. Whether earlier outreach would have resulted in a different outcome is not within the scope of our investigation. To opine on such a hypothetical serves no purpose other than to engage in sheer speculation. Nevertheless, the facts demonstrate that MVC provided data to the Fusion Cell beginning in May. Furthermore, the Fusion Cell was made specifically aware that the Homes were experiencing an outbreak, pursuant to the definition by one its leaders, Todd Richardson, as early as September 10. Nevertheless, it is clear that once the Fusion Cell became involved (without discussing whether they should have become involved sooner given the information at their disposal) in late September and early October, resources were provided to the benefit of the MVC. There is no question that the leaders and others involved in the Fusion Cell have provided critical assistance and guidance to the MVC over the last several weeks.

Ultimately, MVC must establish a more direct line of communication with the Fusion Cell in order to ensure it can take advantage of the collective expertise of its leaders. MVC need not invent such a communication strategy from whole cloth. Indeed, there are several Missouri agencies that provide congregate care which have established direct and impactful relationships with the Fusion Cell. For instance, leaders from the Department of Mental Health are actively engaged in the Fusion Cell, various microcells, and the morning management meetings. It is clear that DMH leaders have no concern reporting information, even "bad news," if the objective is to obtain information and resources. As DMH Director Stringer stated, leaders working through this pandemic must "over

communicate" in order to ensure key stakeholders remain engaged and available to assist. The MVC should take note.

B. Planning for the Outbreak

Proper logistical and tactical planning are the cornerstones of success in achieving any objective. That said our investigation recognizes the novel nature of COVID-19 and the challenges it creates in long-term strategic planning. Even recognizing this acknowledgment, MVC staff demonstrated an absence of leadership in failing to appropriately plan for the COVID-19 outbreak.

Experts agree the primary determinant for whether long-term care facilities will have a COVID-19 positive staff member or resident is its prevalence in the surrounding community.[1274] As was forecast for months, and as the graphs and statistics set forth herein demonstrate, the United States in general and Missouri in particular, are experiencing the predicted fall surge in COVID-19 cases. This surge in cases should not have been unexpected or unanticipated by MVC. Medical experts have predicted the fact of and timing of this COVID-19 surge for several months.[1275] Indeed, individuals interviewed at the Homes and Headquarters acknowledged having concerns about the impact the Labor Day holiday and the return of children to in-person learning may have on COVID-19 positivity rates.

By the beginning of summer 2020, most individuals, including average Americans, understood the highly contagious nature of COVID-19 and the fact it spreads covertly through asymptomatic carriers. As Dr. Turabelidze explained, 40% of people with COVID-19 experience no symptoms yet are contagious and unknowingly spread the virus.[1276]

Additionally, as should have been evident in the spring when Headquarters staff studied the outbreak and deaths at the Kirkland, Washington nursing home,[1277] COVID-19 spreads rapidly and is extremely difficult to control and remediate once it plants its seeds in a nursing home. Stated differently, one break in the chain can result in an entire facility full of COVID-19.

Simply put, the risk of COVID-19 transmission and spread was well known by at least June 2020 and should have resulted in deliberate action. MVC leadership should have developed a well-considered comprehensive plan over the summer to respond to the threat of COVID-19 invading its Homes. Agencies such as the CDC promulgated guidelines as early as February 2020 to address COVID-19[1278] which could have provided the foundation for an MVC plan. Had the MVC timely acted, it could not only have developed a plan but could have vetted that plan with outside agencies

such as DHSS, VA, CDC, and other long-term care facilities. Developing a plan during this time frame would also have allowed MVC to test the plan to ensure its efficacy in the event of an outbreak thereby allowing time for adaption relative to any exposed deficiencies. Had MVC developed a plan even by the end of August, the Homes would have had a strategic playbook or at the very least a basic algorithm to guide them. Our investigation revealed, in large part, an acknowledgment of this failure and missed opportunity.

It is also clear that the lack of a formal preparedness and response plan led to confusion, inefficiencies, and reactive measures. This sentiment was expressed repeatedly in the interviews of the staff in the Homes as well as Headquarters. For example, by the time MVC leadership reached out to State Epidemiologist, Dr. Turabelidze, reality had set in. He described COL. Kirchhoff and Ms. Elwing as "disoriented" and "terrified" when they finally asked for help to address the outbreak.[1279]

1. Lack of COVID-19 Specific Policies

The lack of a comprehensive COVID-19 plan by the end of August almost certainly contributed to the inability to contain its spread once it was introduced into the Homes. Headquarters staff and Homes personnel reported feeling as though they could not have predicted the extent of the outbreak, that they did the best they could under the circumstances, and that there was little time to create a comprehensive plan because the outbreak was unexpected.

The evidence shows, however, that MVC had ample time to develop and test comprehensive polices and plans. A plethora of public health recommendations have been developed to plan for, prevent, and respond to COVID-19. For instance, beginning in February 2020, the CDC began publishing guidelines, templates, and checklists which could have provided the foundational basis for a COVID-19 response plan.[1280] [1281] [1282] [1283] Those checklists and plans were updated over time, but have not significantly changed, likely because they are based on basic universal infection control measures.

Outside of CDC and other public agency resources, open source material existed in early spring depicting the destructive path of COVID-19 in congregate care settings. MVC initially took stock of such resources by studying the outbreak in Kirkland, Washington. Some of the lessons learned from that outbreak informed the MVC's initial COVID-19 planning in the March and April timeframe.[1284] However, the research and review of such resources began and ended with the

Kirkland Home. Multiple other outbreaks followed across the country yet MVC leadership failed to recognize the potential that such an outbreak could occur in the Homes and failed to study these outbreaks to inform its own decision-making.

MVC's failure to act on such information, which was widely and publicly available, is not unlike its failure to plan ahead for a fall surge in positivity. No one at the MVC took the initiative to develop a plan to account for these realities. The MVC should have appreciated the concerns COVID-19 posed to its Homes and proactively developed comprehensive preparedness and response plans in the spring. Had this been done, the plans could have been vetted, tested, and updated as warranted. Had this been done, the MVC could have identified triggers at which specific actions needed to be instituted. Had this been done, the Homes would have had clear direction during the outbreak.

The MVC did not wholly fail to provide COVID-19 related guidance to the Homes. Instead of a comprehensive COVID-19 plan, the MVC frequently issued directives. Directives are not policies, the latter of which are created after thoughtful consideration. The directives MVC issued to the Homes were reactionary and haphazard, frequently inconsistent with each other, generated with seemingly little thought as to their efficacy, practicality, and concordance with best practices. MVC issued the directives with little insight as to how or if they could effectively be implemented at the Homes or how the Homes' personnel would educate their staff.

Issued in such a manner, the directives did not have the effect of being lasting, clear policy. They did not provide a comprehensive or considered plan. Rather, the directives addressed only discrete aspects of care and COVID-19 management. In some instances, the directives did not comply with CDC guidelines and lacked consistency with "best practices" related to infection control.1285

Further, the constant updates and changes led to confusion and frustration among staff. Staff described receiving a barrage of directives, almost daily.1286 This, in turn, led to an inability to provide clear guidance to the staff, an inability to adequately train staff, and an inability of the "boots on the ground" folks caring for the Veterans to keep up with the changes. As a consequence of this practice, the MVC directives were lost and ineffective. As an example, the Cameron Home's frontline staff were not aware of the existence of any COVID-19 polices.1287

Due to the ever-changing nature of the directives, in most Homes they were not printed or bound for easy access. While we understand some polices were housed on a sharefile type directory, many staff members did not know where the policies were or how to access them. One nurse

manager was unable to access the policies even knowing where they were located.[1288] The directives (and policies) should have been printed and placed in a binder at every nurse's station throughout the Homes. While this may seem redundant, it is necessary given the staffs' inability to access the policies, differing levels of technologic capabilities among staff, and lack of access to a computer during a shift such as with dietary, janitorial, and housekeeping staff.

2. Lack of Comprehensive Infection Control Policies

Not only had MVC failed to develop a COVID-19 plan, it also failed to have a current and comprehensive infection prevention policy and procedure manual as required by VA and CDC guidelines. An infection prevention manual would have included an outbreak management plan or emergency management plan. Such a plan would have provided the Homes guidance relative to isolation, quarantine, and universal precautions.

Though MVC developed a general pandemic plan in March, no one reported using it nor was it specifically tailored to be used during the COVID-19 pandemic. We also saw no evidence this plan was updated or reviewed at any time after March. Similar to the infection prevention manual, had this plan been created with due consideration and in line with best practices, the Homes would have had basic guidance relative to quarantine, isolation, and universal precautions which staff could have implemented without having to wait for directives from Headquarters.

3. Lack of Training and Education

The lack of policies and frequently changing directives resulted in an inability to properly and consistently train the staff providing the hands on care and services in the Homes. Signage created in an attempt to educate the staff often contradicted of each other as well as CDC guidelines. Consequently, the staff caring for Veterans were not properly trained or educated regarding COVID-19 prevention, mitigation, and containment. Staff inconsistently and at times inappropriately applied the directives and often had little understanding of how to properly prevent COVID-19's spread within the Homes.

C. Responding to the Outbreak

As stated above, the third category of deficiencies and contributions to the spread of COVID-19 throughout the Missouri Veterans Homes falls generically into the category of the

MVC's and the Homes' responses to the outbreak, and specifically concern testing, cross-contamination, and staffing.

1. Testing for COVID-19

In August 2020, PCR testing of all Veterans and staff, regardless of symptoms, was implemented on a routine twice weekly basis. Although considered the "gold standard" for diagnosing COVID-19, test results are not immediate. Rather, it takes anywhere from 24 to 48 hours for a Home to receive the test results. This is significant relative to the spread of COVID-19 in the Homes because, as Dr. Turabelidze explained, one problem with COVID-19 is that 40% of people who contract it are asymptomatic and spread the virus unknowingly. An additional 20% are pre-symptomatic at the time of testing. In other words, the majority (60%) of individuals tested in this manner are COVID-19 positive but asymptomatic.1289

The days long lag in receiving PCR testing results cannot be overstated. After testing and while awaiting the results, infectious staff and Veterans interacted with one another, some without any PPE. Asymptomatic Veterans and some symptomatic Veterans were not quarantined pending the results and moved freely among the Homes and units, dined together, interacted with each other, remained lodged with their roommates, and engaged in smoke breaks together, thereby promulgating the spread of COVID-19. The same can be said for asymptomatic staff who continued to work, engage with Veterans, and take breaks with other staff members pending test results. The detriment of delayed test results was compounded by the fact that the Home's staff wore only surgical masks prior to the September outbreak.

With assistance of the Fusion Cell, testing frequency has escalated. At the beginning of October, the Homes received BinaxNOW rapid antigen testing. The test can be analyzed on-site in about 15 minutes. All staff and Veterans undergo this test on the days of the week they do not receive PCR testing. The current state of the rapid antigen testing is such that it is considered reliable when the test result is positive. With positive test results, the Homes have been able to send infected staff home sooner, isolate infected Veterans immediately, and more rapidly quarantine exposed Veterans. As an example of the impact rapid testing has had, Ms. Elwing described that they diagnosed two asymptomatic but positive staff who would have otherwise worked up to three shifts before the PCR test yielded results.1290 There is no doubt that using the rapid tests in conjunction

with the PCR tests has had a positive impact on controlling the outbreak as it allows for faster diagnosis, faster isolation, faster quarantine, and reduced spread.

While the false negative rates with the rapid tests can be high, as Dr. Turabelidze explained the benefits of using such tests greatly outweighs the false negative results. This is especially true since the tests are administered five days per week.1291 Overall, the rapid tests are an important tool to identify positive staff and quickly remove them from the Homes.

One early consequence of the perceived unreliability of the rapid antigen tests is that Veterans at some of the Homes who tested positive on the rapid test were allowed to remain on the unit interacting with other Veterans and staff until the results of the PCR test returned. Obviously, this posed a significant risk of transmission. This practice has ceased and any Veteran who tests positive on the daily rapid test is immediately placed in isolation.

As an additional effort to prevent the spread of COVID-19, the Homes have instituted more frequent vital sign monitoring, at least every four hours. The primary vital signs being monitored are temperature and oxygen saturation levels. Medical Directors of the Homes have also developed standing orders for nurses to implement with specific changes of vital signs. Implementing these actions allows staff to identify changes in a Veteran's condition, institute earlier mitigation strategies and obtain more rapid medical intervention.

While this is a commendable practice, not all Homes are monitoring the same vital signs, at the same interval, or with the same response to abnormalities. Further, the Homes are not consistently monitoring Veterans for all of the signs and symptoms of COVID-19; they are only monitoring select vital signs.

2. Insufficient Isolation and Quarantine Spaces as well as the Lack of a Sufficient Placement Management Plan Resulted in Cross-Contamination

At the outset, quarantine should occur if a Veteran displays symptoms but has not yet tested positive for COVID-19 or when a Veteran returns to the Home from the hospital. The period of quarantine should be 14 days. A devoted quarantine unit should be developed with each Veteran being in a private or single room and, if possible, with a private bathroom and shower. If space is not available in a Home for a dedicated quarantine unit, a Veteran can quarantine in his/her own room if there is no roommate. To prevent the spread of COVID-19 from a symptomatic Veteran

who has not yet tested positive, there should be no intermingling among Veterans in the quarantine units.[1292]

Isolation, on the other hand, should be used when Veterans test positive for COVID-19, regardless whether they exhibit symptoms. In isolation, Veterans can be placed together in the same room or same area because they have the same underlying virus. Isolation should occur for at least 10 days following a positive COVID-19 test.[1293]

Issues related to improper quarantine and isolation procedures undoubtedly contributed to the spread of COVID-19 within the Homes. At the outset, the isolation and quarantine spaces lacked a sufficient number of beds. Little consideration had been given to how expansion would occur if and when necessary. For example, Director of Operations Melissa Skinner reported that initially Homes were outfitted with four isolation beds[1294] In the event more space was needed, Ms. Skinner assumed hospitals would take the overflow of Veterans. Only in the midst of the outbreak, when isolation beds were needed but lacking in the Homes, did she learn hospitals would not take COVID-19 patients unless they needed specific care that could not be provided at the Home.[1295]

Indeed, Ms. Skinner admitted, "We were not prepared for the quick spread that occurred in in Cape." Further, Ms. Elwing stated, "Never did I imagine our isolation area, in one week, would have 50 patients." In light of the COVID-19 outbreaks in March and April, including through the rampage of COVID-19 through nursing homes in Washington and New York, these sentiments hold little water.

The insufficient amount of isolation beds was a particular issue at Cape Girardeau Home and Cameron Home, two Homes which experienced a large COVID-19 outbreak. Staff described issues with frequent re-location of Veterans among quarantine and isolation beds at Cape Girardeau Home as "stressful," "chaotic," and "hectic."[1296]

The lack of isolation space forced some Homes to build isolation areas around the COVID-19 positive Veterans which, in turn, allowed co-mingling of COVID-19 positive with COVID-19 negative Veterans. For example, Ms. Elwing described that in Cape Girardeau, they had "to make space for an isolation unit "on the fly," so they moved people that tested negative out into other areas without an infection [not into quarantine status], and in that effort we introduced the virus into the new unit."[1297]

i. Special Considerations of Special Care Units

The Missouri Veterans Homes are unique because they provide more end of life care than a traditional nursing home. Veterans in the Homes typically have significant underlying medical conditions which, according to Dr. Turabelidze, may have contributed to the increased death rates in the Veterans Homes versus traditional nursing homes.1298

Additionally, the Homes care for Veterans with impairments and diseases like dementia and Alzheimer's. Each Home has a special care area which is a locked unit where Veterans with conditions such as dementia and Alzheimer's reside. Due to the unique nature of these Veterans' medical conditions, they are unable to comply with mitigation strategies such as masking, social distancing, hand hygiene, or directives to stay in their rooms. The underlying nature of these conditions renders it incredibly difficult to contain and mitigate COVID-19 once it is present in a special care unit. As a result, even one case of COVID-19 in these units can spread like fire.

For these reasons, staff working in a special care area must be particularly vigilant about doing everything possible to keep COVID-19 out of these units, to immediately isolate positive Veterans, and immediately quarantine exposed Veterans or those showing symptoms.

ii. Delay in Closing Common Spaces Contributed to Cross-Contamination

An obvious transmission risk is the practice of allowing Veterans to move freely about the Homes and about the units on which they reside. At the dawn of the outbreak, Veterans were allowed to move freely among the Home, dine together, and engage in activities together. Many did so without wearing masks, even while exhibiting COVID-19 symptoms, factors which certainly contributed to the spread of COVID-19.

As the outbreak unfolded, residents have been confined to their own units or wings, dining rooms have been closed, and activities have been cancelled. Despite these precautions, many Veterans still do not wear masks or practice social distancing when in common spaces. Several of them also take "smoke breaks" together where they stand close together not wearing a mask thereby continuing to perpetuate a transmission risk.

iii. Movement of Staff among Units Contributed to Cross-Contamination

Similar to Veterans being allowed to move freely among the Homes, at the onset of the outbreak, staff were not consistently assigned to work in a dedicated unit. Rather, many worked across all units of the Homes. The need for staff to be dedicated to one particular unit is evident by the fact that the first surge of cases at the Cape Girardeau Home was tied, in part, to a bath aide who moved through the entire Home.[1299]

Having staff dedicated to working in an assigned unit is easier said than done. Currently, to the extent possible, critical staff in the Homes are assigned to a dedicated unit. However, it is particularly difficult to assign dietary, housekeeping, and environmental services staff to a dedicated unit.

Overall staffing shortages also contributed, and continue to contribute, to the inability to have dedicated staff working in one unit. Even prior to COVID-19, many of the Homes had staffing shortages. Those shortages have been compounded by staff members having to quarantine at home due to COVID-19 exposure or infection. Further, at the onset of the COVID-19 pandemic, the Homes' staff was no longer allowed to work at other long-term care or medical facilities, which many of them did. As a result, several staff members resigned their employment with the Homes thereby contributing to staffing shortages.

With the possible exception of the St. Louis Home, none of the Homes had a contingency plan to address potential staffing shortages. Multiple staffing agencies were prepared to and could have deployed staff to cover COVID-19 related shortages if the Homes or Headquarters had the forethought to plan for staffing shortages.[1300]

Similarly, there was no coordination with the VA at either the individual Homes or at Headquarters concerning outbreak surge staffing until the Homes were in the midst of this current staffing crisis. When asked why not, Ms. Skinner said, "none of the HQ team knew the VA could deploy a team to help."[1301] Currently, additional staffing is being provided as needed through the VA and DMAT.

iv. Inconsistent use of PPE May Have Contributed to Cross-Contamination

PPE, and its proper use, is essential to preventing the spread of COVID-19. None of the Homes reported any current concerns with the amounts and types of PPE they have and our

investigation revealed no concerns in this area. The MVC is to be commended for the amount of and types of PPE the Homes have.

However, our review confirmed that while the Homes currently have appropriate PPE readily available for staff and Veterans, the stock of available PPE, including the availability of N95 respirators, has fluctuated. Due to this fluctuation, staff members had been instructed to use certain forms of PPE for a period of time longer than recommended by the CDC and/or in a condition not recommended by the CDC or other public health recommendations. This practice seems to have abated with the influx of PPE.

Our investigation revealed ongoing inconsistent, improper, and non-CDC compliant PPE use in the Homes. One of the most common deficiencies, masks not covering noses, seems to have been remedied with the supply of N95 respirators. Currently, the most common deficiency centers around the appropriate use of gowns, in particular wearing them from "dirty" (COVID-19 infected) areas to "clean" (non-infected) areas. Adding to this deficiency is the fact that many Homes have inadequate areas for donning (putting on) sterile gowns and doffing (removing) sterile gowns. In many Homes, donning and doffing occurred in the same area, allowing for cross-contamination and potential spread of the virus.

An additional concern this investigation identified is the failure to properly clean medical devices, such as blood pressure cuffs, between uses. Sterilization or disinfection of medical devices is not only necessary to prevent the spread of COVID-19 but a universally accepted infection prevention best practice.

v. Inconsistencies in Initial Screening Process Could Contribute to Cross-Contamination

Given that outside visitors are not allowed in the Homes, consistent screening of staff members coming into the Homes is the first line of defense to prevent the introduction of and spread of COVID-19. Each Home has a robust screening process in which every employee must participate upon entry into the Home and prior to being allowed to work. Before this outbreak, staff members could refuse to be tested, though most employees were compliant. More recently, the policy has changed and now employees who refuse to be tested are sent home without pay.

The two primary deficiencies identified in the staff screening process were that some Homes allowed self-screening of staff and some allowed employees to congregate without social distancing

while awaiting rapid screening results. While we identified these deficiencies in the staff screening process, we found no evidence COVID-19 spread as a result of these deficiencies.

vi. General Staffing Issues

Morale is an issue among the staff across the Homes. Many are overwhelmed by the spread of the virus and the carnage it has left behind. The emotional toll of caring for COVID-19 affected Veterans, infected and non-infected, weighs heavily on these individuals. The negative media attention on the Veterans Homes spotlighting this COVID-19 outbreak has been demoralizing to the individuals laboring in the trenches, battling this virus on a daily basis, and trying their best to combat the effects it is having on the Veterans whom they consider to be family.

With that said, in many Missouri communities, mask mandates are not enforced nor is social distancing. Dr. Turabelidze attributed some of the success of the St. Louis Home's ability to keep COVID-19 at bay to the mask mandates in place and the community's acceptance of and practice of social distancing[1302]. In light of this, all staff should be educated and embrace the fact that the practices employed in the Homes to prevent COVID-19 will have no effect if the staff members do not practice COVID-19 prevention measures outside the Homes and while in their own homes and communities.

Another staffing issue our investigation revealed is that staff serve multiple roles in the Homes, which dilute their overall effectiveness. Specific to the purposes of this investigation, the infection prevention nurses in the Homes are not dedicated to infection prevention but have several other duties. For example, in the Cameron Home, the infection prevention nurse spends only about 15% of her time on infection prevention. She also does not maintain the data about COVID-19 positive patients and staff.[1303] Further, in the Cape Girardeau Home, the Director of Nursing manages infection control activities, not the infection prevention nurse.[1304] Failure to have dedicated infection prevention staff likely contributed to the lack of appropriate training and education discussed above as well as the inappropriate and inconsistent use of PPE in the Homes.

Finally, neither the Homes nor MVC have consistent policies regarding when staff who were exposed to COVID-19 or tested positive could return to work. There was an inconsistency among the Homes regarding when staff were allowed to return to work. We recommend Headquarters develop a policy applicable to all Homes regarding this issue.

vii. Lack of Empowerment

It is axiomatic that the front line staff should collaborate with the MVC in the development of policies and procedures. At the very least, policies should be vetted with each Home prior to implementation. Staff at the Homes should feel empowered to question specific policies and procedures and work freely beyond Headquarters with other entities such at the local health departments.

D. Physical Layout Contributed to the Spread

The physical layout and space restrictions of many of the Homes contributed to the COVID-19 spread. Most of the Homes do not have single rooms or private bathrooms for all of the Veterans. Instead, many of the Veterans have roommates and share shower and toilet facilities. At the outbreak, many of the Homes were at or near capacity which prevented the ability to move Veterans to single rooms and prevent the spread to their roommates. Indeed, many cases of COVID-19 involved transmission from one roommate to another.

Additionally, the HVAC systems may have contributed to the spread. When Ms. Elwing contacted Dr. Turabelidze regarding the outbreak at Cape Girardeau Home, he suggested that Cape Girardeau retain health care ventilation engineers to test and examine the ventilation systems.

E. Dietary/Environmental Services

By all accounts, the Homes are very clean, described repeatedly as "spick and span." The frequency and depth of cleaning has increased. The only issue identified with cleaning is the use of the disinfectant products. They were not being used according to the manufacturer's recommendations. Specifically, the dwelling time for wet cleaning products was 1 minute for bacteria but 10 minutes for viruses including COVID-19. The staff was only using the 1 minute of dwelling time. Thus, while the Homes were clean, they were not disinfected.

Most of the Homes have prohibited meal carts from being brought onto the units. Rather, the carts are left at the entryway to the unit and the nursing staff distribute the meals. Meals are now also being served on disposable plates and with disposable utensils. The Homes which are not following this procedure should do so.

V. RECOMMENDATIONS

The goals of these recommendations are twofold: (1) to prevent another COVID-19 outbreak in the Homes, and (2) in the event of further COVID-19 cases, to have in place a strategic response plan by which the infections can be recognized, isolated, and remediated as quickly as possible to prevent further Veteran and staff illnesses and death.

A. Root Cause: Failure to Analyze Data and Failure to Appreciate the Outbreak

1. Streamline Data Analyzation and Reporting

MVC Headquarters should develop specific trigger points that identify threshold conditions to take further action. Once these thresholds are established, MVC Headquarters should create action plans which correspond to each trigger point and ensure all staff are trained to the same standard. In addition, MVC Headquarters should continue to expand their use of data analytic platforms and dashboards to ensure data collected by the Homes is properly analyzed. MVC should ensure Headquarters staff is trained to identify trends and task key personnel with the responsibility of tracking and analyzing such data. In addition, Headquarters' leadership, led by the Executive Director, must compare MVC data to information provided by the Fusion Cell, local health departments, and other available sources to engage in meaningful decision-making.

Staff at the Homes and Headquarters are tasked with collecting and reporting a large amount of data. The MVC should explore ways to streamline the reporting burdens on all staff. Specifically, the MVC and other external stakeholders should look for ways to reduce duplicative case reporting, in order to minimize the risk of data errors. If possible, the MVC should explore automated recording and monitoring systems and revisit what information needs to be collected and transmitted on a priority basis. These steps will help alleviate the current practice of collecting and verifying data, freeing these critical staff to attend to other matters. Similarly, the MVC should continue to improve and refine the dashboard and interface tools used to analyze data.

B. Root Cause: Lapse of Broader Reporting and Communication

1. Improve Communication and Analysis between the MVC and the Fusion Cell: Perform an After Action Review of the Lessons Learned from August and September 2020

In general, MVC Headquarters accepted responsibility for any lapse in communications, including any assumptions made about who was responsible for actually analyzing the data the MVC shared with the Fusion Cell. COL. Kirchhoff took full responsibility for the MVC's failure to analyze the data, either before or after it was sent to the Fusion Cell. Our impression is that the various leaders clearly understand that they can do better, and it was plain that these leaders mourn the loss of each Veteran. Internally, MVC Headquarters should develop a plan outlining a delegation of duties among MVC Headquarters' staff. Duties related to data management, analyzation, resource procurement, and contingency planning must be clearly assigned to prevent lapses in responsibility. MVC Headquarters' leadership should create unity of command and clearly defined responsibilities related to the continued COVID-19 response.

This recognition is a necessary first step, but it will be meaningless if the external stakeholders and MVC leaders do not improve their communication and cooperation. In addition, it is clear there is little actual supervision by DPS over the MVC. Indeed, Director Karsten stated she has no power to direct COL. Kirchhoff or the MVC.1305 Based on the information available at this time, it appears that the Chief Operating Officer of Missouri, Drew Erdmann, is in the best position to implement the appropriate reforms. Mr. Erdmann, who has a breadth of experience and an impressive pedigree,[12] must immediately spearhead this effort and determine the most efficient method to overcome the inevitable obstacles. The COO must mobilize leaders from the MVC, the Fusion Cell, the Department of Public Safety, and other agencies to restructure the "independent" MVC and its administrative position in the State of Missouri.1306 No longer can the MVC, an independent commission, be left on an island to battle this pandemic.

Put differently, given the information available now, it is not acceptable for leaders to claim that because the MVC is its own independent entity, it bears sole responsibility. Rather, going forward, the leaders of the Fusion Cell, DPS, and the MVC (including the nine Commissioners)

[12] Drew Erdmann was previously a partner in the global consultancy McKinsey & Company, served as a staff member to Secretary of State Colin Powell, and served on the National Security Council staff at the George W. Bush White House. His educational qualifications include a BA in philosophy from the University of Oxford and a PhD in history from Harvard University.

must perform a thorough "After Action Review"[13] of the lessons learned from August and September 2020. This After Action should review the communication that occurred and any assumptions made, as well as determine who at the MVC and the Fusion Cell is actually responsible for and accountable for analyzing the data. Once designated, these individuals must establish a clear line of communication and trusting relationship. The purpose of this ongoing dialogue and analysis is to ensure that leaders outside the MVC know at the earliest opportunity that an outbreak has occurred or that additional resources must be supplied in the fight against COVID-19. A call with 200 people on the line is not sufficient. The stakes are higher here: the aging Veterans are already more vulnerable to this disease and time is not on their side.

While the accountability and reporting structure of the MVC are not well defined, its specific administrative organization is beyond the scope of this investigation. Rather than dissect the governing statues and job titles of each person who might be responsible,[14] we recommend a practical, collaborative approach to address the leadership challenge. Our focus is on saving lives for Veterans and staff, and ensuring that the Homes continue to provide a safe, comfortable environment as Veterans reach the sunset of their lives. We are mindful of the gratitude so many expressed in the more than 75 calls we received from family members of Veterans, including "I couldn't ask for a better place for him to be,"1307 "I'm thankful my brother is where he is through this time;"1308 and "I can't express how grateful I am that these people are there taking care of him when I can't.."1309

[13] First used by the Army on combat missions, an "After Action Review" or "After Action Report" is a structured approach for identifying strengths and weaknesses of command and control, communications, and personnel and logistics support. It highlights lessons learned and identifies alternative solutions and areas for improvement. See Marine Corps Reference Publication (MCRP) 3-0A, Appendix G, "After Action Reviews and Reports."

[14] It should be noted that some of the oversight of the MVC is left to volunteers. *See* Mo. Rev. Stat. § 42.007 (describing the qualifications of volunteer commissioners). In our experience, and even in analogous situations with nursing homes, volunteers—whether commissioners, directors, or trustees—can lack the time and effort needed during difficult times. Thus, meaningful execution should be left to paid, accountable state employees rather than volunteer commissioners.

C. Root Cause: Absence of a Comprehensive Outbreak and Contingency Plan

1. Development of a Comprehensive Plan

MVC Headquarters and Homes should develop a comprehensive COVID-19 outbreak plan based on other infectious disease protocols. The plan should be vetted by other external agencies and resources such as those issued by the CDC, VA, DHSS, and CMS. The plan must be tested and tailored to each Home as appropriate. Once final, all MVC Headquarters and Homes' staff should be trained and have access to the plan for reference.

2. Staffing

Regarding staffing, we recommend the MVC develop clear and consistent policies regarding when staff need to quarantine or isolate and the conditions which must be met before staff can return to work following a COVID-19 infection or exposure thereto.

Each Home should also have a detailed plan to implement in the event of staffing shortages due to COVID-19. According to the State Epidemiologist, Dr. George Turabelidze, "plans are only as good as the paper they are written on." Vague, non-specific plans will not address the staffing shortages which have been caused by COVID-19.

Based upon Pathway's report, we recommend each Home have a dedicated infection prevention nurse who has access to all infective information pertinent to the Home.

The MVC should also continue to develop proper payment programs to ensure appropriate staffing levels while also ensuring that staff are incentivized to report any illness or known direct exposures to COVID-19. Such policies must avoid incentive structures that penalize staff that report symptoms or that must quarantine.

3. Development of a COVID-19 Checklist

Although some Homes established their own checklists, the MVC should develop comprehensive response checklists that can be executed by any member of a Homes' management team following the report of a COVID-19 positive staff or Veteran. In developing the immediate action checklist, at a minimum, the MVC needs to consider and addressing: PPE elevation for the facility, isolation/quarantine decisions, testing protocols, spot cleaning and other environmental hygiene considerations, notification of all relevant stakeholders, standardized contact tracing and

documentation (standardized contact tracing must include a process for identifying exposed MVC staff and/or vendors who cannot be identified through the use of the electronic medical records), and all other follow up infection control best practices.

4. Personal Protective Equipment

Our review confirmed that while many of the Homes currently have appropriate personal protective equipment ("PPE") readily available to treat Veterans with suspected or confirmed cases of COVID-19, the stock of available PPE, including the availability of N95 respirators, has fluctuated. Due to this fluctuation, staff members have been instructed to use certain forms of PPE for a period of time longer than recommended by the CDC and/or in a condition that is not recommended by the CDC or applicable guidance. We recommend the MVC prioritize the acquisition of PPE necessary to ensure appropriate PPE availability through at least April 2021.

We further recommend staff training and education at each Home on the proper use of PPE. Despite the optics of the MVC being "independent," we recommend additional accountability to ensure this recommendation is completed on a regular and ongoing basis. The Executive Director of the MVC should inform the MVC Commissioners, the DPS Director, and the COO of Missouri when this education is completed, in writing and on a monthly basis.

5. Testing

Our review and public reporting confirms that the Homes utilize not only twice a week PCR testing but also Abbott BinaxNOW rapid antigen tests to test both Veteran residents and staff for COVID-19 on a regular basis. Utilizing rapid antigen testing is a powerful tool in detecting COVID-19 among Veterans and staff as it facilitates more rapid diagnosis, more rapid isolation, and more rapid treatment. To the extent resources permit, we recommend the MVC prioritize rapid antigen testing and continue to utilize such testing through at least April 2021 to protect against the intra-Home transmission of COVID-19 and the transmission of COVID-19 into the Homes via community spread. We also recommend continuation of the twice weekly PCR testing.

6. Vaccination Planning

Through the Fusion Cell, the MVC should begin the process of ensuring that, when a safe and effective COVID-19 vaccination becomes available, the Veterans and Homes' staff, receive

priority for the vaccine's distribution. Logistical planning, in consultation with the Home's respective medical directors, should begin as to the means and methods of distribution. Specific attention must be given to the projected vaccination restrictions and requirements (such as whether there are any extreme refrigeration requirements for transportation and storage). The MVC, in consultation with Missouri's State Epidemiologist, should also begin developing policies and procedures in the event that a Veteran or staff member refuses to be vaccinated, or that cannot be Vaccinate through a documented health condition.

D. Root Cause: Lack of Effective PPE Policies and Containment Protocols and Corresponding Difficulties in Staff Training

1. MVC and Homes's Staff Must Undergo a COVID-19 Reset

Every member of the MVC staff and every person working in or associated with the Homes and Veteran care should undergo a "COVID-19 reset." By "COVID-19 reset," we suggest all MVC personnel having any involvement with the Homes, as well as every Home Administrator, Director, Nurse, Nursing Assistant, Dietary, Housekeeping, Administrative, And Janitorial Staff undertake education and training regarding COVID-19 and the ways in which to prevent and mitigate its spread including, but not limited to:

- The fact that COVID-19 is real;
- It is highly contagious;
- It is more deadly than the flu;
- It is spread covertly through asymptomatic people for up to 14 days;
- Masks, social distancing and hand hygiene help prevent the spread;
- Universal precautions such as masks, social distancing and hand hygiene should be practiced not only in the Homes but also in the greater community;
- One of the primary ways by which COVID-19 is introduced into nursing homes is by a COVID-19 positive staff member bringing it into the Home.
- The effect of each and every staff member's actions in the community are not isolated to the community at large, but rather impact the Homes abilities to control and prevent not only COVID-19 but other viruses and infections prevalent in the community.

Each Home should also partner with and collaborate with its local public health department. The local public health department will have more granular community specific information such as specific school, day care and church outbreaks, among other local information, thereby allowing the Homes to adjust their practices and educate their staff, Veterans and their family members accordingly.

2. Development of and Training Related to Infection Prevention and COVID-19 Policies and Procedures

At the Headquarters level, COVID-19 specific policies and procedures should be developed and implemented. In turn, stakeholders at each Home - including as infection prevention, nursing, administration and human resources at a minimum - should have a voice in the development of the policies to ensure they conform with best practices, CDC, VA and other published guidance, as well as to determine how the policies and procedures can effectively be implemented at the Homes. Appendix C sets out the minimum polices which should be developed. In addition to the COVID-19 specific policy and procedure manual, MVC should develop a specific infection control manuals in accordance with VA and CDC guidance and recommendations.

As these policies are developed, a designated Homes' staff member, such as the Staff Development Coordinator or Infection Prevention Nurse, must immediately educate the staff on the contents of the policies and ensure the staff demonstrate relevant competencies. Rather than existing only in a sharefile or database, the policies need to be in binders accessible to all given varying abilities to use technology. Additionally, the policies need to be reviewed and updated annually to ensure compliance with VA and CDC guidelines as well as best practices.

3. Occupational Health Nurse

The MVC should considering retaining an Occupational Health Nurse on the Headquarters staff, through the end of the pandemic, in order to help develop specific policies related to the safety and health of the staff. In addition to infectious disease control considerations, an Occupational Health Nurse could assist in developing policies and programs to support the mental health and well-being of the staff. While the frontline workers at each Home have proven resilient and dedicated, there is well-documented stress working in healthcare during a pandemic and there is well-documented trauma associated with working through COVID-19 outbreaks. In addition to

developing policies and procedures, the Occupational Health Nurse could help monitor the mental health and well-being of the Homes's staff. Taking steps to monitor and elevate morale among the staff will also likely have some mitigating effects on staffing turnover.

4. Communications Between the MVC Headquarters and MVC Homes

The MVC Executive Director must ensure information, guidance, policies, protocols and communications are distributed and implemented as soon as possible to the Homes. In turn, to avoid delays, each Home should designate a contact person to receive, distribute and ensure implementation of the MVC's information, guidance, policies, protocols and communications.

5. Quarantine and Isolation Practices

A necessary practice in preventing the spread of COVID-19 is to separate Veterans with confirmed or suspected cases of COVID-19 from the general Veteran community. We recommend the Homes' nursing staff transfer to an isolation area any Veteran who tests positive for COVID-19, either by PCR or rapid antigen testing. Individual staff members should be able to facilitate this transfer independently, without approval of the Medical Director or Headquarters.

If a Veteran's condition makes such a move difficult, the Veteran should be transferred to a hospital for further treatment. In any case, a Veteran who tests positive for COVID-19 should not continue to reside in an area where the Veteran cannot be isolated from Veterans who have not tested positive for COVID-19.

6. Physical Layout and Room Adjustments

To the extent possible, Veterans should be placed in private rooms with private bathrooms. Additionally, Dr. Turabelidze recommended that each Home undergo an assessment of all ventilation units with health care ventilation engineers to test the system. If possible, he also recommends HVAC systems with air exchanges of 10-12 per hour and HEPA filters with 99.9% efficiency to remove infectious particles.

The MVC should consider adjusting the room assignment of patients that frequently leave the Homes for outpatient medical care, such as for weekly dialysis treatment. To the greatest extent possible, absent other overriding infection control considerations, these high-risk patients should be

assigned to rooms near an exit to allow for easier transfers in and out of the facility. Single occupancy rooms are strongly recommended for these patients, or where not possible, the high exposure risk patients should be paired with other high exposure risk patients, near an exit.

E. Incidental Recommendations

1. Family Considerations

Some family members expressed frustration about a lack of communication from and with the Homes. Other family members feel they have no voice and that they are not receiving timely or specific information about their loved one's condition. From our investigation, this does not seem to be intentional on the part of the Homes but rather, a consequence of rapidly changing protocols in a dynamic and fluid environment. Other family members were extremely grateful for the dedication and unwavering commitment of the MVC and Homes' employees.

We understand there is a telephone number family members can call if they have issues with the Homes. We recommend better publication of the service as well as more timely response when family members call.

2. The Unintended Consequences on the Veterans of the Lockdown must be Addressed

There is another epidemic occurring in the Homes, a "slow killer" and unintended consequence of the very measures put in place to protect the Veterans from COVID-19. That is an outbreak of loneliness, isolation, depression and atrophy.[1310] The Veterans are alive, but not living. This is not consistent with the mission of the Missouri Veterans Homes.

By banning Veterans' interactions with family, much of the physical and mental care of the men and women who served this country has been lost. Not only do family members provide social, cognitive and emotional stimulation for the Veterans, family members are act as important care givers to their loved ones. Some of the many ways in which family members are instrumental in their loved ones' care include feeding or coaxing to eat, cleaning ears to help them hear better, helping them shower, providing passive range of motion, getting them out of bed, helping turn them in the bed to prevent bedsores, trimming their eyebrows, brushing their teeth, dressing them, and communicating with the medical team. Given the prohibition on family interaction, many of the Veterans' basic needs are being unmet.

Additionally, many Veterans are becoming depressed, some have stopped talking and eating, several cry, and many have suffered significant cognitive decline due to a lack of stimulation. One Veteran asked if his wife had divorced him since has not seen her in more than 6 months. Another asked if his daughter had died since he had not seen her in person. Buffy Huffman, Assistant Administrator of St. Louis, recounted the desperation of one Veteran who snuck over a fence to meet his spouse who was on the other side of the fence. Family members described their loved ones as "dying on the vine" and "isolated like a prisoner who has done terrible crimes."

The lockdown restrictions in place at the Homes, while done in an effort to physically protect the Veterans, render their existence similar to living in solitary confinement. Mt. Vernon Veteran's Council President, [redacted] stated "we feel like prisoners," a sentiment echoed by the Infection Preventionist at Cape Girardeau. [redacted] sentiments were echoed by the other Veterans with whom we spoke. [redacted], St. Louis Veterans Council President, described that the lockdown has been difficult on many of the Veterans and that, despite the lockdown, they do still need sunshine and fresh air. [redacted], President of St. James Veterans Council, described there being low morale among the Veterans. [redacted] President of Warrensburg Veterans Council described morale as "just okay" and he himself greatly misses his weekly visits with the therapy dog.

Further, physical therapy, occupational therapy and speech therapy is no longer being provided in the Homes nor are exercise classes, art classes or therapy dogs. The absence of these physically and mentally stimulating activities, is contributing to the deterioration in the Veterans' conditions. Several family members described their loved ones now being wheelchair bound where they did not need a wheelchair prior to the lockdown. Several family members also described a lack of appropriate medical care in that they cannot attend physician visits with their loved ones or Veterans who have difficulty communicating have attended virtual physician visits in which the Veteran was not able to communicate his condition and, as a result, received inappropriate care.

[redacted] also described the restrictions placed even on outside activity. At 6:00 am and 8:00 am, the Veterans are allowed out for 15 minutes. At 10:00 am, they are allowed out of their room for 45 minutes if the activities director is in attendance and there is a planned activity. At 1:00 pm, 3:00 pm, 4:00 pm, 7:00 pm, and midnight, they are allowed out for another 15 minutes. At 10:00 pm they are again allowed out for 45 minutes if they have an activity. The patio breaks used to be longer (30 minutes) but had to be cut short because a family member snuck up to see one of the

residents during a break and now they have to be "supervised" outside by a staff member to enforce the no contact rules.

Operators of long-term care facilities in general, and Administrators of these Homes specifically, are facing an incredibly difficult choice – depriving the Veterans of vital human contact and care versus inviting COVID-19 into the Home. However, in many instances, the restrictions in place at the Homes to "protect" the Veterans are having the opposite effect; they are killing the Veterans through lack of access to proper medical care, lack of exercise and mobility, lack of stimulation and lack of the loving embrace of their family.

Ms. Huffman explained the face-to-face visits allowed before this outbreak were very helpful to Veteran morale. The hand holding stations, while restrictive, also boosted Veteran morale. Our investigation revealed no instances of COVID-19 infection through these family interactions. We found no indication that allowing external visitation with proper precautions resulted in increased COVID-19 spread. In fact, in many instances the family members were practicing better social distancing and mask wearing measures in the community than were the Homes' staff members.

Thus, we recommend the Homes establish a protocol by which a limited number of designated families be allowed to visit their loved one. Doing so will provide the Veterans the contact they desperately need and will also provide the staff some relief.

To be allowed to visit, the designated family members should commit to living a COVID-19 free lifestyle outside the Home with social distancing, mask wearing, frequent hand washing, and other protocols put in place by local and state health departments. The family must also undergo appropriate education and training on the use of PPE and infection control measures. Further, the family must be subject to the same testing and screening processes of the staff and Veterans.

While there is some risk to allowing family interaction inside the Home, if proper protocols are established and enforced, the risk is no greater than a staff member reporting to work.

VI. CONCLUSION

While this investigation identified several deficiencies, it is clear the MVC Headquarters and Homes' staff genuinely care for the Veterans and are working diligently in this stressful and rapidly changing situation to protect the men and woman who have kept them safe. As expressed by one family member referring to her Veteran: "They treated him like a hero." Indeed, many family members expressed their gratitude toward the MVC and their treatment of the Veterans: "I couldn't ask for a better place for him to be," "I'm thankful my brother is where he is through this time;" and "I can't express how grateful I am that these people are there taking care of him when I can't." Missouri citizens should be proud of how their Veterans are taken care of in these unique long-term care facilities, where our inspiring men and women live out the remaining sunset of their lives.

Ordering this rapid independent external investigation is only the first step in a series of future endeavors the MVC and other external stakeholders should take in order to ensure the protection of the Veterans under their care. It is our hope that these findings and recommendations will serve as a launching point of positive change for those who deserve it the most. On behalf of our entire investigatory team we wish to express our deepest gratitude and humility in being a part of this critical mission.

APPENDIX A. TABLE OF INTERVIEWS CONDUCTED

#	NAME	FACILITY/ ORG.	POSITION/ROLE	INTERVIEW DATE
1.	Angela Baker	Mexico	Assistant Administrator	October 15, 2020
2.	Brittany Ritter	St. James	Administrator	October 15, 2020
3.	Leonard Rhine	St. Louis	Administrator	October 15, 2020
4.	Aliesha Edwards	Mexico	Administrator	October 16, 2020
5.	Buffy Huffman	St. Louis	Assistant Administrator	October 16, 2020
6.	David Hibler	Cameron	Administrator	October 17, 2020
7.	April Cutbirth	Mt. Vernon	Administrator	October 18, 2020
8.	Donna Stacye	Mt. Vernon	Assistant Administrator	October 18, 2020
9.	Stephanie Whitney	Cameron	Assistant Administrator	October 18, 2020
10.	Eric Endsley	Warrensburg	Administrator	October 19, 2020
11.	Jamie McCannon	Warrensburg	Assistant Administrator	October 19, 2020
12.	Lorie Steen	St. James	Assistant Administrator	October 19, 2020
13.	Mindi Pruitt	Cape Girardeau	Administrator	October 19, 2020 (pt. 1)
14.	Amber Hamilton	Mt. Vernon	Director of Nursing	October 20, 2020
15.	Dr. Cheryl Williams	Mt. Vernon	Medical Director	October 20, 2020
16.	Mindi Pruitt	Cape Girardeau	Administrator	October 20, 2020 (pt. 2)
17.	Tiffany Woods	Mt. Vernon	Infection Control	October 20, 2020
18.	Becky Williams	Mt. Vernon	Staff Development Coordinator	October 21, 2020
19.	Cari Paynter	Mt. Vernon	Social Worker	October 21, 2020
20.	Christine Strong	Mt. Vernon	HR Director	October 21, 2020
21.	Dawn Coats	Mt. Vernon	Food Service Manager	October 21, 2020

#	NAME	FACILITY/ ORG.	POSITION/ROLE	INTERVIEW DATE
22.	Bob Terry	St. James	Food Services Manager	October 22, 2020
23.	[redacted]	St. James	President of Residents Council	October 22, 2020
24.	Dr. Peggy Barjenbruch	Mexico	Medical Director	October 22, 2020
25.	Emily West	St. James	Director of Nursing	October 22, 2020
26.	Misty Thiel	St. James	HR Director	October 22, 2020
27.	[redacted]	Mt. Vernon	President of Residents Council	October 22, 2020
28.	Bradley Haggard	MVC	Assistant Homes Director	October 23, 2020
29.	Holly Lovel	Cape Girardeau	Human Resources	October 23, 2020
30.	Katelyn Ivie	Cape Girardeau	Staff Development Coordinator	October 23, 2020
31.	Kim Doerge	Cape Girardeau	Social Worker	October 23, 2020
32.	LeAnn Vogt	St. James	Social Worker	October 23, 2020
33.	Melissa Skinner	MVC HQ	Director of Operations	October 23, 2020 (pt. 1)
34.	Monica Bonderer	Cameron	Staff Development Coordinator	October 23, 2020
35.	Nicole Stone	Mexico	Social Worker	October 23, 2020
36.	Valerie Dredge	Cameron	Food Service Manager	October 23, 2020
37.	Daniel Leff	Cameron	Social Worker	October 24, 2020
38.	Kristen Thomas	MVC HQ	Director of Human Resources	October 24, 2020
39.	Anna Myers	Mt. Vernon	Environmental Services	October 26, 2020
40.	Brandi Hobson	St. James	Infection Prevention	October 26, 2020

#	NAME	FACILITY/ ORG.	POSITION/ROLE	INTERVIEW DATE
41.	Dawn Hammerschmidt	St. James	Staff Development Coordinator	October 26, 2020
42.	Diann Ivy	Cape Girardeau	Assistant Administrator	October 26, 2020
43.	Dr. Rachelle Gorrell	St. James	Medical Director	October 26, 2020
44.	Joan Elwing	MVC HQ	Director of Homes	October 26, 2020
45.	[redacted]	Cape Girardeau	Vice President of Residents Council	October 26, 2020
46.	Brittney Owens	Warrensburg	Social Worker	October 27, 2020
47.	[redacted]	St. Louis	President of Residents Council	October 27, 2020
48.	Emily Clark	Warrensburg	Environmental Services Director	October 27, 2020
49.	Jackie Jackson	St. Louis	Staff Development Director	October 27, 2020
50.	Janet Cook	Cape Girardeau	Custodial Manager	October 27, 2020
51.	Jean Sherrill	Cape Girardeau	Director of Nursing Infection Control	October 27, 2020
52.	Laura Weisenburger	Warrensburg	Staff Development	October 27, 2020
53.	Lisa Jewell	Warrensburg	Director of Nursing & Infection Prevention	October 27, 2020
54.	Lisa Schwierjohn	St. Louis	Clinical Case Worker	October 27, 2020
55.	Lornette Harris	St. Louis	Human Resources Manager	October 27, 2020
56.	Lvanjia White	St. Louis	Food Service Manager	October 27, 2020
57.	Melissa Skinner	MVC HQ	Director of Operations	October 27, 2020 (pt. 2)
58.	Mindi Pruitt	Cape Girardeau	Administrator	October 27, 2020 (pt. 3)
59.	Patrick Stevenson	Mexico	Director of Nursing	October 27, 2020

#	NAME	FACILITY/ ORG.	POSITION/ROLE	INTERVIEW DATE
60.	Ryan Richmond	MVC HQ	Deputy Director	October 27, 2020
61.	Aaron Cluff	MVC HQ	Emergency Management Coordinator	October 28, 2020
62.	Becky Hoover	Cape Girardeau	CNA	October 28, 2020
63.	Carolyn Jones	St. Louis	CNA	October 28, 2020
64.	Dr. Riffat Imdad	St. Louis	Medical Director	October 28, 2020
65.	Jennifer Neisler	St. Louis	Infection Prevention	October 28, 2020
66.	[redacted]	Cameron	President of Residents Council	October 28, 2020
67.	Laura Clark	Cameron	HR Specialist	October 28, 2020
68.	Lori Riddle	Mexico	Staff Development Coordinator	October 28, 2020
69.	Monica Halsey	St. Louis	Director of Nursing	October 28, 2020
70.	Pam Bach	St. James	Environmental Services	October 28, 2020
71.	Rachel Brown	Warrensburg	Human Resources Specialist	October 28 2020
72.	Vanessa Smith	Cape Girardeau	Food Service Manager.	October 28, 2020
73.	Dr. Philip Tippen	Cape Girardeau	Medical Director	October 29, 2020
74.	Ed Becker	Cameron	Director of Nursing	October 29, 2020
75.	Heather Casey	Mexico	Human Resources Specialist	October 29, 2020
76.	[redacted]	St. James	President of Residents Council	October 29, 2020
77.	Lloyd Heckman	Cameron	Custodial Supervisor	October 29, 2020
78.	Sandy Karsten	DPS	Director	October 29, 2020

#	NAME	FACILITY/ ORG.	POSITION/ROLE	INTERVIEW DATE
79.	Stephanie Harris	Warrensburg	CNA	October 29, 2020
80.	Aurora Barnett	Mt. Vernon	CNA	October 30, 2020
81.	Dr. Fred Kiehl	Cameron	Medical Director	October 30, 2020
82.	Dr. George Turabelidze	DHSS	Epidemiologist	October 30, 2020
83.	Dr. Srinath Tadakamalla	Warrensburg	Medical Director	October 30, 2020
84.	Teresa Ames	Mexico	Environmental Services Supervisor	October 30, 2020
85.	Bethany Coleman	Warrensburg	Food Service Supervisor	November 2, 2020
86.	Erin Paden	Mexico	CNA	November 2, 2020
87.	Heather Minor	Mexico	Food Service Supervisor	November 2, 2020
88.	[redacted]	Warrensburg	President of Residents Council	November 2, 2020
89.	COL. Paul Kirchhoff	MVC HQ	Executive Director	November 2, 2020
90.	Alyssa Andreae	Cameron	Infection Control	November 3, 2020
91.	Dr. Randall Williams	DHSS	Director of DHSS	November 3, 2020
92.	Adam Crumbliss	DHSS	Director, Div. of Community & Public Health	November 4, 2020
93.	Todd Richardson	MO HealthNet	Director	November 5, 2020
94.	Sarah Steelman	OA	Commissioner	November 9, 2020
95.	Cindy Dixon	OA	Director of Operational Excellence	November 9, 2020

#	NAME	FACILITY/ ORG.	POSITION/ROLE	INTERVIEW DATE
96.	Michele Renkemeyer	DSS	Director Strategic Performance and Innovations	November 9, 2020
97.	Mark Stringer	DMH	Director	November 10, 2020
98.	Dr. Angeline Stanislaus	DMH	Chief Medical Director	November 10, 2020
99.	Kerri Tesreau	DMH	Director of Autism Services	November 10, 2020

APPENDIX B. TABLE OF HOTLINE CALLS

NAME OF CALLER	RELATIONSHIP TO VETERAN	NAME OF VETERAN	HOME	DATE OF INTERVIEW
[redacted]	Son	[redacted]	Cape Girardeau	10/29/2020
	Wife		Mt. Vernon	10/29/2020
	Wife		Cape Girardeau	10/29/2020
	Wife		Warrensburg	10/29/2020
	Wife		Mt. Vernon	10/29/2020
	Daughter		St. Louis	10/30/2020
	Daughter		Cameron	10/30/2020
	Son		Mt. Vernon	10/27/2020 and 10/30/2020
[redacted]	Wife	[redacted]	Mt. Vernon	10/30/2020
	Wife		Mt. Vernon	10/30/2020
	Daughter		Cape Girardeau	10/30/2020
	Wife		Warrensburg	10/30/2020
	Daughter		Warrensburg	10/31/2020
	Son		Mexico	10/31/2020
	Daughter		Cape Girardeau	10/31/2020
	Wife		Mt. Vernon	11/2/2020
	Wife		Warrensburg	11/2/2020
Ernest Allen	Mexico Veterans Home Assistance League		Mexico	11/2/2020
[redacted]	Daughter	[redacted]	Cape Girardeau	11/2/2020
	Sister		Cape Girardeau	11/2/2020
	Wife		Cameron	11/2/2020
	Stepdaughter		Mexico	11/2/2020
	Daughter		Cameron	11/2/2020
Steve Conrad	St. James Veterans Assistance League		St. James	11/2/2020
[redacted]	Daughter	[redacted]	Warrensburg	11/2/2020
	Son		Cameron	11/2/2020
	Granddaughter		Warrensburg	11/3/2020
Darrell Quinley	Warrensburg Veterans Assistance League		Warrensburg	11/3/2020
[redacted]	Daughter	[redacted]	Cameron	11/3/2020

NAME OF CALLER	RELATIONSHIP TO VETERAN	NAME OF VETERAN	HOME	DATE OF INTERVIEW
Gary Summers	Cameron Veterans Assistance League		Cameron	11/3/2020
[redacted]	Wife	[redacted]	Cameron	11/3/2020
	Veteran Resident		Cameron	11/3/2020
	Daughter	[redacted]	Cameron	11/3/2020
Peter Zwally	Warrensburg Veterans Assistance League		Warrensburg	11/3/2020
Robert Simmons	Warrensburg Veterans Assistance League		Warrensburg	11/3/2020
Ross Chambers	Warrensburg Veterans Assistance League		Warrensburg	11/3/2020
[redacted]	Sister	[redacted]	Cape Girardeau	11/3/2020
	Son		Cameron	11/3/2020
	Brother		Cameron	11/4/2020
	Wife		Cameron	11/4/2020
[redacted]	Daughter		Mt. Vernon	11/4/2020
[redacted]	Nephew		Warrensburg	11/4/2020
Karen Shipp	Warrensburg Veterans Assistance League		Warrensburg	11/4/2020
[redacted]	Daughter	[redacted]	Mexico	11/4/2020
Lawrence Olson	Warrensburg Veterans Assistance League		Warrensburg	11/4/2020
[redacted]	Wife	[redacted]	Cape Girardeau	11/4/2020
	Granddaughter		St. James	11/4/2020
	Veteran Resident		Warrensburg	11/4/2020
Ron Azdell	Mexico Veterans Assistance League Board		Mexico	11/4/2020
[redacted]	Veteran Resident		Warrensburg	11/4/2020
Samantha Carlson	Nurse (outpatient)	Mt. Vernon residents		11/4/2020
Susan Paden	Mexico Veterans Assistance League		Mexico	11/4/2020
[redacted]	Daughter	[redacted]	Mexico	11/5/2020

NAME OF CALLER	RELATIONSHIP TO VETERAN	NAME OF VETERAN	HOME	DATE OF INTERVIEW
[redacted]	Granddaughter	[redacted]	Mt. Vernon	11/5/2020
	Daughter		Mexico	11/5/2020
	Daughter		Cameron	11/5/2020
[redacted]	Wife	[redacted]	Cape Girardeau	11/5/2020
	Son		Cameron	11/5/2020
	Son		St. James	11/5/2020
	Wife		Cameron	11/5/2020
	Son and Daughter-in-law		Cameron	11/5/2020
[redacted]	Wife	[redacted]	St. James	11/5/2020
	Ex-husband		Cameron	11/5/2020
	Wife		Warrensburg	11/5/2020
	Son		Cameron	11/5/2020
	Daughter		Mexico	11/5/2020
	Wife		Mt. Vernon	11/6/2020
	Granddaughter		St. James	11/9/2020

* Returned call and left voicemails for the following callers (name and spelling unconfirmed):

[redacted]

APPENDIX C. RECOMMENDED LISTING OF COVID-19 SPECIFIC POLICIES

PPE Use Policy And Practice	• Optimization • Inventory process • Burn rate process • Supply procurement
Universal Source Control	• Mandatory masks • Hand hygiene • Availability of alcohol-based hand disinfectant • Best practices
Veteran Placement	• Cohorts • Quarantine • Isolation • Initiation of transmission-based precaution for isolation • Discontinuation of transmission-based precaution

Physical Plan	• Setting up temporary isolation units / COVID-19 hot units
	• HVAC
	  o Air Exchange 10-12/hr. with 99% efficiency filter
	  o Retrofitting evaluation

Testing Strategy	• Staff • Veterans • Visitors • Vendors • Types of Testing (Rapid Antigen/PCR) • Testing location • Completing testing • Sample handling

	• Awaiting results • Receiving results • Testing cycle
Reporting Processes	• Test results, generally • Test results, positive for COVID-19 • Reporting structure • Internal Headquarters • Veterans and their representatives • State and local health department • Responsible persons for reporting • Who reports • Who receives report notifications • Who is responsible for reporting procedure
Community Prevalence Data	• Knowledge acquisition • Weekly positivity rates in the community • Who is responsible • Incorporate into testing as well as reporting policies • Impacts on testing policy, visitation strategy, vendor access
Memory / Specialty Care	• Nonadherence procedures
Visitation policies	• Tools for documentation, screening, cleaning, disinfection. • Cleaning procedures specifying appropriate surfaces • Screening visitors, employees, vendors • Visits with hand holding (Hygiene/PPE)
Active Screening All Shifts	• No self screening • Self specimen collection monitoring • Nasal specimen collection • Nasopharyngeal collection

	• Forms and Logging • Contact tracing
Communal Spaces	• Dining • Hallways • Recreation/Congregation • Visitation Areas
Veterans Care: Observation Care	• Negative patients • Under-Observation patients • Quarantine/Isolation Patients • Monitoring people on shift for 24 hours.
Medical Equipment	• Acquisition of • Dedicated equipment • Lack of dedicated equipment • Cleaning procedures • Aerosol-generating procedures and medications • Nebulizer, CPAP, BiPAP, Suctioning, CPR, High-level O2 requirement • Communication with practitioners re switching to metered doses and avoiding aerosol generation • Required aerosol-generating treatments: clean room, no roommate, sanitation, etc.
Cleaning Inspection	• Cleaning solution reconstitution • Package Labeling / Manufacturer guidance for viral disinfection
Staffing	• Staffing contingency plans • Pandemic contingency plan • Plan activation • Dedication assignments • COVID-19 unit dedicated staff • COVID-19 dedicated housekeeping • COVID-19 dedicated nursing

	• Determining and limiting to essential staff for COVID-19 units • Dietary required for meal delivery? • Housekeeping required? • Training nursing staff for these activities to limit staff interaction • Lack of dedicated staff • Rotation sequencing to limit exposure of negative and potentially-negative Veterans (negative unit >> observation >> positive unit) • Employee illness
Infection Control	• "Line lists" for data tracking • Infection Preventionist • Communication of infection control to internal team
Training	• Best practices • COVID-19 specific training • Overall training, Just-in-time training, Ongoing training • Training for external vendors, Veterans, family members, and compassionate care • Training new staff or crisis staff • Competency testing

APPENDIX D. LISTING OF DOCUMENTS REVIEWED

#	DOCUMENT NAME	DESCRIPTION
1	Active Employees by Org for April	List of Employees and Job Title
2	Katherine Culberston 10/30/2020 email re MVC Interviews - [redacted]	Katherine Culberston 10/30/2020 email re MVC Interviews - [redacted]
3	MVC HQ Org Chart-Aug 20 2020	MVC Organizational Chart w/job descriptions
4	Mt. Vernon - April Cutbirth 10.18.2020 email re MVC Family Member Testing	Holding Hands Communications Timeline
5	Staff Testing Procedure and Leave Guidance 10 7 20 FINAL	Staff Testing Procedure and Leave Guidance 10 7 20 FINAL
6	2020 Annual Training Agendas - Revised 10.13.20	Training Schedule and Topics for NEO Training
7	Brittany Ritter 10.16.2020 email re hand hand-holding visits	Email sending Hand-Holding directives
8	Brittany Ritter 10.16.2020 email re Infection Control Practitioner VA Report	Brittany Ritter 10.16.2020 email re Infection Control Practitioner VA Report
9	Brittany Ritter 10.16.2020 email re New Hire Quarantine	Email sending directive to discontinue 14 day quarantine for new hires that previously worked in a healthcare setting
10	Brittany Ritter 10.16.2020 email re St. James Department Heads	Email sending list of department heads and contact info
11	Brittany Ritter 10.16.2020 email re St. James Hand Station	Email sending Pic of Hand Station
12	Brittany Ritter 10.16.2020 email re St. James Timeline	Email sending Positive Corona Virus Timeline for St. James
13	Hand Holding 1 - Joan Elwing 8.11.2020 email to MVC team re State Lab_DPOA testing_Random	State Health Lab Testing for Hand Holding Visits
14	Hand Holding 2 - Joan Elwing 8.20.2020 _ 15:51 email to Rhine, Ritter and Cutbirth re COVID testing requirements	Request for COVID-19 testing at certain locations
15	Hand Holding 3 - Joan Elwing 8.20.2020 _ 15:59 email to Ritter, Cutbirth and Rhine re State Lab _ DPOA Testing _ Random	State Health Lab Testing for Hand Holding Visits
16	Infection Control Practitioner VA Report	Infection Control Practitioner VA Report
17	Positive Corona Virus Timeline - St. James	Positive Corona Virus Timeline for St. James for 9/4/2020 to 10/16/2020
18	St_James_Hand_Station	Picture of Hand Station
19	Brittany Ritter 10.16.2020 email re 2020 Annual Training Agendas - Revised 10.13.20	New Employee Orientation
20	David Hibler 10.18.2020 email re [redacted] went to CRMC	Timeline of [redacted] going to CRMC and return
21	201005 State Congregate Care Facilities Census	201005 State Congregate Care Facilities Census (Blank)
22	COVID Positive Staff and Veterans 10.10.2020	COVID Positive Staff and Veterans Tracker
23	COVID Positive Staff and Veterans 10.8.2020	COVID Positive Staff and Veterans Tracker
24	doc13402520201030073005	MVC Weekly Briefings from March 2020 to June 2020
25	doc13402620201030073031	MVC Weekly Briefings from June 2020 to

#	DOCUMENT NAME	DESCRIPTION
		October 2020
26	doc13402720201030073125	COL. Paul Kirchhoff emails
27	doc13402820201030073152	MVC Fiscal Concerns _ White Paper _ 9/22/2020
28	doc13402920201030073228	COL. Paul Kirchhoff emails
29	doc13403020201030073343	COL. Paul Kirchhoff emails
30	doc13406120201030093104 (Sandy Karsten email with screenshots of text messages to COL. Paul Kirchhoff)	Sandy Karsten email with screenshots of text messages to COL. Paul Kirchhoff
31	doc13406420201030100813 (Nathan Weinert emails)	Nathan Weinert emails
32	doc13406520201030100842 (Nathen Weinert emails)	Nathan Weinert emails
33	doc13406620201030100906 (Nathan Weinert emails)	Nathan Weinert emails
34	doc13406820201030101011 (Nathan Weinert emails)	Nathan Weinert emails
35	doc13406920201030101035 (Nathan Weinert emails)	Nathan Weinert emails
36	doc13407020201030101121 (Noonan, Karsten, Williams, Willard, Richmond, and Kirchhoff emails)	Noonan, Karsten, Williams, Willard, Richmond, and Kirchhoff emails
37	doc13407120201030101144 (MVC Commission Meeting slides 7.27.2020)	MVC Commission Meeting slides 7.27.2020
38	doc13407220201030101205 (MVC meeting slides and Paul Kirchhoff emails)	MVC meeting slides and Paul Kirchhoff emails
39	doc13407420201030101310 (Tim Noonan emails)	Tim Noonan Emails
40	doc13407520201030101342 (Tim Noonan emails and Financial Summary)	Tim Noonan emails and Financial Summary
41	doc13407620201030101415 (Tim Noonan emails and slides from Missouri Veterans Health and Care Program Oct 2020)	Tim Noonan emails and slides from Missouri Veterans Health and Care Program Oct 2020
42	doc13407720201030101432 (Tim Noonan emails)	Tim Noonan Emails
43	DPS Weekly Report 28September2020	DPS Weekly Report 28September2020
44	Judy Murray 10.30.2020 11:20 am email sending doc13407720201030101432	Judy Murray 10.30.2020 11:20 am email sending doc13407720201030101432
45	Judy Murray 10.30.2020 email sending doc13407420201030101310	Judy Murray 10.30.2020 email sending doc13407420201030101310
46	Judy Murray 10.30.2020 email sending doc13407520201030101342	Judy Murray 10.30.2020 email sending doc13407520201030101342
47	Judy Murray 10.30.2020 email sending doc13407620201030101415	Judy Murray 10.30.2020 email sending doc13407620201030101415
48	Judy Murray 10.30.2020 email sendingdoc13407120201030101144	Judy Murray 10.30.2020 email sendingdoc13407120201030101144
49	MO_COVID_Result_Template_Version8	Template for COVID Test results
50	MVC COVID Containment Plan	MVC COVID Containment Plan
51	MVC COVID Tracking _ 10.1.2020	MVC COVID Tracking
52	MVC COVID Tracking _ 10.3.2020	MVC COVID Tracking

#	DOCUMENT NAME	DESCRIPTION
53	MVC COVID Tracking _ 10.4.2020	MVC COVID Tracking
54	MVC COVID Tracking _ 9.30.2020	MVC COVID Tracking
55	Nathan Weinert 10.29.2020 email to Judy Murray re RRF-DR-4490 MVC Request for Assistance_ Cameron 09Oct20 (signed)	Nathan Weinert 10.29.2020 email to Judy Murray re RRF-DR-4490 MVC Request for Assistance_ Cameron 09Oct20 (signed)
56	Paul Kirchhoff 10.1.2020 email to various parties re MVC Cumulative Data	Paul Kirchhoff 10.1.2020 email to various parties re MVC Cumulative Data
57	Paul Kirchhoff 10.10.2020 email to various parties re MVC COVID Update October 10, 2020 (with attachment)	Paul Kirchhoff 10.10.2020 email to various parties re MVC COVID Update October 10, 2020 (with attachment)
58	Paul Kirchhoff 10.2.2020 email to various parties re SVH review report	Paul Kirchhoff 10.2.2020 email to various parties re SVH review report
59	Paul Kirchhoff 10.3.2020 email to various parties re Cumulative Data 3 Oct 20	Paul Kirchhoff 10.3.2020 email to various parties re Cumulative Data 3 Oct 20
60	Paul Kirchhoff 10.4.2020 email to Sandy Karsten re MONG Assistance	Paul Kirchhoff 10.4.2020 email to Sandy Karsten re MONG Assistance
61	Paul Kirchhoff 10.4.2020 email to various parties re MVC Cumulative Data 4 Oct 20	Paul Kirchhoff 10.4.2020 email to various parties re MVC Cumulative Data 4 Oct 20
62	Paul Kirchhoff 10.5.2020 email to Karsten, Richmond, and Skinner re MVC Onboarding	Paul Kirchhoff 10.5.2020 email to Karsten, Richmond, and Skinner re MVC Onboarding
63	Paul Kirchhoff 10.8.2020 email to various parties re MVC COVID Update 10.8.2020	Paul Kirchhoff 10.8.2020 email to various parties re MVC COVID Update 10.8.2020
64	Paul Kirchhoff 9.30.2020 email to various parties re MVC Cumulative Data	Paul Kirchhoff 9.30.2020 email to various parties re MVC Cumulative Data
65	RRF-DR-4490 MVC Request for Assistance_Cameron 09Oct20 (signed)	Resource Request Form - Requesting Temp LPNs, RNs, CNAs
66	RRF-DR-4490 MVC Request for Assistance_Warrensburg 02Oct20 (signed)	Resource Request Form - Requesting Temp LPNs, RNs, CNAs
67	Sandy Karsten 10.3.2020 email to various parties re FEMA approval for Warrensburg and Mt Vernon Homes	Sandy Karsten 10.3.2020 email to various parties re FEMA approval for Warrensburg and Mt Vernon Homes
68	Sandy Karsten 10.5.2020 email to Paul Kirchhoff re Data Request COB 5 Oct _ State Congregate Care Facilities	Sandy Karsten 10.5.2020 email to Paul Kirchhoff re Data Request COB 5 Oct _ State Congregate Care Facilities
69	Sandy Karsten 9.14.2020 email to various parties 10.29.2020 re Critical Position Exemption Request	Sandy Karsten 9.14.2020 email to various parties 10.29.2020 re Critical Position Exemption Request
70	Sandy Karsten 9.30.2020 email to Kirchhoff, Erdmann, and Willard re MVC Weekly Update for Week of September 28, 2020	Sandy Karsten 9.30.2020 email to Kirchhoff, Erdmann, and Willard re MVC Weekly Update for Week of September 28, 2020
71	SVH Review 9-29-20	Comprehensive SVH Review report
72	Rhine Leonard 10/19/2020 email re St. Louis Floor plan and Rapid test	Email with St. Louis Floor Plan
73	St. Louis floor plan _ 20201019102347655	St. Louis Floor Plan
74	3132_001 - Floor Plan of Cape Home	Floor Plan of Cape Girardeau Home
75	3169_001 _ Emails re Rapid test at Cape facility	Emails re Rapid Test at Cape Facility
76	Cape Girardeau - Time line for [redacted]	Timeline of [redacted] COVID-19 test
77	Cape Girardeau - Time line for Positive COVID	Cape Timeline Positive COVID-19 Test results

#	DOCUMENT NAME	DESCRIPTION
	Test results	of multiple people _ 7/16/2020 to 7/19/2020
78	Cape Girardeau COVID positive [redacted]	Timeline of [redacted] COVID test
79	Cape Quality Assessment- RCA minutes	RCA Cape COVID-19 - Quality Assessment - Meeting Minutes - 10/6/2002
80	Cape Veteran's Home Visit by VA	Laura Bennett, RN, CIC, 9/17/2020 (year not listed) Cape Home visit report
81	RCA Cape COVID 10.02.20 brief minutes	COVID Root Cause Analysis Conference Call Minutes for Cape - 10/2/2020
82	Skilled Care Assessment Tool 812-1238 (06-17)	Template of Skilled Care Assessment Tool for patients/residents
83	SVH Review 9-29-20 - VA report	Infection Prevention Review Results from 9/29/2020 (year not listed)
84	1.18 survey - St. James	Harry S. Truman Memorial Veterans' Hospital Recognition Survey of St. James Home
85	1397_001 - Mexico Home Survey	Harry S. Truman Memorial Veterans Annual Survey of Mexico State Veterans Home 3/26/19-3/28/19
86	2019 St James Letter signed by Director 8-6-19 FULLY MET	St. James Signed Letter
87	2019 St James SVH FINAL Survey MET 8-6-19	Department of Veterans Affairs (Standard - Nursing Home Care) Completed 1/25/2019 Survey
88	201910080835 - Warrensburg	Kansas City VA Survey of Mo. Veterans Home in Warrensburg 10/8-10/10 of 2019
89	26 October 2020 Meeting Slides pdf	10.26.20 Commission Meeting (Conference Call and Live Stream)
90	26 October 2020 Meeting Slides pdf	10.26.20 Commission Meeting (Conference Call and Live Stream)
91	Brief to CFC Sep 10	Direct Care Agency Testing "So What" Through 9.10
92	CAMERON - provided by K. Welch at MVC	Excel Spreadsheet
93	Cameron 2018 Full Compliance Letter	Kansas City VA Survey Team
94	CAMERON Staff & Contact Info - provided by K. Welch at MVC	Phone Directory Missouri Veterans Home
95	Cameron SVH Survey 2018	Department of Veterans Affairs 2018 Survey Completed 4/12/2018
96	Cameron's SVH Survey and Cert Letter April 2019	Kansan City VA'S Annual Survey 4/2/19-4/4/2019; Ltr Stating Deficiencies Sent Out 4/22/19
97	CAPE - provided by K. Welch at MVC	Spreadsheet of Recent Employment Departures
98	CAPE Staff & Contact Info - provided by K. Welch at MVC	Employees Home Telephone Numbers CG
99	Cape Survey 2018 completed	Department of Veterans Affairs Cape Girardeau's Annual Review Completed 6/28/2018
100	Cape SVH survey report	Department of Veterans Affairs Cape Girardeau's Annual Review Completed 6/20/2019
101	CDC Hand Washing Presentation V3 6OCT2020	Handwashing Slide Show

#	DOCUMENT NAME	DESCRIPTION
102	CEMETERIES - provided by K. Welch at MVC	Recent Departures and Reasons
103	CEMETERIES Staff & Contact Info- provided by K. Welch at MVC	Employment Contact Information (Bloomfield, Higginsville, Jacksonville, Fort Leonard Wood, and Springfield
104	CFC Begin Portal	Email Correspondence re COVID Testing Status Updates (Attached Testing Trackers)
105	CFC Begin Reporting	Email Correspondence re 2 Positive Staff Members
106	Corrected survey letter - Warrensburg	Kansas City VA Annual Survey 10/8/2019 - 10/10/2019 With Needed Corrections
107	COVID Response Communications Plan REVISED 19OCT2020	COVID 19 Response Plan
108	COVID-19-Prevention-Audit-Tool	COVID Prevention & Outbreak Management Audit Tool for Long-Term Care
109	Daily Cleaning Inspection Form	Daily Cleaning Checklist
110	Daily COVID Report to HQ	Daily COVID Tracker
111	Dashboard Daily COVID Report to HQ	Daily COVID Tracker
112	DIRECTOR NURSING SERVICES Job Description	Mo. Veterans Home Nursing Director Job Synopsis
113	Donning & Doffing Step by Step	Putting on PPE instructions
114	file_sdvdfilp1930.state.mo.us_PB_jelwing_Desktop_Guidance%20f (2)	CDC Guidance for SARS-CoV-2 Point-of-Care-Testing _ 10/14/2020
115	file_sdvdfilp1930.state.mo.us_PB_jelwing_Desktop_Guidance%20f (3)	CDC Guidance for SARS-CoV-2 Point-of-Care-Testing _ 10/14/2020
116	Final CAP - POC - Warrensburg	Ltr dated 11/16/29 encl Veteran's Home Survey Report/Plan of Correction - October 2019
117	Full Certification from MCD 7-12-2019 - Cape	Ltr re Cape Home Survey results 2019
118	Full Certification letter from MCD 2018 - Cape	Ltr Cape Home Survey results 2018
119	FW MVC Family Member Testing (2)	Memo re Testing of Family Members
120	HQ - provided by K. Welch at MVC	List of Recent employee departures
121	HQ ADMINISTRATOR Job Description	Administrator Job Description
122	HQ Assistant Administrator Job Description	Administrative Manager Job Description
123	HQ Assistant Director of Nursing Job Description	Registered Nurse Specialist/Supervisor Job Description
124	HQ Contact List	Contact List
125	HQ Contact List	Contact List
126	HQ COVID Response Communications Plan REVISED 19OCT2020	Communications Plan
127	HQ DIRECTOR NURSING SERVICES Job Description	Director Nursing Job Description
128	HQ FW MVC Family Member Testing	Plan to test Family Members
129	HQ Contact List	Contact List
130	HQ MVC_EOP_COOPCOG_MASTER	Emergency Operations Program and Plan Manual
131	HQ Staff & Contact Info - provided by K. Welch at MVC	List of Staff and contact info

#	DOCUMENT NAME	DESCRIPTION
132	HQ STAFF DEVELOPMENT COORDINATOR Job Description	Registered Nurse Specialist/Supervisor Job Description
133	Infection Control Log	Infection Control Log
134	Infection Control Log (2)	Infection Control Log
135	Infection Control Surveillance Tool 12.09 revised 04.03.19	Infection Control Checklist
136	Isolation Cameron 9.19.20	Floor Plan for Cameron
137	Isolation Cape Girardeau 9.23.20	Floor Plan for Cape
138	Isolation Mexico 9.22.20	Floor Plan for Mexico
139	Isolation Mt. Vernon 9.22.20	Floor Plan for Mt. Vernon
140	Isolation St. James 9.28.20	Floor Plan for St. James
141	Isolation St. Louis 9.23.20	Floor Plan for St. Louis
142	Isolation Warrensburg 9.19.20	Floor Plan for Warrensburg
143	MEXICO - provided by K. Welch at MVC	Quarterly departures and reasons
144	MEXICO Staff & Contact Info - provided by K. Welch at MVC	Contact List for Mexico
145	MVC PPE Training Protocols	PPE Training Protocols
146	MT. VERNON - provided by K. Welch at MVC	Quarterly departures and reasons
147	MT. VERNON Staff & Contact Info - provided by K. Welch at MVC	Contact list for Mt. Vernon
148	MtVernon2019 finished survey	Survey
149	MVC Test Status Template 6.08.20	Daily testing report
150	MVC Test Status Template 6.15.20	Daily testing report
151	MVC Test Status Template 6.22.20	Daily testing report
152	MVC Test Status Template 6.29.20	Daily testing report
153	MVC Test Status Template 7.06.20	Daily testing report
154	MVC Test Status Template 7.13.20	Daily testing report
155	MVC Test Status Template 7.13.20_2	Daily testing report
156	MVC Test Status Template 7.20.20	Daily testing report
157	MVC Test Status Template 7.21.20	Daily testing report
158	MVC Test Status Template 7.22.20	Daily testing report
159	MVC Test Status Template 7.23.20	Daily testing report
160	MVC Test Status Template 7.24.20	Daily testing report
161	MVC Test Status Template 7.27.20	Daily testing report
162	MVC Test Status Template 7.28.20	Daily testing report
163	MVC Test Status Template 7.29.20	Daily testing report
164	MVC Test Status Template 7.30.20	Daily testing report
165	MVC Test Status Template 7.31.20	Daily testing report
166	MVC Test Status Template 8.03.20	Daily testing report
167	MVC Test Status Template 8.04.20	Daily testing report
168	MVC Test Status Template 8.05.20	Daily testing report
169	MVC Test Status Template 8.06.20	Daily testing report
170	MVC Test Status Template 8.07.20	Daily testing report

#	DOCUMENT NAME	DESCRIPTION
171	MVC Test Status Template 8.10.20	Daily testing report
172	MVC Test Status Template 8.11.20	Daily testing report
173	MVC Test Status Template 8.12.20	Daily testing report
174	MVC Test Status Template 8.13.20	Daily testing report
175	MVC Test Status Template 8.14.20	Daily testing report
176	MVC Test Status Template 8.17.20	Daily testing report
177	MVC Test Status Template 8.18.20	Daily testing report
178	MVC Test Status Template 8.19.20	Daily testing report
179	MVC Test Status Template 8.20.20	Daily testing report
180	MVC Test Status Template 8.21.20	Daily testing report
181	MVC Test Status Template 8.24.20	Daily testing report
182	MVC Test Status Template 8.25.20	Daily testing report
183	MVC Test Status Template 8.26.20	Daily testing report
184	MVC Test Status Template 8.27.20	Daily testing report
185	MVC Test Status Template 8.28.20	Daily testing report
186	MVC Test Status Template 8.31.20	Daily testing report
187	MVC Test Status Template 9.01.20	Daily testing report
188	MVC Test Status Template 9.02.20	Daily testing report
189	POC Acceptance Letter - Mt. Vernon	ltr re Mt. Vernon survey results and Corrective Action Plan
190	Poster 197768_36x24_NO BLEED_GRACE LINK_FINAL_JB	COVID Prevention guide
191	Poster 197768_contact-precautions-sign_24x36_PROOF 1_JB	Contact Precautions
192	Poster 197768_covid-19-doffing-step-by-step_12.75X36_PROOF1 _JB	PPE Doffing Instructions
193	Poster 197768_DHSS_novel-coronavirus-factsheet_36x24_JB	Missouri Department of Health and Senior Services Novel Coronavirus fact sheet
194	Poster 197768_droplet-precautions-sign_24x36_PROOF 1_JB	CDC Droplet Precautions sign
195	Poster 197768_PPE healthcare poster_24x36_PROOF 1_PROOF 1_JB	CDC PPE poster
196	Poster 197768_PPE-Sequence-508_15.25X36_PROOF 1_JB	CDC PPE instructions
197	Poster 197768_share facts poster_24x36_PROOF 1_JB	CDC COVID-19 Facts
198	Poster 197768_Stop germs poster_24x36_PROOF 1_JB	CDC Stop Germs Poster
199	Poster 197768_UnderstandDifferenceInfographic-508_24x36_PROOF 1_JB	CDC Mask difference
200	Poster 197768_Wash Your Hands poster_24x36_PROOF 1_JB	CDC Hand Washing Poster
201	ST. JAMES - provided by K. Welch at MVC	St. James Recent Departures and Reasons
202	St. James Coronavirus Daily Tracking September	St. James Coronavirus Daily Tracking September
203	ST. JAMES Staff & Contact Info - provided by K.	St. James Contact Info

#	DOCUMENT NAME	DESCRIPTION
	Welch at MVC	
204	ST. LOUIS - provided by K. Welch at MVC	St. Louis Recent Departures and Reasons
205	St. Louis Coronavirus Daily Tracking September	St. Louis Coronavirus Daily Tracking September
206	ST. LOUIS Staff & Contact Info - provided by K. Welch at MVC	St. Louis Staff Contact List
207	Staff Testing Procedure and Leave Guidance 10 7 20 FINAL	Staff Testing Procedure and Leave Guidance 10 7 20 FINAL
208	STL SVH CAP Report FY 18 Final	St. Louis Survey Results 2018
209	STL SVH Full Certification Report	St. Louis Survey Results 2019
210	STL SVH Full Certification 2018	ltr re St. Louis Survey and Corrective Action 2018
211	STL SVH Full Certification Letter 2019	ltr re St. Louis Survey and Corrective Action 2019
212	STL SVH Survey FY18	St. Louis Survey Results 2018
213	Survey and Cert Letter - Mexico Home	ltr re Mexico Survey 2018
214	Survey Documentation - Warrensburg	Warrensburg Survey results 2020
215	TIME LINE MVH COVID-19 Timeline and Communication MVH update 3.6.20 (AutoSaved)	Coronavirus/COVID-19 Plan and agency Timeline
216	Training 102A-EvSBasic ICP_Learner Slides	Basic Principles of Infection Control for Environmental Services Technicians (EVS)
217	Training Associated Infections Program Adherence Monitoring Tool	Checklist
218	Training CDC Hand Washing Presentation V3 6OCT2020	Training CDC Hand Washing Presentation
219	Training COVID-19-Prevention-Audit-Tool	COVID-19-Prevention-Audit-Tool
220	Training Daily Cleaning Inspection Form	Daily Cleaning Inspection Form
221	Training Donning & Doffing Step by Step	PPE Instructions
222	Training file_sdvdfilp1930.state.mo.us_PB_jelwing_Desktop_Guidance%20f	CDC Guidance for SARS-CoV-2 Point-of-Care-Testing _ 10/14/2020
223	Training Infection Control Surveillance Tool 12.09 revised 04.03.19	Infection Control Surveillance Tool 12.09 revised 04.03.19
224	Training MVC PPE Training Protocols	MVC PPE Training Protocols
225	Training PPE-Competency-SPICErev-1-EC02272020	PPE Checklist
226	VA Full Cert Letter scan 3.23.20 - St. James	ltr re St. James Survey 2020
227	VA Results 2018 - Mt. Vernon	ltr re Mt. Vernon Survey 2018
228	VA Survey Report 2018 - Warrensburg	ltr re Warrensburg Survey 2018
229	VA Survey SOD St James	ltr re St. James Survey 2020
230	VSP - provided by K. Welch at MVC	Recent Departures and Reasons
231	VSP Staff & Contact Info - provided by K. Welch at MVC	Contact List
232	WARRENSBURG - provided by K. Welch at MVC	Warrensburg contact list
233	Warrensburg 2019 survey	ltr re Cameron Survey 2019
234	Warrensburg For Cause Full Certification Letter LH	ltr Warrensburg Survey 2020

#	DOCUMENT NAME	DESCRIPTION
235	WARRENSBURG Staff & Contact Info - provided by K. Welch at MVC	Warrensburg contact list
236	COOPCOG_MVC	Continuity of Operations Plan/Continuity of Government _ December 2019
237	Daily COVID Report to HQ - 11.3.2020	Daily COVID Report to HQ - 11.3.2021
238	Kathryn Welch 11.5.2020 email re Family member [redacted]	Kathryn Welch 11.5.2020 email re Family member [redacted]
239	MVC HQ Emergency Manual	MVC HQ Emergency Manual 1/6/2020
240	MVC Testing Tracker Grp 1	MVC Testing Tracker Grp 1
241	MVC Testing Tracker Grp 2	MVC Testing Tracker Grp 1
242	MVC Tracking 10.05.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
243	MVC Tracking 10.05.20 Staff Call - Morning	MVC COVID-19 Update Meeting
244	MVC Tracking 10.06.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
245	MVC Tracking 10.06.20 Staff Call - Morning	MVC COVID-19 Update Meeting
246	MVC Tracking 10.07.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
247	MVC Tracking 10.07.20 Staff Call - Morning	MVC COVID-19 Update Meeting
248	MVC Tracking 10.08.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
249	MVC Tracking 10.08.20 Staff Call - Morning	MVC COVID-19 Update Meeting
250	MVC Tracking 10.09.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
251	MVC Tracking 10.09.20 Staff Call - Morning	MVC COVID-19 Update Meeting
252	MVC Tracking 10.26.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
253	MVC Tracking 10.26.20 Staff Call - Morning	MVC COVID-19 Update Meeting
254	MVC Tracking 10.27.20 Staff Call - Morning	MVC COVID-19 Update Meeting
255	MVC Tracking 10.28.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
256	MVC Tracking 10.28.20 Staff Call - Morning	MVC COVID-19 Update Meeting
257	MVC Tracking 10.29.20 Staff Call - Morning	MVC COVID-19 Update Meeting
258	MVC Tracking 10.30.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
259	MVC Tracking 10.30.20 Staff Call - Morning	MVC COVID-19 Update Meeting
260	MVC Tracking 8.28.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
261	MVC Tracking 8.28.20 Staff Call - Morning	MVC COVID-19 Update Meeting
262	MVC Tracking 8.3.20 internal slide	MVC COVID-19 Update Meeting
263	MVC Tracking 8.3.20 Staff Call Afternoon	MVC COVID-19 Update Meeting
264	MVC Tracking 8.4.20 Staff Call	MVC COVID-19 Update Meeting
265	MVC Tracking 8.5.20 internal slide	MVC COVID-19 Update Meeting
266	MVC Tracking 8.5.20 Staff Call	MVC COVID-19 Update Meeting
267	MVC Tracking 8.6.20 internal slide	MVC COVID-19 Update Meeting
268	MVC Tracking 8.6.20 Staff Call	MVC COVID-19 Update Meeting
269	MVC Tracking 8.7.20 internal slide	MVC COVID-19 Update Meeting
270	MVC Tracking 8.7.20 Staff Call	MVC COVID-19 Update Meeting
271	MVC Tracking 8.8.20 internal slide	MVC COVID-19 Update Meeting
272	MVC Tracking 8.8.20 Staff Call	MVC COVID-19 Update Meeting
273	MVC Tracking 9.07.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
274	MVC Tracking 9.07.20 Staff Call - Morning	MVC COVID-19 Update Meeting

#	DOCUMENT NAME	DESCRIPTION
275	MVC Tracking 9.08.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
276	MVC Tracking 9.08.20 Staff Call - Morning	MVC COVID-19 Update Meeting
277	MVC Tracking 9.09.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
278	MVC Tracking 9.09.20 Staff Call - Morning	MVC COVID-19 Update Meeting
279	MVC Tracking 9.10.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
280	MVC Tracking 9.10.20 Staff Call - Morning	MVC COVID-19 Update Meeting
281	MVC Tracking 9.11.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
282	MVC Tracking 9.11.20 Staff Call - Morning	MVC COVID-19 Update Meeting
283	MVC Tracking 9.12.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
284	MVC Tracking 9.21.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
285	MVC Tracking 9.21.20 Staff Call - Morning	MVC COVID-19 Update Meeting
286	MVC Tracking 9.22.20 Staff Call - Morning	MVC COVID-19 Update Meeting
287	MVC Tracking 9.23.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
288	MVC Tracking 9.23.20 Staff Call - Morning	MVC COVID-19 Update Meeting
289	MVC Tracking 9.24.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
290	MVC Tracking 9.24.20 Staff Call - Morning	MVC COVID-19 Update Meeting
291	MVC Tracking 9.25.20 Staff Call - Afternoon	MVC COVID-19 Update Meeting
292	MVC Tracking 9.25.20 Staff Call - Morning	MVC COVID-19 Update Meeting
293	MVH - Cape Girardeau COVID-19 Outbreak Final Review 10.20.20 (003)	MVH - Cape Girardeau COVID-19 Outbreak Final Review 10.20.20 (003)
294	Tableau Dashboard	Tableau Dashboard
295	Cameron 20201020133534729	Visit Screening forms
296	Cameron 20201020135222715	Visit Screening forms 9/4/2020
297	Cameron 8.10.20 Visits	Visit Screening forms
298	Cameron 8.11.20 visits	Visit Screening forms
299	Cameron 8.12.20 visits	Visit Screening forms
300	Cameron 8.13.20 visit	Visit Screening forms
301	Cameron 8.13.20 visits	Visit Screening forms
302	Cameron 8.14.20 visits	email sending Visit Screening forms
303	Cameron 8.15 visits	Visit Screening forms
304	Cameron 8.15.20 Visits	Visit Screening forms
305	Cameron 8.17.20 Visits	Visit Screening forms
306	Cameron 8.17.20.2 Visits	Visit Screening forms
307	Cameron 8.20.20 Visits	Visit Screening forms
308	Cameron 8.22.20	Visit Screening forms
309	Cameron 8.23.20	Visit Screening forms
310	Cameron 8.24.20 Visits	Visit Screening forms
311	Cameron 8.25.20 Visits	Visit Screening forms
312	Cameron 8.27.20 visits	Visit Screening forms
313	Cameron 8.27.20 Visits.2	Visit Screening forms
314	Cameron 8.29.20 visits	Visit Screening forms
315	Cameron 8.30.20 visits	Visit Screening forms

#	DOCUMENT NAME	DESCRIPTION
316	Cameron 8.31.20 visits	Visit Screening forms
317	Cameron 8.4.20	Visit Screening forms
318	Cameron 8.5.20	Visit Screening forms
319	Cameron 8.7.20 visits	Visit Screening forms
320	Cameron 8.8.20 visits	Visit Screening forms
321	Cameron 8.9.20 visits	Visit Screening forms
322	Cameron 9.1.20	Visit Screening forms
323	Cameron 9.1.20.2	Visit Screening forms
324	Cameron 9.11.20 visits	Visitor Logs and Screening sheets
325	Cameron 9.12.20	Visitor Logs and Screening sheets
326	Cameron 9.13.20	Visitor Logs and Screening sheets
327	Cameron 9.14.20	Visitor Logs and Screening sheets
328	Cameron 9.15.20	Visitor Logs and Screening sheets
329	Cameron 9.17.20	Visitor Logs and Screening sheets
330	Cameron 9.18.20 visits	Visitor Logs and Screening sheets
331	Cameron 9.19.20	Visitor Logs and Screening sheets
332	Cameron 9.20.20	Visitor Logs and Screening sheets
333	Cameron 9.21.20 visits	Visitor Logs and Screening sheets
334	Cameron 9.22.20 visits	Visitor Logs and Screening sheets
335	Cameron 9.24 Hand Holding	Visitor Logs and Screening sheets
336	Cameron 9.24 visits	Visitor Logs and Screening sheets
337	Cameron 9.25 visits	Visitor Logs and Screening sheets
338	Cameron 9.25.20 visits	Visitor Logs and Screening sheets
339	Cameron 9.26 visits	Visitor Logs and Screening sheets
340	Cameron 9.3.20 Visits	Visit Screening forms
341	Cameron 9.4.20 visit	email sending Visit Screening forms
342	Cameron 9.5.20	Visitor Logs and Screening sheets
343	Cameron 9.6.20	Visitor Logs and Screening sheets
344	Cameron 9.7.20	Visitor Logs and Screening sheets
345	Cameron 9.8.20	Visitor Logs and Screening sheets
346	Cameron August 2020 Register	List of Admissions and discharges (expired)
347	Cameron August Nursing Schedule	Cameron August Nursing Schedule
348	Cameron August Schedule	Cameron August Employee Schedule
349	Cameron August Staffing Sheets	Cameron August Staffing Sheets
350	Cameron August Town Hall	Meeting sign in sheet and slides
351	Cameron August Visitor Logs	Visitor Logs and Screening sheets
352	Cameron Clinical_ProgressNotesReport	Social Services Progress Notes
353	Cameron Coronavirus Daily Tracking August	Coronavirus daily tracker
354	Cameron Coronavirus Daily Tracking September	Coronavirus daily tracker
355	Cameron October 2020 Register	List of patients that expired
356	Cameron October Town Hall	Town Hall Meeting Sign-in sheet and Presentation

#	DOCUMENT NAME	DESCRIPTION
357	Cameron September 2020 Register	List of patient admissions and discharges (expired)
358	Cameron September Town Hall	Town Hall Meeting Sign-in sheet and slides
359	Cameron SPECIAL AIRBORNE CONTACT PRECAUTIONS	Special Airborne/Contact Precautions
360	Cameron8.6.20 visits	Visitor Logs and Screening sheets
361	Dashboard Cameron Coronavirus Daily Tracking August	Coronavirus Daily Tracker
362	Dashboard Cameron Coronavirus Daily Tracking September	Coronavirus Daily Tracker
363	ORG CHART CAMERON 7 2020	Job organization chart
364	A WING COVID MAP (provided by Jean Sherrill)	Map COVID Wing in Cape Girardeau
365	Cape Girardeau 2020 BTO	Presentation or Training Schedule
366	Cape Girardeau 3.24.20 INCREASED OBSERVATION POST HOSPITALIZATION	Instructions for Veterans that are hospitalized
367	Cape Girardeau 5.11.20 New instructions	Memo - new instructions
368	CAPE GIRARDEAU 8 2020	Job organization chart
369	Cape Girardeau A WING COVID MAP	A-Wing Floor plan
370	Cape Girardeau Cape - signed inservices	Employee Training Record and sign-in sheet
371	Cape Girardeau Cape 08.25.20 - 09.30.20 staffing	Daily Staffing Sheets
372	Cape Girardeau Cape August staffing	Daily Staffing Sheets
373	Cape Girardeau Cape HR policies 03.07.20	Risk Guidance for COVID-19; ltr stating to temporary suspend employees second employment (if they have any) and various emails
374	Cape Girardeau Cape HR policies updated 3.16.2020	Update to HR Policies to include COVID-19 policies - 3/16/2020
375	Cape Girardeau Cape isolation - quarantine staffing	Spreadsheet of schedules July and Aug 2020 (year is a guess)
376	Cape Girardeau Cape October staffing	Daily Staffing Sheets
377	Cape Girardeau Cape pharmacist nebulizer	Emails re Nebulizer April 2020 time frame
378	Cape Girardeau Cape policies related to breaks	Policies related to Breaks
379	Cape Girardeau CMS-20081 Respiratory Care	Request to Dept of Health and Human Services and Medicare and Medicaid for Respiratory Care (blank)
380	Cape Girardeau Copy of Infection Control Surveillance Tool 12.09 revised 04.03.19	Infection Control Surveillance Tool; checklist of employee tasks
381	Cape Girardeau Coronavirus Daily Tracking August	Coronavirus daily tracker
382	Cape Girardeau Coronavirus Daily Tracking September	Coronavirus daily tracker
383	Cape Girardeau Deaths Admission 8.1.20 - 10.19.20	List of patient admissions and discharges (expired)
384	Cape Girardeau DNS AGENDA Cape Girardeau 3.31.20	Meeting Agenda
385	Cape Girardeau FW Isolation room schedule	Email chain re Isolation room schedule (one email was March 2020, the other was October 2020)

#	DOCUMENT NAME	DESCRIPTION
386	Cape Girardeau FW encrypt First two scripts for Fam Calls	Emails re Notifying families that Veteran tested positive for COVID
387	Cape Girardeau Guideline for Coronavirus testing from HQ 3.23.20	Protocol for Veterans with Respiratory infection signs and symptoms
388	Cape Girardeau Infection Control Worksheet2020 March	spreadsheet of patients with certain infections
389	Cape Girardeau Infection Control Worksheet2020 April	spreadsheet of patients with certain infections
390	Cape Girardeau Infection Control Worksheet2020 July	spreadsheet of patients with certain infections
391	Cape Girardeau Infection Control Worksheet2020 June	spreadsheet of patients with certain infections
392	Cape Girardeau Infection Control Worksheet2020 May	spreadsheet of patients with certain infections
393	Cape Girardeau NEO.BTO 2020	NEO agenda (missing)
394	Cape Girardeau Veteran COVID-19 Testing Plan (002)	Training Veterans for COVID-19 Procedure
395	Cape Girardeau Visitor logs - Cape	Visitor Temperature Log. Dates are in Aug and Sept
396	Dashboard Cape Girardeau Coronavirus Daily Tracking August	Coronavirus Tracker
397	Dashboard Cape Girardeau Coronavirus Daily Tracking September	Coronavirus Tracker
398	Employees Communication Cape Girardeau Timeline	Employee daily communication 3/16/2020
399	Jean Sherrill 10/27/2020 email re Map of Cape	Email attaching Map of COVID-19 Wing in Cape Girardeau
400	MVC Tracking 10.28.20 Staff Call - Afternoon - Cape Girardeau	COVID-19 Update Meeting
401	ORG CHART CAPE GIRARDEAU 8 2020	Employee Organization Chart
402	Positive Case Checklist	Positive Case Checklist (blank)
403	Dashboard Mexico Coronavirus Daily Tracking August	Coronavirus Tracker
404	Dashboard Mexico Coronavirus Daily Tracking September	Coronavirus Tracker
405	H1N1 Plan from 2009 (used by DON at Mexico facility as a guide for COVID)	H1N1 Plan from 2009 (used by DON at Mexico facility as a guide for COVID)
406	Mexico - MVC Tracking 9.25.20 Staff Call - Afternoon	COVID-19 Update Meeting
407	MEXICO 8 2020	Employee Organization Chart
408	Mexico Afternoon Staff Call Reference Slides	Aaron Cluff 9/25/2020 email to various parties re Afternoon Staff Call Reference Slides
409	Mexico Coronavirus Daily Tracking August	Coronavirus Tracker
410	Mexico Coronavirus Daily Tracking September	Coronavirus Tracker
411	Mexico Covid PPE SOP (08-19-2020)	Standard Operating Procedure for COVID PPE
412	Mexico COVID-19 Focused Survey for Nursing Homes- Mt Vernon 10.8.20	Survey results

#	DOCUMENT NAME	DESCRIPTION
413	Mexico Document Request 10.16.2020 Pathway Homes	Document request from Pathway
414	Mexico file_sdvdfilp1930.state.mo.us_PB_jelwing_Desktop _Guidance%20f	CDC Guidance for SARS-CoV-2 Point-of-Care-Testing _ 10/14/2020
415	Mexico FW MVC Family Member Testing	April Cutbirth 10/18/2020 email to Joan Elwing re MVC Family Member Testing (hand holding stations)
416	Mexico Homes Antigen Reporting Requirements	Guidance on Antigen Testing/Reporting
417	Mexico Homes Antigen Reporting Requirements	Guidance on Antigen Testing/Reporting
418	Mexico MDS FAQ Document for MO 9-25-20 version	FAQ Document for Missouri NHs Concerning 10/1/20 MDS Changes
419	Mexico MDS FAQ Document for MO 9-25-20 version	FAQ Document for Missouri NHs Concerning 10/1/20 MDS Changes
420	Mexico MVC Tracking 8.14.20 Staff Call - Afternoon	COVID-19 Update Meeting
421	Mexico MVC Tracking 8.14.20 Staff Call - Afternoon	COVID-19 Update Meeting
422	Mexico SLS6008P_Infection Prevention Guide to Long-Term C (1)	Infection Prevention Guide to Long-Term Care
423	Mexico Visitor Logs - August 11th thru August 25st - 10.20.2020 - Copy	Visitor Temperature Log
424	Mexico Visitor Logs - August 26th thru August 31st - 10.20.2020	Visitor Temperature Log
425	Mexico Visitor Logs - August 3rd thru August 5th - 10.20.2020 - Copy	Visitor Temperature Log
426	Mexico Visitor Logs - August 6th thru August 10th - 10.20.2020 - Copy	Visitor Temperature Log
427	Mexico Visitor Logs - July 14th thru July 16th - 10.20.2020	Visitor Temperature Log
428	Mexico Visitor Logs - July 17th thru July 20th - 10.20.2020	Visitor Temperature Log
429	Mexico Visitor Logs - July 1st thru July 3rd - 10.20.2020	Visitor Temperature Log
430	Mexico Visitor Logs - July 6th thru July 7th - 10.20.2020	Visitor Temperature Log
431	Mexico Visitor Logs - July 9th thru July 10th - 10.20.2020	Visitor Temperature Log
432	Mexico Visitor Logs - September 1st thru September 2nd - 10.20.2020	Visitor Temperature Log
433	Mexico Visitor Logs - September 29th thru September 30th - 10.20.2020	Visitor Temperature Log
434	Mexico Visitor Logs - September 3rd thru September 28th - 10.20.2020	Visitor Temperature Log
435	ORG CHART MEXICO 8 2020	Employee Organization Chart
436	OSHA Appendix C - Fit Testing	OSHA respirator Medical Evaluation Questionnaire
437	Veteran and Staff Positive Log	Veteran and Staff Positive COVID-19 tracking log

#	DOCUMENT NAME	DESCRIPTION
438	Acknowledgement form	COVID-19 CDC Videos Acknowledgement Form
439	Associated Infections Program Adherence Monitoring Tool	Fluorescent Marker Assessment Tool (blank)
440	best-hospitals19-20@1x	Unable to open
441	Binax check in sheet - Employee's (002)	Employee Temperature Log (blank)
442	checklist-n95-strategy-h	CDC Strategies for Optimizing the Supply of N95 Respirators during COVID-19 Response
443	common-questions-3m-n95-particulate-respirator-surgmask	3M Health Care Particulate Respirator and Surgical Mask Commonly Asked Questions
444	Copy of Binax check in sheet - Employee's (002)	Employee Temperature Log (blank)
445	Copy of Covid Related Time Tracker	Copy of Covid Related Time Tracker
446	Copy of Isolation- quarantine log	Copy of Isolation- quarantine log
447	Copy of Sign In Log	Copy of Sign In Log
448	cover ur cough	Cover Your Cough poster/sign
449	COVID 19 DAILY REPORT	COVID-19 Daily Report (blank)
450	Covid PPE SOP (08-19-2020)	COVID PPE Standard Operating Procedure
451	covid rapid test guide	COVID Rapid Test Guide
452	COVID vs. Flu, Cold	COVID v. Flue v. Allergies comparison
453	COVID-19 Positive Resident Questionnaire Final	COVID-19 Positive Resident Questionnaire Final
454	COVID-19 Positive Staff Questionnaire Final	COVID-19 Positive Staff Questionnaire Final
455	COVID-19 resources for providers Nebraska Medicine Omaha, NE	Cannot Open. Appears to be an internet link
456	COVID-19 short videos all staff (002)	COVID-19 Annual Training presentation _ August 2020
457	COVID-19-poster	Attention Visitors poster re COVID-19 Precautions
458	COVID-19-Prevention-Audit-Tool	COVID Prevention and Outbreak Management Audit Tool for Long-Term Care (blank)
459	COVID19-symptoms	CDC poster/sign re COVID-19 Symptoms
460	CPAP and Neb treatments direction	New Direction related to Veterans with CPAP and Nebulizer treatments
461	css	Unable to open
462	css(1)	Unable to open
463	css_87GMcmxT1ib8ziQiU2KUAnTDFtZQV6iP-KGslA9LigM	Unable to open
464	css_QMDA3gcnD4GjsMYIymw5Dl3e10rlCq2itWoVFlMRiac	Unable to open
465	Daily Cleaning Inspection Form	Daily Cleaning Inspection Form (blank)
466	DIRTY GOGGLES	"Discard Dirty Goggles Here" sign
467	Do Not Enter 2	"Restricted Area" Sign
468	Donning & Doffing Step by Step	PPE Instructions
469	do-not-enter-notice-sign-s-0912	"Do not Enter" sign
470	Door closed	Sign "Notice Keep this Door Closed at All Times"

#	DOCUMENT NAME	DESCRIPTION
471	Door Closed With Tx	"Keep Door Closed" sign
472	droplet-precautions-sign-P	Droplet Precautions Sign
473	droplet-precautions-sign-P (002)	Droplet Precautions Sign
474	Flyer for Mini Webinar Series- COVID-19 Prevention Training for Long-Term Care Staff	Flyer for Mini Webinar Series- COVID-19 Prevention Training for Long-Term Care Staff
475	Google cleaning DUR	Goggle Cleaning Instructions
476	grunticon.loader	Unable to open
477	Handwashing-Middle-School-8x11-p	CDC Handwashing poster/sign
478	Infection Control Surveillance Tool 12.09 revised 04.03.19	Infection Control checklist (blank)
479	infographic-cdc-protects-508	CDC poster/sign re CDC is aggressively responding COVID-19
480	ISO	Phone Directory of MVC Personnel
481	Isolation Rooms or Areas	Instructions for Isolation Rooms or areas
482	ISO-Q phone numbers	Phone Directory of MVC Personnel
483	Johnetta Morton Fit testing 3-13-2020	N95 Respirator Fitting form for Johnetta Morton
484	Joseph Blessing Fit testing 3-13-2020	N95 Respirator Fitting form for Joseph Blessing
485	js	Unable to open
486	js__Jr1XdVYRsG5tdmr4ZKef9hVwDgmcK1Ri6SdfvPivpw	Unable to open
487	js_fDeCvIfsDuJ1Kke9urMwbfpMnHMm68dKJwSyPYGPqWQ	Unable to open
488	Karen Sartain Fit testing 3-13-2020	N95 Respirator Fitting form for Karen Sartain
489	Katie Allison Fit testing 3-13-2020	N95 Respirator Fitting form for Katie Allison
490	KeyFactorsRequiedResp01042018-508	CDC Instructions re Effective Respirator
491	Kortnie Pearson Fit testing 3-13-2020	N95 Respirator Fitting form for Kortnie Pearson
492	LTC-Resp-OutbreakResources-P	Instructions for the Long-Term Care Respiratory Surveillance Line List
493	Mandy Totten fit testing 3-13-2020	N95 Respirator Fitting form for Mandy Totten
494	Mark Kirkwood fit testing 3-13-2020	N95 Respirator Fitting form for Mark Kirkwood
495	Mask Effectiveness	List of Different Masks' Effectiveness percentages
496	mask-illustrationMisRep	Picture showing Exterior Markings on Respirator
497	mask-wearing-guide-e1580353261286	Picture of N95 respirator Wearing Guide
498	MED NURSE cleaning	Med Nurse/CMT ISO Cleaning Responsibilities
499	Medical Screens 07.31-08.13	Medical Screens 07.31-08.14
500	Melissa Joiner Fit testing 3-13-2020	N95 Respirator Fitting form for Mellisa Joiner
501	Mexico CDC Prep Checklist with Signature	Mexico CDC Prep Checklist with Signature
502	MVC PPE Training Protocols	MVC PPE Training Protocols
503	MVC PPE Training Protocols	MVC PPE Training Protocols

#	DOCUMENT NAME	DESCRIPTION
504	Monica Warrington & Jenna Bergthold fit testing	OSHA Respirator Medical Evaluation Questionnaire for Monica Warrington and Jenna Bergthold
505	N95 Sign In and Out	N95 Sign out form (blank)
506	NMed_logo	Unable to open
507	O2	Sign "Danger Oxygen No Smoking No Open Flames"
508	OSHA Appendix C - Fit Testing	Respirator Medical Evaluation Questionnaire (blank)
509	OSHA Appendix C - Fit Testing	OSHA Respirator Medical Evaluation Questionnaire
510	OSHA-Quarantine-Sign-ODE-18377_1000	Sign "Danger Quarantine Area"
511	OSHA-Restricted-Area-Sign-ONE-37281_1000	Sign "Notice Isolation Area"
512	Pamela Tapous Fit testing 3-13-2020	N95 Respirator Fitting form for Pamela Tapous
513	Patrick Stevenson Fit testing 3-13-2020	N95 Respirator Fitting form for Patrick Stevenson
514	PH Initial N95 Respirator Use Form 030620	N95 Respirator Use Form
515	player	Unable to open
516	PPE-Sequence-508	PPE Instructions
517	Quar and Iso Procedures	Quarantine/Isolation Procedures
518	Quar.	Sign that read "COVID-19 Quarantine Area Do not Enter without Authorization"
519	Quarantine Quick Reference	Quarantine Quick Reference
520	Racheal Unger Fit testing 3-13-2020	N95 Respirator Fitting form for Racheal Unger
521	Rapid Tests Step by Step	Step-by-Step instructions on administering the Rapid test
522	Rapid Tests Step by Step	Step-by-Step instructions on administering the Rapid test
523	Rapid Tests Step by Step Mexico	Step-by-Step instructions on administering the Rapid test
524	REPORT TO NURSE BEFORE ENTERING ROOM	Picture of Stop sign. "Report to Nurse Before Entering Room" under stop sign
525	Resp Mask	Sign that reads "Caution Wear your Respirator"
526	Respirator Training	N95 Respirator Training
527	Respirator Training	N95 Respirator Training
528	Respiratory Protection Plan 1	MVC Respiratory Protection Plan
529	Rhonda Kestler Fit testing 3-13-2020	N95 Respirator Fitting form for Rhonda Kestler
530	Ronda Hall Fit testing 3-13-2020	N95 Respirator Fitting form for Ronda Hall
531	Rose Yates Fit testing 3-13-2020	N95 Respirator Fitting form for Rose Yates
532	Sally Beasley Fit testing 3-13-2020	N95 Respirator Fitting form for Sally Beasley
533	share-facts-h	CDC "Know the facts about coronavirus disease 2019 and help stop the spread of rumors."
534	Sheila George Fit testing 3-13-2020	N95 Respirator Fitting form for Sheila George
535	Shinita Watson fit testing 3-13-2020	N95 Respirator Fitting form for Shinita Watson

#	DOCUMENT NAME	DESCRIPTION
536	sick-with-2019-nCoV-fact-sheet	CDC "Sick with COVID-19" instructions
537	single-sound-7dba54e-56135f08	Unable to open
538	SLS6008P_Infection Prevention Guide to Long-Term C (1)	Infection Prevention Guide to Long-Term Care
539	Social Distancing 2	Poster/Sign that give Social Distancing instructions
540	Stephanie Bowden fit testing 3-13-2020	N95 Respirator Fitting form for Stephanie Bowden
541	stop	Picture of Stop sign that reads "Stop Do Not Enter"
542	Stop	Picture of Stop sign that reads "Stop Do Not Enter"
543	Stop Do Not Enter	Instructions for entering building re COVID
544	stop-the-spread-of-germs	CDC "Stop the spread of respiratory diseases" sign/poster
545	surgical mask	Poster/Sign that reads "Caution, Mask Required"
546	Surrounding Counties	Surrounding Counties COVID-19 Stat
547	Surveillance Log	Appears to be a Cover Page to their COVID-19 Surveillance Logs # 2
548	Talking with children about Coronavirus Disease 2019	Talking with children about Coronavirus Disease 2020 instructions
549	Teresa Ames Fit testing 3-13-2020	N95 Respirator Fitting form for Teresa Lynn Ames
550	widget-d3c340c-38e60ab1	Unable to open
551	Dashboard Mt. Vernon Coronavirus Daily Tracking August	Daily Coronavirus Tracking
552	Dashboard Mt. Vernon Coronavirus Daily Tracking September	Daily Coronavirus Tracking
553	Mt. Vernon 08.04.20 patio visits	Sign-in sheet and screening for visitors
554	Mt. Vernon 08.05 & 08.06.20 patio visits	Sign-in sheet and screening for visitors
555	Mt. Vernon 08.05.20 patio visits	Sign-in sheet and screening for visitors
556	Mt. Vernon 08.07.20 Patio visit	Sign-in sheet and screening for visitors
557	Mt. Vernon 08.07.20 patio visits	Sign-in sheet and screening for visitors
558	Mt. Vernon 08.21.20 patio visits	Sign-in sheet and screening for visitors
559	Mt. Vernon 09.01 & 09.10.20 patio visits	Sign-in sheet and screening for visitors
560	Mt. Vernon 09.02.20 patio visits	Sign-in sheet and screening for visitors
561	Mt. Vernon 09.09 & 09.16.20 patio visits	Sign-in sheet and screening for visitors
562	Mt. Vernon 09.17.20 patio visits	Sign-in sheet and screening for visitors
563	MT. VERNON 7 2020	Employee Organization Chart
564	Mt. Vernon 8.10 - 8.12 patio visits	Sign-in sheet and screening for visitors
565	Mt. Vernon 8.12 - 8.14 Patio visits	Sign-in sheet and screening for visitors
566	Mt. Vernon 8.13-8.14 Patio visits	Sign-in sheet and screening for visitors
567	Mt. Vernon 8.18-8.19 Patio visits	Sign-in sheet and screening for visitors
568	Mt. Vernon 8.19 - 8.21 Patio visits	Sign-in sheet and screening for visitors
569	Mt. Vernon 8.21 Patio visits	Sign-in sheet and screening for visitors

#	DOCUMENT NAME	DESCRIPTION
570	Mt. Vernon 8.25-8.26 patio visits	Sign-in sheet and screening for visitors
571	Mt. Vernon 8.26 - 8.28 Patio visits	Sign-in sheet and screening for visitors
572	Mt. Vernon 9.10 - 9.15 Patio visits	Sign-in sheet and screening for visitors
573	Mt. Vernon 9.1-9.11 patio visits	Sign-in sheet and screening for visitors
574	Mt. Vernon 9.1-9.8 Patio Visits	Sign-in sheet and screening for visitors
575	Mt. Vernon 9.8 - 9.15 Patio Visits	Sign-in sheet and screening for visitors
576	Mt. Vernon Aerosol-Nebulized medication procedure	Poster/flyer re Procedures to follow when patient is receiving aerosol-Generating Treatment/Procedure
577	Mt. Vernon Aug 2020 Staffing schedule	Staffing Schedule
578	Mt. Vernon August 2020 visitor log and screening tools	Sign-in sheet and screening for visitors
579	Mt. Vernon Coronavirus Daily Tracking August	Coronavirus daily tracker
580	Mt. Vernon Coronavirus Daily Tracking September	Coronavirus daily tracker
581	Mt. Vernon Donning. Doffing surveillance Tool	PPE Donning and Doffing surveillance Tool
582	Mt. Vernon Hand Holding Visits	Sign-in sheet and screening for visitors
583	Mt. Vernon Infection Control Line listing	MVC Infection Control Line listing
584	Mt. Vernon Infection control log August 2020	Infection Control Log - list of Veterans with certain conditions
585	Mt. Vernon Infection Control log Sept 2020	Infection Control Log - list of Veterans with certain conditions
586	Mt. Vernon Infection Control surveillance tool	Infection Control surveillance tool
587	Mt. Vernon Infection mapping August 2020	Facility Map with location of patients with various conditions
588	Mt. Vernon Infection mapping September 2020	Facility Map with location of patients with various conditions
589	Mt. Vernon Isolation-transmission based respiratory assessment (wellsky)	COVID-19 Daily Resident Screening
590	Mt. Vernon October 2020 Staffing schedule	Staffing Schedule
591	Mt. Vernon Sept 2020 staffing schedule	Staffing Schedule
592	Mt. Vernon September 2020 visitor log and screening tools	Sign-in sheet and screening for visitors
593	Mt. Vernon Weekly communication talking points	Standard Operating Procedure for Family Communication 10/19/2020
594	ORG CHART MT. VERNON 7 2020	Employee Organization Chart
595	1.0 MECHANICAL LIFT	1.0 MECHANICAL LIFT
596	1.0 NEBULIZER, USE OF	1.0 NEBULIZER, USE OF
597	1.0 ORIENTATION OF THE RESIDENT	1.0 ORIENTATION OF THE RESIDENT
598	1.0 PAIN MANAGEMENT POLICY	1.0 PAIN MANAGEMENT POLICY
599	1.0 RAZOR MAINTENANCE	1.0 RAZOR MAINTENANCE
600	1.0 SELF ADMINISTRATION OF DRUGS	1.0 SELF ADMINISTRATION OF DRUGS
601	1.0 THERMOMETER, USE OF	1.0 THERMOMETER, USE OF
602	1.0 UNNA'S BOOT	1.0 UNNA'S BOOT
603	1.0 URINARY DRAINAGE BAGS	1.0 URINARY DRAINAGE BAGS
604	1.0 VAGINAL CREAM	1.0 VAGINAL CREAM

#	DOCUMENT NAME	DESCRIPTION
605	1.1 HOW TO WRAP UNNA'S BOOT NEW ATTACH 1	1.1 HOW TO WRAP UNNA'S BOOT NEW ATTACH 2
606	12 Restorative Dining Program	13 Restorative Dining Program
607	2.0 MEDICATION ADMINISTRATION	2.0 MEDICATION ADMINISTRATION
608	2.0 NEUROLOGICAL ASSESSMENT	2.0 NEUROLOGICAL ASSESSMENT
609	2.0 OXYGEN ADMINISTRATION AND ADMINISTRATION	2.0 OXYGEN ADMINISTRATION AND ADMINISTRATION
610	2.0 RECTAL SUPPOSITORY	2.0 RECTAL SUPPOSITORY
611	2.0 SKIN TEAR TREATMENT	2.0 SKIN TEAR TREATMENT
612	2.0 SKIN-WOUND ASSESSMENT	2.0 SKIN-WOUND ASSESSMENT
613	2.0 TRACHEOSTOMY CARE	2.0 TRACHEOSTOMY CARE
614	2016 Omnicare - Crosswalk Infusion Therapy Procedure Manual	2017 Omnicare - Crosswalk Infusion Therapy Procedure Manual
615	2016 Omnicare Nurses Infusion Manual	2017 Omnicare Nurses Infusion Manual
616	3.0 NOSE DROPS	3.0 NOSE DROPS
617	3.0 OXYGEN SATURATION	3.0 OXYGEN SATURATION
618	3.0 PRESSURE REDUCING MATTRESSES PADS UPDATED	3.0 PRESSURE REDUCING MATTRESSES PADS UPDATED
619	3.0 SOAKS, WARM	3.0 SOAKS, WARM
620	3.0 UROSTOMY WITH ILLEAL CONDUIT CARE	3.0 UROSTOMY WITH ILLEAL CONDUIT CARE
621	3.0 WEIGHT AND HEIGHT MEASUREMENT	3.0 WEIGHT AND HEIGHT MEASUREMENT
622	4.0 MEDADMIN-THERAPEUTIC DRUG MONITORING	4.0 MEDADMIN-THERAPEUTIC DRUG MONITORING
623	4.0 PSYCHOTROPIC DRUGS-BEHAVIOR FLOW REC	4.0 PSYCHOTROPIC DRUGS-BEHAVIOR FLOW REC
624	4.0 REPORT GUIDELINES FOR NSG RPT	4.0 REPORT GUIDELINES FOR NSG RPT
625	4.0 SPECIMEN COLLECTION	4.0 SPECIMEN COLLECTION
626	4.0 TRANSFER (EMERGENCY, SCHEDULED, WITHIN)	4.0 TRANSFER (EMERGENCY, SCHEDULED, WITHIN)
627	5.0 ADMIN MED RES WITH FEED TUBE IN PLACE	5.0 ADMIN MED RES WITH FEED TUBE IN PLACE
628	5.0 RAI-MDS	5.0 RAI-MDS
629	5.0 SPECIMEN CULTURE COLLECTION	5.0 SPECIMEN CULTURE COLLECTION
630	5.0 TUBERCULIN TEST	5.0 TUBERCULIN TEST
631	6.0 MEDICATION ERRORS AND	6.0 MEDICATION ERRORS AND
632	6.0 RESTRAINTS	6.0 RESTRAINTS
633	6.0 STOOLS FOR OCCULT BLOOD	6.0 STOOLS FOR OCCULT BLOOD
634	6.0 TUBEX SYRINGE	6.0 TUBEX SYRINGE
635	7.0 CLEANING-REFRIGERATORS	7.0 CLEANING-REFRIGERATORS
636	7.0 SUCTION MACHINE	7.0 SUCTION MACHINE
637	7.0 THICKENED LIQUIDS	7.0 THICKENED LIQUIDS
638	8.0 CLEANING-MED and TX CART	8.0 CLEANING-MED and TX CART
639	8.0 SUTURE-STAPLE REMOVAL UPDATED	8.0 SUTURE-STAPLE REMOVAL

#	DOCUMENT NAME	DESCRIPTION
		UPDATED
640	A-1 MVH Introduction	A-1 MVH Introduction
641	A-2 Statutory Authority	A-2 Statutory Authority
642	A-3 Vision Mission Statement	A-3 Vision Mission Statement
643	A-4 Org. Chart	A-4 Org. Chart
644	A-5 Anti-Wandering	A-5 Anti-Wandering
645	A-5 Open Meetings and Record Law	A-5 Open Meetings and Record Law
646	A-6 Demonstrations at Homes	A-6 Demonstrations at Homes
647	A-7 No Smoking Policy	A-7 No Smoking Policy
648	A-8 Surveillance and Monitoring	A-8 Surveillance and Monitoring
649	Absence of Recreation Director	Absence of Recreation Director
650	Accounting Peer Audit Tool	Accounting Peer Audit Tool
651	Accounting Peer Review Tool	Accounting Peer Review Tool
652	Accounting Tasks	Accounting Tasks
653	ACE BANDAGE	ACE BANDAGE
654	ACE BANDAGE (2)	ACE BANDAGE (2)
655	Acknowledgement	Acknowledgement
656	Active Games	Active Games
657	Activities of Daily Living Enhancement	Activities of Daily Living Enhancement
658	Activities with Maintenance-Best Practice	Activities with Maintenance-Best Practice
659	Activity and Leisure Education Planning	Activity and Leisure Education Planning
660	Activity Calendar Schedule	Activity Calendar Schedule
661	ADMIN MED RES WITH FEED TUBE IN PLACE	ADMIN MED RES WITH FEED TUBE IN PLACE
662	ADMISSION	ADMISSION
663	ADMISSION (2)	ADMISSION (2)
664	Admission Application Management	Admission Application Management
665	Admission Process	Admission Process
666	Admission Standard Communication	Admission Standard Communication
667	Admission-discharge-expiration 8.1.20-Mt. Vernon 9.30.20	Admission-discharge-expiration 8.1.20-Mt. Vernon 9.30.21
668	Admissions 2nd Request for Annual Medical Information Update	Admissions 2nd Request for Annual Medical Information Update
669	Admissions Removal from Waiting List for Failure to Update Medical Info	Admissions Removal from Waiting List for Failure to Update Medical Info
670	Admissions ART	Admissions ART
671	Admissions Decline and Removal from Waiting List Letter	Admissions Decline and Removal from Waiting List Letter
672	Admissions Decline-Gold Status	Admissions Decline-Gold Status
673	Admissions Denial of Admission	Admissions Denial of Admission
674	Admissions Incomplete Application	Admissions Incomplete Application
675	Admissions No Response to Offer of Admission	Admissions No Response to Offer of Admission
676	Admissions Non-Eligibility	Admissions Non-Eligibility

#	DOCUMENT NAME	DESCRIPTION
677	Admissions Removal from Waiting List at Applicants Request	Admissions Removal from Waiting List at Applicants Request
678	Admissions Request for Annual Medical Information Update	Admissions Request for Annual Medical Information Update
679	Admissions Waiting List Approval Letter	Admissions Waiting List Approval Letter
680	Advance Directives	Advance Directives
681	AIMS ASSESSMENT	AIMS ASSESSMENT
682	AIMS ASSESSMENT (2)	AIMS ASSESSMENT (2)
683	ALLERGIES	ALLERGIES
684	ALLERGIES (2)	ALLERGIES (2)
685	ALTERNATING PRESSURE AIR MATTRESS	ALTERNATING PRESSURE AIR MATTRESS
686	ALTERNATING PRESSURE AIR MATTRESS (2)	ALTERNATING PRESSURE AIR MATTRESS (2)
687	AMA RELEASE	AMA RELEASE
688	AMA RELEASE (2)	AMA RELEASE (2)
689	AMBU BAG, USE OF	AMBU BAG, USE OF
690	AMBU BAG, USE OF (2)	AMBU BAG, USE OF (2)
691	AMPUTATION OF EXTREMITY	AMPUTATION OF EXTREMITY
692	AMPUTATION OF EXTREMITY (2)	AMPUTATION OF EXTREMITY (2)
693	ANTIEMBOLYTIC STOCKINGS	ANTIEMBOLYTIC STOCKINGS
694	ANTIEMBOLYTIC STOCKINGS (2)	ANTIEMBOLYTIC STOCKINGS (2)
695	Antimicrobial Stewardship Program	Antimicrobial Stewardship Program
696	Antimicrobial Stewardship Program - GI and ENT	Antimicrobial Stewardship Program - GI and ENT
697	Antimicrobial Stewardship Program - GI and ENT (2)	Antimicrobial Stewardship Program - GI and ENT (2)
698	Antimicrobial Stewardship Program - RTI	Antimicrobial Stewardship Program - RTI
699	Antimicrobial Stewardship Program - RTI (2)	Antimicrobial Stewardship Program - RTI (2)
700	Antimicrobial Stewardship Program - Skin Infections	Antimicrobial Stewardship Program - Skin Infections
701	Antimicrobial Stewardship Program - Skin Infections (2)	Antimicrobial Stewardship Program - Skin Infections (2)
702	Antimicrobial Stewardship Program - UTI	Antimicrobial Stewardship Program - UTI
703	Antimicrobial Stewardship Program - UTI (2)	Antimicrobial Stewardship Program - UTI (2)
704	Antimicrobial Stewardship Program (2)	Antimicrobial Stewardship Program (2)
705	APICAL PULSE	APICAL PULSE
706	AQUA K PAD	AQUA K PAD
707	Aquatics Therapy	Aquatics Therapy
708	ARTIFICIAL EYE	ARTIFICIAL EYE
709	Assistance League Meetings	Assistance League Meetings
710	Attending Funerals and Memorial Services Best Practice	Attending Funerals and Memorial Services Best Practice
711	Awareness and Engagement Best Practice	Awareness and Engagement Best Practice
712	BATH-WHIRLPOOL-HYDRAULIC LIFT	BATH-WHIRLPOOL-HYDRAULIC LIFT

#	DOCUMENT NAME	DESCRIPTION
713	BATH-WHIRLPOOL-HYDRAULIC LIFT (2)	BATH-WHIRLPOOL-HYDRAULIC LIFT (2)
714	BED RAILS	BED RAILS
715	BED-CHAIR ALARM SYSTEMS	BED-CHAIR ALARM SYSTEMS
716	BED-CHAIR ALARM SYSTEMS (2)	BED-CHAIR ALARM SYSTEMS (2)
717	BioMed Electrical Appliance	BioMed Electrical Appliance
718	Birthday Celebration Best Practice	Birthday Celebration Best Practice
719	Birthdays	Birthdays
720	BLADDER IRRIGATION AND INSTILLATION	BLADDER IRRIGATION AND INSTILLATION
721	BLADDER IRRIGATION AND INSTILLATION (2)	BLADDER IRRIGATION AND INSTILLATION (2)
722	BLADDERSCAN, USE OF	BLADDERSCAN, USE OF
723	BLADDERSCAN, USE OF (2)	BLADDERSCAN, USE OF (2)
724	BLOOD PRESSURE MEASUREMENT	BLOOD PRESSURE MEASUREMENT
725	BLOOD PRESSURE MEASUREMENT (2)	BLOOD PRESSURE MEASUREMENT (2)
726	Blood Spills	Blood Spills
727	BLOOD SUGAR MONITORING	BLOOD SUGAR MONITORING
728	BLOOD SUGAR MONITORING (2)	BLOOD SUGAR MONITORING (2)
729	Bowel and Bladder	Bowel and Bladder
730	BRADEN SCALE	BRADEN SCALE
731	BRADEN SCALE (2)	BRADEN SCALE (2)
732	Breakfast on the Care Units Best Practice	Breakfast on the Care Units Best Practice
733	BREATHING-PURSED LIP	BREATHING-PURSED LIP
734	Budget Management	Budget Management
735	C-1 Capital Improvement Project Management	C-1 Capital Improvement Project Management
736	C-2 State Owned Vehicles	C-2 State Owned Vehicles
737	C-3 Management of Supply Inventory	C-3 Management of Supply Inventory
738	C-4 Procurement of Goods and Services	C-4 Procurement of Goods and Services
739	C-5 State Fire Marshall Inspection Report	C-5 State Fire Marshall Inspection Report
740	C-6 Disaster and Emergency Preparedness	C-6 Disaster and Emergency Preparedness
741	C-7 Outside Resource Agreements	C-7 Outside Resource Agreements
742	CDC Hand Washing Presentation V3 6OCT2020	CDC Handwashing Presentation
743	Dashboard St. James Coronavirus Daily Tracking August	Coronavirus daily tracker
744	Dashboard St. James Coronavirus Daily Tracking September	Coronavirus daily tracker
745	ORG CHART ST. JAMES 8 2020	Employee Organization Chart
746	St. James 10.1.20	Weekly Team Update
747	St. James 20201020075331352	Employee Town Hall Meetings sign-in sheets
748	St. James 20201020132331086	Visitor Screening Forms
749	St. James 20201020132849324	Visitor Screening Forms
750	St. James 20201020133104779	Visitor Screening Forms
751	St. James 20201020133321979	Visitor Screening Forms

#	DOCUMENT NAME	DESCRIPTION
752	St. James 7.30.20	Weekly Team Update
753	St. James 8.14.20	Weekly Team Update
754	St. James 8.21.20	Weekly Team Update
755	St. James 8.27.20	Weekly Team Update
756	St. James 8.6.20	Weekly Team Update
757	St. James 9.3.20	Weekly Team Update
758	St. James Admission-discharges	Admissions and discharges from Aug to October 2020
759	St. James Aug 1-15	Daily Assignment Sheets
760	St. James Aug 16-31	Daily Assignment Sheets
761	St. James Aug-Oct Schedule	Staff Schedule
762	St. James Breaks	appears to be Chapter 3 from an HR policy/manual re payroll system SAM II
763	St. James CDC Hand Washing Presentation And Rapid Testing FAQs	Email re FAQ Rapid Test and CDC Handwashing Presentation
764	St. James infection control	Infection Control meeting minutes
765	St. James LTC surveillance line list Staff	Screening for possible outbreak of respiratory illness
766	St. James LTC surveillance line list Veterans	Screening for possible outbreak of respiratory illness
767	St. James MVH-St. James COVID Update	Email re new directives from HQ
768	St. James New Report on Handwashing Behaviors Among U.S. Adults	Brittany Ritter 10/10/2020 email to DPS.MVC.Everyone-STJ re hand hygiene
769	St. James Oct 1-18th	Daily Assignment Sheets
770	St. James Outside Visitor Schedule	Outside Visitor Schedule
771	St. James Outside Visitor Schedule 1	Outside Visitor Schedule 1
772	St. James Positive Corona Virus TimeLine	St. James Positive Corona Virus TimeLine Sept and Oct
773	St. James Rapid Test and Screening Procedure Update	Brittany Ritter 10/9/2020 email to DPS.MVC.Everyone-STJ re Rapid Test and Screening Procedure Update
774	St. James Rapid Tests	Brittany Ritter 10/5/2020 email to DPS.MVC.Everyone-STJ re Rapid tests
775	St. James Reminder For Screening In	Brittany Ritter 10/16/2020 email to DPS.MVC.Everyone-STJ
776	St. James Sept 16th-30	Daily Assignment Sheets
777	St. James September 1-15th	Daily Assignment Sheets
778	St. James Staff Testing Procedure and Leave Guidance 10 7 20 FINAL	Brittany Ritter email re Rapid Tests
779	St. James Veteran Co. Minutes 03-02-2020	Veteran Council Minutes
780	St. James Veteran Co. Minutes 03-16-2020	Veteran Council Minutes
781	St. James Veteran Co. Minutes 03-30-2020	Veteran Council Minutes
782	St. James Veteran Co. Minutes 04-13-2020	Veteran Council Minutes
783	St. James Veteran Co. Minutes 04-20-2020	Veteran Council Minutes
784	St. James Veteran Co. Minutes 04-27-2020	Veteran Council Minutes

#	DOCUMENT NAME	DESCRIPTION
785	St. James Veteran Co. Minutes 05-04-2020	Veteran Council Minutes
786	St. James Veteran Co. Minutes 05-11-2020	Veteran Council Minutes
787	St. James Veteran Co. Minutes 05-18-2020	Veteran Council Minutes
788	St. James Veteran Co. Minutes 06-01-2020	Veteran Council Minutes
789	St. James Veteran Co. Minutes 06-10-2020	Veteran Council Minutes
790	St. James Veteran Co. Minutes 06-22-2020	Veteran Council Minutes
791	St. James Veteran Co. Minutes 06-29-2020	Veteran Council Minutes
792	St. James Veteran Co. Minutes 07-13-2020	Veteran Council Minutes
793	St. James Veteran Co. Minutes 07-20-2020	Veteran Council Minutes
794	St. James Veteran Co. Minutes 07-27-2020	Veteran Council Minutes
795	St. James Veteran Co. Minutes 7-6- 2020	Veteran Council Minutes
796	St. James Veteran Council Minutes 8 10 2020	Veteran Council Minutes
797	St. James Veteran Council Minutes 8 17 2020	Veteran Council Minutes
798	St. James Veteran Council Minutes 8 24 2020	Veteran Council Minutes
799	St. James Veteran Council Minutes 8 31 St. James 2020	Veteran Council Minutes
800	Dashboard St. Louis Coronavirus Daily Tracking August	Daily Coronavirus Tracking
801	Dashboard St. Louis Coronavirus Daily Tracking September	Daily Coronavirus Tracking
802	ORG CHART ST. LOUIS 8 2020	Employee Organization Chart
803	Screening form for everyone entering/visiting Veterans Home	Screening form for everyone entering/visiting Veterans Home
804	St. Louis Admissions.discharges.deaths	List of Admissions, Discharges, and deaths from 8/6/2020 to 10/15/2020
805	St. Louis Family Notification	Family notification log from March 2020 to September 2020
806	St. Louis hand holding screenings August	Visitor Screening Forms
807	St. Louis Nursing Schedule August Evenings	Assignment Sheets
808	St. Louis Nursing Schedule August days	Assignment Sheets
809	St. Louis Visitor screening August 16- 31	Visitor Screening Forms
810	Saint Louis - Summary of Site visit conducted by VA - 9/23/2020	Summary of Site Visit Conducted by VA - 9/23/2020
811	Dashboard Warrensburg Coronavirus Daily Tracking August	Coronavirus daily tracker
812	Dashboard Warrensburg Coronavirus Daily Tracking September	Coronavirus daily tracker
813	Highland Park - Infection Control	Infection Control Audit form and facility layout
814	Highland Park - Infection Control (2)	Infection Control Audit form and facility layout
815	ORG CHART WARRENSBURG 9 2020	Employee Organization Chart
816	Warrensburg ADT Report	Admission/Return, Discharge, Expired report 8/1/2020 TO 10/20/2020
817	Warrensburg August Infection Control Audits	Antibiotic Recap 2020
818	Warrensburg August Nursing QAPI	Monthly Clinical Subcommittee Minutes
819	Warrensburg August Nursing Schedules	Assignment Sheets

#	DOCUMENT NAME	DESCRIPTION
820	Warrensburg August Visitor Logs	Visit Screening Forms
821	Warrensburg Highland Park - Infection Control	Infection Control Audit form and facility layout
822	Warrensburg Infection Control Log	Infection Control Log
823	Warrensburg October Nursing Schedules	Assignment Sheets
824	Warrensburg Pleasant Valley - Infection Control	Infection Control Audit form and facility layout
825	Warrensburg September Nursing QAPI	Clinical Subcommittee Minutes
826	Warrensburg September Nursing Schedules	Assignment Sheets
827	Warrensburg September Visitor Logs	Visit Screening Forms
828	Warrensburg Sleepy Hollow - Infection Control	Infection Control Audit form and facility layout
829	Warrensburg Staff Positive Log (2)	Log of Staff that tested Positive for COVID-19 June 2020 to October 2020
830	Warrensburg Talking Points to Warrensburg Families	Talking Points to Families for Weekly COVID-19 Updates
831	Warrensburg Veteran Council and Overheard Pages	Veteran Council Meeting Minutes March 2020 to September 2020
832	Warrensburg Veteran COVID-19 POSITIVE Tracking (2)	Positive COVID-19 tracking for Veterans Sept 2020
833	Warrensburg Whispering Hills - Infection Control	Infection Control Audit form and facility layout
834	June 22 - St Louis	Photo
835	April 3 - St James	Photo
836	June 7 - St James	Photo
837	June 18 - St James	Photo
838	July 21 - St James	Photo
839	May 15 - Mt Vernon_3	Photo
840	May 15 - Mt Vernon_2	Photo
841	May 15 - Mt Vernon	Photo
842	June 11 - Mt Vernon	Photo
843	June 18 - Mt Vernon	Photo
844	July 31 - Mt Vernon	Photo
845	Aug 7 - Mt Vernon_2	Photo
846	Aug 7 - Mt Vernon	Photo
847	May 16 - Mt Vernon_3	Photo
848	May 16 - Mt Vernon_2	Photo
849	May 16 - Mt Vernon	Photo
850	July 7 - Mt Vernon	Photo
851	July 8 - Mt Vernon	Photo
852	Sept 3 - Mt Vernon	Photo
853	Sept 4 - Mt Vernon_2	Photo
854	Sept 4 - Mt Vernon	Photo
855	Sept 9 - Mt Vernon	Photo
856	May 14 - Mexico_7	Photo
857	May 14 - Mexico_6	Photo
858	May 14 - Mexico_5	Photo

#	DOCUMENT NAME	DESCRIPTION
859	April 9 - Mexico	Photo
860	April 15 - Mexico_2	Photo
861	April 15 - Mexico	Photo
862	April 28 - Mexico	Photo
863	April 29 - Mexico	Photo
864	May 14 - Mexico	Photo
865	May 20 - Mexico_3	Photo
866	May 20 - Mexico_2	Photo
867	May 20 - Mexico	Photo
868	May 21 - Mexico_4	Photo
869	May 21 - Mexico_3	Photo
870	May 21 - Mexico_2	Photo
871	May 21 - Mexico	Photo
872	June 12 - Mexico	Photo
873	April 2 - Cameron_13	Photo
874	April 2 - Cameron_12	Photo
875	April 2 - Cameron_11	Photo
876	April 2 - Cameron_10	Photo
877	April 2 - Cameron_9	Photo
878	April 2 - Cameron_8	Photo
879	April 2 - Cameron_7	Photo
880	April 2 - Cameron_6	Photo
881	April 2 - Cameron_5	Photo
882	April 2 - Cameron_4	Photo
883	April 2 - Cameron_3	Photo
884	April 2 - Cameron_2	Photo
885	April 2 - Cameron	Photo
886	March 25 - Cape Girardeau	Photo
887	March 31 - Cameron_3	Photo
888	March 31 - Cameron_2	Photo
889	March 31 - Cameron	Photo
890	April 2 - Cape Girardeau	Photo
891	April 14 - Cape Girardeau	Photo
892	May 1 - Cape Girardeau	Photo
893	June 2 - Cape Girardeau_2	Photo
894	June 2 - Cape Girardeau	Photo
895	June 4 - Cape Girardeau	Photo
896	June 22 - Cape Girardeau	Photo
897	June 29 - Cape Girardeau	Photo
898	July 2 - Cape Girardeau	Photo
899	July 8 - Cape Girardeau	Photo
900	July 14 - Cape Girardeau	Photo

#	DOCUMENT NAME	DESCRIPTION
901	Aug 13 - Cape Girardeau	Photo
902	Aug 21 - Cape Girardeau	Photo
903	Sept 9 - Cape Girardeau	Photo
904	Michele Renkemeyer 11.9.2020 email re MVC Testing 10.8.2020	Michele Renkemeyer 11.9.2020 email re MVC Testing 10.8.2020
905	MVC testing 10.8.20	MVC Testing spreadsheets
906	Michele Renkemeyer 11.9.2020 email re COVID-19 Positive Staff and Veteran Status 10.7.2020	Michele Renkemeyer 11.9.2020 email re COVID-19 Positive Staff and Veteran Status 10.7.2020
907	COVID Positive Staff and Veteran Status mls 10.7.20	COVID Positive Staff and Veterans Status spreadsheet
908	Adam Crumbliss 11.5.2020 email re screen shot of text message re Cape Testing 1	Adam Crumbliss 11.5.2020 email re screen shot of text message re Cape Testing 2
909	Adam Crumbliss 11.5.2020 email re screen shot of text message re Cape Testing 2	Adam Crumbliss 11.5.2020 email re screen shot of text message re Cape Testing 3
910	Paul Kirchhoff 11.5.2020 email re Deaths within the Homes	Paul Kirchhoff 11.5.2020 email re Deaths within the Homes
911	Paul Kirchhoff 11.5.2020 email re St. James Media Request - Mike O'Connell	Paul Kirchhoff 11.5.2020 email re St. James Media Request - Mike O'Connell
912	Paul Kirchhoff 11.5.2020 email re MVC Update - Outbreak in Cape	Paul Kirchhoff 11.5.2020 email re MVC Update - Outbreak in Cape
913	September CFC Reporting	Chart listing COVID updates in September
914	Cindy Dixon 11.11.2020 email re Information Requested	Cindy Dixon 11.11.2020 email re Information Requested
915	Management Call Log Entries DPS DMH DOC	Management Call Log Entries DPS DMH DOC
916	RE_ who is the name of the MVC data reporter for the state executive dashboard_ thanks (eom)	Cindy Dixon 10/10/2020 email to Drew Erdmann re who is the name of the MVC data reporter for the state executive dashboard? Thanks (eom)
917	RE_ executive website	Cindy Dixon 9/29/2020 email to Erdmann and Wessing re executive website
918	My review of MVC positive test data	Cindy Dixon 10/5/2020 email to Erdmann, Steelman, and Wessing re My Review of MVC positive test data
919	RE_ quick info	Cindy Dixon 10/5/2020 email to Erdmann, Steelman, McElroy, and Wessing re quick info

APPENDIX E. PATHWAY REPORTS

APPENDIX E1. Pathway Report: Cameron Veterans Home Summary

Cameron Veterans Home

Summary Overview

The attached is Onsite Facility Infection Control/COVID-19 Evaluation report with specific findings identified. Below is a summary of highlighted trends identified during the onsite visit for this Home.

- The Home leadership team was cooperative and informative throughout the onsite evaluation. Staff are dedicated to the needs of the veterans they serve.
- Infection Control lead has multiple roles and spends approximately 15% of allocated time to IP activities, which does not align with standards of practice
- The Infection Control Nurse does not routinely maintain the Line Lists or cases of COVID, did not have a listing of those veterans/employees who had exhibited symptoms as would be expected per standards of practice. Difficult to obtain total number of COVID-19 status for veterans and staff. See report for details.
- There was no evidence of general infection prevention and control policies and procedures as well as COVID-19 specific policies and procedures
- No evidence of written pandemic response plan
- Front line staff indicated they were not aware of infection control and COVID-19 policies and procedures as would be expected per standards of practice
- Identified there was no formal plan for process surveillance
- Symptom Screening for veterans for all symptoms of COVID-19 was not present
- Common area use and social distancing not consistent with CDC guidance
- Process for screening and testing at entry was not consistent with guidance including social distancing, testing close together
- Veteran Placement did not consistently follow current guidance relative to quarantine and isolation guidance.
- Signage does not reflect COVID-19 guidance
- Cleaning and Disinfection does not follow current guidance for:
    - Equipment reuse
    - PPE cleaning and disinfection for reuse
- PPE use per current guidance - breaks in practice identified
    - Use and reuse (30 times), storage, varying strategies for gown use, sequencing
- PPE optimization – not in accordance with CDC guidance.
- Dedicated staff on the COVID unit was not consistently practiced.
- Education – content received from headquarters, materials were not present or available, directives via emails and monthly Town Hall meetings were utilized
- Communication flow related to COVID-19 guidance comes from Headquarters to Administration. Administration manages communications. Unable to determine communication flow to direct care staff relative to updated guidance.

APPENDIX E2. Pathway Report: Cameron Veterans Home Onsite Infection Control Review Report

Onsite Facility Infection Control/COVID-19 Evaluation

Facility Demographics	**Veterans Home Name: Cameron Veterans Home** **Date: 10/26/20 and 10/27/20** **Consultant: Amy Harroff** **Administrator: David Hibler** **Director of Nursing Services: Ed Becker** **Number of Licensed Beds: 200** **Average Daily Census: 125** **<u>COVID-19 Status</u>** **Number of total COVID Cases: 112** **Number of Veteran Cases: 74** **Number of Staff Cases: 38** **Number of COVID related deaths: 18** **Current COVID Status: 13** **Veterans: 11** **Staff: 2**

Topic	Activity	Findings
Infection Control Lead	☒An infection lead has been designated to address and improve infection control ☒ RN ☒How long in IP Position- 1 year ☒Infection Preventionist Training – Describe: CMS IP Training ☒Infection Preventionist is assigned other duties in the facility	• [redacted] • She has a secondary role as charge nurse 1 of the 4 units • Infection Preventionist Training – completed the CMS IP Training • ***Interview revealed she had not been able to keep up with a line list and was working on that day (10/26/20)*** • She receives her directives regarding COVID-19 from the administrator • Spends approximately 15% of her full-time position on infection control • She did not have a listing of those veterans/employees who had exhibited

	Describe: ☒Hours allotted for Infection Preventionist role – Describe: ☒Infection Preventionist maintains a line list Veterans with s/sx or confirmed COVID-19 Employees with s/sx or confirmed COVID-19 ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☒ Describe the inventory process, burn rate process for PPE ☒ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) ☒ Familiar with PPE optimization process Spend time discussing their role, responsibility as the IP Discuss the COVID status, and is this the same process before, during COVID and is it now your process Describe fit testing process Describe COVID-19 preparation, mitigation and response process	symptoms • IP not aware of current burn rate or PPE supply • If her unit needs supplies, she contacts the Nursing Supervisor • Not aware of the inventory process for PPE • Able to describe the current N95 and Face shield reuse process, unfamiliar with the differing levels of optimization • IP was open regarding not having enough time to keep up with tracking of COVID-19 related data, stating "I just don't have the time with working on the unit." She further noted that over the last "three weeks" they have received increased assistance with staffing from the VA nurses and testing supplies. The facility initially started with random testing, moved to two day a week testing, and as more cases developed increased testing of both veterans and staff. Stated that they just received the Abbott Point of Care testing "2-3 weeks ago." • Current rapid testing occurs daily with all incoming staff, on PCR testing for all staff/veterans on Monday's and Thursday's • Was unable to provide any policies and procedures related to COVID-19 • She was able to accurately describe the test fitting process and indicated that all staff had been fitted
Policies and Procedures	☒ Infection Control Policies and Procedures ☒ COVID -19 Policies and Procedures • Screening for all	• Administrator, DNS, IP, Staff Development Coordinator (SDC), and nursing supervisors were all asked regarding accessing policies/procedures and processes related to COVID-19. Response was there was nothing in writing they could show to me, but they were "following the CDC

	○ Veterans ○ Staff ○ Visitors ○ Vendors, hospice, therapy ○ ERAY, Pharmacy ○ Supply delivery process • PPE • Veteran Placement (quarantine process, confirmed COVID-19 process) • Admission, re-admission, discharge • Universal Source Control (Staff and Veterans) • Visitation (when started, where located, infection control measures, documentation, etc.) • Hand holding stations • Aerosol generating medications, nebulizer • Postmortem care • Testing ○ Overall ○ Specimen process ○ Rapid Antigen POC ○ PCR and Lab process ○ Reporting process • Reporting and Communication process (Reporting of S/S, confirmed cases, quarantine, PPE, all COVID related communication – to whom and how communicated to home and departments and staff) ○ Timing of reporting ○ Direction for reporting ○ Changes in reporting process in last 3 months • Veterans psychosocial needs	guidelines, had 3Xweek calls with headquarters and were following their directives." During the interview with the nursing supervisors, they indicated that they received communications regarding COVID via email and during monthly "townhall" meetings. • They further noted that they felt that communication was slow to reach them. Example they gave was they are responsible for staffing, but currently did not know which staff members were positive • Administrator/DNS/IP were able to verbalize screening process and placement process: ➢ Symptomatic veterans are rapid tested and if positive placed in isolation for 10 days – a PCR test is also done to confirm ➢ Veterans returning from the hospital and those exposed are placed in quarantine for 14 days ➢ Employees who test positive, quarantine for 10 days/positive 10 days ➢ Hand holding visitation has stopped based on the recent outbreak ➢ Currently no aerosol generating procedures ➢ Testing results are reported up to headquarters and Health Department by the Administrator ➢ All communal activities have stopped, veterans eating in their rooms or in the common areas of units ➢ Evidence in the medical records reviewed contact with family members/responsible parties via phone and tablet visits ➢ All veterans are monitored each shift for a change in condition and specific COVID-19 symptoms ➢ Unable to produce a written pandemic response plan

	• Communal activities • Dining • Special Care Unit specific • Hand Hygiene • Employee illness • Return to work • Education • Staffing and Staff assignment • Cleaning and disinfection – all departments ☒Change in condition for COVID-19 ☒Facility has a COVID-19 pandemic plan	
Clinical Care and Veteran Monitoring	☒Monitoring for Change of Condition with COVID-19 ☒Systems are in place identify COVID-19 early via screening processes ☒All veterans are screened for symptoms of COVID-19 and have their vital signs monitored, including oxygen saturation and temperature checks including: ☒Is the symptom list up to date for COVID-19: Fever or chills Cough Shortness of breath or difficulty breathing Fatigue Muscle or body aches Headache New loss of taste or smell Sore throat Congestion or runny nose Nausea or vomiting Diarrhea	• All veterans monitored q shift for s/s of COVID-19, if symptomatic, rapid testing done and documented • Symptom list is updated • There is a COVID alert included on the electronic health record • No Root Cause Analysis process – it was difficult to get a clear number of total COVID-19 positive veterans and current number of employees

	Trouble breathing Persistent pain or pressure in the chest New confusion Inability to wake or stay awake Bluish lips or face ☒Does the E H R have a system for alerts? Are they able to monitor trends, contact tracing based upon trends, etc.? Who monitors this process and how is it communicated? ☒Is there are RCA process when COVID is identified to determine potential risks, breaks in practice, contact tracing, etc.?	
Entrance to Home – Screening Process	☒Facility screens every individual entering the facility (including staff) for COVID-19 symptoms. Questionnaire, temperature taken. ☒Entry access is limited, and the entrance has screening stations. ☒Those permitted entry are instructed about frequent hand hygiene, limiting interactions with others and with surfaces touched and limiting their visit to designated areas ☒Those permitted entry are instructed about monitoring for signs and symptoms of COVID-19 ☒Observe Screening criteria and process includes temperature checks. ☒Tracks and monitors for fever ☒Tracks and monitors COVID-19 symptoms ☒Review screening process, log, paperwork and questionnaire	• All entering the facility are screened using a comprehensive questionnaire and temperature check. Evaluator did leave a space blank to test response and the staff member did pick up on the unanswered question • There is a video at entrance that repeats itself on hand hygiene, donning, and doffing of PPE • Screening Process Observations: ➢ All enter through a coded door ➢ To the immediate left of the door is a table, where a member of FEMA was checking temperatures and doing the rapid tests ➢ There was a plexiglass partition on the short end of the table closest to the entry way, ➢ The FEMA worker then moved to the long side of the table where she handed me a swab and instructed me on how to obtain my specimen ➢ As a visitor, I had to sign in at the front desk with the receptionist and complete the screening tool ➢ Other staff was also in the vicinity and was observed obtaining their specimens within 2 feet of the FEMA worker – social distancing not observed (or encouraged), at one point, 6 staff members were standing in front of the long table waiting for their results ➢ There was a staff member sitting at a separate table next to the

		long table. This staff member was wearing just a surgical mask (which was observed pulled down several times), she was checking in staff members who were getting PCR testing. ➢ PCR testing was occurring between the 2 sliding glass doors, staff member in full Tyvex suit and Papper – employee would enter the area and be swabbed in the glassed-in area
COVID-19 – Confirmed or Suspected **Status, Plan and System**	☐Confirmed positive or recovering COVID-19 veterans are placed on COVID-19 Unit/Wing ☒Co-horting or in a private room ☒If no room is available on COVID-19 Unit, veteran placed in private room or co-horted with other confirmed case ☒All veterans who are not suspected to be infected with COVID-19 are in rooms or units that do not include confirmed or suspected cases. ☒Veteran cohorting is re-evaluated by infection control lead and clinical staff and implemented each day based on results of any of the following: surveillance testing (if available), symptom screening and temperature checks. ☒Veteran cohorting is re-evaluated by infection control lead and clinical staff ☒There is an outlined process for determination of when a veteran comes off of the COVID-19 unit or quarantine ☒ How long have these processes been in place?	• (2) units currently in use for active COVID-19 veterans – veterans were observed in single rooms • Observations related to the COVID-19 units ➢ There were (3) negative veterans on the COVID-19 unit who refused to move from their rooms. According to the staff, they stay in their room and staff puts a gown over their Tyvex suit when entering the veteran's room ➢ The fire doors leading into the common area that is between both the units, remains open d/t air flow ➢ There was a table with regular gowns and then moving into the common area, staff donning Tyvex gowns (unable to identify rationale as to what/why need to don a regular gown to enter the common area. Staff referred to the area a "clean" ➢ The area was cluttered with staff personal belongings ➢ Enter the COVID through a plastic wall, immediately to the right was a room with 2 full trash cans with used PPE, unmarked face shields on a bedside table and on the wall, (2) used gowns hanging on the closet door, staff stated they use the room to don and doff PPE ➢ Proceed into the COVID unit through fire doors and another plastic door ➢ The staff was observed leaving the unit through the same entry way with used N95 masks in place and exited through a doorway in common area ➢ (2) staff members coming to work (who were known COVID-19 positive) entered through the doorway in the common area (wearing surgical masks) – no screening was done, they passed several staff members who were not gowned – increasing the risk of cross contamination ➢ Since no screening was completed – not able to determine if these staff members were symptomatic • No written processes outlining expectations

Communal and Congregate Areas – Veteran Care	☒Outings, group activities and communal dining are adjusted per COVID-10 status Explain the process, review policy ☒Describe current status on veterans using congregate spaces Ask about activities, dining, what they are using their communal spaces for, has the process changed over time? ☒Social distancing is observed ☒Universal source control is observed ☒Describe the Special Care Unit process for communal space and mitigation ☒Terminal cleaning is completed after each use	• Facility has adjusted activities, which includes discontinuing communal dining • Environmental Services able to describe terminal cleaning process, sanitation crew comes to the facility and deep cleans common areas twice weekly • Designated housekeeper on the COVID-19 unit • Most staff utilized N95 masks, but did not see consistently
Hand Hygiene and Necessary Supplies	☒Necessary supplies are available and accessible for hand hygiene. Describe what is used, accessibility, etc. **Hand Hygiene** **OBSERVATION** Staff perform hand hygiene (even if gloves are used) when indicated ☒Before and after glove use ☒Before & after veteran contact ☒After contact with blood, body fluids or visibly contaminated surfaces ☒After contact with objects and surfaces in the veteran's environment ☒Before performing procedures such as an aseptic task	• Currently using Purell product which is readily available • Cross contamination observation: ➢ Observation of a meal on the non-COVID unit revealed the following: ▪ Multiple pour bottles and cartons were delivered from the kitchen in large grey tubs with ice ▪ During the mealtime, multiple staff handled the bottles without performing hand hygiene ▪ The grey tubs with the bottles/cartons were then taken back to the kitchen • Staff interviews and observations revealed no issues with availability of Alcohol Based Hand Rub (ABHR)

	☒After removing PPE ☒Alcohol-based hand rub (ABHR) is readily available ☒Staff use ABHR preferentially for hand hygiene – if available, it is readily accessible and preferentially used ☐If ABHR is not available or limited, staff wash their hands with soap and water ☒Staff wash their hands with soap and water for 20 seconds when visibly soiled ☒**Staff interviewed** indicated there is an adequate supply of hand soap and paper towels	
Cleaning and Disinfection	**OBSERVATION** **Supplies and Disinfection (multiple departments)** ☒Dedicated or disposable non-critical care equipment is used ☒Reusable equipment is cleaned and disinfected after use according to manufacturer's directions using an EPA registered disinfectant List N before use on another veteran ☒Objects and environmental surfaces that are touched frequently and are close to the veteran are cleaned and disinfected at least daily and when visibly soiled ☒Staff appropriately perform environmental cleaning and disinfection ☒Staff appropriately reprocess reusable equipment (cleaning and disinfecting per device and according to manufacturer's instructions and contact time)	• Dedicated equipment available on the COVID-19 unit • Equipment cleaning observation: ➢ Observed staff utilizing BP cuff and thermometer on multiple veterans without sanitizing between use • Observed staff cleaning medication carts and wiping down the nursing stations and computers • Environmental Services (EVS) staff able to verbalize appropriate cleaning and disinfection procedures and was observed using appropriate EPA products • Facility awaiting 1-minute kill time product, had been using 5-6 minute product • All EVS staff complete a check list for each room daily, which is reviewed by the EVS manager • EVS manager has not observed/monitored EVS staff cleaning to ensure competency

	Ask Staff: Housekeeping/Environmental Services ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Nursing ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Dining Services ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Activities/Recreation ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants	
PPE	☒All staff are practicing universal source control (i.e. face masks) ☒Staff have been trained on selecting, donning, and doffing appropriate PPE, were staff tested, competency verification ☒If there are COVID-19 cased identified in the facility, staff is wearing recommended PPE for care of all veterans, in line with the most recent guidance. ☒Observe and describe – if extended or	• All staff are expected to wear N95s and face shields • Received verbal validation from the educator that all staff received training on N95 mask re-use: Staff told they could use N95 "30 times" before discarding, place in a paper bag with their name on it an open alcohol swab at the bottom of the bag when not in use • Face shields were to be worn and reused: according to the educator, they had been trained to wipe down their face shields and hang on a thumb tack to dry, no length of time of use was identified • Educator stated training material came from headquarters • Observations revealed staff donning and doffing in the appropriate sequence • PPE Observation

	re-use of PPE is practiced, describe the home's process ☒Necessary PPE is immediately available upon entrance to the COVID-19 unit **OBSERVATION: (Nursing and Multiple departments)** ☒Staff demonstrate proper sequencing of PPE per COVID-19 per CDC guidance Don 1. Identify and gather the proper PPE to don. 2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown. 4. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). 5. Put on face shield or goggles. 6. Put on gloves. 7. Healthcare personnel may now enter patient room. (Doff) PPE 1. Remove gloves. 2. Remove gown. 3. Healthcare personnel may now exit patient room. 4. Perform hand hygiene. 5. Remove face shield or goggles. 6. Remove and discard respirator (or facemask if used instead of respirator).	➢ Multiple staff interviews revealed that it was not clear if mask was 30 days or 30 times – several also indicated they were taking the bags home ➢ Observations on each unit and in the women's locker room, revealed paper bags with no identifiable date, some had names, others did not ➢ Observations also revealed face masks without names, some hanging, others found on tables and in nursing stations – was unable to determine if they were in use ➢ Observations and interviews surrounding use of PPE revealed there was no common practice and no monitoring to ensure staff were compliant with outlined expectations • Signage ➢ Signage does not clearly indicate PPE necessary for entrance ➢ Multiple signs at each entrance ➢ Signage at the entrance of all units was the same and included donning gloves, but there were no gloves available with the gowns ➢ There was a small, printed sign that was on the doors that had gloves crossed out, but the large, laminated CDC signs still were in place indicating use of gloves ➢ There was no signage on the COVID-19 units to indicate isolation • Trash ➢ Multiple observations of trash large and small trash cans overflowing with PPE ➢ In the donning and doffing room located on the COVID positive units, the biohazard trash bins were located immediately when you entered the room. These bins were observed full on one unit, thus providing an opportunity for cross contamination when exiting the room after donning clean PPE • Veterans were wearing masks • Hand sanitizer accessible • EVS, maintenance, dietary, and therapy staff all observed utilizing appropriate PPE • Laundry Observations: ➢ Laundry from the quarantine and isolation units is supposed to have a blue tag – currently not using specific biohazard bags to

	7. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing re-use.* ☒Signage - Signs on the use of PPE are posted in appropriate locations- posted immediately outside of veteran rooms indicating appropriate infection control precaution and required PPE per guidelines. ☒Trash disposal bins are positioned as near as possible to the exit inside of the veteran room ☒ Is hand sanitizer is accessible location ☒Veterans are donning face masks whenever: o leave their room o leave facility for essential medical appointments ☒ General observations of universal source control and PPE use per guidance in multiple departments – describe	delineate contaminated laundry ➢ Do have a designated washer and dryer for COVID use ➢ Laundry staff member was observed sneezing with mask down, then handling clean pillows
Admissions, Readmissions, Communication Processes	**Admissions, Readmissions, Appointments** ☒Facility has a plan for admissions that aligns with guidance ☒ Describe placement and process for New and Re-Admissions (i.e. where, how long, testing, decision, monitoring, PPE use, etc.) ☒Readmission has a plan for admissions that aligns with guidance ☒Facility has a process for veterans who have routine medical appts (i.e. dialysis)	• Charge nurse and house supervisors able to verbally confirm process for admissions and placement: Positive admissions to isolation for 10-20 days, unknown or negative to quarantine for 14 days. Veterans that go to medical appointments return to assigned rooms.

Communication Process	**Communication Requirements** ☒Describe process for communication of COVID status ☒Describe designated person assigned responsibility for daily communications with: ☐Staff ☐Veteran ☐Families ☐ Headquarters ☒All communications include status and impact of COVID-19 in the facility – prevalence of confirmed cases in staff and veterans and PPE availability ☒Facility provides routine updates to staff re COVID-19. Staff have received updated education as needed	• Communication observation: ➢ Managers and staff interviewed indicated that the administrator was the one who provided the communication related to COVID updates ➢ The house supervisors (spoke with day and evening) indicated that they felt as if communication needed to improve (unaware of current employee status), infrequent email updates – one stated *"I feel like I am flying by the seat of my pants and am the one that is here and responsible for the care of these veterans, without clear direction"* ➢ Discussion with (2) maintenance employees revealed that the Friday before Columbus day they had been called in "about 0530, to move multiple veterans, but had not been told who was positive and who was negative" They further noted that communication could be better • Record review revealed documented communication with family members regarding COVID status of the veteran
Staffing and Staff Contingency Related to COVID-19 and Outbreak	☒There is a policy and procedure for staffing strategies in an emergency and is part of Emergency Preparedness plan ☒The plan includes: ☒Dedicated and consistent staffing teams who directly interact with veterans that are COVID-19 positive ☒Limiting clinical and other staff who have direct veteran contract to specific floors or wings – there should be no rotation of staff between floors or wings during the period they are working for the day ☒An established policy to minimize the number of staff interacting with each veteran ☒List the designated person assessing responsibility for conducting a daily	• No written policy available for review • Currently, the facility had assistance from outside VA nurses – 14 day tour doing 12 hour shifts – they had their own supervisor present in the facility • According to the house supervisors, they do their best to ensure consistent staffing on the units

	assessment for staffing needs including back up plans as needed	
Education, monitoring and screening of staff Staff Development Coordinator discussion	☒Staff education has been provided education about COVID-19 including (when did it start, how often, when was the last education, do you have any written resources to use after you have been educated and where are they located) ☒Signs and Symptoms of COVID-19 ☒How it is transmitted ☒PPE ☒ Cleaning and disinfection ☒Prevention strategies Social distancing Universal source control Hand hygiene Visitation Common use areas ☒ Testing – (licensed nurses) ☒Identification and reporting of change of condition ☒Screening criteria ☒ Training Materials – who develops, where does the information come from, who provides the training, modality of training, how often is training provided to staff in all departments, is there a plan outlined for the COVID-19 training ☒ Describe and review training provided ☒ Has the home conducted ongoing COVID-19 education – (describe process, frequency, accountability, documentation, etc.) ☒ Describe competency verification	• Interview with the Staff Development Coordinator revealed facility started education in March 2020 • Directives come from headquarters to her through the administrator • Email appeared to the main conduit for communication, there is a monthly Town Hall meeting where there is a review of current initiatives around COVID • Education observations: ➢ Educator was asked about who provided education updates to the staff during the recent outbreak, she stated "she did not know" ➢ Educator could not produce any materials, policies, or procedures for review ➢ During an interview with the maintenance employees, they stated that at "one point in time, there seemed to be confusion regarding isolation, they had quarantine and isolation backwards – it's right now" They stated it was when the outbreak first occurred • Educator indicated they had competency validations on all staff for PPE utilization, symptom identification, and regarding isolation • Training material comes from headquarters • Donning/doffing video is on 24/7 at the employee entrance • Monitoring observation: ➢ Staff confirms training and validation following training, but no on-going monitoring of compliance with expectations

	process for: (PPE, Hand hygiene, screening, etc.) ☒ Describe process when breaks in practice are identified ☒Interview of staff – are they aware of processes/protocols for COVID-19 Transmission Based Precautions, ask staff specific questions based upon training reviewed (i.e. PPE training and what the process is, observe PPE use and alignment with P&P as well as training)	
Record Review	☒Review *2 records of veteran and their roommates* who were COVID positive in September – (Goal is to review pre and post diagnosis, identification of CoC, timely intervention, appropriate quarantine and isolation, treatments, etc.) • Review a time span 14 days prior and post COVID diagnosis • Change of condition – immediate identification • Monitoring of resident prior to and post positive result • Documentation • Reporting • Notifications • Testing – process and how long it took for testing after s/s identified (time line of what testing was done) • How long it took to get results • Asymptomatic – what was the process, mitigation, placement • Roommate review of chart • Did veteran placement change	• Records for review were identified during interviews with the house supervisors • All veterans were being monitored q shift for s/s of COVID • (4) records were reviewed, 3 positive veterans and 1 with a roommate ➢ Veteran #1: ▪ Nursing notes (NN) 10/7/20: Symptomatic with low grade fever, rapid test done negative ▪ NN 10/9/20: Resident moved to quarantine ▪ NN 10/11/20: Resident with decreased O2 sat (88%), rapid test negative ▪ NN 10/13/20: Increased weakness, SOB, O2 sat (78%), transferred to hospital ▪ NN 10/14/20: Died in hospital with dx of hypoxia and COVID positive ▪ COVID care plan in place ➢ Veteran #2: ▪ NN indicate weekly COVID testing and veteran remained asymptomatic and COVID negative ▪ NN 10/15/20: Rapid test positive and veteran moved to isolation ▪ COVID-19 care plan in place ▪ Appropriate notifications ➢ Veteran #3: • COVID care plan in place and updated

	occur? • Care plan change • Special treatments • Nebs, CPaP, BiPaP, aerosol generating, trach • Dialysis • Did the veteran leave for external appts prior to COVID diagnosis • Any visitors or visitations occurred prior, during – also hand holding visits • Review of clinical notes • If Special care unit resident – wandering status, did they wander into rooms, masking,	• Veteran asymptomatic with negative, PCR COVID tests weekly until 10/3/20 • NN 10/3/20: Positive COVID PCR test moved to isolation • NN while in isolation indicate asymptomatic until 10/10/20 • NN 10/10/20: Veteran with increased wheezing, elevated pulse, was transferred to hospital • NN 10/17/20: Veteran on vent • 10/25/20: Veteran died in the hospital ➢ Veteran #4: • COVID assessment and care plan in place • NN 10/7/20: PCR COVID Positive results, placed in isolation, asymptomatic • Continued to be tested and remained positive 10/24/20 and 10/26/20
Staff Interviews - Additional Questions during observation process and meetings	**<u>All Departments</u>** Questions when meeting with staff (various departments, positions) (recommend that you interview people from every department including *one charge nurse, one-unit manager and one house supervisor*): • Do you know where the COVID related P&P Manual is? o Can you show me? • Do you have one for example, on PPE donning and doffing? • Do you use the P&P Manual for direction? • How often have you accessed the P&P since March? • Have there been any changes to the policies? • How are you informed of the changes of the Policies? • Nurses – Discuss your process for	• Multiple interviews conducted with all departments • Response to availability of specific policies/procedures was the same: ➢ Nursing assistant: "I don't know where they are" ➢ EVS: "I get my directions from by supervisor and don't know where I would find COVID policies" ➢ House Supervisors: "They are not in Sharepoint, I have looked" ➢ Nursing: "I would call the administrator for directions if I had a question regarding placement of a COVID positive veteran" • See comments in IP section • PPE Procurement: ➢ Supply manager does a daily count of PPE ➢ Has no difficulty obtaining from assigned suppliers ➢ The supervisors keep a stock of PPE – if they run out, they contact the administrator who tells them where a key is to the supply room. The key placement is moved based on control concerns ➢ Supply manager has an employee who stocks the units • See comments in EVS section

	admissions, re-admissions, quarantine, positive COVID-19 veteran? What resource do you use for decision making or resource? • Nurse – How is it determine when a veteran comes off of COVID-19 unit or quarantine? • How have polices changed since positive COVID cases? **IP Lead** ☒Describe your role in managing care for veterans with infections? ☒Do you routinely participate in calls with headquarters and describe your role in the overall COVID plan? ☒Describe your Line List or tracking process? Veterans, staff ☒Do you participate in decisions about isolation, quarantine, monitoring, screening, PPE use, policy development, training, staff supervision? ☒What is your reporting relationship to the clinical analyst? Headquarters Infection Control lead? ☒Are you aware of CDC and DHHS COVID-19 guidelines and recommendations? Do you utilize those in the decision process for COVID guidance? ☒Discuss how you collaborate with non-clinical departments within your home ☒Describe your process for reporting and communicating infections and COVID cases ☒Are you involved in the overall COVID prevention processes – including testing of veterans and staff, data collection,	

	reporting of outcomes, ☒Who communicates with the LDPH? ☒Do you conduct contact tracing? ☒ Describe how you work with Procurement Officer, Environmental Services and other departments related to COVID-19 and Infection Control **PPE Process for IP** ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☒ Describe the inventory process, burn rate process for PPE ☒ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) **Procurement Officer** ☐PPE –Who is assigned to replenish supply of PPE on each unit and department ☐ Describe the Communication process if supplies are running low ☐ Describe the inventory process, burn rate process for PPE ☐ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) ☐ Describe how much PPE inventory that is currently available in house ☐ Describe the process for procuring PPE	

	Environmental Services Lead ☒Describe how you oversee the housekeeping staff's disinfection process ☒How often are surfaces in common areas disinfected ☒Where are the cleaning and disinfection polices located, describe accessibility? ☒Describe the process for selection of disinfectants used, when did you start using EPA List N products ☒Describe the laundry process ☒Do you utilize consistent assignment? If not do they start negative unit to positive?	
Additional Observations and Summary		

APPENDIX E3. Pathway Report: Cape Girardeau Veterans Home Summary

Cape Girardeau Veterans Home

Summary Overview

The attached is Onsite Facility Infection Control/COVID-19 Evaluation report with specific findings identified. Below is a summary of highlighted trends identified during the onsite visit for this Home.

- Infection Control lead activities are being managed by the Director of Nursing Services, rather than the Infection Control Nurse
- The Infection Control Nurse does not routinely maintain the Line Lists as would be expected per standards of practice
    - Reporting of infections is completed to the DNS weekly or more often as identified, not as soon as identified as would be expected per standards of practice
- There was no evidence of general infection prevention and control policies and procedures as well as COVID-19 specific policies and procedures
- Front line staff indicated they were not aware of infection control and COVID-19 policies and procedures as would be expected per standards of practice
- Symptom Screening for veterans for all symptoms of COVID-19 was not identified.
- Charting is completed by exception; therefore, it does not identify evidence of routine screening of COVID-19 symptoms.
- Common area use and social distancing not consistent with CDC guidance
- Screening of Staff and Visitors – Active screening was not consistently completed as would be expected per standards of practice
- Veteran Placement did not consistently follow current guidance relative to quarantine and isolation guidance.
- Signage does not reflect COVID-19 guidance
- Cleaning and Disinfection does not follow current guidance for:
    - Equipment reuse
    - PPE cleaning and disinfection for reuse
- Social distancing is not consistent since initiation of outbreak
- PPE use per current guidance - multi breaks in practice identified
    - Use and reuse, storage, varying strategies for gown use, sequencing
- PPE optimization – not in accordance with CDC guidance.
- Dedicated staff on the COVID unit was not consistently practiced.
- Veterans not consistently following universal source control
- Communication flow related to COVID-19 guidance comes from Headquarters to Administration. Administration manages communications. Unable to determine communication flow to direct care staff relative to updated guidance.
- The Home leadership team was cooperative and informative throughout the onsite evaluation. Staff are dedicated to the needs of the veterans they serve.

APPENDIX E4. Pathway Report: Cape Girardeau Veterans Home Onsite Infection Control Review Report

Onsite Facility Infection Control/COVID-19 Evaluation

Facility Demographics	**Veterans Home Name: Cape Girardeau Veterans Home** **Date: 10/28-10/29** **Consultant: Margaret Fazzio RN** **Administrator: Mindi** **Director of Nursing Services: Jean** **Number of Licensed Beds: 150** **Average Daily Census: usual is 147-149. No admissions since March, current 88** **<u>COVID-19 Status</u>** **Number of total COVID Cases:** **Number of Veteran Cases: 97** **Number of Staff Cases: 48** **Number of COVID related deaths: 29 veterans** **Current COVID Status:** **Veterans: 3 in house, 2 hospitalized** **Staff: 4**

Topic	Activity	Findings
Infection Control Lead (DON)	☒An infection lead has been designated to address and improve infection control ☒ RN ☒How long in IP Position- 9 years ☒Infection Preventionist Training – Describe: CDC IP training, finished this year	• (The Director of Nursing Services (DNS) reported a [redacted] overlapping the outbreak and surge in September) • The DNS is the Infection Control Lead for 9 years • The DNS spends 60-70% of designated time to IP activities • Infection Preventionist Training – The Centers for Disease Control and Prevention (CDC) Infection Prevention training, finished this year

	☒Infection Preventionist is assigned other duties in the facility Describe: DON ☒Hours allotted for Infection Preventionist role – Describe: 60-70% ☒Infection Preventionist maintains a line list □ Veterans with s/sx or confirmed COVID-19 □ Employees with s/sx or confirmed COVID-19 ☒PPE –Who is assigned to replenish supply of PPE on each unit and department Procurement team ☒ Describe the Communication process if supplies are running low call, shift sup has access ☒ Describe the inventory process, burn rate process for PPE: HQ ☒ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) ☒ Familiar with PPE optimization process Spend time discussing their role, responsibility as the IP Discuss the COVID status, and is this the same process before, during COVID and is it now your process Describe fit testing process: SDC and HIM trained. Describe COVID-19 preparation, mitigation and response process	• Infection Control Nurse (ICN) or Infection Control Lead tasks include: surveillance, antibiotic stewardship, education, audits (COVID and routine IPC auditing), TBP, APIC guidance for infection criteria, mapping, reporting, weekly and monthly reporting and data monitoring, and coordination and oversight of unit manager IPC activities. • Unit managers' report IPC activities including management of TBP, observations for change of condition, antibiotic use, infections and reporting to the DNS weekly or more often as identified. • See discussion below for Personal Protective Equipment (PPE) optimization. • Head Quarters (HQ) provided guidance on PPE optimization needs. • Facility team designated off wing areas (office space) for COVID care unit and observation, and this was apparently used with first case in July. • This was abandoned in September with surge and eventually 2 halls on all 3 wings were deemed COVID +. • It was reported that HQ was making bed placement decisions and guiding veteran reassignments. • Currently 1 hall of the dementia wing remains designated, though the plastic barrier walls and zipper doors remain in place on all wings. Wing C unit manager stated she has 1 empty hall, terminally cleaned and ready for observation status if needed. • Entry screening started in March with limits on activities and visitors. • PPE use per HQ guidance, see below

Policies and Procedures	☒ Infection Control Policies and Procedures ☒ COVID -19 Policies and Procedures • Screening for all o Veterans o Staff o Visitors o Vendors, hospice, therapy o ERAY, Pharmacy o Supply delivery process • PPE • Veteran Placement (quarantine process, confirmed COVID-19 process) • Admission, re-admission, discharge • Universal Source Control (Staff and Veterans) • Visitation (when started, where located, infection control measures, documentation, etc) • Hand holding stations • Aerosol generating medications, nebulizer • Postmortem care • Testing o Overall o Specimen process o Rapid Antigen POC o PCR and Lab process o Reporting process • Reporting and Communication process (Reporting of S/S, confirmed cases, quarantine, PPE, all COVID related communication – to whom and how communicated to home and departments and staff) o Timing of reporting	• DNS reports policies and procedures (P&P) come down from HQ, though the DNS work group has input and reviews policies, shares ideas for best practice, and recommendations for policy revisions. • IP P&P were reported to be on the computer and accessible by all staff. • Administration support staff queried for this and was able to locate a blood borne pathogen P&P on the computer. No other policies were available. • Charge nurse queried and a nursing manual was located, which did not contain any infection control P&P. • Charge nurse stated he would query his unit manager for this and get back to auditor (though audit ended shortly thereafter). • Certified Nursing Assistant (CNA) queried and she stated she did not know. She had never viewed an IP P&P, but if had questions she would query Staff Development Coordinator (SDC). <u>Visitation</u> • Outdoor visiting description in line with CDC guidance. June to July and briefly in August, discontinued since then • Closed window visits continue • Hand hold station was not started. <u>Postmortem Care</u> • Change to postmortem process: FH do not enter the building. <u>Testing</u> • Testing started in the spring with 1-2x a week testing (PCR) • Rapid POC testing available in early September. • PCR collected Mon/Thurs and Rapid POC collected the remaining days for veterans and staff. This auditor tested with the Rapid POC both days of the audit.

	○ Direction for reporting ○ Changes in reporting process in last 3 months • Veterans psychosocial needs • Communal activities • Dining • Special Care Unit specific • Hand Hygiene • Employee illness • Return to work • Education • Staffing and Staff assignment • Cleaning and disinfection – all departments ☒Change in condition for COVID-19 ☒Facility has a COVID-19 pandemic plan	• DNS and Administrator share the reporting responsibilities to MO DHSS and HQ. • Veteran hand hygiene wash clothes (soapy water, per staff report) available at 3 observed meals, but inconsistently offered and assisted with by staff. • Veterans observed in all common areas, 1 hour prior to mealtimes, contrary to what was communicated to the auditor; veterans were to be quarantined to their rooms.
Clinical Care and Veteran Monitoring	☒Monitoring for Change of Condition with COVID-19 ☒Systems are in place identify COVID-19 early via screening processes ☒All veterans are screened for symptoms of COVID-19 and have their vital signs monitored, including oxygen saturation and temperature checks including: (Describe their screening and monitoring process) ☒Is the symptom list up to date for COVID-19: Fever or chills Cough Shortness of breath or difficulty breathing Fatigue Muscle or body aches	• Monitoring of Veterans Temp and oxygen (O2) Q4 hours. • Collected by CNA and recorded in EHR. Charge nurse is to review and alert shift supervisor or unit manager to any concerns. • Charting by exception for additional s/s of COVID. • Respiratory assessment and progress note for "Condition charting" initiated with any identified s/s or change in vitals. • Vital parameters consistently reported by nurses in interview. (Temp >=100.4 and/or O2 sat <= 90). • No nurse reported routine query of veteran for additional COVID s/s. • Charge nurse, shift supervisor, and CNA queried about s/s of COVID and were able to report most to auditor. • Charge nurse did state he is alert to any temps above 99.3 or changes to respiratory status and would initiate assessment and monitoring at this time. • No nurse reported isolating the veteran as a first step after identification of possible s/s. • Collection a Rapid POC test and calling the shift supervisor/medical director were more often reported as first steps. • Charge nurse also reported Q2 hour vital signs (VS) for 1 hall due to positive staff and mandatory gown change upon exiting this hall, though this was not evident in the signage or communicated to the auditor during earlier

	Headache New loss of taste or smell Sore throat Congestion or runny nose Nausea or vomiting Diarrhea Trouble breathing Persistent pain or pressure in the chest New confusion Inability to wake or stay awake Bluish lips or face ☒Does the E H R have a system for alerts? Are they able to monitor trends, contact tracing based upon trends, etc.? Who monitors this process and how is it communicated? ☒Is there are RCA process when COVID is identified to determine potential risks, breaks in practice, contact tracing, etc.?	observations. • Most s/s listed on entry questionnaire for staff and visitors. • Unit manager described use of an EHR tool ("hot chart" ?) to quickly identify change charting for her wing. • DNS reports the Root Cause Analysis (RCA) process is not yet complete for the outbreaks. • She reports community COVID activity and changes to state and county mask and social distancing requirements as likely contributing factors.
Entrance to Home – Screening Process	☒Facility screens every individual entering the facility (including staff) for COVID-19 symptoms. Questionnaire, temperature taken. ☒Entry access is limited, and the entrance has screening stations. ☒Those permitted entry are instructed about frequent hand hygiene, limiting interactions with others and with surfaces touched and limiting their visit to designated areas ☒Those permitted entry are instructed about monitoring for signs and symptoms of COVID-19 ☒Observe Screening criteria and process includes temperature checks.	• Large entry space with room for social distancing with entry of multiple staff. • Signs with instructions, s/s, prevention, hand hygiene (HH). • Screener experienced and trained. • Rapid POC or PCR test (per current schedule) administered at this point, staff wait for results (rapid only) prior to proceeding to duty area. • MO Disaster Medical Assistance Team (DMAT) assisting with entry screening and testing. • This auditor was also fit tested for the N95 at entry by the SDC. • Any outlier on entry questionnaire is reported to shift sup for further direction. • Exit Temps are also collected and recorded. When this auditor exited, a staff person had to be located by the auditor to verify the exit temp and record. • Entry signage states the door locks at 7pm. Administration reported this was manned at all times until locked ("around dusk")

	☒Tracks and monitors for fever ☒Tracks and monitors COVID-19 symptoms ☒Review screening process, log, paperwork and questionnaire	• Auditor exit between 530 to 6 pm: no staff present at entry station. Auditor located the Activity director close by who stated this can happen and staff are to find someone to sign-off on exit temp. She performed this for the auditor. • It seems possible a visitor could have gained entry to building without being observed or screened.
COVID-19 – Confirmed or Suspected **Status, Plan and System**	☒Confirmed positive or recovering COVID-19 veterans are placed on COVID-19 Unit/Wing ☒Co-horting or in a private room ☐If no room is available on COVID-19 Unit, veteran placed in private room or co-horted with other confirmed case ☒All veterans who are not suspected to be infected with COVID-19 are in rooms or units that do not include confirmed or suspected cases. ☒Veteran cohorting is re-evaluated by infection control lead and clinical staff and implemented each day based on results of any of the following: surveillance testing (if available), symptom screening and temperature checks. ☒Veteran cohorting is re-evaluated by infection control lead and clinical staff ☒There is an outlined process for determination of when a veteran comes off of the COVID-19 unit or quarantine ☒ How long have these processes been in place?	Current plan: • A200: COVID isolation unit. 3 positive, with 2 moving out today. Will return to their usual room • C100: empty and terminally cleaned. Ready for observation/PUI if needed. • C100 for new admission or reentry for veteran who is not deemed positive or COVID recovered. • COVID recovered are returned to their usual room with no additional precautions. • Veterans who develop signs and symptoms (s/s) are maintained in their current room with no additional precautions until return of the Rapid POC or PCR test. Stated logic for this that all wings are using full PPE with all Veterans and changing between. (though this was not the practice observed or reported by staff) • Bed placement and cohorting decisions are a team approach including administration, pertinent department heads, and unit managers. Administration team reports this is very individualized due to all the potential scenarios and they use the CDC to guide decisions. • Medical director remains highly involved and provides final clinical clearance prior to deeming the veteran recovered. Rapid POC testing was also reported prior to moving off the COVID isolation hall for one veteran moving today. • This process has been evidently evolving. DNS reported HQ made many bed placement decisions in and around the September outbreak and was still involved in guiding these decisions.

		• It is also of note that many single and double veteran rooms share a common bathroom, accessed in the common hall area. Few rooms have in-room bathrooms. Shower and bathing rooms are also common to the hall.
Communal and Congregate Areas – Veteran Care	☒Outings, group activities and communal dining are adjusted per COVID-10 status Explain the process, review policy ☒Describe current status on veterans using congregate spaces Ask about activities, dining, what they are using their communal spaces for, has the process changed over time? ☒Social distancing is observed ☒Universal source control is observed ☒Describe the Special Care Unit process for communal space and mitigation ☒Terminal cleaning is completed after each use – describe the process Describe	• March 8-9: outings discontinued, dining adjusted • Staff reported veterans quarantined to rooms, though this was not evident on any of the wings. • Veterans observed accessing outdoor smoking areas, sitting in common areas, some evidently brought by staff as they were in BRODA/GERI style chairs. Most wearing masks, except those observed in common areas on the dementia/secured wing • All wings with many chairs and seating options, not socially distanced set up. Though veterans observed were social distanced.
Hand Hygiene and Necessary Supplies	☒Necessary supplies are available and accessible for hand hygiene. Describe what is used, accessibility, etc. **Hand Hygiene** **OBSERVATION** Staff perform hand hygiene (even if gloves are used) when indicated ☒Before and after glove use ☒Before & after veteran contact ☒After contact with blood, body fluids or visibly contaminated surfaces ☒After contact with objects and	• All staff report ample Alcohol Based hand Rub (ABHR) and HH supply throughout pandemic period. • Shift supervisors perform daily auditing of no less than 10 staff per shift and return results to DNS. • Audit tool reviewed, does not contain specific steps for check off, though some supervisors included content of re-education if needed. • Shift supervisor and unit manager reported daily checks of CNA staff for competency of HH. • Observations of soap and water and ABHR HH technique demonstrated good compliance with technique and time. • Observations: • 2 staff observed to ‘fan’ hands in the air in attempt to dry the ABHR rapidly.

	surfaces in the veteran's environment ☒Before performing procedures such as an aseptic task ☒After removing PPE ☒Alcohol-based hand rub (ABHR) is readily available ☒Staff use ABHR preferentially for hand hygiene – if available, it is readily accessible and preferentially used ☒If ABHR is not available or limited, staff wash their hands with soap and water ☒Staff wash their hands with soap and water for 20 seconds when visibly soiled ☒**Staff interviewed** indicated there is an adequate supply of hand soap and paper towels	• Staff report education and frequent/daily observations and auditing. • No staff reported lack of supplies for HH
Cleaning and Disinfection	**OBSERVATION** **Supplies and Disinfection (multiple departments)** ☒Dedicated or disposable non-critical care equipment is used ☒Reusable equipment is cleaned and disinfected after use according to manufacturer's directions using an EPA registered disinfectant List N before use on another veteran ☒Objects and environmental surfaces that are touched frequently and are close to the veteran are cleaned and disinfected at least daily and when visibly soiled ☒Staff appropriately perform environmental cleaning and disinfection ☒Staff appropriately reprocess reusable	• Staff reported correct disinfection procedures in interview. • Alcohol wipes, moist wipes, cavi wipes, microkill bleach wipes, dispatch, Virex II, Oxivir TB, equate beauty original clean wipes, and Expose II all observed in PPE area, veteran wings, and/or in use by ancillary staff. Not all are EPA List N. • Staff reported different surface times for Virex II and Oxivir TB in interview. • 2 CNAs queried for disinfectant for lifts. Both had to look a few places to find it, despite 1 having just finished using a lift and purportedly cleaning it.

	equipment (cleaning and disinfecting per device and according to manufacturer's instructions and contact time) Ask Staff: Restorative/Therapy Dining Services Activities/Recreation	 <u>Restorative/Therapy</u> • Contract Skilled therapy discontinued for 3 months (March to June time frame) • Restorative staff utilized to work on veteran wings 9/3-10/13, during outbreak. • All are now back to working, though all services provided in rooms. Equipment is not stored in rooms, but taken and sanitized when treatments completed. • Reduced restorative dining services due to need for social distancing. • Regular assignments, if working COVID +, this is the last stop prior to end of work day. PPE gown and gloves reported as changed between veterans. Contract therapists follow the same practices. <u>Dining Services</u> • Dining transitioned to 1 veteran per table, 1 unit at a time (spring) to on unit dining in communal spaces or rooms (until July). Since then all dining is on unit and in room (though all observations of dining included some veterans in the common areas eating, though socially distanced). • All paper except utensils which are returned and washed accordingly. • No concerns in kitchen tour. • Carts for meal delivery are open framed carts with no cover or protection for trays of food and drinks (all in closed containers), silverware rolled with napkin, but uncovered. • Dietary manager and staff report frequent team observations and demonstrations for PPE use amongst their team. <u>Observation:</u> • CNA collecting used meal trays, sorting trash and utensils for disposal or return to kitchen, from room to room without hand hygiene and glove changes. ABHR performed on gloves, without glove change once in this observation. <u>Activities/Recreation</u>

		• March 9th: volunteers, visitors, outings ended. • Group activities, by wing and with social distancing occurring in large common areas through July. • Communal activities on the wing using social distancing at table in common areas and doorway activities until outbreak in Sept. • Now all room-based activities, 1:1. Reported appropriate HH and glove use (this also observed by auditor) • Dedicated staff. • Oxivir and disinfection wipes used for activity supplies. Maintenance staff not made available for this audit.
PPE	☒All staff are practicing universal source control (i.e. face masks) ☒Staff have been trained on selecting, donning, and doffing appropriate PPE, were staff tested, competency verification ☒If there are COVID-19 cased identified in the facility, staff is wearing recommended PPE for care of all veterans, in line with the most recent guidance. ☒Observe and describe – if extended or re-use of PPE is practiced, describe the home's process ☒Necessary PPE is immediately available upon entrance to the COVID-19 unit **OBSERVATION: (Nursing and Multiple departments)** ☒Staff demonstrate proper sequencing of PPE per COVID-19 per CDC guidance Don 1. Identify and gather the proper PPE	• 2 staff observed in closed office space, SD, but 1 without face mask. • Evidence of recent and ongoing emphasis on PPE use, donning, doffing, and hand hygiene. • Shift supervisor shared current audits including daily auditing of above tasks, goal of at least 10 staff observed for each supervisor shift. • Unit managers, charge nurses, and CNAs all report daily auditing, donning and doffing demonstrations, and competencies. • Current PPE use started on 9/8 (per SDC records), prior to this date staff report use of surgical mask universally and standard precautions. • It was not reported that any changes to PPE use occurred with the first outbreak in July. • Unit staff and managers' report reuse/extended use strategies for gowns, eye protection, and N95 masks. • Masks worn for a shift, not removed, and discarded at the end of the shift. • Eye protection extended for useful life (goggles or shields). Some staff use facility issued and some staff have purchased goggles for their own use. These are disinfected and the end of the shift and stored in bags on the assigned wing or in bags in their personal cars (more often in the case of goggle use) • Disinfection of shields and goggles was reported as a necessary step upon leaving any of the veteran wings (as part of the doffing process) though this was not routinely observed. • Gowns worn on all wings, though varying strategies to reuse the gowns were demonstrated. • Gowns worn throughout the shift on A wing, changed only if soiled. (all veterans are COVID recovered) • A200(COVID isolation hall): Gowns from A worn into A200, though removed

	to don. 2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown. 4. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). 5. Put on face shield or goggles. 6. Put on gloves. 7. Healthcare personnel may now enter patient room. (Doff) PPE 1. Remove gloves. 2. Remove gown. 3. Healthcare personnel may now exit patient room. 4. Perform hand hygiene. 5. Remove face shield or goggles. 6. Remove and discard respirator (or facemask if used instead of respirator). 7. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing reuse.* ☒Signage - Signs on the use of PPE are posted in appropriate locations- posted immediately outside of veteran rooms indicating appropriate infection control precaution and required PPE per guidelines.	upon exit from A200. Med techs store A200 gown in transition space to wear again when entering multiple times a shift, apparently changing gown in the transition space. • B wing actively utilizing hooks in veteran rooms to store dedicated gown for use during cares and on current shift. Gowns donned upon wing entry, removed in room or just outside room, 'in-room' gown donned, cares provided, 'in-room' gown doffed, wing gown donned. • C wing had hooks in veteran rooms but these were mostly empty and staff not observed utilizing them. Gown donned upon entry to wing, changed when cares are provided or close contact (definition varied by staff member) and fresh gown donned. Additionally, charge nurse reported gowns were to be changed upon exiting either hall, though this was not posted or communicated during earlier observations • Queried Administration (DON and Administrators) just prior to exit and they reported only reuse/extended use plan currently active were the N95 and eye protection as noted above. • Donning and doffing sequencing for entry and exit of wings was muddled. • Signage at wing entries did not match. (many signs, some with different steps and sequencing.) • Staff observations of donning were essentially the same, but exit doffing varied. • Some staff observed doffing gown, gloves on wing, some doffed off wing (in donning area). 1 staff doffed gown in donning area, but kept gloves on and proceeded to pick up her lunch and return to wing area. Not clear if she did change gloves (this was communicated to unit manager at the time). • Very infrequent observation of staff disinfection eye protection, including when exiting the COVID isolation hall, • Query of administration upon exit for clarity of doffing process and this differed from observations, including which side of door to doff gloves, gown, and shield (in wing or out of wing) and when or if shield/goggle disinfection would occur. Additionally, supplies and availability of supplies for disinfection varied across wing entry/exit spaces. • Overwhelming quantity of signage at all PPE stations, entry, exit areas. • Droplet Transmission Based Precautions (TBP) signage not consistent with

	☒Trash disposal bins are positioned as near as possible to the exit inside of the veteran room ☒ Is hand sanitizer accessible location ☒Veterans are donning face masks whenever: o leave their room o leave facility for essential medical appointments ☒ General observations of universal source control and PPE use per guidance in multiple departments – describe	CDC COVID TBP • Sequencing signage for PPE donning and doffing did not all instruct the same sequences. • Contact TBP sign on entry to one hall, though unit manager did not know why (this was reported as accidental and promptly removed) • 1 veteran room with "keep door closed" sign at entry, though door was open and CNA in this hall did not know there was a veteran in the hall until auditor pointed it out (only one veteran residing on this hall during observations) so could not provide further info. <u>Observations:</u> • 1 medication cart observed with med cup with medication in it, uncovered and no staff present. • COVID + unit with 3 veterans, 2 reported to transfer out today. 1 of these with reported "catheter issue". Observed shift supervisor and unit manager from the veteran's home hall called into isolation hall to assist with catheter, rather than transferring the veteran out of the isolation hall as additional, non-COVID hall staff were needed. • A number of staff observed in gowns that did not adequately meet in the back for full coverage. Discussed with unit manager who reported all gowns are 'one size for all'. She suggested 2 gowns might be used, though no directive for this and the staff may get too hot. • 2 staff observed with N95 straps improperly positioned on head. • Staff on all wings observed exiting veteran rooms and walking through common areas to discard gloves and/or gowns, HH, and obtain replacement PPE. Often walking to multiple locations to achieve all these activities. • 2 gowns hanging in entry way to COVID unit (for medication aide use) though staff were already in the unit and it seemed unlikely 2 additional aides were working. Gown hooks positioned such that PPE doffing guide was not visible without moving these used gowns. • 3 nurses/medication aides observed reaching under PPE gown and into uniform pocket for medication cart keys. • 1 CNA observed reaching under PPE gown to place hands in pockets. • PPE supplies in wing communal areas (halls) stored in a variety of locations including PPE carts, on tables, in a bucket next to a potted plant (touching clean gowns), cabinets. • PPE supply carts often with miscellaneous stuff and PPE piled in disarray on the top

		• 1 staff observed with gown not tied at the top, falling off shoulders.
Admissions, Readmissions, Communication Processes	**Admissions, Readmissions, Appointments** ☒Facility has a plan for admissions that aligns with guidance ☒ Describe placement and process for New and Re-Admissions (i.e. where, how long, testing, decision, monitoring, PPE use, etc.) ☒Readmission has a plan for admissions that aligns with guidance ☒Facility has a process for veterans who have routine medical appts (i.e. dialysis)	• Currently not taking admissions, staff report only a couple since March. • DNS states admission process includes Veteran assessment, COVID PCR test, rapid test, and observation/PUI status upon entry. • Placement discussed in another section. <u>Observation:</u> • One readmission during observations. This veteran, COVID recovered, returned to his private room, no additional precautions different from wing PPE practices. Observed sitting out in common area the next morning. • Same practice for another veteran on the same wing who transferred out to the ER and returned over the night hours, COVID status not shared with auditor.
Communication Process	**Communication Requirements** ☒Describe process for communication of COVID status ☒Describe designated person assigned responsibility for daily communications with: ☒Staff ☒Veteran ☒Families ☒ Headquarters ☒All communications include status and impact of COVID-19 in the facility – prevalence of confirmed cases in staff and veterans and PPE availability ☒Facility provides routine updates to staff re COVID-19. Staff have received updated education as needed Describe	• Staff all reported excellent communication with administration. • Tools for communication noted in education section. • Status reports at morning report and communicated to nursing teams and ancillary departments. • Administration manages communication with staff and HQ • Social services communicate with veterans and families. • Reported communications every 1-2 weeks since March including COVID status (+ staff/veterans, but no PUI or s/s that are not confirmed), current policies, changes to procedures. • Communications are often scripted and reviewed by 2 social services staff and administration to ensure a consistent message. • Occasional communications are relayed from HQ and are scripted by HQ.
Staffing and Staff Contingency Related to COVID-19 and Outbreak	☒There is a policy and procedure for staffing strategies in an emergency and is part of Emergency Preparedness plan	• DNS manages nursing staffing. • HQ provides emergency staffing plan and has supplied some nurses. None needed currently.

	☒The plan includes: ☒Dedicated and consistent staffing teams who directly interact with veterans that are COVID-19 positive ☒Limiting clinical and other staff who have direct veteran contract to specific floors or wings – there should be no rotation of staff between floors or wings during the period they are working for the day ☒An established policy to minimize the number of staff interacting with each veteran ☒List the designated person assessing responsibility for conducting a daily assessment for staffing needs including back up plans as needed	• DNS states she also has access to agency staff, but would use as last resort. • DMAT staff for assistance with entry screening and testing. • Dedicated nursing staffing since March, other departments report this since March or earlier. • Ancillary departments report some limitation to staff entering COVID hall, though this was not evident in nursing. • Nurse and CNA observed on unit, 2 additional nurses called in to assist with a catheter, and unit manager reported medication tech also entered the hall periodically during a shift. • Housekeeping also reported providing service in COVID isolation hall, though only 3 veterans were there with 2 staff. • Unit manager on the wing with the COVID hall did report limiting her own activity in/out of the COVID hall to a minimum.
Education, monitoring and screening of staff Staff Development Coordinator discussion	☒Staff education has been provided education about COVID-19 including (when did it start, how often, when was the last education, do you have any written resources to use after you have been educated and where are they located) ☒Signs and Symptoms of COVID-19 ☒How it is transmitted ☒PPE ☒ Cleaning and disinfection ☒Prevention strategies Social distancing Universal source control Hand hygiene Visitation Common use areas ☒ Testing – (licensed nurses)	• DNS and SDC report many strategies for communication and education: • Town hall, meetings, handouts, email, on the spot training, small group training, in-service, messaging on the kiosk, video, and webinar are some. • Education provided via written materials and video/webinar training for those collecting the PCR swab and administering the Rapid POC test. Testers all reported education and competency demonstrations. • SDC provided yearly education binder for inspection. COVID education started March 5th. • All COVID educations, specific content, slides and handouts, dates, and staff signatures were well organized and easy to reference. • She reports accessing CDC and DHSS frequently to review changes and aims to provide handouts and updates to staff to take with them on PCR testing days. • SDC and HIM were trained in fit testing and perform this for all staff and with changes to the N95 supply. This auditor fit tested upon entry. • Some staff needing alternate options are fit tested for these and instructed in use. All staff and visitors entering are given the N95 regardless of their

	☒Identification and reporting of change of condition ☒Screening criteria ☒ Training Materials – who develops, where does the information come from, who provides the training, modality of training, how often is training provided to staff in all departments, is there a plan outlined for the COVID-19 training ☒ Describe and review training provided ☒ Has the home conducted ongoing COVID-19 education – (describe process, frequency, accountability, documentation, etc.) ☒ Describe competency verification process for: (PPE, Hand hygiene, screening, etc.) ☒ Describe process when breaks in practice are identified ☒Interview of staff – are they aware of processes/protocols for COVID-19 Transmission Based Precautions, ask staff specific questions based upon training reviewed (i.e. PPE training and what the process is, observe PPE use and alignment with P&P as well as training)	likelihood of interacting with veterans or others. • Cleaning and disinfecting guidance and education managed by environmental services. • SDC coordinates new staff orientation and annual educations, competencies for all staff. Some walking observations, and reeducation if requested for individual staff or if needed for corrective actions. • Staff did report she was approachable and available for questions.
Record Review	☐Review *2 records of veteran and their roommates* who were COVID positive in September – (Goal is to review pre and post diagnosis, identification of CoC, timely intervention, appropriate quarantine and isolation, treatments, etc.) • Review a time span 14 days prior	<u>Veteran 1</u> [redacted] 7/14: poor appetite 7/15: poor appetite, drowsy 7/16: poor appetite 7/17: COVID + per PCR 7/18: cough 7/19: to ER and returned, documentation stated the only reason was due to

	and post COVID diagnosis • Change of condition – immediate identification • Monitoring of resident prior to and post positive result • Documentation • Reporting • Notifications • Testing – process and how long it took for testing after s/s identified (time line of what testing was done) • How long it took to get results • Asymptomatic – what was the process, mitigation, placement • Roommate review of chart • Did veteran placement change occur? • Care plan change • Special treatments • Nebs, CPaP, BiPaP, aerosol generating, trach • Dialysis • Did the veteran leave for external appts prior to COVID diagnosis • Any visitors or visitations occurred prior, during – also hand holding visits • Review of clinical notes • If Special care unit resident – wandering status, did they wander into rooms, masking,	COVID + status. Temps of 99.2 & 99.4. Bed census only showed room A304 At some point moved to initial COVID isolation space (somewhere off the veteran wings). Not clear when he returned to the wing. Documentation does not indicate when or if isolation was initiated. <u>Roommate [redacted]</u> No nursing notes 7/1-7/17. 7/19: COVID -, moved out of this room, no s/s. Multiple days following of "heightened observation" charting, though not clear what this was or if veteran was in PUI/quarantine status with associated isolation practices. Bed census: 7/18 moved from A304 to C105 and 8/1 moved to A304 <u>Veteran 2 [redacted]</u> 9/9: COVID +, isolation also documented. No evidence of change to VS or prior s/s. 9/10: supportive O2, temp 99.9 9/11: temp 99.9 9/13: temp 99.4 Bed census: 9/10 to C103, 9/29 to B200, 10/26 to B106 <u>Roommate [redacted]</u> 9/11: COVID – 9/14: COVID +, cough, temp 99.3, 99.4 9/17, 9/20, 9/21 cough noted, otherwise charting reported no s/s. No documentation to indicate if or when isolation was practiced. Bed census: 9/14 B104, 9/18 B200, 9/20 C101, 9/23 B104
Staff Interviews - Additional Questions during observation process and meetings	**<u>All Departments</u>** Questions when meeting with staff (various departments, positions) (recommend that you interview people from every department including *one*	See notes throughout. Nurses report s/s, change of condition and additional concerns to unit manager or shift supervisor. These provide guidance and direction for needed TBP, isolation.

	charge nurse, one-unit manager and one house supervisor): • Do you know where the COVID related P&P Manual is? o Can you show me? • Do you have one for example, on PPE donning and doffing? • Do you use the P&P Manual for direction? • How often have you accessed the P&P since March? • Have there been any changes to the policies? • How are you informed of the changes of the Policies? • Nurses – Discuss your process for admissions, re-admissions, quarantine, positive COVID-19 veteran? What resource do you use for decision making or resource? • Nurse – How is it determine when a veteran comes off of COVID-19 unit or quarantine? • How have polices changed since positive COVID cases? **IP Lead** ☒Describe your role in managing care for veterans with infections? ☒Do you routinely participate in calls with headquarters and describe your role in the overall COVID plan? ☒Describe your Line List or tracking process? Veterans, staff ☒Do you participate in decisions about isolation, quarantine, monitoring, screening, PPE use, policy development,	All staff reported good communication from administration, lots of information, even daily updates and changes. Some staff appeared overwhelmed by the amount of information and seemly ever-changing guidance, with more than one stating “it seems to change daily”

	training, staff supervision? ☒What is your reporting relationship to the clinical analyst? Headquarters Infection Control lead? ☒Are you aware of CDC and DHHS COVID-19 guidelines and recommendations? Do you utilize those in the decision process for COVID guidance? ☒Discuss how you collaborate with non-clinical departments within your home ☒Describe your process for reporting and communicating infections and COVID cases ☒Are you involved in the overall COVID prevention processes – including testing of veterans and staff, data collection, reporting of outcomes, ☒Who communicates with the DPH? ☒Do you conduct contact tracing? ☒ Describe how you work with Procurement Officer, Environmental Services and other departments related to COVID-19 and Infection Control **PPE Process for IP** ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☒ Describe the inventory process, burn rate process for PPE ☒ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory)	HQ calls were daily in the spring, now M-W-F. Administrators, DNS, unit managers routinely attend, others are invited to attend if they wish. Line list maintained for COVID status staff and veterans. No HQ IC specific resource. DHSS has some resources, pharmacy and lab also assist with IPC data. CDC is reported as primary source of information. DNS and department heads all reported good communication and collaboration. Reporting as noted above. DNS reports doing contact tracing of staff. See below Sources PPE from vendors and HQ (gowns and N95).

	Procurement Officer ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☒ Describe the inventory process, burn rate process for PPE ☒ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) ☒ Describe how much PPE inventory that is currently available in house ☒ Describe the process for procuring PPE	2 staff stock PPE areas 5 days a week in 17 areas. They do not stock within the COVID isolation hall. Additional supplies are accessible by the shift supervisors at any time. This officer was not familiar with burn calculations, HQ manages this. She reports daily inventory counts to the administrator who communicated to HQ. She is aware of the number of PPE items she has, but cannot state how many days supply this is, except N95 mask supply which was reported at 21 days.
	Environmental Services Lead ☒Describe how you oversee the housekeeping staff's disinfection process ☒How often are surfaces in common areas disinfected ☒Where are the cleaning and disinfection polices located, describe accessibility? ☒Describe the process for selection of disinfectants used, when did you start using EPA List N products ☒Describe the laundry process ☒Do you utilize consistent assignment? If not do they start negative unit to positive?	• Environmental services P&P reported to be in department office and housekeeping closets. (not observed by auditor) • HQ provides list of approved products and she is not conversant about the EPA listing. • DNS reviews and approves products from IPC perspective. • Bleach solution for use with C-diff rooms requires mixing and is not regularly used. Instructions and room cleaning guidance are provided to housekeepers as needed and check sheet to confirm correct cleaning of C-diff spaces is maintained. • MSDS is maintained on computer, not verified in this observation • Dedicated staff, though staffing challenges necessitate floaters. • Reported process of taking linen and trash from COVID hall outside and around building to dumpsters and laundry entry. <u>Observations</u>: Laundry delivery: • Veteran laundry delivered in uncovered cart (per HQ directive). Veteran clothing actually touching a trash barrel in the common area of one wing. • Laundry staff observed room to room delivering and stowing veteran's

		clothing without hand hygiene or glove changes. • Laundry staff observed exiting wing, doffing process as posted at this location was not followed (though there are differing signs throughout facility). • Not observed to disinfect eye protection. • Housekeeper reported cleaning high touch surfaces 1-3x per shift, focusing on nursing desk area as this continues to have high use. • Multiple cardboard trash bins without covers for disposal of gowns on wings and halls. • Many with gowns hanging over the side or out of the bins. • Fans blowing in and around all wing common areas. • Seating in all observed unit common areas not supportive of social distancing. • Boxes of gowns and gloves on the floors in common areas of wings and entry donning areas. • Used alcohol wipes and packaging observed lying on PPE supply carts on wing. • 2 wings with storage carts for briefs with tops covered with an assortment of care items. • Multiple chairs, tables, wheelchairs, walkers, miscellaneous equipment for chairs and such, empty beds stored in common areas of wings. Though administration reported veterans were quarantined to their rooms, all wing observations evidenced 1-4 veterans using the common areas, some obviously seated there by staff as they were in BRODA/GERI style chairs. Disinfection status of all these items was not clear. One CNA reported needing to store wheelchairs in common areas due to limited space in rooms. • 2 veterans handed common area TV remotes by staff, no evidence of disinfection before or after this.
Additional Observations and Summary		

APPENDIX E5. Pathway Report: Mexico Veterans Home Summary

Mexico Veterans Home

Summary Overview

The attached is Onsite Facility Infection Control/COVID-19 Evaluation report with specific findings identified. Below is a summary of highlighted trends identified during the onsite visit for this Home.

- The Home leadership team was cooperative and informative throughout the onsite evaluation. Staff are dedicated to the needs of the veterans they serve.
- The Home has a strong leadership team which collaborates with the Medical Director and facility staff. They empower their staff to take necessary actions in accordance with their plan. The team has accessed information needed and disseminated to staff for appropriate actions.
- They have a large COVID Emergency plan binder ("COVID Bible") including prevention and mitigation strategies.
- There were no formal infection control and COVID policies and procedures, however the team utilizes the COVID Binder for direction and education needs.
- Symptoms screening was not completed as part of the veteran monitoring process as would be expected per best practice guidelines
    - Every shift a COVID assessment was completed. The COVID-19 assessment does not list all of these symptoms, but staff were aware of the current symptom list.
- Overall PPE conning and doffing was consistent with current guidance; however, the Home is optimizing based on directives or guidance from Head Quarters. The CDC guidance indicates if the facility has adequate PPE, they should practice conventional capacity.

APPENDIX E6. Pathway Report: Mexico Veterans Home Onsite Infection Control Review Report

Onsite Facility Infection Control/COVID-19 Evaluation

Facility Demographics	**Veterans Home Name:** Mexico Veterans Home **Date:** October 30, 2020 **Consultant:** Karolee Alexander **Administrator:** Aliesha Edwards **Director of Nursing Services:** Patrick **Number of Licensed Beds:** 150 **Average Daily Census:** 117 in-house, 1 in hospital- not COVID related **COVID-19 Status** **Number of total COVID Cases:** **Number of Veteran Cases** 8 PCR confirmed, 3 RA positive on 10/27, 1 symptomatic 10/27 **Number of Staff Cases** 2 recovered, 5 new **Number recovered** 2 **Number of COVID related deaths: 0** **Current COVID Status:** **Veterans** as above **Staff** 7	
	Activity	**Findings**
Infection Control Lead	☐An infection lead has been designated to address and improve infection control ☒ RN/LPN (Circle one) ☒How long in IP Position- ☒Infection Preventionist Training – Describe:	The Infection Control Lead (IP) is a House Supervisor without dedicated time specific to infection preventio. She is responsible for veterans' vaccinations, outcome surveillance, analysis and mapping for veteran infections, Identification of new infections and actions taken. There are scheduled process and outcome infection surveillance for all departments. Some COVID related surveillance is performed in every department. The IP oversees all surveillance. There is a weekly risk meeting where infections are discussed and a monthly QAPI meeting where

	☒Infection Preventionist is assigned other duties in the facility Describe: ☐Hours allotted for Infection Preventionist role – Describe: ☐Infection Preventionist maintains a line list □ Veterans with s/sx or confirmed COVID-19 □ Employees with s/sx or confirmed COVID-19 ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☒ Describe the inventory process, burn rate process for PPE ☐ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) ☐ Familiar with PPE optimization process Spend time discussing their role, responsibility as the IP Discuss the COVID status, and is this the same process before, during COVID and is it now your process Describe fit testing process Describe COVID-19 preparation, mitigation and response process	trending and tracking is discussed. Another house Supervisor fulfills the role of Employee health, tracking, trending and reporting employee infections. The purchasing agent distributes PPE to the care areas. House supervisors can access PPE supplies off-shift, weekends and holidays, if needed. No one was familiar with the term optimization. They are re-using N95 respirators for up to 40 hours. It was reported that the respirators do not last that long and are replaced as soon as they are not useable. Gowns are issued at the beginning of each shift for each nursing assistant for each resident to use for one shift. They hang on the outside of the resident's door until the end of the shift. The purchasing agent keeps a detailed inventory of PPE and cleaning supplies. Inventory is reported to HQ daily. The IP is not involved in PPE decisions. Staff were fit tested in March for N95 respirators from at least 2 manufacturers. New employees are fit tested at the time of hire. There is a master log with all employees' fit testing information. N95 supply in March was poor so staff for the isolation unit were fit tested first. The facility has been on modified "lock-down" since March. They had a COVID-19 Project Management Plan in place since before March. This is essentially an emergency response plan for COVID-19. The plan was reviewed and updated frequently over the last months. House supervisors have been using a COVID-19 monitoring tool that has been completed each shift. It acts as a reminder about the things that require monitoring to prevent the spread of COVID. They had their first case of COVID on Sat, Oct 28. Since then residents have been encouraged to stay in their rooms, with the exception of the Special Care Unit. Staff remind those veterans to wear their mask and socially distance. Rapid Antigen testing occurs daily for staff and residents. PCR testing is completed twice per week for staff and residents and to confirm positive results from RA testing. All staff wear an N95 and eye protection in the building. Veterans were actively encouraged to wear a surgical mask. Staff is encouraged to use Alcohol Based

		Hand Rub (ABHR) frequently and there are abundant ABHR supplies. There was a ten bed COVID positive unit on A Core that was being expanded to twenty beds last week. An area of the 2nd floor Special Care unit had several positive RA tests this week. Because there seemed to be spread in that geographic area, fire doors were closed, and veterans were quarantined to their rooms except a few who needed assistance with eating. Staff began wearing full PPE and changing between residents.
Policies and Procedures	☐ Infection Control Policies and Procedures ☐ COVID -19 Policies and Procedures • Screening for all o Veterans o Staff o Visitors o Vendors, hospice, therapy o ERAY, Pharmacy o Supply delivery process • PPE • Veteran Placement (quarantine process, confirmed COVID-19 process) • Admission, re-admission, discharge • Universal Source Control (Staff and Veterans) • Visitation (when started, where located, infection control measures, documentation, etc) • Hand holding stations • Aerosol generating medications, nebulizer • Postmortem care • Testing o Overall	Although there are scant organizational policies and procedures, the leadership team at Mexico has assembled the "COVID Bible", a large collection of resources available in a central location. The resources include guidance from the CDC, CMS and DHHS as well as emails from HQ. There is a large supply of color copies of signs that may be needed. There is a large supply of blank screening logs and CDC PUI Investigation forms. Completed forms and logs are retained in the same location for contact tracing. The Staff Development Coordinator uses these resources as the basis for training.

	○ Specimen process ○ Rapid Antigen POC ○ PCR and Lab process ○ Reporting process • Reporting and Communication process (Reporting of S/S, confirmed cases, quarantine, PPE, all COVID related communication – to whom and how communicated to home and departments and staff) ○ Timing of reporting ○ Direction for reporting ○ Changes in reporting process in last 3 months • Veterans psychosocial needs • Communal activities • Dining • Special Care Unit specific • Hand Hygiene • Employee illness • Return to work • Education • Staffing and Staff assignment • Cleaning and disinfection – all departments ☐Change in condition for COVID-19 ☐Facility has a COVID-19 pandemic plan	
Clinical Care and Veteran Monitoring	☐Monitoring for Change of Condition with COVID-19 ☒Systems are in place identify COVID-19 early via screening processes ☒All veterans are screened for symptoms of COVID-19 and have their vital signs monitored, including oxygen saturation and temperature checks including: (Describe their screening and monitoring	Veterans are monitored for temp and SPO2 every 4 hours since the COVID positive case. Monitoring is performed by nurse aides and reported to licensed nurses. The COVID-19 assessment in the E.H.R. has not been updated since March to include all potential symptoms of COVID identified by CDC. When COVID was identified, there was an RCA process to identify the source. A bath aide (asymptomatic) working on 2nd floor for 4 days tested positive. A few days later, veterans in that area began to test positive. She wore an N95 and gown

	process) ☐Is the symptom list up to date for COVID-19: Fever or chills Cough Shortness of breath or difficulty breathing Fatigue Muscle or body aches Headache New loss of taste or smell Sore throat Congestion or runny nose Nausea or vomiting Diarrhea Trouble breathing Persistent pain or pressure in the chest New confusion Inability to wake or stay awake Bluish lips or face ☐Does the E H R have a system for alerts? Are they able to monitor trends, contact tracing based upon trends, etc.? Who monitors this process and how is it communicated? ☒Is there are RCA process when COVID is identified to determine potential risks, breaks in practice, contact tracing, etc.?	when caring for the veterans but was in very close proximity while giving baths. .
Entrance to Home – Screening Process	☒Facility screens every individual entering the facility (including staff) for COVID-19 symptoms. Questionnaire, temperature taken. ☒Entry access is limited, and the entrance	Every person entering is screened with a self-reporting questionnaire which is immediately reviewed. Each person gets a RA test and is told about hand hygiene and given an N95, if staff or a surgical mask if not. Only critical people are allowed to enter. Temperatures are taken upon entrance and at exit.

	has screening stations. ☒Those permitted entry are instructed about frequent hand hygiene, limiting interactions with others and with surfaces touched and limiting their visit to designated areas ☐Those permitted entry are instructed about monitoring for signs and symptoms of COVID-19 ☐Observe Screening criteria and process includes temperature checks. ☐Tracks and monitors for fever ☐Tracks and monitors COVID-19 symptoms ☐Review screening process, log, paperwork and questionnaire	
COVID-19 – Confirmed or Suspected Status, Plan and System	☐Confirmed positive or recovering COVID-19 veterans are placed on COVID-19 Unit/Wing ☒Co-horting or in a private room ☒If no room is available on COVID-19 Unit, veteran placed in private room or co-horted with other confirmed case ☐All veterans who are not suspected to be infected with COVID-19 are in rooms or units that do not include confirmed or suspected cases. ☐Veteran cohorting is re-evaluated by infection control lead and clinical staff and implemented each day based on results of any of the following: surveillance testing (if available), symptom screening and temperature checks.	COVID positive veterans are moved to the isolation unit as soon as they test positive on the RA test. A PCR test is also done. Quarantined veterans are kept alone in a room or in a private room. Those veterans include dialysis patients, returns from the hospital with a negative RA test. The facility is quick to quarantine or isolate a veteran who has been exposed, tests positive or is symptomatic and test positive. They test symptomatic veterans for COVID and Influenza. The Administrator make the final decision about veteran location, but the DNS and House Supervisors are free to act while waiting for the Administrator's response. The Infection Control lead is not involved in this process. Each symptomatic and COVID positive veteran is discussed at the weekly risk meeting.

	☐Veteran cohorting is re-evaluated by infection control lead and clinical staff ☒There is an outlined process for determination of when a veteran comes off of the COVID-19 unit or quarantine ☐ How long have these processes been in place?	
Communal and Congregate Areas – Veteran Care	☒Outings, group activities and communal dining are adjusted per COVID-10 status Explain the process, review policy ☐Describe current status on veterans using congregate spaces Ask about activities, dining, what they are using their communal spaces for, has the process changed over time? ☐Social distancing is observed ☐Universal source control is observed ☒Describe the Special Care Unit process for communal space and mitigation ☐Terminal cleaning is completed after each use – describe the process Describe	There are no group activities. Common areas are used by veterans and staff for assistance with eating. Veterans on the Special Care Unit are socially distanced when out of their rooms and frequently reminded and assisted to wear a mask. Did not observe terminal cleaning of common areas after each use.
Hand Hygiene and Necessary Supplies	☒Necessary supplies are available and accessible for hand hygiene. Describe what is used, accessibility, etc. **Hand Hygiene** **OBSERVATION** Staff perform hand hygiene (even if gloves are used) when indicated ☒Before and after glove use ☐Before & after veteran contact	Supplies for hand hygiene are abundant. ABHR is used appropriately.

	☒After contact with blood, body fluids or visibly contaminated surfaces ☐After contact with objects and surfaces in the veteran's environment ☒Before performing procedures such as an aseptic task ☒After removing PPE ☒Alcohol-based hand rub (ABHR) is readily available ☐Staff use ABHR preferentially for hand hygiene – if available, it is readily accessible and preferentially used ☐If ABHR is not available or limited, staff wash their hands with soap and water ☒Staff wash their hands with soap and water for 20 seconds when visibly soiled ☒**Staff interviewed** indicated there is an adequate supply of hand soap and paper towels	
Cleaning and Disinfection	**OBSERVATION** **Supplies and Disinfection (multiple departments)** ☐Dedicated or disposable non-critical care equipment is used ☐Reusable equipment is cleaned and disinfected after use according to manufacturer's directions using an EPA registered disinfectant List N before use on another veteran ☐Objects and environmental surfaces that are touched frequently and are close to the veteran are cleaned and disinfected at	Disinfection if every veteran room is completed daily. Common areas are disinfected on the evening shift and PRN. There is weekly disinfection and fogging of common areas by contracted company. Cleaning and disinfectants are available and used appropriately. HQ ensures that purchased items are on the EPA N list. In the Isolation unit nursing staff is acting as universal workers. They received training on housekeeping techniques and proper use of the chemicals. I observed staff disinfecting tabletops and a shower room. Due to a lack of storage space, clean disposable and reusable items were stored

	least daily and when visibly soiled ☐Staff appropriately perform environmental cleaning and disinfection ☐Staff appropriately reprocess reusable equipment (cleaning and disinfecting per device and according to manufacturer's instructions and contact time) Ask Staff: Housekeeping/Environmental Services ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Nursing ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Dining Services ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Activities/Recreation ☐Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Comments/Observations	on an open wire shelf in the hallway. During the expansion of the unit, a utility room will be constructed. All items on the shelf were in original packaging. Housekeeping mixed only floor cleaning solution. Spray cleaners and disinfectants were used from original manufacturer packaging by all departments.
PPE	☒All staff are practicing universal source control (i.e. face masks) ☐Staff have been trained on selecting,	Staff wear N95s and eye protection throughout the building. Direct care staff wear gowns when in close contact with the veterans. Staff were observed properly donning and doffing PPE.

	donning, and doffing appropriate PPE, were staff tested, competency verification ☐If there are COVID-19 cased identified in the facility, staff is wearing recommended PPE for care of all veterans, in line with the most recent guidance. ☒Observe and describe – if extended or re-use of PPE is practiced, describe the home's process ☒Necessary PPE is immediately available upon entrance to the COVID-19 unit **OBSERVATION: (Nursing and Multiple departments)** ☒Staff demonstrate proper sequencing of PPE per COVID-19 per CDC guidance Don 1. Identify and gather the proper PPE to don. 2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown. 4. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). 5. Put on face shield or goggles. 6. Put on gloves. 7. Healthcare personnel may now enter patient room. (Doff) PPE	The nursing assistants receive one gown per resident on their assignment for the shift, labeled with their name for identification. The gown is hung on the outside of the veteran's door when not in use. There is signage in appropriate places that is pertinent to the task to be performed in that location. PPE caddies are used on the door of each veteran with an infection requiring transmission-based precautions. The caddy contains information about the PPE that should be used. I did not observe trash cans near the veteran's rooms doorways. There were large trash cans in common areas with manual lids for PPE. On the Isolation unit, red biohazard bags and cans were used for trash and yellow isolation bags were used for laundry.

	1. Remove gloves. 2. Remove gown. 3. Healthcare personnel may now exit patient room. 4. Perform hand hygiene. 5. Remove face shield or goggles. 6. Remove and discard respirator (or facemask if used instead of respirator). 7. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing reuse.* ☒Signage - Signs on the use of PPE are posted in appropriate locations- posted immediately outside of veteran rooms indicating appropriate infection control precaution and required PPE per guidelines. ☒Trash disposal bins are positioned as near as possible to the exit inside of the veteran room ☐ Is hand sanitizer is accessible location ☐Veterans are donning face masks whenever: o leave their room o leave facility for essential medical appointments ☐ General observations of universal source control and PPE use per guidance in multiple departments – describe	
Admissions, Readmissions, Communication Processes	**Admissions, Readmissions, Appointments** ☐Facility has a plan for admissions that	No admissions at this time

	aligns with guidance ☐ Describe placement and process for New and Re-Admissions (i.e. where, how long, testing, decision, monitoring, PPE use, etc.) ☐Readmission has a plan for admissions that aligns with guidance ☐Facility has a process for veterans who have routine medical appts (i.e. dialysis)	
Communication Process	**Communication Requirements** ☐Describe process for communication of COVID status ☐Describe designated person assigned responsibility for daily communications with: ☐Staff ☐Veteran ☐Families ☐ Headquarters ☒All communications include status and impact of COVID-19 in the facility – prevalence of confirmed cases in staff and veterans and PPE availability ☒Facility provides routine updates to staff re COVID-19. Staff have received updated education as needed Describe	If a resident is symptomatic or tests positive on the RA test, the charge nurse alerts the House Supervisor. The Charge nurse calls the physician and family. The House Supervisor reports the case to the DNS and Administrator. The Administrator calls HQ. There is the twice per week call and daily reports as in other homes.
Staffing and Staff Contingency Related to COVID-19 and Outbreak	☐There is a policy and procedure for staffing strategies in an emergency and is part of Emergency Preparedness plan ☐The plan includes: ☒Dedicated and consistent staffing teams who directly interact with veterans that are	There is a new staffing plan, initiated last year, that is based on consistent assignment. Staff were asked to choose a home Core and they are scheduled there consistently. The staffing filling in for days off is also consistent. If staff working in a “Hot Spot”, a location with recent positive cases, are mandated, they stay on their unit and another staff member will go to another location.

	COVID-19 positive ☐Limiting clinical and other staff who have direct veteran contract to specific floors or wings – there should be no rotation of staff between floors or wings during the period they are working for the day ☐An established policy to minimize the number of staff interacting with each veteran ☒List the designated person assessing responsibility for conducting a daily assessment for staffing needs including back up plans as needed Describe	Dietary staff do not enter units but are consistently assigned to drop off food at the same unit. Staff recovered from COVID work only in the Isolation unit. Staff are not allowed to reenter the building for at least 8 hours after working in the Isolation unit. The staffing coordinator attends management meetings to be fully updated on the status of the facility.
Education, monitoring and screening of staff Staff Development Coordinator discussion	☐Staff education has been provided education about COVID-19 including (when did it start, how often, when was the last education, do you have any written resources to use after you have been educated and where are they located) ☐Signs and Symptoms of COVID-19 ☐How it is transmitted ☐PPE ☐ Cleaning and disinfection ☐Prevention strategies Social distancing Universal source control Hand hygiene Visitation Common use areas ☐ Testing – (licensed nurses) ☐Identification and reporting of	Staff Development Coordinator is responsible for formal education and has provided much of the ongoing education since March. She bases education on CDC, CMS and DHHS guidance and recommendations. Staff is tracked for attendance. Education is provided prior to starting the shift if a class has been missed. Observational audits are conducted frequently for PPE, hand hygiene.

	change of condition ☐Screening criteria ☐ Training Materials – who develops, where does the information come from, who provides the training, modality of training, how often is training provided to staff in all departments, is there a plan outlined for the COVID-19 training ☐ Describe and review training provided ☐ Has the home conducted ongoing COVID-19 education – (describe process, frequency, accountability, documentation, etc.) ☐ Describe competency verification process for: (PPE, Hand hygiene, screening, etc.) ☐ Describe process when breaks in practice are identified ☐Interview of staff – are they aware of processes/protocols for COVID-19 Transmission Based Precautions, ask staff specific questions based upon training reviewed (i.e. PPE training and what the process is, observe PPE use and alignment with P&P as well as training) Observations	
Record Review	☐Review *2 records of veteran and their roommates* who were COVID positive in September – (Goal is to review pre and post diagnosis, identification of CoC, timely intervention, appropriate quarantine and isolation, treatments, etc.)	Resident [redacted] Admitted July 30, 2019 Moved to Special Care unit Aug 19, 2019 On sentinel testing on Oct 21 his RA test was positive. He was moved to isolation. It was learned that there was a presumptive positive employee on Oct 24 On Oct 24 he had diminished lung sounds and SPO2 90 -97% on RA

	• Review a time span 14 days prior and post COVID diagnosis • Change of condition – immediate identification • Monitoring of resident prior to and post positive result • Documentation • Reporting • Notifications • Testing – process and how long it took for testing after s/s identified (time line of what testing was done) • How long it took to get results • Asymptomatic – what was the process, mitigation, placement • Roommate review of chart • Did veteran placement change occur? • Care plan change • Special treatments • Nebs, CPaP, BiPaP, aerosol generating, trach • Dialysis • Did the veteran leave for external appts prior to COVID diagnosis • Any visitors or visitations occurred prior, during – also hand holding visits • Review of clinical notes • If Special care unit resident – wandering status, did they wander into rooms, masking,	He remained stable until late on Oct 25 when he developed clear nasal discharge. He remained unchanged through October 30. Resident [redacted] Long term resident Was hospitalized one day in Jan 2020 On 10/19 fell without serious injury On Oct 24 RA was negative but PCR was positive so he was moved to the Isolation unit He remained stable with SPO2 between 93 – 95% on RA and Afebrile until Oct 26 when he developed a "slight" cough. Lungs were clear. SPO2 fell to 89%. He began to be lethargic with SPO2 from 89 – 92% on 2L oxygen. On Oct 27 SPO@ was in the upper 70% on 5L, HR and BP decreased. He was sent to the hospital early Oct 28. The hospital called on 10/30 to let the facility know that he had an extremely poor prognosis. COVID care plans are a generic template written by HQ. When asked if it could be personalized the MDS Coordinator seemed to be puzzled by my question and said, "No. HQ wrote it."
Staff Interviews - Additional Questions during observation process and meetings	**<u>All Departments</u>** Questions when meeting with staff (various departments, positions) (recommend that you interview people	Overall, staff were compliant with PPE except for touching masks.

	from every department including *one charge nurse, one-unit manager and one house supervisor*): • Do you know where the COVID related P&P Manual is? o Can you show me? • Do you have one for example, on PPE donning and doffing? • Do you use the P&P Manual for direction? • How often have you accessed the P&P since March? • Have there been any changes to the policies? • How are you informed of the changes of the Policies? • Nurses – Discuss your process for admissions, re-admissions, quarantine, positive COVID-19 veteran? What resource do you use for decision making or resource? • Nurse – How is it determine when a veteran comes off of COVID-19 unit or quarantine? • How have polices changed since positive COVID cases?	The "COVID Bible" is known to multiple staff. They can access it through the House Supervisor. Nurses were confident to make decisions immediately as needed to keep people safe, such as quarantining and cohorting. There were references to CDC and DHHS sources throughout conversations. Nurses were knowledgeable They had the first COVID positive case 6 days prior to my visit so some systems were still being worked on. The COVID Project Management Plan was their guide.
	IP Lead ☐Describe your role in managing care for veterans with infections? ☐Do you routinely participate in calls with headquarters and describe your role in the overall COVID plan? ☐Describe your Line List or tracking	The IP Lead is a House Supervisor and works very closely with the DNS. There is strong support, coordination and collaboration among the nursing team and the leadership team. There is an active line list that is updated daily as needed. Nursing leaders and Administrator are very familiar with CDC and DHHS guidance.

	process? Veterans, staff ☐Do you participate in decisions about isolation, quarantine, monitoring, screening, PPE use, policy development, training, staff supervision? ☐What is your reporting relationship to the clinical analyst? Headquarters Infection Control lead? ☐Are you aware of CDC and DHHS COVID-19 guidelines and recommendations? Do you utilize those in the decision process for COVID guidance? ☐Discuss how you collaborate with non-clinical departments within your home ☐Describe your process for reporting and communicating infections and COVID cases ☐Are you involved in the overall COVID prevention processes – including testing of veterans and staff, data collection, reporting of outcomes, ☐Who communicates with the LDPH? ☐Do you conduct contact tracing? ☐ Describe how you work with Procurement Officer, Environmental Services and other departments related to COVID-19 and Infection Control **PPE Process for IP** ☐PPE –Who is assigned to replenish supply of PPE on each unit and department ☐ Describe the Communication process if supplies are running low ☐ Describe the inventory process, burn	The Administrator, an RN, communicates several times per week with the local health department.

	rate process for PPE ☐ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) **Procurement Officer** ☐PPE –Who is assigned to replenish supply of PPE on each unit and department ☐ Describe the Communication process if supplies are running low ☐ Describe the inventory process, burn rate process for PPE ☐ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) ☐ Describe how much PPE inventory that is currently available in house ☐ Describe the process for procuring PPE **Environmental Services Lead** ☐Describe how you oversee the housekeeping staff's disinfection process ☐How often are surfaces in common areas disinfected ☐Where are the cleaning and disinfection polices located, describe accessibility? ☐Describe the process for selection of disinfectants used, when did you start using EPA List N products ☐Describe the laundry process ☐Do you utilize consistent assignment? If not do they start negative unit to positive?	Same purchasing process as St. James Common areas disinfected every evening. Disinfection and fogging of common areas weekly. There are no policies Isolation linens are yellow bagged and laundered in a dedicated washing machine and dryer. There are consistent laundry staff for delivery of laundry to specific units.

Additional Observations and Summary	This team is very knowledgeable, beyond HQ directives. They are close-knit and communicate well. The DNS is actively involved in care of the veterans and thrives on mentoring his team.	

APPENDIX E7. Pathway Report: Mt Vernon Veterans Home Summary

Mt. Vernon Veterans Home

Summary Overview

The attached is Onsite Facility Infection Control/COVID-19 Evaluation report with specific findings identified. Below is a summary of highlighted trends identified during the onsite visit for this Home.

- The Home leadership team was cooperative and informative throughout the onsite evaluation. Staff are dedicated to the needs of the veterans they serve.
- Infection Control lead activities are being managed by the Director of Nursing Services, rather than the Infection Control Nurse
- The Infection Control Nurse is not involved in the routine Head Quarter meetings related to COVID-19 activities and response
- The Infection Control Nurse does not routinely maintain the Line Lists as would be expected per standards of practice
- There was no evidence of general infection prevention and control policies and procedures as well as COVID-19 specific policies and procedures
- Front line staff indicated they were not aware of infection control and COVID-19 policies and procedures as would be expected per standards of practice
- Home staff indicated no plan for Process Surveillance audits
- Based upon interview and observation, aerosol generated procedures (i.e. nebulizer treatments) continue to be performed with procedures for cleaning and disinfection
- Symptom Screening for veterans was not part of 4 hour screening process. There was no evidence of daily documentation of symptom screening beyond vitals -
- Screening of Staff and Visitors – Active screening was not consistently completed and not all COVID1- symptoms were included in the screening documents per current guidance.
- Veteran Placement did not consistently follow current guidance relative to quarantine and isolation guidance.
    - Bed placement and cohorting decisions are referred to the Medical Director which does not allow for quick response for mitigation
    - Co-horting does not follow current guidance
- Signage does not reflect COVID-19 guidance
- Cleaning and Disinfection does not follow current guidance for:
    - Equipment reuse
    - PPE cleaning and disinfection for reuse
- Social distancing is not consistent since initiation of outbreak
- PPE use per current guidance - multi breaks in practice
- PPE optimization – not in accordance with CDC guidance.
- Education lacks interaction, ability to ask questions – employees are provided with written materials and videos, however a formal plan with ongoing targeted training was not indicated. See report for details.

- Communication flow related to COVID-19 guidance comes from Headquarters to Administration. Administration manages communications. Unable to determine communication flow to direct care staff relative to updated guidance.

APPENDIX E8. Pathway Report: Mt Vernon Veterans Home Onsite Infection Control Review Report

Onsite Facility Infection Control/COVID-19 Evaluation

Facility Demographics	**Veterans Home Name: Mt Vernon Veterans Home** **Date: 10/26 and 10/27** **Consultant: Margaret Fazzio RN** **Administrator: April** **Director of Nursing Services: Amber** **Number of Licensed Beds: 200** **Average Daily Census: Usual 180's, current 139. Since COVID Pandemic declaration, only a few admissions in August, stopped when first COVID-19+ cases identified in September** **<u>COVID-19 Status</u>** **Number of total COVID Cases:** **Number of Veteran Cases: 41** **Number of Staff Cases: 27** **Number of COVID related deaths: 9** **Current COVID Status:** **Veterans: 8** **Staff: 3**

Topic	Activity	Findings
Infection Control Lead: "Infection Control Nurse (ICN)"	☒An infection lead has been designated to address and improve infection control ☒ RN ☒How long in IP Position- approx. 1 year ☒Infection Preventionist Training ☒Infection Preventionist is assigned other duties in the facility Describe: "Clerical Nurse"	• Interview with Infection Control Nurse (ICN)was completed 10/26/2020 • ICN was out of the facility on [redacted] August-Sept this year. • ICN reports little involvement in COVID-19 specific Infection Prevention (IPC) and Control activities since return [redacted], as these tasks had been assigned to others in her absence. • The ICN reports attendance in 2 seminars in IPC (not specific to Veterans commission.) • The ICN states she is about ½ way through completing the Centers for Disease

	This entails following after Provider visits and completing the orders. ☒Hours allotted for Infection Preventionist role ☒Infection Preventionist maintains a line list: see notes □ Veterans with s/sx or confirmed COVID-19 □ Employees with s/sx or confirmed COVID-19 ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☐ Describe the inventory process, burn rate process for PPE: see procurement ☒ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) ☐ Familiar with PPE optimization process Spend time discussing their role, responsibility as the IP Discuss the COVID status, and is this the same process before, during COVID and is it now your process Describe fit testing process: staff development Describe COVID-19 preparation, mitigation and response process	Control and Prevention (CDC) training. • ICN reports that normal role is approximately spent 50% of her time on IPC. Since return from FMLA, she has been focusing completely on IPC work. <u>Usual ICN tasks:</u> Antibiotic stewardship, infection monitoring, verifying APIC criteria, mapping, auditing, some COVID specific training, observations of donning/doffing. <u>Line List</u> • Line list data is collected by the Shift supervisors or unit managers. • The Director of Nursing Services (DNS) maintains the line list for reporting purposes, using a tool that she has adapted to include COVID-19 specific items along with data about other infections and/or influenza. • Staffing maintains the staff line list, shared with Administrator and DNS for reporting. <u>Supplies</u> • ICN reports no specific staff member is responsible for replenishing supplies, though unit managers and shift supervisors will check for supply needs and all staff have access to collect supplies as needed. • A call is placed to shift supervisor or procurement. It is indicated that they are very responsive and supplies are replenished. <u>PPE Supplies - Optimization</u> • Optimization of N95 mask is in use. • N95 mask are used facility wide • Per current practice, staff not working the COVID-19 unit are asked to use N95 mask over 40 hours, unless damaged or soiled. • Storage is in paper bag in entry area, labeled with name, and stored with an alcohol wipe in the bag. (Per guidance from an unidentified team member who heard this at a conference?) <u>Monitoring and Evaluation</u> • Monthly IPC meeting with department representation including administration, dietary, nursing Health Information Management (HIM), accounting.

		• Audits include standard IPC audits, wound cares, medication carts, medication rooms, med pass, etc. • Shift supervisor reported his usual IPC auditing has been suspended since COVID emergency. He performs walking rounds with on the spot educations but completes no formal tools. <u>COVID Preparation and Response</u> • Team planning in March/April time period included selection of Unit area for COVID-19 quarantine space. This 9 bed space was prepped, including Air management for negative flow, UV light, and HEPA filtration (per maintenance director). • Staff selection for working in this unit was also identified. • Training for staff in known COVID-19 s/s, PPE and isolation precautions. • Screening started sometime in the spring with symptom screening and temp checks. • Use of surgical masks universally at that time. • Testing at this time was random selection of Veteran and staff using the PCR lab tests. • Testing varied from 1-2x/week, random 40% selection until identified case in September (veteran). • Home has Rapid tests and performs daily testing since early September. 2x/week PCR and remaining days Rapid POC tests. Staff does not come in on day off, unless needed for PCR test.
Policies and Procedures	☒ Infection Control Policies and Procedures ☒ COVID -19 Policies and Procedures • Screening for all o Veterans o Staff o Visitors o Vendors, hospice, therapy o XRAY, Pharmacy o Supply delivery process • PPE • Veteran Placement (quarantine process, confirmed COVID-19 pro-	• Per ICN, all Policy and Procedures from Veterans Corporate team. • Binders with Policies available on units. • Requested to view this on one unit. Charge nurse provided audit or a small folder with 3-4 pages of undated COVID specific guidance and the Respiratory Protection Policy. • Policies and Procedures (P&P) also reported to be available on the computer, not observed during this audit. <u>Admissions</u> • Currently not taking admissions. A few in August.

	cess)
	• Admission, re-admission, discharge
	• Universal Source Control (Staff and Veterans)
	• Visitation (when started, where located, infection control measures, documentation, etc)
	• Hand holding stations
	• Aerosol generating medications, nebulizer
	• Postmortem care
	• Testing
	  o Overall
	  o Specimen process
	  o Rapid Antigen POC
	  o PCR and Lab process
	  o Reporting process
	• Reporting and Communication process (Reporting of S/S, confirmed cases, quarantine, PPE, all COVID related communication – to whom and how communicated to home and departments and staff)
	  o Timing of reporting
	  o Direction for reporting
	  o Changes in reporting process in last 3 months
	• Veterans psychosocial needs
	• Communal activities
	• Dining
	• Special Care Unit specific
	• Hand Hygiene
	• Employee illness
	• Return to work
	• Education
	• Staffing and Staff assignment
	• Cleaning and disinfection – all de-
		• PCR COVID-19 testing is completed prior to admission.
		• Observation isolation for 14 days and re-tested.
		
		<u>Observation</u>
		• Most Veterans observed with surgical masks on their person and/or wearing them when out of room.
		• Staff observed providing reminders when needed.
		• Staff not observed asking Veterans to don mask in room when providing cares, in interview this was reported as not their practice.
		• Nebulizer treatments in use. Full PPE is required during and for 1 hour after with sign posted in Veteran's room.
		
		<u>Visitation</u>
		• Outdoor visits (now discontinued) described and process aligned with CDC guidance.
		• Hand hold stations with plastic divider, gloves, masks for veterans and families, but briefly as this ended with outbreak.
		• Closed window visits have also ended.
		
		<u>Postmortem Care</u>
		• ICN reports only changes to postmortem cares are a request by some funeral homes for the deceased to be placed in body bag prior to pick-up and pick-up from COVID unit is through an exit with direct access to outside.
		
		<u>Testing Strategy</u>
		Current testing:
		Mon/Thurs: all staff and Veteran PCR testing. 24-48 hour turn over. Staff reports they are not notified, unless +.
		Remaining days: POC testing for staff and Veterans.
		Staff are not tested on their days off unless this is a PCR test.
		Staff and Veterans who are recovered are not added to the testing group until they pass 90 days.
		
		<u>Reporting of Results</u>
		• Reporting to Veterans commission and DPH are completed by DON and Administrator.

	partments ☐Change in condition for COVID-19 ☒Facility has a COVID-19 pandemic plan	• Some change to this process recently to streamline the process. • Multiple staff report communication at the morning meeting about current status, changes, new procedures, case counts, etc. Staff COVID return to work policy in line with CDC.
Clinical Care and Veteran Monitoring	☒Monitoring for Change of Condition with COVID-19 ☒Systems are in place identify COVID-19 early via screening processes ☒All veterans are screened for symptoms of COVID-19 and have their vital signs monitored, including oxygen saturation and temperature checks including: (Describe their screening and monitoring process) ☒Is the symptom list up to date for COVID-19: Fever or chills Cough Shortness of breath or difficulty breathing Fatigue Muscle or body aches Headache New loss of taste or smell Sore throat Congestion or runny nose Nausea or vomiting Diarrhea Trouble breathing Persistent pain or pressure in the chest New confusion	• Veterans are screened Q4 hr.: Temp and O2 sat. • Temp of 99-100.4 reportable (varied per staff interviewed) and/or O2 sat <90% are triggers for follow-up assessment. • Symptom screening is not part of the Q 4 hr. screening process. <u>Staff and Visitor Screening</u> • Screening upon entry included most of these s/s. • Visitor/staff complete form, screener is to review form. • Observed to briefly check form during entry. • Veteran screening: T & O2 Q4hrs. Collected by CNA, recorded in EHR, and

	Inability to wake or stay awake Bluish lips or face ☒Does the E H R have a system for alerts? Are they able to monitor trends, contact tracing based upon trends, etc.? Who monitors this process and how is it communicated? ☒Is there are RCA process when COVID is identified to determine potential risks, breaks in practice, contact tracing, etc.?	paper copy to nurse. • These reviewed by nurses. Temp parameter reported as anything higher than 99-100.4 (differing responses from interviews) and O2 reported as anything <90%. • If above parameter met, further assessment per progress notes. Respiratory assessment tool containing s/s screening utilized after confirmed COVID +. • No evidence of daily documentation of s/s screening beyond vitals noted above. • No report of using EHR for alerts. Shift supervisor reports emailed to clinical leadership and reviewed for 24 hour changes. • ICN states there is some built in alerts for changes, but appears also to use report from unit managers, shift supervisor, or morning report for info. • DNS and Administrator both reported root cause investigation upon identification of initial cases. o Likely source thought to be 2 staff working in the affected unit. o Additional cases found off this unit were linked to restorative staff who tested COVID+ and worked with residents who were identified COVID +, but did not live in the affected unit. o Specific transmission avenue not identified.
Entrance to Home – Screening Process	Facility screens every individual entering the facility (including staff) for COVID-19 symptoms. Questionnaire, temperature taken. ☒Entry access is limited, and the entrance has screening stations. ☒Those permitted entry are instructed about frequent hand hygiene, limiting interactions with others and with surfaces touched and limiting their visit to designated areas ☒Those permitted entry are instructed about monitoring for signs and symptoms of COVID-19 ☒Observe Screening criteria and process includes temperature checks.	• Additionally, temperature is recorded upon exit. • COVID unit staff exit outside the unit, screening temps upon exit, though some staff leave individually and are performing their own exit temperature. • Recorded at this exit, though not clear if or when these temps are reviewed.

	☒Tracks and monitors for fever ☒Tracks and monitors COVID-19 symptoms ☒Review screening process, log, paperwork and questionnaire	
COVID-19 – Confirmed or Suspected **Status, Plan and System**	☒Confirmed positive or recovering COVID-19 veterans are placed on COVID-19 Unit/Wing ☒Co-horting or in a private room ☒If no room is available on COVID-19 Unit, veteran placed in private room or co-horted with other confirmed case ☒All veterans who are not suspected to be infected with COVID-19 are in rooms or units that do not include confirmed or suspected cases. ☐Veteran cohorting is re-evaluated by infection control lead and clinical staff and implemented each day based on results of any of the following: surveillance testing (if available), symptom screening and temperature checks. ☐Veteran cohorting is re-evaluated by infection control lead and clinical staff ☒There is an outlined process for determination of when a veteran comes off of the COVID-19 unit or quarantine ☒ How long have these processes been in place?	• Veteran rooms are private or semi-private with shared entry and bath, but solid wall between bed spaces. • Unit D identified for COVID+ area, this was also the unit where the outbreak occurred. The initial 9 bed space was insufficient, so 2 halls were converted to use as COVID+ space. • At this time, all Veterans in the unit are COVID recovered or + and completing the isolation period. The Medical Director clears all Veterans individually from isolation and is using a 20 day period, on average. • Veterans returning to other units after the COVID recovery are then placed in an additional 14 days of quarantine/observation in their rooms, though doors are not kept closed. • One resident on the dedicated COVID+ unit remains COVID-, but has not been moved due to needing the secure unit and has no separate precautions or limitations, cohorted with roommate who is recovered. • Oversight of cohorting and bed placement is supervised by DNS, though she reported the Medical Director is actively involved in making decisions to move or not move veterans. This process is since the outbreak in September. • Precaution practice for a veteran who may show s/s was not clearly reported by all nursing staff. When queried about when isolation would be initiated, some pointed out that all staff are already using PPE. It was not clear to the auditor that a standard practice per CDC guidelines would be practiced. • Nurses did report that once a veteran who is COVID + is confirmed, then the veteran would move to the COVID + unit. Additionally, what precautions would be taken for a roommate in this situation was also not clearly articulated by all interviewed. • It appeared to the auditor that the current PPE use practices may contribute to confusion about additional needed signage and Transmission Based Precautions (TBP).

		• Observation/Persons Under Investigation (PUI) on units with Droplet TBP signs rather than COVID, door caddy, and trash/linen barrels in the room entry. • Caddies were mostly empty, supplies and PPE in all were evidently not maintained and varied by room. • Clipboards on some for staff to document entry, though most appeared incomplete. • Droplet TBP sign content not in line with CDC guidance for COVID TPB and eye protection (sign appears to suggest this as optional)
Communal and Congregate Areas – Veteran Care	☒Outings, group activities and communal dining are adjusted per COVID-10 status Explain the process, review policy ☒Describe current status on veterans using congregate spaces Ask about activities, dining, what they are using their communal spaces for, has the process changed over time? ☒Social distancing is observed ☒Universal source control is observed ☒Describe the Special Care Unit process for communal space and mitigation ☒Terminal cleaning is completed after each use – describe the process Describe	• Common areas essentially closed. (Special Care Unit (SCU) excepted) • Occasional veteran observed out of room, most wearing masks, no congregating in common area. • SCU had a group of veterans watching a movie in common area, not socially distanced and not wearing masks. • One veteran on non-COVID unit placed in hall for meal, eating and drinking and without mask. Staff reported "for supervision". • 2 additional veterans in adjoining dining area and out of hall at separate tables for feeding assistance. No explanation for why one was in the hall area. • Exercise equipment observed in hall of one Unit. Restorative nurse reported these are used in the hall areas by some veterans who do not care for the small exam space on the units (being used temporarily as exercise spaces for restorative). Not evident that these devices allow social distancing from hall traffic. • Dining room used for staff breaks for social distancing and cleaning supplies available.
Hand Hygiene and Necessary Supplies	☒Necessary supplies are available and accessible for hand hygiene. Describe what is used, accessibility, etc. **Hand Hygiene OBSERVATION**	On site observation: • CNA observed passing meal trays without performing Hand Hygiene (HH) between rooms. • CNA observed entering Droplet precaution room with meal tray, no gloves and no HH. Proceeded to handle tray and multiple items in room without gloves or HH.

	Staff perform hand hygiene (even if gloves are used) when indicated: See notes ☒Before and after glove use ☒Before & after veteran contact ☐After contact with blood, body fluids or visibly contaminated surfaces ☒After contact with objects and surfaces in the veteran's environment ☐Before performing procedures such as an aseptic task ☒After removing PPE ☒Alcohol-based hand rub (ABHR) is readily available ☒Staff use ABHR preferentially for hand hygiene – if available, it is readily accessible and preferentially used ☒If ABHR is not available or limited, staff wash their hands with soap and water ☒Staff wash their hands with soap and water for 20 seconds when visibly soiled ☒**Staff interviewed** indicated there is an adequate supply of hand soap and paper towels	• CNA observed removing meal trays from rooms with no HH performed before or after donning/doffing gloves. • 1 staff utilized personal Alcohol Based Hand Rub (ABHR) dispenser for HH (clipped to name badge and hanging under and over the front of the PPE gown). • All staff interviewed reported ample ABHR and hand washing supplies. • ICN reports ABHR available in wall dispensers in halls, in veteran rooms, and on carts with PPE supplies. • Multiple ABHR observations did not demonstrate adherence to 20 second time. Signage sequences appropriate hand hygiene practices and required time. • CNA staff on SCU reported assisting veterans with hand hygiene regularly after meals and toileting only.
Cleaning and Disinfection	**OBSERVATION** **Supplies and Disinfection (multiple departments)** ☒Dedicated or disposable non-critical care equipment is used ☒Reusable equipment is cleaned and disinfected after use according to manufacturer's directions using an EPA registered disinfectant List N before use on another veteran	• Oxivir-TB: bottle is refilled, dilution not needed. Is on EPA List N • Sani wipe, bleach wipe, Moist wipe, and Cavi wipe, and Micro-kill wipe products also observed in use for disinfection on units and for disinfecting extended use face shields and goggles. • Staff Development Coordinator (SDC) reported alcohol prep pads should no longer be used for disinfection. This guidance also reviewed with DNS and administrator who reported use of all these products is allowed. <u>Unit Observation:</u> • CNA reported using alcohol wipes for disinfection of thermometer and pulse oxygen device, accessed wipes from uniform pocket under PPE gown.

	☒Objects and environmental surfaces that are touched frequently and are close to the veteran are cleaned and disinfected at least daily and when visibly soiled ☒Staff appropriately perform environmental cleaning and disinfection ☒Staff appropriately reprocess reusable equipment (cleaning and disinfecting per device and according to manufacturer's instructions and contact time) Nursing ☐Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Dining Services Restorative/Therapy	• CNA observed using alcohol wipe to clean goggles after exiting a Droplet TBP room, accessed wipes from uniform pocket under PPE gown. • CNA reported use of Oxivir-TB to spray mechanical lift for disinfection between veterans. Reported 1-minute surface time but was unsure if she then needed to wipe the lift or just use it. • Dedicated equipment reported for TBP rooms. Equipment and gait belts observed in some TBP door caddies, no observations in veteran rooms to verify presence of equipment. • No mixing of cleaning products was reported by any staff. <u>Dining Services</u> • Dining transitioned in April/May to one unit at a time, 1 veteran per table in dining area. At outbreak (September) this ended. Transitioned to all disposable products, except specialized utensils that are returned and washed. • On site observation kitchen and dining space: adequate ABHR in dining area and exits from kitchen. No concerns identified in kitchen. • Sinks in kitchen were clean and adequately supplied. • One sink, also the eye wash station, blocked by some carts. Dietary manager stated this sink was only used as eye wash station, but was blocked by a cart due to limited storage space (not further explained). Dietary manager wondered if social distancing in dining should have been initiated sooner. Additional observations: • Meal cart delivery observed with overflow veteran meal trays stacked on top of cart. • Dining tables observed on 2 units, set up in hall/communal space and with condiments, though staff reported these are not used presently for dining. <u>Restorative/Therapy</u> • Gym space with social distancing used until outbreak in September. Gym now closed. Equipment distributed to unit exam rooms, one veteran and staff person at a time.

	Activities/Recreation Comments/Observations	• Observed equipment on one unit: 1 piece in exam room and 2 pieced in niche area of halls. Restorative reported some veterans use equipment in the hall, though it was not evident social distancing could be maintained. • Dedicated staff and 1 float staff (works just one unit area per float shift). <u>Activity Director:</u> • March shut down: no outings volunteers, visitors. • Transition to unit based activities, but gatherings on unit common areas did occur with social distancing. • September: activities on units changed to doorway or in room activities with individual dedicated supplies. • Activity director did report learning a lot about cleaning and disinfection of activity supplies, alternative ways to maintain supplies (i.e. individual bingo supplies) and feels she and her team have improved awareness of IPC and improved application of this in their work. • Staff is dedicated to assigned units.
	Maintenance	<u>Maintenance</u> • Maintenance staff limit work on units as able. • Tools are carried in as needed and disinfected upon exit. • COVID unit has a dedicated tool cart. • Outside contractors are limited to only necessary activities and escorted, limiting access to veteran areas. • Facility tools are used whenever possible and disinfected. • Maintenance director disinfects/cleans offices every 2 days or so.
PPE	☒All staff are practicing universal source control (i.e. face masks) ☒Staff have been trained on selecting, donning, and doffing appropriate PPE, were staff tested, competency verification ☒If there are COVID-19 cased identified in the facility, staff is wearing recommended PPE for care of all veterans, in line with the most recent guidance. ☒Observe and describe – if extended or	• All staff reported re-education in the last week with return demonstration and competency in donning and doffing. • Donning and doffing signage noted at entry areas to all units with step by step instructions. Prior to outbreak, directive from Head Quarters (HQ) was surgical mask at all times and standard/TBP. <u>Current practice:</u> • N95 mask for all staff and in general areas of facility. <u>3 Non-COVID units</u>: • Gown, mask, and eye protection on the unit.

	re-use of PPE is practiced, describe the home's process ☒Necessary PPE is immediately available upon entrance to the COVID-19 unit **OBSERVATION: (Nursing and Multiple departments)** ☐Staff demonstrate proper sequencing of PPE per COVID-19 per CDC guidance Don 1. Identify and gather the proper PPE to don. 2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown. 4. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). 5. Put on face shield or goggles. 6. Put on gloves. 7. Healthcare personnel may now enter patient room. (Doff) PPE 1. Remove gloves. 2. Remove gown. 3. Healthcare personnel may now exit patient room. 4. Perform hand hygiene. 5. Remove face shield or goggles. 6. Remove and discard respirator (or facemask if used instead of respirator).	• Glove use per standard precautions. • Gown changed upon exit from veteran room when in close contact/providing cares. Some degree of interpretation evident in interviews with DNS, Administrator, Nurses, CNAs, housekeepers, activity and SS staff as to what constituted close contact. • One staff member defined it as 15 minutes in close contact of veteran, most defined this in terms of the cares or other tasks provided. <u>TBP rooms (droplet):</u> • Gown removed upon exit from room and disinfection of eye protection. • TBP room (contact): • Gown and gloves. This gown donned over the first gown upon entry to room. <u>COVID unit:</u> • Gown, gloves, mask, eye protection, and shoe covers upon entry to unit. • Gowns changed as described above. • Gloves changed per standard precautions. <u>Observations:</u> • One staff member in office with door open and without face mask. • One staff observed eating breakfast tray while manning the front desk and with other staff in the entry or passing through. • 4 staff observed wearing PPE gowns not properly secured, while on unit or in veteran rooms. 2 staff with top tie not secure and gown slipping off shoulders and 2 staff with waist tie not secure. • Dietary staff observed entering non-COVID unit with goggles on top of her head. DON observed and re-educated at that time. • Multiple staff exit rooms (non- TBP rooms) after providing cares, walk through hall to distant PPE cart and trash, remove gown and dispose. 2 observations missed HH at this point and prior to donning the clean gown. • One CNA observed adjusting face shield with bare hands while providing cares with no f/u HH. • One nurse adjusted N95 mask without f/u HH. <u>Observations of TBP rooms (outside COVID unit):</u> • Staff entered rooms prior to donning gloves, as gloves are stored in the room. • CNA entered TBP room (droplet/COVID observation) with meal tray and no gloves. Objects in room moved and handled. Gown removed and hand

	7. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing reuse.* ☒Signage - Signs on the use of PPE are posted in appropriate locations- posted immediately outside of veteran rooms indicating appropriate infection control precaution and required PPE per guidelines. ☒Trash disposal bins are positioned as near as possible to the exit inside of the veteran room ☒ Is hand sanitizer is accessible location ☐Veterans are donning face masks whenever: o leave their room o leave facility for essential medical appointments ☒ General observations of universal source control and PPE use per guidance in multiple departments – describe	hygiene performed prior to exit and goggles cleaned after new gown was donned at cart down the hall. • When queried, CNA reported not wearing gloves into room, despite precaution sign, as she could not retrieve the meal and wear gloves out of the room to maintain precautions. <u>COVID unit observation:</u> • 1 staff on COVID unit observed exiting outside in full PPE, then removing PPE for smoking break. Carried personal jacket out in hands and against front of PPE gown. <u>Reuse of PPE:</u> Optimization of N95 mask: • 1 mask/40 hrs work, unless soiled or seal is breached. • Masks are stored after the shift in a clean, labeled paper bag with an alcohol wipe enclosed. • Goggles or face shield cleaned with Cavi wipes and stored in the same bag with mask. • All staff store these on tables in front entry area except COVID unit staff who dispose of these as they exit directly outside this unit. <u>Signage</u> • Signage posted in entry and exit areas sequencing donning and doffing procedure with instructions and pictures. • Sequencing of doffing not matched to CDC guidance for COVID. • TBP Droplet precaution signs on 3 non-COVID units for veterans in observation status stated eye protection only if contact with fluids or splash may be expected. • TBP Contact precaution sign for 1 veteran with a non-COVID pathogen. Sign matched current CDC guidelines for contact precautions. <u>Trash Receptacle</u> • Trash and linen disposal bins positioned in all occupied rooms in COVID unit and TBP rooms in the non-COVID units. • All remaining non-COVID units had trash and supply carts for PPE, one for each hall. Staff need to exit non-COVID rooms with gown and gloved to

		discard them. • ABHR dispensers in veteran rooms. Entry/exit spaces, medication and treatment carts, PPE supply carts, and common areas for units. • One staff observed using personal ABHR dispenser attached to her name tag, under her PPE gown. • Most veterans wearing face masks if out of room, responded well to staff reminders. SCU (also the COVID unit) veterans were understandably less compliant.
Admissions, Readmissions, Communication Processes	**Admissions, Readmissions, Appointments** ☒Facility has a plan for admissions that aligns with guidance ☒ Describe placement and process for New and Re-Admissions (i.e. where, how long, testing, decision, monitoring, PPE use, etc.) ☒Readmission has a plan for admissions that aligns with guidance ☒Facility has a process for veterans who have routine medical appts (i.e. dialysis)	• Admissions since March have been limited. • Short period in August when admissions were accepted with 14 day observation period practiced. This is discontinued now since outbreak in September. • Veterans returning from hospitalizations are placed in single room observation for 14 days.
Communication Process	**Communication Requirements** ☒Describe process for communication of COVID status ☒Describe designated person assigned responsibility for daily communications with: ☒Staff ☒Veteran ☒Families ☒ Headquarters ☒All communications include status and impact of COVID-19 in the facility – prevalence of confirmed cases in staff and veterans and PPE availability ☒Facility provides routine updates to staff re COVID-19. Staff have received updated	• Staff and HQ communications per DNS and Administrator. • Morning start up meeting is used for communication, disseminated to staff by unit managers and department heads. • Social Services (SS) manager and her team communicate weekly with veterans and staff reporting the status of COVID cases and protocol changes. Phone call is the usual practice. PPE availability specifically may not be discussed, but process and protocol updates are given. • Dedicated SS staff for units.

	education as needed Describe	
Staffing and Staff Contingency Related to COVID-19 and Outbreak	☒There is a policy and procedure for staffing strategies in an emergency and is part of Emergency Preparedness plan ☒The plan includes: ☒Dedicated and consistent staffing teams who directly interact with veterans that are COVID-19 positive ☒Limiting clinical and other staff who have direct veteran contract to specific floors or wings – there should be no rotation of staff between floors or wings during the period they are working for the day ☒An established policy to minimize the number of staff interacting with each veteran ☒List the designated person assessing responsibility for conducting a daily assessment for staffing needs including back up plans as needed Describe	• Policy and Procedures per HQ. • All departments reported dedicated staffing practices throughout the pandemic. • DNS and nursing staffing monitor for staffing needs for nursing. HQ provides support. • Emergency staffing available through the MO VA, some nurses currently filling night shift positions and an alternate staffing agency (not yet needed) • Missouri Disaster Medical Assistance Team (DMAT) provides regular staffing for Rapid POC and PCR testing of staff.
Education, monitoring and screening of staff Staff Development Coordinator (SDC) discussion	☒Staff education has been provided education about COVID-19 including (when did it start, how often, when was the last education, do you have any written resources to use after you have been educated and where are they located) ☒Signs and Symptoms of COVID-19	• All staff interviewed reported beginning COVID education in March time period. • Staff Development Coordinator (SDC) confirmed education as noted here, though no formal plan was available for review. • Education materials are written in paper format and signed by staff attending. Written copy made available to those who missed. • Some staff reported also viewing videos for COVID training. • Video (YouTube) used for training on performing the PCR swab. • POC rapid testing instruction per Department of Public Health (DPH) and

	☒How it is transmitted ☒PPE ☒ Cleaning and disinfection ☒Prevention strategies Social distancing Universal source control Hand hygiene Visitation Common use areas ☒ Testing – (licensed nurses) ☒Identification and reporting of change of condition ☒Screening criteria ☒ Training Materials – who develops, where does the information come from, who provides the training, modality of training, how often is training provided to staff in all departments, is there a plan outlined for the COVID-19 training ☒ Describe and review training provided ☒ Has the home conducted ongoing COVID-19 education – (describe process, frequency, accountability, documentation, etc.) ☒ Describe competency verification process for: (PPE, Hand hygiene, screening, etc.) ☒ Describe process when breaks in practice are identified ☒Interview of staff – are they aware of processes/protocols for COVID-19 Transmission Based Precautions, ask staff specific questions based upon training reviewed (i.e. PPE training and what the	nursing or CNA staff perform these. • SDC does not provide education to screener. • Screener interviewed stated he had been trained originally in Feb/Mar time period and updated often since then as the process changed. • SDC reported some materials for HQ and she also access CDC and American Nursing Association or other “reputable” sources. • The SDC does not maintain a COVID education binder. • The SDC has the sign in sheets for educations but does not maintain a list of topics covered. • She also maintains the documentation for N95 fit testing, and performs fit testing. • Competency with return demonstration for PPE. • Department heads and nursing mangers all reported walking observations of their staff for HH and PPE practices, but no formal audit tools for COVID. • On the spot education is provided and disciplinary actions are taking for any repeat breaks are identified. • SDC reported guidance for PPE use directed from HQ and wonders if N95 use, increased use of PPE sooner, or earlier access to Rapid POC testing may have mitigated outbreak.

	process is, observe PPE use and alignment with P&P as well as training) Observations	• Interviewed multiple nursing staff, housekeeping unit staff, activity unit staff, and department managers. Consistent verbal descriptions of PPE processes. • See notes above for observations.
Record Review	☒Review *2 records of veteran and their roommates* who were COVID positive in September – (Goal is to review pre and post diagnosis, identification of CoC, timely intervention, appropriate quarantine and isolation, treatments, etc.) • Review a time span 14 days prior and post COVID diagnosis • Change of condition – immediate identification • Monitoring of resident prior to and post positive result • Documentation • Reporting • Notifications • Testing – process and how long it took for testing after s/s identified (time line of what testing was done) • How long it took to get results • Asymptomatic – what was the process, mitigation, placement • Roommate review of chart • Did veteran placement change occur? • Care plan change • Special treatments • Nebs, CPaP, BiPaP, aerosol generating, trach • Dialysis • Did the veteran leave for external appts prior to COVID diagnosis	<u>Veteran 1:</u> [redacted] Baseline temp and O2: 97.5 and mid 90's 9/15: c/o pain with cares, pain and redness to all arm and leg joints with am cares. 9/15: 1030 am temp 99 and O2 sat 86% (these reported after above changes and FNP had assessed resident). 9/15: transfer to ER. 9/16: Hospital return call with report of no findings and plan to discharge to home. 9/16: Hospital COVID test +. 9/27: Readmission. S/S of cough and wheezing reported upon reentry. (No roommate with Veteran 1 at that time) <u>Veteran 2:</u> [redacted] Baseline temp and O2: 97.5 and mid 90's Dementia unit: wandering and physical behaviors, normal. 9/28: T 99.2, room temp adjusted down. STAT CXR and COVID test. Pneumonia diagnosis with ABX x 10 d. 10/9: T 100.9 "Placed on DRS board" for reporting as she had just finished the ABX. Coarse LS continue to be reported in notes. 10/10: Rapid POC COVID (-) 10/12: PCR (+), though results reported in notes just over 24 hrs after test. 10/14: Respiratory assessments documentation in MAR began. <u>Veteran Roommate:</u> [redacted] Baseline temp and O2: 96-97 degree for temp and mid 90s for O2. Dementia unit: Anxiety, exit seeking, wandering expected 9/29, 9/30: multiple episodes of emesis noted. 10/4: lethargy, diaphoretic, and loose BM. 10/5: emesis 10/7: Rapid POC COVID (+) 10/8: Temp 99.1

	• Any visitors or visitations occurred prior, during – also hand holding visits • Review of clinical notes • If Special care unit resident – wandering status, did they wander into rooms, masking,	10/9: Respiratory assessment documentation in MAR began. • Veteran 2 and roommate were on the Dementia care unit which was the location of the outbreak and the first case (Veteran 1, above). • Medical director determined all had been exposed and therefore should not be transferred out of the unit. • COVID unit PPE use and precautions in place as described in section above, but no additional or resident specific isolation was practiced for these roommates as s/s developed, per report from DNS.
Staff Interviews - Additional Questions during observation process and meetings	**<u>All Departments</u>** Questions when meeting with staff (various departments, positions) (recommend that you interview people from every department including *one charge nurse, one-unit manager and one house supervisor*): • Do you know where the COVID related P&P Manual is? o Can you show me? • Do you have one for example, on PPE donning and doffing? • Do you use the P&P Manual for direction? • How often have you accessed the P&P since March? • Have there been any changes to the policies? • How are you informed of the changes of the Policies? • Nurses – Discuss your process for admissions, re-admissions, quarantine, positive COVID-19 veteran? What resource do you use for decision making or resource? • Nurse – How is it determine when a veteran comes off of COVID-19	• All department heads report COVID specific education starting in March time period. • None reported having specific P&P manuals. • All reported multiple places they can access PPE signage, donning and doffing guides, and direct further questions to SDN, Administrator, or DON with good responses from all. • All report changes to PPE use and social distancing and activity practices multiple times since March. • Information is disseminated through education, daily morning start up and email. • Admissions on hold. • Charge nurses report to the shift supervisor any changes or concerns. • Shift supervisor provides guidance for next steps for isolation, quarantine. • Resources per administration guidance, CDC and HQ. • Staff interviewed did not cite P&P as source of information and updates for COVID. • See notes on information dissemination above.

	unit or quarantine? • How have polices changed since positive COVID cases? **IP Lead** ☒Describe your role in managing care for veterans with infections? ☒Do you routinely participate in calls with headquarters and describe your role in the overall COVID plan? ☒Describe your Line List or tracking process? Veterans, staff ☒Do you participate in decisions about isolation, quarantine, monitoring, screening, PPE use, policy development, training, staff supervision? ☒What is your reporting relationship to the clinical analyst? Headquarters Infection Control lead? ☒Are you aware of CDC and DHHS COVID-19 guidelines and recommendations? Do you utilize those in the decision process for COVID guidance? ☒Discuss how you collaborate with non-clinical departments within your home ☒Describe your process for reporting and communicating infections and COVID cases ☒Are you involved in the overall COVID prevention processes – including testing of veterans and staff, data collection, reporting of outcomes, ☒Who communicates with the DPH? ☐Do you conduct contact tracing? ☒ Describe how you work with Procurement Officer, Environmental Services and other departments related to	IP lead activities here are managed by the DNS. • ICN maintains door caddies for TBP. • HQ calls were daily (7 days a week) initially, but now are 3x a week. Administrator, Assistant Administrator, DON, procurement are most likely to attend, though all nursing leadership is invited if they wish to attend. • Line list is maintained in spreadsheet format by DON. • Bed placement and cohorting decisions are referred to the Medical director. • Observation status was noted prior. • DON reports clinical nurses from VA HQ offer some IPC assistance. Epidemiology and more specific COVID and IPC guidance comes from DPH. • Reporting by Administrator and DON to HQ and DPH. • ICN assists with COVID testing. See notes below. Nurses, CNAs, ICN, DNS, department heads interviewed about supply of PPE and ease of access since March. No supply concerns reported. All reported having adequate and safe supply.

	COVID-19 and Infection Control **PPE Process for IP** ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☒ Describe the inventory process, burn rate process for PPE ☒ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) **Procurement Officer** ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☒ Describe the inventory process, burn rate process for PPE ☒ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) ☒ Describe how much PPE inventory that is currently available in house ☒ Describe the process for procuring PPE **Environmental Services Lead**	• Daily inventory and counts are reported to HQ. • HQ calculated burn rate. • Home maintains 30-60 day supply in house. • No difficulty obtaining PPE, though some changes over the past months as supplies and sources have been altered to ensure adequacy. • HQ has access to FEMA supplies which have replaced some other sources of PPE for this home. (N95 and disposable gowns) • The most significant change occurred with house wide use of PPE for all units after the outbreak. Cloth gown supplies and laundry capacity were not sufficient to sustain this. • Procurement officer and 2 staff manage intake and distribution to units. Shift supervisors have access if needed. • All staff report easy access to PPE. • Department head for linen and housekeeping. • Disinfection products all approved by HQ and were changed recently

	☒Describe how you oversee the housekeeping staff's disinfection process ☒How often are surfaces in common areas disinfected ☒Where are the cleaning and disinfection polices located, describe accessibility? ☒Describe the process for selection of disinfectants used, when did you start using EPA List N products ☒Describe the laundry process ☒Do you utilize consistent assignment? If not do they start negative unit to positive?	(after outbreak). Performex used for all daily housekeeping • Department head was not familiar with EPA listing, HQ manages this. • Home uses red and yellow precaution bags for all COVID/COVID observation veterans with separate handling, disposal and washing practices. • Significant increase in workload for these departments was reported due to the precaution bagging and use of all disposable food service items since the outbreak. • Consistent assignments. Linen staff do not enter COVID unit. Housekeeping observation: • 2 unit housekeeping staff observed performing high touch surface disinfection. Performex cleaner used for all housekeeping cleaning tasks. No dilution or mixing needed. Both reported cleaning high touch surfaces 1x a day, 2x a day if time permits. • Environmental services manager reported 1x a day is minimum, but 2-3x a day is preferred, though staffing is often a barrier. Environment: • All units had 1-2 fans positioned in or around the nursing stations and always blowing. • Linen delivery observed with cart cover open and linens piled on top of the cart. • 2/4 rooms entered and exited without ABHR HH performed prior to entry of next room. • Linen/Landry department tour unremarkable. • Though, concern for social distancing in laundry processing areas as rooms are smallish and there were 3-4 staff in the space. • Clean linens (not bagged) stacked on chair in hall of COVID + unit, later moved to another table, also in the hall.
Additional Observations and Summary		

APPENDIX E9. Pathway Report: St James Veterans Home Summary

St. James Veterans Home

Summary Overview

The attached is Onsite Facility Infection Control/COVID-19 Evaluation report with specific findings identified. Below is a summary of highlighted trends identified during the onsite visit for this Home.

- The Home leadership team was cooperative and informative throughout the onsite evaluation. Staff are dedicated to the needs of the veterans they serve.
- The Infection Control lead did not have designated hours for infection prevention and control responsibilities
- There was no evidence of general infection prevention and control policies and procedures as well as evidence of COVID-19 specific policies and procedures
- Front line staff indicated they were not aware of infection control and COVID-19 policies and procedures as would be expected per standards of practice
- All directives come from Head Quarters
- Veteran placement (isolation, quarantine, isolation and co-horting) did not consistently follow current guidance. Medical director determines resident placement. Infection Control lead is not involved in the process.
- Observed that doors not closed during quarantine in alignment with current guidance.
- Symptoms screening was not completed as part of the veteran monitoring process as would be expected per best practice guidelines
    - Every shift a COVID assessment was completed. The COVID-19 assessment does not list all of these symptoms, but staff were aware of the current symptom list.
- Aerosol generated treatments are currently utilized which is not in accordance with current guidance
- Social distancing is not consistently observed. Common area uses and social distancing not consistent with CDC guidance
- Terminal cleaning after meals was not consistent and cleaning and disinfection observations indicated breaks in practice
- Cleaning and disinfection dwell times not consistent with product directions
  Hand hygiene not consistently observed to be practiced as best practice approach indicates. Alcohol Based Hand Rub (ABHR) was not determined as the preferred method of hand hygiene per current guidance
  PPE use per current guidance - multi breaks in practice identified
    - Use and reuse, storage, varying strategies for gown use, sequencing
    - Multiple breaks in practice were observed
    - SEMA video on PPE, for staff re-education and reminder, was not consistent with current CDC COVID
- Veterans not consistently following universal source control as indicated in the report
- Education began in March 2020 and has been ongoing. There is no evidence of competency verification at the time of education. (Most education is email oriented with no reconciliation of employee list to verify that all staff have been educated).

APPENDIX E9

APPENDIX E10. Pathway Report: St James Veterans Home Onsite Infection Control Review Report

Onsite Facility Infection Control/COVID-19 Evaluation

Facility Demographics	**Veterans Home Name:** St. James Veterans Home **Date:** October 28 – 29, 2020 **Consultant:** Karolee Alexander **Administrator:** Brittany Ritter **Director of Nursing Services:** Emily West **Number of Licensed Beds:** 150 **Average Daily Census:** 96 in-house, 3 in hospital- COVID related **COVID-19 Status** **Number of total COVID Cases:** **Number of Veteran Cases** 16 PCR confirmed, 3 RA positive on 10/27, 1 symptomatic 10/27 **Number of Staff Cases** 2 **Number recovered** 3 **Number of COVID related deaths:** 9 **Current COVID Status:** **Veterans** 17 **Staff** 0 ***the numbers that were reported during the onsite, do not coincide*	
	Activity	**Findings**
Infection Control Lead	☐An infection lead has been designated to address and improve infection control ☒ RN/LPN (Circle one) ☒How long in IP Position- ☒Infection Preventionist Training – Describe:	One of the House Supervisors was the designated IP. Her job was to retrospectively collect outcome surveillance data for infections other than COVID-19, analyze the data for trends and report it to the DNS. Brandy attended an Infection Prevention Bootcamp in Feb 2020.

	☒Infection Preventionist is assigned other duties in the facility Describe: ☐Hours allotted for Infection Preventionist role – Describe: ☐Infection Preventionist maintains a line list □ Veterans with s/sx or confirmed COVID-19 □ Employees with s/sx or confirmed COVID-19 ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☒ Describe the inventory process, burn rate process for PPE ☐ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) ☐ Familiar with PPE optimization process Spend time discussing their role, responsibility as the IP Discuss the COVID status, and is this the same process before, during COVID and is it now your process Describe fit testing process Describe COVID-19 preparation, mitigation and response process	There were no specific hours allotted for IP Line list and employee health were collected retrospectively The Director of Purchasing distributed PPE Staff call the House Supervisor who will ask purchasing to replenish supplies. The House Supervisor has a key to supply area on off-shifts, weekends and holidays. The inventory was kept in detail by the purchasing Director. He concurrently tracks inventory of all PPE related items and reports inventory to Head Quarters (HQ) daily. The leaders I interviewed were unaware of the optimization modes. COVID-19 related information and processes were managed by the Administrator and delegated to the DNS, Staff Development, Director of Purchasing, Director of housekeeping, etc. IP was not involved in any way. There were 2 certified fit-testers onsite. New employees were fit tested during orientation.
Policies and Procedures	☐ Infection Control Policies and Proce-dures	There were none at this facility

	☐ COVID -19 Policies and Procedures • Screening for all o Veterans o Staff o Visitors o Vendors, hospice, therapy o ERAY, Pharmacy o Supply delivery process • PPE • Veteran Placement (quarantine process, confirmed COVID-19 process) • Admission, re-admission, discharge • Universal Source Control (Staff and Veterans) • Visitation (when started, where located, infection control measures, documentation, etc) • Hand holding stations • Aerosol generating medications, nebulizer • Postmortem care • Testing o Overall o Specimen process o Rapid Antigen POC o PCR and Lab process o Reporting process • Reporting and Communication process (Reporting of S/S, confirmed cases, quarantine, PPE, all COVID related communication – to whom and how communicated to home and departments and staff) o Timing of reporting o Direction for reporting o Changes in reporting pro-	

	cess in last 3 months • Veterans psychosocial needs • Communal activities • Dining • Special Care Unit specific • Hand Hygiene • Employee illness • Return to work • Education • Staffing and Staff assignment • Cleaning and disinfection – all departments ☐Change in condition for COVID-19 ☐Facility has a COVID-19 pandemic plan	
Clinical Care and Veteran Monitoring	☐Monitoring for Change of Condition with COVID-19 ☒Systems are in place identify COVID-19 early via screening processes ☒All veterans are screened for symptoms of COVID-19 and have their vital signs monitored, including oxygen saturation and temperature checks including: (Describe their screening and monitoring process) ☐Is the symptom list up to date for COVID-19: Fever or chills Cough Shortness of breath or difficulty breathing Fatigue Muscle or body aches Headache New loss of taste or smell	Temperature and SPO2 were recorded every 4 hours. The House supervisor and physician were notified when a resident demonstrated symptoms. Every shift a COVID assessment was completed. The COVID-19 assessment does not list all of these symptoms, but staff were aware of the current symptom list. Staff indicated that the COVID assessment has not been updated since March 2020.

	Sore throat Congestion or runny nose Nausea or vomiting Diarrhea Trouble breathing Persistent pain or pressure in the chest New confusion Inability to wake or stay awake Bluish lips or face ☐Does the E H R have a system for alerts? Are they able to monitor trends, contact tracing based upon trends, etc.? Who monitors this process and how is it communicated? ☐Is there are RCA process when COVID is identified to determine potential risks, breaks in practice, contact tracing, etc.?	Charge nurse unaware of any alerts The Administrator and DNS attempt contact tracing but often stop at the first possible scenario for spread. Very focused on employees transmitting to veterans. No thought of internal practices causes spread. There was no evidence of root cause analysis process.
Entrance to Home – Screening Process	☒Facility screens every individual entering the facility (including staff) for COVID-19 symptoms. Questionnaire, temperature taken. ☒Entry access is limited, and the entrance has screening stations. ☒Those permitted entry are instructed about frequent hand hygiene, limiting interactions with others and with surfaces touched and limiting their visit to designated areas ☐Those permitted entry are instructed about monitoring for signs and symptoms of COVID-19 ☐Observe Screening criteria and process includes temperature checks.	There was a standard symptom and exposure questionnaire required at the time of entry for everyone. The person completes the questionnaire and hands it to a DMAT screener. Although I reported travel in the US, no one asked me about it. The symptoms of COVID-19 were not described to me or others entering the building. People entering the facility had their temp taken by a DMAT screener upon entry.

	☐Tracks and monitors for fever ☐Tracks and monitors COVID-19 symptoms ☐Review screening process, log, paperwork and questionnaire	
COVID-19 – Confirmed or Suspected Status, Plan and System	☐Confirmed positive or recovering COVID-19 veterans are placed on COVID-19 Unit/Wing ☒Co-horting or in a private room ☒If no room is available on COVID-19 Unit, veteran placed in private room or co-horted with other confirmed case ☐All veterans who are not suspected to be infected with COVID-19 are in rooms or units that do not include confirmed or suspected cases. ☐Veteran cohorting is re-evaluated by infection control lead and clinical staff and implemented each day based on results of any of the following: surveillance testing (if available), symptom screening and temperature checks. ☐Veteran cohorting is re-evaluated by infection control lead and clinical staff ☒There is an outlined process for determination of when a veteran comes off of the COVID-19 unit or quarantine ☐ How long have these processes been in place?	A veteran with symptoms was quarantined to their room (with roommate, if there is one) and immediately tested using the Rapid Antigen process. If the Rapid Antigen test was positive, they were moved to the Isolation unit for 20 days, per Medical Director directive. A PCR test was also performed. The roommate also received RA and PCR tests. The facility did try to move the resident to a private room as soon as possible. If the RA was negative the veteran stays in quarantine until the PCR result was available. If it's positive, they move to isolation. If it's negative, they stay in their room. Monitoring continues every 4 hours. However, doors are not closed consistently in accordance with current guidance. Some veterans in the isolation unit share rooms. Veteran cohorting was not a focus of concern or priority for Administration. The Medical Director determined when a veteran can come off the isolation unit. They must stay in isolation at least 20 days, not have a cough, have improving symptoms and be afebrile for 72 hours without antipyretics. They must also have a negative RA test. The veteran goes to the "step-down" unit for at least a week for monitoring before returning to their original room. The IP was not involved in the decision-making.
Communal and Congregate Areas – Veteran Care	☒Outings, group activities and communal dining are adjusted per COVID-10 status	Group activities and regular dining were on hold. Window visits with a cell phone were still happening. On the Special Care unit, veterans were seated one to a table in the dining room. They were 6 feet apart facing another veteran but closer than 6 feet back to back

	Explain the process, review policy ☐Describe current status on veterans using congregate spaces Ask about activities, dining, what they are using their communal spaces for, has the process changed over time? ☐Social distancing is observed ☐Universal source control is observed ☒Describe the Special Care Unit process for communal space and mitigation ☐Terminal cleaning is completed after each use – describe the process Describe	in some cases. Other veterans were served meals in their rooms. On A and C cores a few residents were in the hallways. Some had masks, mostly pulled down. Staff did not cue residents to cover their noses with the masks until I asked about it. Therapy staff walked residents in the hallway. Both staff and therapists wore masks but were very close together when using a gait belt. On B core, Special Care Unit residents did not have masks and were congregated in front of the nurse station watching a movie. These veterans self-propelled about in wheelchairs. There were no attempts by staff to socially distance them or provide masks. I did not observe terminal cleaning of the common area surfaces after the area emptied at lunch time. The Special Care Unit Manager told me they tried masks on residents for a few days but experienced an increase in falls. He called HQ and was given permission to stop using masks for source control on this unit.
Hand Hygiene and Necessary Supplies	☒Necessary supplies are available and accessible for hand hygiene. Describe what is used, accessibility, etc. **Hand Hygiene** **OBSERVATION** Staff perform hand hygiene (even if gloves are used) when indicated ☒Before and after glove use ☐Before & after veteran contact ☒After contact with blood, body fluids or visibly contaminated surfaces ☐After contact with objects and surfaces in the veteran's environment ☒Before performing procedures such as an aseptic task ☒After removing PPE ☒Alcohol-based hand rub (ABHR) is readily available	Staff were told through videos from SEMA and from Staff Development that soap, and water hand hygiene was preferred. There was an ample supply of Alcohol Based Hand Rub (ABHR) in care areas except on B core. There were no hand hygiene stations in hallways on B core. Staff touched residents, repositioned a resident, touched resident walkers and wheelchairs without performing hand hygiene. I observed a nursing assistant perform vital signs for 2 veterans without sanitizing the machine between veterans. She pushed the machine into the nurses' station without sanitizing it. When I brought this to the Unit manager's attention, he asked who used the machine and asked the nursing assistant if she sanitized it after use. She said, "It was clean when I started". The Unit Manager said, "whatever".

	☐Staff use ABHR preferentially for hand hygiene – if available, it is readily accessible and preferentially used ☐If ABHR is not available or limited, staff wash their hands with soap and water ☒Staff wash their hands with soap and water for 20 seconds when visibly soiled ☒**Staff interviewed** indicated there is an adequate supply of hand soap and paper towels	
Cleaning and Disinfection	**OBSERVATION** **Supplies and Disinfection (multiple departments)** ☐Dedicated or disposable non-critical care equipment is used ☐Reusable equipment is cleaned and disinfected after use according to manufacturer's directions using an EPA registered disinfectant List N before use on another veteran ☐Objects and environmental surfaces that are touched frequently and are close to the veteran are cleaned and disinfected at least daily and when visibly soiled ☐Staff appropriately perform environmental cleaning and disinfection ☐Staff appropriately reprocess reusable equipment (cleaning and disinfecting per device and according to manufacturer's instructions and contact time) Ask Staff: Housekeeping/Environmental Services ☒Describe process for mixing,	A-Core: A glucometer used for multiple veterans was wiped after use at the nurses' station with "purple-top" wipe and returned immediately to the med cart drawer. When asked, the med tech said the wipe had a 3-minute kill time and understood that to mean it should not be wiped dry for 3 minutes. The wipe had a 2 min contact time for viruses. The med tech said she used purple top wipes to disinfect everything. C Core: A nursing assistant wheeled a resident out of the shower room after providing a shower. She was holding the bag of soiled linen in one hand. She did not return to the shower room to disinfect the shower chair. I did not see her change her gown. B-Core: Oxygen E tanks were used. Observed a tank changed and the used tank put into storage without being disinfected. Used and unused tanks were stored together. Multiple, used RA test cards were observed on a cart in the hallway, then wheeled to the nurses' station, uncovered. All staff wear an N95, face shield or goggles in the facility. Upon entering a veteran care unit, they don an isolation gown. I did not observe any staff to change the gown after providing care. They doffed the gown upon exiting the unit. Donning and doffing occur in the same space without any separation. The Administrator told me they used 1200 gowns per day as proof that the gowns were being changed after veteran care. Housekeeping thoroughly disinfects surfaces at least daily.

	reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Nursing ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Dining Services ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Activities/Recreation ☐Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Comments/Observations	Cleaning chemicals were mixed by housekeeping for floor cleaning. Dietary chemicals were mixed by dietary for floor cleaning. Spray chemicals used by nursing staff and other departments were used in manufacturer's packaging. Nursing assistants and med techs who were interviewed were not aware of accurate dwell times for wipes and spray disinfectants. A nursing assistant told me she used the "1 minute" spray to disinfect shower chairs and vital signs machines. I looked at the label. It was a 1-minute dwell time for bacteria and a 10 minute dwell time for SARS Coronavirus. Observed a male staff member in the hallway of the Special Care Unit (B Core) with a small treatment cart. The staff member who an N95 and no other PPE. He was returning supplies to the drawers of the cart without cleaning/disinfecting supplies. He stopped, spoke to a veteran, and used an electric razer from the cart to shave around the veteran's mouth (in the hallway). The staff member did not perform hand hygiene, did not wear gloves and did not disinfect the razer before or after its use. When asked staff who this male staff member was, they indicated it was the barber.
PPE	☒All staff are practicing universal source control (i.e. face masks) ☐Staff have been trained on selecting, donning, and doffing appropriate PPE, were staff tested, competency verification ☐If there are COVID-19 cased identified in the facility, staff is wearing recommended PPE for care of all veterans, in line with the most recent guidance. ☒Observe and describe – if extended or re-use of PPE is practiced, describe the home's process	Staff donned an N95 mask and face shield or goggles upon entering the building, after RA testing. A SEMA video about donning and doffing PPE, playing in the lobby for staff education, did not match CDC guidance for doffing PPE. Staff were not required to demonstrate PPE donning and doffing at the time of education but must be observed donning and doffing by an RN at least weekly. N95 masks were used for up to 40 hours or unless visibly soiled. Face shields were disinfected by Virex after each shift by the employee. Masks were stored in a paper bag hanging in the employee entrance between used. Face shields were reused indefinitely. This practice was implemented as the result of a directive from HQ. N95's are sent out to an external company for disinfection after extended use as

	☒Necessary PPE is immediately available upon entrance to the COVID-19 unit **OBSERVATION: (Nursing and Multiple departments)** ☒Staff demonstrate proper sequencing of PPE per COVID-19 per CDC guidance Don 1. Identify and gather the proper PPE to don. 2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown. 4. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). 5. Put on face shield or goggles. 6. Put on gloves. 7. Healthcare personnel may now enter patient room. (Doff) PPE 1. Remove gloves. 2. Remove gown. 3. Healthcare personnel may now exit patient room. 4. Perform hand hygiene. 5. Remove face shield or goggles. 6. Remove and discard respirator (or facemask if used instead of respirator). 7. Perform hand hygiene after removing the respirator/facemask	indicated above. Donning PPE for the Isolation unit was done in the entrance to the VSO building, next to the exterior door to the Isolation unit. Staff donned their PPE and walked outside the facility to the Isolation unit entrance. Nursing staff were consistently observed donning and doffing PPE correctly when they changed PPE. They were not observed to change gowns after providing care or having close contact with veterans See observation above related to Special Care Unit and barber.

	and before putting it on again if your workplace is practicing re-use.* ☒Signage - Signs on the use of PPE are posted in appropriate locations- posted immediately outside of veteran rooms indicating appropriate infection control precaution and required PPE per guidelines. ☒Trash disposal bins are positioned as near as possible to the exit inside of the veteran room ☐ Is hand sanitizer is accessible location ☐Veterans are donning face masks whenever: o leave their room o leave facility for essential medical appointments ☐ General observations of universal source control and PPE use per guidance in multiple departments – describe	There was plentiful signage throughout the facility. Trash cans were not observed at the veterans' room doorways. There were large trash cans in each common area with manual lids. ABHR was located along the walls in hallways and in veterans' rooms except on B Core where it was missing from hallways. Veterans inconsistently wore face coverings when out of their rooms. Veterans room doors were not consistently closed
Admissions, Readmissions, Communication Processes	**Admissions, Readmissions, Appointments** ☐Facility has a plan for admissions that aligns with guidance ☐ Describe placement and process for New and Re-Admissions (i.e. where, how long, testing, decision, monitoring, PPE use, etc.)	No admissions were being accepted at the time of the visit.

	☐Readmission has a plan for admissions that aligns with guidance ☐Facility has a process for veterans who have routine medical appts (i.e. dialysis)	
Communication Process	**Communication Requirements** ☐Describe process for communication of COVID status ☐Describe designated person assigned responsibility for daily communications with: ☐Staff ☐Veteran ☐Families ☐ Headquarters ☒All communications include status and impact of COVID-19 in the facility – prevalence of confirmed cases in staff and veterans and PPE availability ☒Facility provides routine updates to staff re COVID-19. Staff have received updated education as needed Describe	When a resident developed symptoms, the House supervisor, physician and family were notified by the Charge Nurse. The House Supervisor notified the DNS and Administrator. The Administrator called HQ. The Administrator tracked resident and employee COVID-19 status. Cumulative and new case information was shared with HQ on a call twice per week and in an emailed report daily. PPE inventory and staffing were shared in the same communications. Updates or directives from HQ were shared with staff by email. Employees were responsible for reading their email, but there was no validation that they had read them. One Unit Manager I spoke with told me he educates his own staff after receiving an update. This education was not formally documented.
Staffing and Staff Contingency Related to COVID-19 and Outbreak	☐There is a policy and procedure for staffing strategies in an emergency and is part of Emergency Preparedness plan ☐The plan includes: ☒Dedicated and consistent staffing teams who directly interact with veterans that are COVID-19 positive ☐Limiting clinical and other staff who have direct veteran contract to specific floors or wings – there should be no rotation of staff	There was no emergency staffing policy and procedure. The practice at St. James was for staff to have a consistent assignment. This was a new practice, implemented “just a few weeks” before. Last week the dietary staff began to have a consistent assignment for dropping off meals. Staff who worked in the isolation unit must go directly home after their shift. They were not allowed to enter the building for at least 8 hours. The DNS, Administrator and HR made staffing decisions based on the census and location of veterans as well as acuity.

	between floors or wings during the period they are working for the day ☐An established policy to minimize the number of staff interacting with each veteran ☒List the designated person assessing responsibility for conducting a daily assessment for staffing needs including back up plans as needed Describe	
Education, monitoring and screening of staff Staff Development Coordinator discussion	☐Staff education has been provided education about COVID-19 including (when did it start, how often, when was the last education, do you have any written resources to use after you have been educated and where are they located) ☐Signs and Symptoms of COVID-19 ☐How it is transmitted ☐PPE ☐ Cleaning and disinfection ☐Prevention strategies Social distancing Universal source control Hand hygiene Visitation Common use areas ☐ Testing – (licensed nurses) ☐Identification and reporting of change of condition ☐Screening criteria ☐ Training Materials – who develops, where does the information come from,	The Staff Development Coordinator was responsible for the "formal" education provided to staff. Education began in March 2020 and has been ongoing. There was no on-line education program. There is no evidence of competency verification at the time of education. Attendance was tracked by paper sign-in sheets. There was no reconciliation process to ensure that all staff were educated. The Staff Development Coordinator used CDC information as the basis for most of the training. Other sources included directives from HQ and the Administrator, email from HQ and the Administrator. Training was provided in-person, via video and via read and sign packets. No post tests were used. Practice audits were performed at least weekly for PPE use and hand hygiene. Audits were performed by House Supervisors, Staff Development and Unit Managers. 1:1 education was provided when there was an observed breach in procedure. A Unit Manager told me he feels very Up-To-Date in his knowledge and believes that the facility performs above and beyond CDC recommendations. Three nursing assistants, interviewed separately, reported that they get updates from the nurse and had done well on PPE audits. A housekeeper stated that she got updates from her supervisor. The Dietary Manager related that he provided weekly and more frequent updates to staff.

	who provides the training, modality of training, how often is training provided to staff in all departments, is there a plan outlined for the COVID-19 training ☐ Describe and review training provided ☐ Has the home conducted ongoing COVID-19 education – (describe process, frequency, accountability, documentation, etc.) ☐ Describe competency verification process for: (PPE, Hand hygiene, screening, etc.) ☐ Describe process when breaks in practice are identified ☐Interview of staff – are they aware of processes/protocols for COVID-19 Transmission Based Precautions, ask staff specific questions based upon training reviewed (i.e. PPE training and what the process is, observe PPE use and alignment with P&P as well as training) Observations	
Record Review	☐Review *2 records of veteran and their roommates* who were COVID positive in September – (Goal is to review pre and post diagnosis, identification of CoC, timely intervention, appropriate quarantine and isolation, treatments, etc.) • Review a time span 14 days prior and post COVID diagnosis • Change of condition – immediate identification	Resident [redacted] admitted to the facility on 6/7/19. Sentinel testing was conducted on 6/8/20. He refused testing. He was asymptomatic. No other action was documented. On July 5, 2020 he developed a temperature of 99 F but testing was not completed. On Sept. 5 his daughter in law was notified that there was COVID in the building and testing was being done. His vital signs on 9/5: T99.6F, SPO2 93% on RA. The next day his fever went down. On Sept 7 his SPO2 was 87% and lungs were clear. No other action was documented. On Sept 9 his PCR test was positive and he moved to the isolation unit. On 9/10 his SPO2 was 89% -95% on 2L oxygen. On Sept 10 he fell from bed without serious injury. On Sept 11 he had labored breathing, R36, SPO2 96% on 2 L O2 159/56 and HR 73. The physician was

	• Monitoring of resident prior to and post positive result • Documentation • Reporting • Notifications • Testing – process and how long it took for testing after s/s identified (time line of what testing was done) • How long it took to get results • Asymptomatic – what was the process, mitigation, placement • Roommate review of chart • Did veteran placement change occur? • Care plan change • Special treatments • Nebs, CPaP, BiPaP, aerosol generating, trach • Dialysis • Did the veteran leave for external appts prior to COVID diagnosis • Any visitors or visitations occurred prior, during – also hand holding visits • Review of clinical notes • If Special care unit resident – wandering status, did they wander into rooms, masking,	notified and ordered Duoneb and solumedrol IM. His son requested the veteran be sent to the hospital. The Medical Director felt he would be a candidate for Resmedivir. He was transferred to the hospital ER and returned a few hours later, not having received Resmedivir. On Sept 13 he developed "coarse" breath sounds and a frequent non-productive cough. At 0700 he was transferred to the hospital and returned at 1715, unchanged. He began to receive Duonebs TID with little effect. On Sept 15 Cefepime IV was ordered but the medication was not available from the pharmacy. He missed the first two doses. He had a frequent, productive cough. SPO2 89% on 3 L O2. On Sept 17 at 1803 he became unarousable. The medical Director discontinued his routine meds and started comfort care medications. He expired on Sept 17. Resident [redacted] Al long term resident of the home On June 15, 2020 he tested negative for COVID-19. He moved from the C Core to the A Core on June 17. On Sept 5, family was notified that a staff tested positive for COVID-19 and residents would be tested. On Sept 9 he developed a coarse, loose cough with expiratory wheezing. The PCR test was positive and he was moved to isolation. He developed a Tmax 102 and emesis x2. On Sept 12, the social worker notified family they were packing up his personal belongings and moving them to storage to make more private rooms. He remained febrile through Sept 13. On Sept 14 he developed coarse lung sounds in the RLL. SPO2 95% on RA. On Sept 15 his sputum was green and Azithromycin was ordered. On Sept 17 the physician ordered Decadon but it was unavailable from the pharmacy, so the order was changed to Solumedrol. A CXR was ordered and O2 at 5L per nc. He transferred to the hospital on 9/17. The hospital ICU called on 10/3 to inform the facility he had expired. Resident [redacted] Long term resident of the home. After a staff tested positive on 9/4 the veteran was tested. He refused to have his temp taken for several days. On Sept 9 he had diminished lung sounds bilaterally and his PCR results showed he was COVID positive. He was moved to isolation. On Sept 10 he had a dry cough which became productive on Sept 10. His belongings were moved to storage on Sept 12. On September 13 he developed emesis. A message was left for the family by social services "according to the script provided by the Administrator". On Sept 17 he was still coughing but lungs were clear. He had a poor intake. On Sept 23 the physician ordered Zinc, Vit D and Vit c. He refused these medications. On Sept 28 he developed a sore throat, no cough. On

		Sept 30 he did not have any symptoms and his SPO2 was 95 – 99% on RA On 10/1/20 Family was contacted about moving him to stepdown.
Staff Interviews - Additional Questions during observation process and meetings	**<u>All Departments</u>** Questions when meeting with staff (various departments, positions) (recommend that you interview people from every department including *one charge nurse, one-unit manager and one house supervisor*): • Do you know where the COVID related P&P Manual is? o Can you show me? • Do you have one for example, on PPE donning and doffing? • Do you use the P&P Manual for direction? • How often have you accessed the P&P since March? • Have there been any changes to the policies? • How are you informed of the changes of the Policies? • Nurses – Discuss your process for admissions, re-admissions, quarantine, positive COVID-19 veteran? What resource do you use for decision making or resource? • Nurse – How is it determine when a veteran comes off of COVID-19 unit or quarantine? • How have polices changed since positive COVID cases? **IP Lead** ☐Describe your role in managing care for veterans with infections? ☐Do you routinely participate in calls with	There were no policies and procedure related to COIVD-19. Changes were communicated via email and directives from HQ. See prior sections of the report for this information

	headquarters and describe your role in the overall COVID plan? ☐Describe your Line List or tracking process? Veterans, staff ☐Do you participate in decisions about isolation, quarantine, monitoring, screening, PPE use, policy development, training, staff supervision? ☐What is your reporting relationship to the clinical analyst? Headquarters Infection Control lead? ☐Are you aware of CDC and DHHS COVID-19 guidelines and recommendations? Do you utilize those in the decision process for COVID guidance? ☐Discuss how you collaborate with non-clinical departments within your home ☐Describe your process for reporting and communicating infections and COVID cases ☐Are you involved in the overall COVID prevention processes – including testing of veterans and staff, data collection, reporting of outcomes, ☐Who communicates with the LDPH? ☐Do you conduct contact tracing? ☐ Describe how you work with Procurement Officer, Environmental Services and other departments related to COVID-19 and Infection Control **PPE Process for IP** ☐PPE –Who is assigned to replenish supply of PPE on each unit and department	

	☐ Describe the Communication process if supplies are running low ☐ Describe the inventory process, burn rate process for PPE ☐ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) **Procurement Officer** ☐PPE –Who is assigned to replenish supply of PPE on each unit and department ☐ Describe the Communication process if supplies are running low ☐ Describe the inventory process, burn rate process for PPE ☐ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) ☐ Describe how much PPE inventory that is currently available in house ☐ Describe the process for procuring PPE **Environmental Services Lead** ☐Describe how you oversee the housekeeping staff's disinfection process ☐How often are surfaces in common areas disinfected ☐Where are the cleaning and disinfection polices located, describe accessibility? ☐Describe the process for selection of disinfectants used, when did you start using EPA List N products ☐Describe the laundry process	The purchasing agent at the facility had a detailed and intricate tracking system for PPE inventory. He personally distributed PPE to unit stock. He was unaware of the term "contingency" and distributed PPE according to directives from HQ. The ES Lead personally trained each new staff member and closely supervised their work. There are currently 2 housekeeping staff out with COVID-19. She increased common area cleaning in March 2020. She has a long-standing relationship with Industrial Soap and primarily used Virex as the sanitizer of choice. She correctly stated it has a 10 min kill time. She did not know why trash from the Isolation unit was being red bagged and disposed by the Biohazard disposal company each week.

	☐Do you utilize consistent assignment? If not do they start negative unit to positive?	She stated that housekeeping staff don a gown upon entering a unit. They are to change the gown after cleaning a veteran's room and perform hand hygiene. When I told her, I had not seen that happen, she had no response. The laundry area had a new washer and dryer set up with specific cycles and chemicals for COVID-19. The laundry from the Isolation unit was washed and dried in these machines. Clean linens are delivered to the regular units on a covered cart which was sprayed after leaving the units. The Isolation Unit linens were dropped off at the door for nursing staff to being in. Red bagged linen was left outside the door for pickup at a separate. Time.
Additional Observations and Summary	In the Isolation unit • There was a box with a red biohazard bag in it and no cover. Staff informed me it was for the "contaminated food" left over from meals. • A resident sat at a table in a common area in his johnny. There was no mask available. He was left to eat and drink alone. • The initial "wave" of vets to isolation came from A Core. Recent vets to isolation came from C Core. Only 15 of 50 veterans remain on C Core at the present time. • Veterans were not actively kept in their rooms except for those awaiting test results after showing symptoms. • Mask compliance was excellent amongst staff, not good among veterans.	

APPENDIX E11. Pathway Report: St Louis Veterans Home Summary

St. Louis Veterans Home

Summary Overview

The attached is Onsite Facility Infection Control/COVID-19 Evaluation report with specific findings identified. Below is a summary of highlighted trends identified during the onsite visit for this Home.

- The Home leadership team was cooperative and informative throughout the onsite evaluation. Staff are dedicated to the needs of the veterans they serve.
- The Home develop a COVID Team with a specific clinical lead to oversee the efforts for preparation and prevention
- There was limited general infection prevention and control policies and procedures as well as evidence of no COVID-19 specific policies and procedures
- Front line staff indicated they were not aware of infection control and COVID-19 policies and procedures as would be expected per standards of practice
    - Most policies and procedures that were available were outdated
- All directives come from Head Quarters
    - Communication flow related to COVID-19 guidance comes from Headquarters to Administration. Administration manages communications. Unable to determine communication flow to direct care staff relative to updated guidance.
- There appears to be confusion between quarantine for exposure (14 days) and how long residents need to stay in Transmission Based Precautions (TBP) after positive COVID diagnosis (10 days unless immunocompromised or critically ill – 20 days)
- Social distancing is not consistently observed. For example, group activities such as Bingo are played while they are in their rooms, but also noted to have 6 people around table yesterday without masks.
    - The Home indicated that they have suspended communal dining and using congregate spaces, but they were still present on observation.
    - Common area uses and social distancing not consistent with CDC guidance
- Terminal cleaning after meals was not consistent and cleaning and disinfection observations indicated breaks in practice
- Hand hygiene not consistently observed to be practiced as best practice approach indicates.
- PPE use per current guidance - multi breaks in practice identified
    - Use and reuse, storage, varying strategies for gown use, sequencing
    - Multiple breaks in practice were observed
- Symptoms screening was not completed as part of the veteran monitoring process as would be expected per best practice guidelines
- Veterans not consistently following universal source control
- Staff Development Coordinator verbalized that some COVID-19 education was provided, However, evidence of ongoing education on COVID-19 and competency verification was not found.

APPENDIX E12. Pathway Report: St Louis Veterans Home Onsite Infection Control Review Report

Onsite Facility Infection Control/COVID-19 Evaluation

Facility Demographics	**Veterans Home Name: St. Louis Veterans Home** **Date: 10/28-10/29/2020** **Consultant: J Morey** **Administrator: Leonard Rhine, LHA** **Director of Nursing Services: Monica Halsey RN** **Number of Licensed Beds: 181** **Average Daily Census: 143 1-LOA, 1 Hospital** **<u>COVID-19 Status</u> (Lockdown began March 7, 2020)** **Number of total COVID Cases: 1** **Number of Veteran Cases-0** **Number of Staff Cases-17 (16 recovered)** **Number of COVID related deaths: 1** **Current COVID Status: 1** **Veterans-0** **Staff-1**

	Activity	Findings
Infection Control Lead	☒An infection lead has been designated to address and improve infection control ☒ RN ☒How long in IP Position ☒Infection Preventionist Training – ☒Infection Preventionist is assigned other	• The Assistant Director of Nursing Services (ADON), Jen, Infection Control Lead (IP) is responsible for the day to day Infection Control and Prevention (ICP). • IP has been in this position since March 2020, her training includes the

	duties in the facility Describe: ☒Hours allotted for Infection Preventionist role – Describe: ☒Infection Preventionist maintains a line list ☒Veterans with s/sx or confirmed COVID-19 ☒Employees with s/sx or confirmed COVID-19 ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☒ Describe the inventory process, burn rate process for PPE ☒ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory)? ☒ Familiar with PPE optimization process	Centers for Disease Control and Prevention (CDC) web- based Infection Control (IC) as well as webinars. IP states, "she spends 90% of her time on ICP." • The facility has developed a COVID Team with a specific nurse identified to act as lead. • Currently there are no positive COVID veterans • Review of the Line List was completed. The line list for employees, they may return to work after 10 days off plus 24 hours without signs and symptoms (s/s). This can extend to a longer time frame depending on s/s. • Procurement Officer, Bryan rounds daily and counts all PPE in house, orders as needed and delivers to units, if they run short on weekends or nights the supervisor can access. He submits an excel spread sheet of available in-house products to Executive Director (ED) by 11 am daily. • He has not had to use different levels of optimization, he well versed on supply and he gave me a copy of his supply list which updates daily. • The Covid team (Quarantine Team with 12 members) have all been fit tested by OSHA certified trainer
Policies and Procedures	☒ Infection Control Policies and Procedures ☒ COVID -19 Policies and Procedures • Screening for all o Veterans o Staff o Visitors o Vendors, hospice, therapy o ERAY, Pharmacy o Supply delivery process • PPE • Veteran Placement (quarantine process, confirmed COVID-19 process)	• Infection Control Policies and Procedures are limited • Both the Director of Nursing Services (DNS) and ADON were unsure what was requested nor could locate a Policy and Procedure (P&P) book. This is a list of what was present in the IP binder: a. Antibiotic Stewardship 5/18/18 b. Surveillance 10/22/20 (audit tool) this tool covers dining, workstations, interviews, medication rooms, environmental services, resident rooms, and bathrooms c. 1 page Policy for ICP d. Infection Control Guidelines for LTC Facilities; Emphasis on Body Substance Precautions (January 2005) e. IC committee meeting May 2020 f. Weekly flu rounds (audit sheets) g. Copy of training, not content, but sign in sheets

	• Admission, re-admission, discharge
	• Universal Source Control (Staff and Veterans)
	• Visitation (when started, where located, infection control measures, documentation, etc)
	• Hand holding stations
	• Aerosol generating medications, nebulizer
	• Postmortem care
	• Testing
	  o Overall
	  o Specimen process
	  o Rapid Antigen POC
	  o PCR and Lab process
	  o Reporting process
	• Reporting and Communication process (Reporting of S/S, confirmed cases, quarantine, PPE, all COVID related communication – to whom and how communicated to home and departments and staff)
	  o Timing of reporting
	  o Direction for reporting
	  o Changes in reporting process in last 3 months
	• Veterans psychosocial needs
	• Communal activities
	• Dining
	• Special Care Unit specific
	• Hand Hygiene
	• Employee illness
	• Return to work
	• Education
	• Staffing and Staff assignment
	• Cleaning and disinfection – all departments
		h. Employees Training 2019 (sign in not content)
		i. Exposure to body substance report
		j. Bloodborne Pathogen (revised 7/1/98)
		k. Influenza worksheet (2019-2020)
		l. Disease Case Report
		m. Reportable Diseases in MO
		n. Contact # for environmental health
		
		• No evidence of COVID specific P&P
		• No evidence of annual review process
		
		• Visitation is on hold, but they are allowing outdoor visits, and use of iPad for face to face visits.
		
		• The Home has currently stopped hand holding
		
		• Nebulizers have been discontinued, but 2 veterans are utilizing inhalers only.
		
		• Daily rapid testing and twice a week with PCR, results usually back within 48 hours.
		• Communication Steps: The Home notifies Joan at headquarters, notify staff, documentation on website, county health notified, and the Social

	☐Change in condition for COVID-19 ☒Facility has a COVID-19 pandemic plan	Worker notifies families when there is a positive Covid.
Clinical Care and Veteran Monitoring	☒Monitoring for Change of Condition with COVID-19 ☒Systems are in place identify COVID-19 early via screening processes ☒All veterans are screened for symptoms of COVID-19 and have their vital signs monitored, including oxygen saturation and temperature checks including: (Describe their screening and monitoring process) ☒Is the symptom list up to date for COVID-19: Fever or chills Cough Shortness of breath or difficulty breathing Fatigue Muscle or body aches Headache New loss of taste or smell Sore throat Congestion or runny nose Nausea or vomiting Diarrhea Trouble breathing Persistent pain or pressure in the chest New confusion Inability to wake or stay awake Bluish lips or face ☒Does the E H R have a system for alerts?	• All veterans have daily rapid test Covid-19 testing, staff go to individual rooms to accomplish this. • Vital signs are performed every 4 hours. • The veterans have been instructed to report any adverse s/s and there is plenty of signage around the building that includes the most recent symptoms to watch for. • Twice weekly PCR performed on everyone.

	Are they able to monitor trends, contact tracing based upon trends, etc.? Who monitors this process and how is it communicated? ☒Is there are RCA process when COVID is identified to determine potential risks, breaks in practice, contact tracing, etc.?	• The Electronic Health record (HER) computer system does not have alerts, trends are monitored on paper and communication is daily presented the ED who in turn is on a scheduled call for headquarters daily to convey the most recent changes and any trending. All directives come from headquarters. • Did not see any root cause analysis.
Entrance to Home – Screening Process	☒Facility screens every individual entering the facility (including staff) for COVID-19 symptoms. Questionnaire, temperature taken. ☒Entry access is limited, and the entrance has screening stations. ☒Those permitted entry are instructed about frequent hand hygiene, limiting interactions with others and with surfaces touched and limiting their visit to designated areas ☐Those permitted entry are instructed about monitoring for signs and symptoms of COVID-19 ☒Observe Screening criteria and process includes temperature checks. ☒Tracks and monitors for fever ☒Tracks and monitors COVID-19 symptoms ☒Review screening process, log, paperwork and questionnaire	• Facility screening: Anyone who wishes entry will need to: use hand sanitizer, apply face mask, complete a one page questionnaire, have the temperature taken, receive a rapid Covid test and await the results for 15 minutes at individual tables set up in the Dining Room (DR) prior to entry into the facility. • One screening station at the front of the building, otherwise the entrances are closed.
COVID-19 – Confirmed or Suspected Status, Plan and System	☐Confirmed positive or recovering COVID-19 veterans are placed on COVID-19 Unit/Wing ☒Co-horting or in a private room ☒If no room is available on COVID-19 Unit, veteran placed in private room or co-horted with other confirmed case	• There are ZERO veterans with Covid, but they are ready to place any positive in special units specifically for Covid. • Veterans have been moved around in the building to allow them to have PRIVATE rooms.

	☒All veterans who are not suspected to be infected with COVID-19 are in rooms or units that do not include confirmed or suspected cases. ☒Veteran cohorting is re-evaluated by infection control lead and clinical staff and implemented each day based on results of any of the following: surveillance testing (if available), symptom screening and temperature checks. ☒Veteran cohorting is re-evaluated by infection control lead and clinical staff ☒There is an outlined process for determination of when a veteran comes off of the COVID-19 unit or quarantine ☒ How long have these processes been in place?	• NA • At this time does not apply, daily testing with rapid Covid test • NA • There appears to be confusion between quarantine for exposure (14 days) and how long residents need to stay in Transmission Based Precautions (TBP) after positive COVID diagnosis (10 days unless immunocompromised or critically ill – 20 days) • Processes are changing, they will start wearing face shields with masks as of Thursday the 29th of October.
Communal and Congregate Areas – Veteran Care	☒Outings, group activities and communal dining are adjusted per COVID-10 status Explain the process, review policy ☒Describe current status on veterans using congregate spaces Ask about activities, dining, what they are using their communal spaces for, has the process changed over time? ☒Social distancing is observed ☒Universal source control is observed ☒Describe the Special Care Unit process for communal space and mitigation	• Veterans continue to have meals on individual neighborhoods together. The meals are placed in Styrofoam containers and brought to the Veterans. • Group activities such as Bingo are played while they are in their rooms, but also noted to have 6 people around table yesterday without masks. o Was told that they have suspended communal dining and using congregate spaces, but they are still present. • Social distancing is not observed • Was told terminal cleaning occurs after each meal, but I did not see it as often there would be food left on the tables or spilled on the floors that stayed there for a while.

	☒Terminal cleaning is completed after each use – describe the process Describe	
Hand Hygiene and Necessary Supplies	☒Necessary supplies are available and accessible for hand hygiene. Describe what is used, accessibility, etc. **Hand Hygiene** **OBSERVATION** Staff perform hand hygiene (even if gloves are used) when indicated ☒Before and after glove use ☐Before & after veteran contact ☐After contact with blood, body fluids or visibly contaminated surfaces ☐After contact with objects and surfaces in the veteran's environment ☒Before performing procedures such as an aseptic task ☐After removing PPE ☒Alcohol-based hand rub (ABHR) is readily available ☒Staff use ABHR preferentially for hand hygiene – if available, it is readily accessible and preferentially used ☒If ABHR is not available or limited, staff wash their hands with soap and water ☒Staff wash their hands with soap and water for 20 seconds when visibly soiled ☒**Staff interviewed** indicated there is an adequate supply of hand soap and paper	• Hand sanitizers are noted throughout the facility as well has stand-alone jugs with pumps. • Hand hygiene not consistently observed to be practiced as best practice approach indicates.

	towels	
Cleaning and Disinfection	**OBSERVATION** **Supplies and Disinfection (multiple departments)** ☒Dedicated or disposable non-critical care equipment is used ☒Reusable equipment is cleaned and disinfected after use according to manufacturer's directions using an EPA registered disinfectant List N before use on another veteran ☒Objects and environmental surfaces that are touched frequently and are close to the veteran are cleaned and disinfected at least daily and when visibly soiled ☒Staff appropriately perform environmental cleaning and disinfection ☒Staff appropriately reprocess reusable equipment (cleaning and disinfecting per device and according to manufacturer's instructions and contact time) Ask Staff: Housekeeping/Environmental Services ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Nursing ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Dining Services	• Rolling vital machine was not observed to be disinfected between veterans • Housekeeping indicated that high touch areas are to be disinfected 3 X day, but she also stated that they need more help and so sometimes this might be overlooked. • The housekeeper interviewed was able to describe preparation and use of disinfectants. She repeatedly stated they are short staffed. • All cleansers are Premixed by housekeeping lead and services have spray bottles to use

	☐Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Activities/Recreation ☐Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Comments/Observations	
PPE	☒All staff are practicing universal source control (i.e. face masks) ☒Staff have been trained on selecting, donning, and doffing appropriate PPE, were staff tested, competency verification ☒If there are COVID-19 cased identified in the facility, staff is wearing recommended PPE for care of all veterans, in line with the most recent guidance. ☒Observe and describe – if extended or re-use of PPE is practiced, describe the home's process ☐Necessary PPE is immediately available upon entrance to the COVID-19 unit NA but plenty in house **OBSERVATION:** (Nursing and Multiple departments) ☒Staff demonstrate proper sequencing of PPE per COVID-19 per CDC guidance Don	• Everyone is mandated to wear masks, but often they are pulled below the nose or off when at the nursing station. • Not all staff have indicated that they have been trained in proper PPE donning and doffing. • Upon interview of the staff educator, who is responsible for PPE training, requested to watch 2 people don and doff PPE. Here are the responses: ▪ What is donning and doffing? ▪ One staff member got up and walked away ▪ Reviewed donning and doffing by 2 staff members and neither one did it correctly. ▪ The staff that showed me how to apply PPE first dropped the gloves on the floor and then returned them to the box, grabbed the gown and slung it over her shoulder as she was trying to keep it off the floor, did not follow the steps correctly even though the staff development was trying to help her. ▪ The second staff also did not follow the correct steps in PPE application. ▪ Noted an aide emptying garbage's without gloves and did not have a mask on

	1. Identify and gather the proper PPE to don. 2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown. 4. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). 5. Put on face shield or goggles. 6. Put on gloves. 7. Healthcare personnel may now enter patient room. (Doff) PPE 1. Remove gloves. 2. Remove gown. 3. Healthcare personnel may now exit patient room. 4. Perform hand hygiene. 5. Remove face shield or goggles. 6. Remove and discard respirator (or facemask if used instead of respirator). 7. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing reuse.* ☒Signage - Signs on the use of PPE are posted in appropriate locations- posted immediately outside of veteran rooms indicating appropriate infection control precaution and required PPE per guidelines.	• Signage is noted throughout the building • The trash bins are often overflowing with garbage laying along the bins

	☒Trash disposal bins are positioned as near as possible to the exit inside of the veteran room ☒ Is hand sanitizer is accessible location ☐Veterans are donning face masks whenever: o leave their room o leave facility for essential medical appointments ☐ General observations of universal source control and PPE use per guidance in multiple departments – describe	• The veterans are required when they leave the building, it was observed that one re-entered from an appointment with the mask. Often when they are in the hall they do not have on masks.
Admissions, Readmissions, Communication Processes	**Admissions, Readmissions, Appointments** ☒Facility has a plan for admissions that aligns with guidance ☐ Describe placement and process for New and Re-Admissions (i.e. where, how long, testing, decision, monitoring, PPE use, etc.) ☐Readmission has a plan for admissions that aligns with guidance ☒Facility has a process for veterans who have routine medical appts (i.e. dialysis)	• Currently all admissions are on hold unless it is a readmission. • Those residents that are re-admitted are placed into 14-day isolation. • Veterans are allowed to leave if they have an appointment that can't be changed, they wear a mask, and then return to their room on return.
Communication Process	**Communication Requirements** ☒Describe process for communication of COVID status ☒Describe designated person assigned responsibility for daily communications with: ☐Staff ☐Veteran ☐Families ☐ Headquarters ☒All communications include status and	• Human Resources, Lonette, keeps track of all data regarding Covid positives, quarantines, tracing, Temp sheets, the call ins and recovered, filed by date and month. • Communication lead is the ED, who in turns uses management staff to pass along information. Veterans and Families receive information from the Social Worker (MSW).

	impact of COVID-19 in the facility – prevalence of confirmed cases in staff and veterans and PPE availability ☒Facility provides routine updates to staff re COVID-19. Staff have received updated education as needed Describe	
Staffing and Staff Contingency Related to COVID-19 and Outbreak	☒There is a policy and procedure for staffing strategies in an emergency and is part of Emergency Preparedness plan ☒The plan includes: ☒Dedicated and consistent staffing teams who directly interact with veterans that are COVID-19 positive ☒Limiting clinical and other staff who have direct veteran contract to specific floors or wings – there should be no rotation of staff between floors or wings during the period they are working for the day ☒An established policy to minimize the number of staff interacting with each veteran ☒List the designated person assessing responsibility for conducting a daily assessment for staffing needs including back up plans as needed	• Staffing is regulated by the DNS and ADON • Did not observe an established policy to minimize the number of staff interacting with each veteran
Education, monitoring and screening of staff Staff Development	☒Staff education has been provided education about COVID-19 including (when did it start, how often, when was the last education, do you have any	• The Staff Development Coordinator (educator), Jackie indicated that she started education in February or March. The last documented evidence available was July 2020, but she said she tries to educate every other week using the town hall methodology. She indicated that she will

Coordinator discussion	written resources to use after you have been educated and where are they located) ☒Signs and Symptoms of COVID-19 ☒How it is transmitted ☐PPE ☐ Cleaning and disinfection ☐Prevention strategies Social distancing Universal source control Hand hygiene Visitation Common use areas ☐ Testing – (licensed nurses) ☐Identification and reporting of change of condition ☐Screening criteria ☒ Training Materials – who develops, where does the information come from, who provides the training, modality of training, how often is training provided to staff in all departments, is there a plan outlined for the COVID-19 training ☒ Describe and review training provided ☒ Has the home conducted ongoing COVID-19 education – (describe process, frequency, accountability, documentation, etc.) ☒ Describe competency verification process for: (PPE, Hand hygiene, screening, etc.) ☒ Describe process when breaks in practice are identified	disseminate information to managers and they in turn review with staff. • The education she uses is based on the CDC website for Covid-19. She does not have competency training. She is in the process of providing new employee orientation so has not had a chance to provide more Covid education. • List of evidence of training: o Handwashing o Covid Prevention o Similarities of Covid and Flu per the CDC o PPE Donning and Doffing o Webinar Series for LTC on Covid o Blood/body fluids o Alcohol Based sanitizer • Staff educator stated she stops the staff member and reinforces when infractions are noted, but this was not observed when the staff dropped the glove on the ground and placed in back in the box. • Based upon observation and rounds, discussed with staff development coordinator the opportunity to provide re-education on hand hygiene and PPE and start competencies for IC. The Home did not have documentation of all subjects being taught

	☐Interview of staff – are they aware of processes/protocols for COVID-19 Transmission Based Precautions, ask staff specific questions based upon training reviewed (i.e. PPE training and what the process is, observe PPE use and alignment with P&P as well as training)	
Record Review	☐Review *1 records of veteran and their roommates* who were COVID positive in September – (Goal is to review pre and post diagnosis, identification of CoC, timely intervention, appropriate quarantine and isolation, treatments, etc.) • Review a time span 14 days prior and post COVID diagnosis • Change of condition – immediate identification • Monitoring of resident prior to and post positive result • Documentation • Reporting • Notifications • Testing – process and how long it took for testing after s/s identified (time line of what testing was done) • How long it took to get results • Asymptomatic – what was the process, mitigation, placement • Roommate review of chart • Did veteran placement change occur? • Care plan change • Special treatments • Nebs, CPaP, BiPaP, aerosol generating, trach • Dialysis • Did the veteran leave for external	• 1 chart review for the **single** Covid Veteran, not much information. • Veteran started with low grade temp (99.7 and 100.4), dyspnea, body aches and they sent out to the ER. *History of BP, pain, Constipation, Diabetes, Osteoarthritis, depression*, *ASHD, A-fib. And dizziness with giddiness.* • The first test at the hospital was negative, but they put him on a Covid floor and after 3 days he tested positive. • The care-plans reviewed listed social distancing and isolation with Covid as a problem, NO infection precautions noted - reviewed 5 different care plans including those with a wound infection. • This veteran also did not have a roommate, and he [redacted] to all vet's house wide prior to being sent to ER. He died 3 weeks later after learning of his spouse's death. The hospital did confirm he was positive for Covid. • The unit he was housed on was treated as an isolation unit and cleaned accordingly.

	appts prior to COVID diagnosis • Any visitors or visitations occurred prior, during – also hand holding visits • Review of clinical notes • If Special care unit resident – wandering status, did they wander into rooms, masking,	
Staff Interviews - Additional Questions during observation process and meetings	**<u>All Departments</u>** Questions when meeting with staff (various departments, positions) (recommend that you interview people from every department including *one charge nurse, one-unit manager and one house supervisor*): • Do you know where the COVID related P&P Manual is? o Can you show me? • Do you have one for example, on PPE donning and doffing? • Do you use the P&P Manual for direction? • How often have you accessed the P&P since March? • Have there been any changes to the policies? • How are you informed of the changes of the Policies? • Nurses – Discuss your process for admissions, re-admissions, quarantine, positive COVID-19 veteran? What resource do you use for decision making or resource? • Nurse – How is it determine when a veteran comes off of COVID-19 unit or quarantine?	• The IP Manual has the following P&P: a. Antibiotic Stewardship 5/18/18 b. Surveillance 10/22/20 (audit tool) c. 1 page Policy for ICP d. Infection Control Guidelines for LTC Facilities; Emphasis on Body Substance Precautions (January 2005) • They also have a Covid Book (blue binder) In this book there are handouts from the CDC • Staff Interviews based on highlighted questions: • *Haven't see the manual in a while, but I know we have it. It's usually here though.* • *If they changed the policy, we never got a copy* • *We have in-services so if something is new, they tell us* • *Resource manual (yellow book) has the steps we take for admission, or readmissions* • *The resident could come off isolation when we are told its ok, but don't think we have any right now.* • *I'm sure our policies have changed but I'm not sure how.*

	• How have polices changed since positive COVID cases? **IP Lead** ☐Describe your role in managing care for veterans with infections? ☐Do you routinely participate in calls with headquarters and describe your role in the overall COVID plan? ☐Describe your Line List or tracking process? Veterans, staff ☐Do you participate in decisions about isolation, quarantine, monitoring, screening, PPE use, policy development, training, staff supervision? ☐What is your reporting relationship to the clinical analyst? Headquarters Infection Control lead? ☐Are you aware of CDC and DHHS COVID-19 guidelines and recommendations? Do you utilize those in the decision process for COVID guidance? ☒Discuss how you collaborate with non-clinical departments within your home ☒Describe your process for reporting and communicating infections and COVID cases ☒Are you involved in the overall COVID prevention processes – including testing of veterans and staff, data collection, reporting of outcomes, ☒Who communicates with the LDPH? ☐Do you conduct contact tracing? ☒ Describe how you work with Procurement Officer, Environmental Services and other departments related to COVID-19 and Infection Control	• The IP is required to attend headquarters calls, her line listing is based on daily information from Covid testing, she is also part of a Covid team that is ready in the event they have a breakout. The information she receives comes from headquarters where everyone receives guidance.

	PPE Process for IP ☐PPE –Who is assigned to replenish supply of PPE on each unit and department ☐ Describe the Communication process if supplies are running low ☐ Describe the inventory process, burn rate process for PPE ☐ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) **Procurement Officer** ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☒ Describe the inventory process, burn rate process for PPE ☒ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) ☒ Describe how much PPE inventory that is currently available in house ☒ Describe the process for procuring PPE **Environmental Services Lead** ☒Describe how you oversee the housekeeping staff's disinfection process ☒How often are surfaces in common areas disinfected ☒Where are the cleaning and disinfection	• See information regarding Procurement officer, Bryan • Procurement officer, Bryan rounds daily and counts all PPE in house, orders as needed and delivers to units, if they run short on weekends or nights the supervisor can access. He submits an excel spread sheet of available in-house products to ED by 11 am daily. He has a special log in the PPE room where items can be signed out. He stated I am prepared for an outbreak, so I am building up my supply as I can. (Chapter 34 rules) I have direct contact with Headquarters and receive daily guidance. Example of some of his excel sheet: Tyvek suits: 408, Full face masks 23, N95 small: 360, N95 M/L: 2470 • Policy and Procedures for housekeeping services are located in each of the housekeeping rooms on the neighborhoods. Cleaning entails mopping, wiping down handrails, etc. to help control the virus. All chemical used are

	polices located, describe accessibility? ☒Describe the process for selection of disinfectants used, when did you start using EPA List N products ☒Describe the laundry process ☒Do you utilize consistent assignment? If not do they start negative unit to positive?	premixed in the basement and then placed into small spray bottles • Germicidal bleach, Virex in a dispenser and 128 Disinfectant for cleaning. Housekeeping usually have a consistent hall, but we also have floaters.
Manual Additional Observations and Summary		

APPENDIX E13. Pathway Report: Warrensburg Veterans Home Summary

Warrensburg Veterans Home

Summary Overview

The attached is Onsite Facility Infection Control/COVID-19 Evaluation report with specific findings identified. Below is a summary of highlighted trends identified during the onsite visit for this Home.

- The Home leadership team was cooperative and informative throughout the onsite evaluation. Staff are dedicated to the needs of the veterans they serve.
- Infection Control lead is the Director of Nursing Services, holding multiple roles which does not align with standards of practice
- Infection Control lead (DNS) has no formal training in infection control
- The DNS and the Administrator work together to maintain the Line List, which does not align with standards of practice
- There is no "official" root cause analysis performed on positive cases
- There was no evidence of general infection prevention and control policies and procedures as well as COVID-19 specific policies and procedures
- Front line staff indicated they were not aware of infection control and COVID-19 policies and procedures as would be expected per standards of practice
- Staffing plan there was no written contingency plan and related policies available
- Signage does not reflect COVID-19 guidance
- PPE use per current guidance - breaks in practice identified
    - Use and reuse (30 times), storage, varying strategies for gown use, sequencing
- PPE optimization – not in accordance with CDC guidance.

APPENDIX E14. Pathway Report: Warrensburg Veterans Home Onsite Infection Control Review Report

Onsite Facility Infection Control/COVID-19 Evaluation

Facility Demographics	**Veterans Home Name: Warrensburg Veterans Home** **Date: 10/28/20 and 10/29/20** **Consultant: Amy Harroff** **Administrator: Eric Endsley** **Director of Nursing Services: Lisa Jewel** **Number of Licensed Beds: 200** **Average Daily Census: 115** **<u>COVID-19 Status</u>** **Number of total COVID Cases: 37** **Number of Veteran Cases: 15** **Number of Staff Cases: 22** **Number of COVID related deaths: 7** **Current COVID Status: 2** **Veterans: 0** **Staff: 2**

Topic	Activity	Findings
Infection Control Lead	☒An infection lead has been designated to address and improve infection control ☒ RN ☒How long in IP Position- 1 year ☒Infection Preventionist Training – Describe: CMS IP Training ☒Infection Preventionist is assigned other duties in the facility	• DNS is currently in the IP role – receives assistance from the unit managers • DNS has been in her position 13 years • Has not had specific IP training • Works with the administrator to maintain line list • Supply clerk is responsible for PPE distribution • Educator has been responsible for COVID training with support for the nursing leadership team

	Describe: ☒Hours allotted for Infection Preventionist role ☒Infection Preventionist maintains a line list Veterans with s/sx or confirmed COVID-19 Employees with s/sx or confirmed COVID-19 ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☒ Describe the inventory process, burn rate process for PPE ☒ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) ☒ Familiar with PPE optimization process	• IC efforts was described as a team effort since there was not a designated position
Policies and Procedures	☒ Infection Control Policies and Procedures ☒ COVID -19 Policies and Procedures • Screening for all o Veterans o Staff o Visitors o Vendors, hospice, therapy o ERAY, Pharmacy o Supply delivery process • PPE • Veteran Placement (quarantine process, confirmed COVID-19 process) • Admission, re-admission, dis-	• Policy/Procedure Observations: ➢ No written policies/procedures available for review • Strong screening process – well managed and flow of employees allows for appropriate social distancing • Employees are asked to wash hands, complete questionnaire, temp is taken with screener behind plexiglass • Screening area is separated from other activities and veterans • Rapid testing is in the large chapel area with video running 24/7 reviewing donning/doffing and rapid testing procedures • All visitors are screened • Currently no communal activities • No visitation occurring, except for end of life visits • Reviewed post-mortem care and body transfer – no issues identified • PCR testing is done on all employees and negative veterans on Mondays and Thursdays

	charge
	• Universal Source Control (Staff and Veterans)
	• Visitation (when started, where located, infection control measures, documentation, etc.)
	• Hand holding stations
	• Aerosol generating medications, nebulizer
	• Postmortem care
	• Testing
	  o Overall
	  o Specimen process
	  o Rapid Antigen POC
	  o PCR and Lab process
	  o Reporting process
	• Reporting and Communication process (Reporting of S/S, confirmed cases, quarantine, PPE, all COVID related communication – to whom and how communicated to home and departments and staff)
	  o Timing of reporting
	  o Direction for reporting
	  o Changes in reporting process in last 3 months
	• Veterans psychosocial needs
	• Communal activities
	• Dining
	• Special Care Unit specific
	• Hand Hygiene
	• Employee illness
	• Return to work
	• Education
	• Staffing and Staff assignment
	• Cleaning and disinfection – all departments
	☒Change in condition for COVID-19
		• All veterans are being monitored for COVID signs and symptoms (s/s)
		• Employees are to report any symptoms prior to the start of their shift – drive by testing is then performed to identify status
		• Staff interviews revealed an overall understanding of employee quarantine expectations, as well as veteran quarantine and isolation times
		• Symptom list is up to date
		• Positive employee and veteran tests are reported to the administrator and up to headquarters
		• There is no “official” root cause analysis performed on positive cases

	☒Facility has a COVID-19 pandemic plan	
Clinical Care and Veteran Monitoring	☒Monitoring for Change of Condition with COVID-19 ☒Systems are in place identify COVID-19 early via screening processes ☒All veterans are screened for symptoms of COVID-19 and have their vital signs monitored, including oxygen saturation and temperature checks including: ☒Is the symptom list up to date for COVID-19: Fever or chills Cough Shortness of breath or difficulty breathing Fatigue Muscle or body aches Headache New loss of taste or smell Sore throat Congestion or runny nose Nausea or vomiting Diarrhea Trouble breathing Persistent pain or pressure in the chest New confusion Inability to wake or stay awake Bluish lips or face ☒Does the E H R have a system for alerts? Are they able to monitor trends, contact tracing based upon trends, etc.? Who monitors this process and how is it communicated?	• Monitoring occurs q shift and there is an alert in the electronic health record • Screening process above • Symptom list is all inclusive

	☒Is there are RCA process when COVID is identified to determine potential risks, breaks in practice, contact tracing, etc.?	
Entrance to Home – Screening Process	☒Facility screens every individual entering the facility (including staff) for COVID-19 symptoms. Questionnaire, temperature taken. ☒Entry access is limited, and the entrance has screening stations. ☒Those permitted entry are instructed about frequent hand hygiene, limiting interactions with others and with surfaces touched and limiting their visit to designated areas ☒Those permitted entry are instructed about monitoring for signs and symptoms of COVID-19 ☒Observe Screening criteria and process includes temperature checks. ☒Tracks and monitors for fever ☒Tracks and monitors COVID-19 symptoms ☒Review screening process, log, paperwork and questionnaire	• All that enter the facility are screened • There is one coded entrance • Instructions are provided both verbally and with signage
COVID-19 – Confirmed or Suspected Status, Plan and System	☐Confirmed positive or recovering COVID-19 veterans are placed on COVID-19 Unit/Wing ☒Co-horting or in a private room ☒If no room is available on COVID-19 Unit, veteran placed in private room or co-horted with other confirmed case ☒All veterans who are not suspected to be infected with COVID-19 are in rooms or units that do not include confirmed or suspect-	• No positive veterans in the facility at the time of the evaluation • Quarantine unit in place with PPE readily available and staff observed donning and doffing appropriately at each veteran's room • If a veteran was identified as positive, they would immediately be placed in in a room on the COVID unit • Quarantine unit is used for exposed or newly admitted for "several months" according to the Director of Nursing/IP

	ed cases. ☒Veteran cohorting is re-evaluated by infection control lead and clinical staff and implemented each day based on results of any of the following: surveillance testing (if available), symptom screening and temperature checks. ☒Veteran cohorting is re-evaluated by infection control lead and clinical staff ☒There is an outlined process for determination of when a veteran comes off of the COVID-19 unit or quarantine ☒ How long have these processes been in place?	
Communal and Congregate Areas – Veteran Care	☒Outings, group activities and communal dining are adjusted per COVID-10 status Explain the process, review policy ☒Describe current status on veterans using congregate spaces Ask about activities, dining, what they are using their communal spaces for, has the process changed over time? ☒Social distancing is observed ☒Universal source control is observed ☒Describe the Special Care Unit process for communal space and mitigation ☒Terminal cleaning is completed after each use	• No group activities or outings • Several common areas in each unit, veterans were observed utilizing the space with appropriate social distancing • Mask utilization for veterans ➢ 10 veterans on the memory care unit were observed not wearing face coverings – when staff was questioned about this practice, they indicated "they don't keep them on" – later, while rounding on the unit, found all veterans with face coverings in place
Hand Hygiene and Necessary Supplies	☒Necessary supplies are available and accessible for hand hygiene.	• Opportunity for improved placement of Alcohol Based Hand Rub (ABHR) ➢ Bottles of ABHR readily accessible; however, several opportunities identified (between elevator and stairway and on education

	Describe what is used, accessibility, etc. **Hand Hygiene** **OBSERVATION** Staff perform hand hygiene (even if gloves are used) when indicated ☒Before and after glove use ☒Before & after veteran contact ☒After contact with blood, body fluids or visibly contaminated surfaces ☒After contact with objects and surfaces in the veteran's environment ☒Before performing procedures such as an aseptic task ☒After removing PPE ☒Alcohol-based hand rub (ABHR) is readily available ☒Staff use ABHR preferentially for hand hygiene – if available, it is readily accessible and preferentially used ☐If ABHR is not available or limited, staff wash their hands with soap and water ☒Staff wash their hands with soap and water for 20 seconds when visibly soiled ☒**Staff interviewed** indicated there is an adequate supply of hand soap and paper towels	hallway) where sanitizer placement would be beneficial • Staff was observed frequently utilizing the ABHR, as well as soap and water • Staff indicated during interviews there were no issues with availability • Hand hygiene was not observed to be provided to the veterans before meals
Cleaning and Disinfection	**OBSERVATION** **Supplies and Disinfection (multiple departments)** ☒Dedicated or disposable non-critical care equipment is used	• Dedicated equipment was available • Staff observed wiping down thermometers after use • Environmental Services (EVS) staff was interviewed regarding cleaning product knowledge and cleaning methods were observed with no issues identified • Nursing staff members familiar with appropriate kill time and observed

	☒Reusable equipment is cleaned and disinfected after use according to manufacturer's directions using an EPA registered disinfectant List N before use on another veteran ☒Objects and environmental surfaces that are touched frequently and are close to the veteran are cleaned and disinfected at least daily and when visibly soiled ☒Staff appropriately perform environmental cleaning and disinfection ☒Staff appropriately reprocess reusable equipment (cleaning and disinfecting per device and according to manufacturer's instructions and contact time) Ask Staff: Housekeeping/Environmental Services ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Nursing ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Dining Services ☒Describe process for mixing, reconstituting, labeling, following manufacturers contact time/kill time for disinfectants Activities/Recreation ☒Describe process for mixing, reconstituting, labeling, following	wiping down surfaces after meals – product is provided to them already mixed

	manufacturers contact time/kill time for disinfectants	
PPE	☒All staff are practicing universal source control (i.e. face masks) ☒Staff have been trained on selecting, donning, and doffing appropriate PPE, were staff tested, competency verification ☒If there are COVID-19 cased identified in the facility, staff is wearing recommended PPE for care of all veterans, in line with the most recent guidance. ☒Observe and describe – if extended or re-use of PPE is practiced, describe the home's process ☒Necessary PPE is immediately available upon entrance to the COVID-19 unit **OBSERVATION: (Nursing and Multiple departments)** ☒Staff demonstrate proper sequencing of PPE per COVID-19 per CDC guidance Don 1. Identify and gather the proper PPE to don. 2. Perform hand hygiene using hand sanitizer. 3. Put on isolation gown. 4. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available).	• All staff are expected to wear N95s and face shields • Mask reuse procedure is posted (place in paper bag with name, date – may use for 30 days unless mask becomes soiled or breaks) • PPE readily available at the entrance of each unit • Interview with educator revealed extensive education was provided and documented regarding PPE utilization – nursing leadership is also monitoring and providing on the spot training if breaks in procedure occur • Signage ➢ There was no signage on COVID units to indicate what PPE was necessary to don prior to entering through the closed fire doors • Trash ➢ Upon entering the COVID positive unit, there were (2) large trash cans with red biohazard bags – the DNS indicated the cans were where used PPE would be placed – indicated that this would provide a high potential for cross contamination • Staff from all departments were observed donning and doffing in the appropriate order • All veteran's rooms had isolation caddies that were fully stocked

	5. Put on face shield or goggles. 6. Put on gloves. 7. Healthcare personnel may now enter patient room. (Doff) PPE 1. Remove gloves. 2. Remove gown. 3. Healthcare personnel may now exit patient room. 4. Perform hand hygiene. 5. Remove face shield or goggles. 6. Remove and discard respirator (or facemask if used instead of respirator). 7. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing reuse.* ☒Signage - Signs on the use of PPE are posted in appropriate locations- posted immediately outside of veteran rooms indicating appropriate infection control precaution and required PPE per guidelines. ☒Trash disposal bins are positioned as near as possible to the exit inside of the veteran room ☒ Is hand sanitizer is accessible location ☒Veterans are donning face masks whenever: o leave their room o leave facility for essential medical appointments	

	☒ General observations of universal source control and PPE use per guidance in multiple departments – describe	
Admissions, Readmissions, Communication Processes	**Admissions, Readmissions, Appointments** ☒Facility has a plan for admissions that aligns with guidance ☒ Describe placement and process for New and Re-Admissions (i.e. where, how long, testing, decision, monitoring, PPE use, etc.) ☒Readmission has a plan for admissions that aligns with guidance ☒Facility has a process for veterans who have routine medical appts (i.e. dialysis)	• All new admissions are quarantined for 14 days, unless they are COVID positive, in which case, would be placed on the COVID unit • Veteran's return to their assigned rooms following scheduled appointments
Communication Process	**Communication Requirements** ☒Describe process for communication of COVID status ☒Describe designated person assigned responsibility for daily communications with: ☐Staff ☐Veteran ☐Families ☐ Headquarters ☒All communications include status and impact of COVID-19 in the facility – prevalence of confirmed cases in staff and veterans and PPE availability ☒Facility provides routine updates to staff re COVID-19. Staff have received updated education as needed	• Clear line of communication exists between the nursing leadership team, administration and the front-line staff • Review of medical records revealed documentation of family/veteran notification by the facility social worker • Administrator and management team attend 3Xweek calls with headquarters • Administrator has daily stand-up meetings to keep the management team informed of facility status
Staffing and Staff Contingency Related to COVID-19 and	☒There is a policy and procedure for	• No written policy available for review

Outbreak	staffing strategies in an emergency and is part of Emergency Preparedness plan ☒The plan includes: ☒Dedicated and consistent staffing teams who directly interact with veterans that are COVID-19 positive ☒Limiting clinical and other staff who have direct veteran contract to specific floors or wings – there should be no rotation of staff between floors or wings during the period they are working for the day ☒An established policy to minimize the number of staff interacting with each veteran ☒List the designated person assessing responsibility for conducting a daily assessment for staffing needs including back up plans as needed	• Confirmed that consistent staffing occurs on all the units • Nursing management staff assists if there are staffing issues
Education, monitoring and screening of staff Staff Development Coordinator discussion	☒Staff education has been provided education about COVID-19 including (when did it start, how often, when was the last education, do you have any written resources to use after you have been educated and where are they located) ☒Signs and Symptoms of COVID-19 ☒How it is transmitted ☒PPE ☒ Cleaning and disinfection ☒Prevention strategies Social distancing Universal source control	• Staff Development Coordinator has been in the position for (6) years • COVID education started in March and has been on-going • She supplements the education provided by headquarters with additional resources from the CDC and other validated sources • Education materials are readily available to staff in binders on the unit • Confirmed there are no specific policies related to COVID • Staff Development Coordinator and the nursing leadership are responsible for monitoring compliance with COVID related procedures

	Hand hygiene Visitation Common use areas ☒ Testing – (licensed nurses) ☒Identification and reporting of change of condition ☒Screening criteria ☒ Training Materials – who develops, where does the information come from, who provides the training, modality of training, how often is training provided to staff in all departments, is there a plan outlined for the COVID-19 training ☒ Describe and review training provided ☒ Has the home conducted ongoing COVID-19 education – (describe process, frequency, accountability, documentation, etc.) ☒ Describe competency verification process for: (PPE, Hand hygiene, screening, etc.) ☒ Describe process when breaks in practice are identified ☒Interview of staff – are they aware of processes/protocols for COVID-19 Transmission Based Precautions, ask staff specific questions based upon training reviewed (i.e. PPE training and what the process is, observe PPE use and alignment with P&P as well as training)	
Record Review	☒Review *2 records of veteran and their roommates* who were COVID positive in September – (Goal is to review pre and	• (4) veteran records were reviewed, and no issues were identified related to identification, testing, documentation, and reporting • All veterans were receiving weekly PCR testing

	post diagnosis, identification of CoC, timely intervention, appropriate quarantine and isolation, treatments, etc.) • Review a time span 14 days prior and post COVID diagnosis • Change of condition – immediate identification • Monitoring of resident prior to and post positive result • Documentation • Reporting • Notifications • Testing – process and how long it took for testing after s/s identified (time line of what testing was done) • How long it took to get results • Asymptomatic – what was the process, mitigation, placement • Roommate review of chart • Did veteran placement change occur? • Care plan change • Special treatments • Nebs, CPaP, BiPaP, aerosol generating, trach • Dialysis • Did the veteran leave for external appts prior to COVID diagnosis • Any visitors or visitations occurred prior, during – also hand holding visits • Review of clinical notes • If Special care unit resident – wandering status, did they wander into rooms, masking,	• COVID care plans were developed when veterans moved to the isolation unit • Symptom monitoring q shift was documented • Timely notification of positive results and movement of veteran to isolation was documented • None of the (4) left the facility or had visitors • Veteran #1 was negative and asymptomatic until 9/17/20 when he had a positive result – was immediately moved to isolation where he remained for 14 days and returned to his former room • Veteran #1- had weekly testing that was negative until 9/19/20 when results were positive – was immediately moved to isolation where he remained until 9/25/20 when he was found unresponsive – was a DNR • Veteran #2 was Veteran #1s roommate – remained asymptomatic and COVID negative • Veteran #3 was negative and asymptomatic until 9/17/20 when he had a positive result – was immediately moved to isolation where he remained for 14 days and returned to his former room – was on the same unit (memory care as Veteran #1) • Veteran #4 had weekly testing and was asymptomatic – COVID positive result on 9/17/20 and was moved to isolation – was also on the memory care unit

Staff Interviews - Additional Questions during observation process and meetings	**<u>All Departments</u>**
	Questions when meeting with staff (various departments, positions) (recommend that you interview people from every department including *one charge nurse, one-unit manager and one house supervisor*):
	• Do you know where the COVID related P&P Manual is?
	  o Can you show me?
	• Do you have one for example, on PPE donning and doffing?
	• Do you use the P&P Manual for direction?
	• How often have you accessed the P&P since March?
	• Have there been any changes to the policies?
	• How are you informed of the changes of the Policies?
	• Nurses – Discuss your process for admissions, re-admissions, quarantine, positive COVID-19 veteran? What resource do you use for decision making or resource?
	• Nurse – How is it determine when a veteran comes off of COVID-19 unit or quarantine?
	• How have polices changed since positive COVID cases?
	
	IP Lead
	☒Describe your role in managing care for veterans with infections?
	☒Do you routinely participate in calls with headquarters and describe your role in the overall COVID plan?
		• Multiple interviews conducted with all departments – response to policy availability was consistently "not available"
		• See comments in education section
		• PPE Procurement:
		  ➢ Supply manager does a daily count of PPE
		  ➢ Has no difficulty obtaining from assigned suppliers
		  ➢ The supervisors keep stock of PPE – if they run out, they contact the administrator who tells them where a key is to the supply room. The key placement is moved based on control concerns
		  ➢ Supply manager has an employee who stocks the units
		• Toured with the EVS manager and reviewed current cleaning/sanitizing procedures – identified no issues
		• Toured the laundry – staff using red biohazard bags for laundry in the quarantine and COVID positive units
		• EVS employees have consistent assignments
		• Designated washer and dryer
		• Laundry clean and organized
		• Interviews with nursing staff revealed they feel supported and that communication regarding COVID has been "clear"

	☒Describe your Line List or tracking process? Veterans, staff ☒Do you participate in decisions about isolation, quarantine, monitoring, screening, PPE use, policy development, training, staff supervision? ☒What is your reporting relationship to the clinical analyst? Headquarters Infection Control lead? ☒Are you aware of CDC and DHHS COVID-19 guidelines and recommendations? Do you utilize those in the decision process for COVID guidance? ☒Discuss how you collaborate with non-clinical departments within your home ☒Describe your process for reporting and communicating infections and COVID cases ☒Are you involved in the overall COVID prevention processes – including testing of veterans and staff, data collection, reporting of outcomes, ☒Who communicates with the LDPH? ☒Do you conduct contact tracing? ☒ Describe how you work with Procurement Officer, Environmental Services and other departments related to COVID-19 and Infection Control **PPE Process for IP** ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☒ Describe the inventory process, burn	

	rate process for PPE ☒ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) **Procurement Officer** ☒PPE –Who is assigned to replenish supply of PPE on each unit and department ☒ Describe the Communication process if supplies are running low ☒ Describe the inventory process, burn rate process for PPE ☒ Have you had to go into the different levels of PPE optimization (i.e. conventional, contingency, crisis, out of inventory) ☒ Describe how much PPE inventory that is currently available in house ☒ Describe the process for procuring PPE **Environmental Services Lead** ☒Describe how you oversee the housekeeping staff's disinfection process ☒How often are surfaces in common areas disinfected ☒Where are the cleaning and disinfection polices located, describe accessibility? ☒Describe the process for selection of disinfectants used, when did you start using EPA List N products ☒Describe the laundry process ☒Do you utilize consistent assignment? If not do they start negative unit to positive?	

Additional Observations and Summary	***Summary:*** Observations and interviews revealed that this facility has a strong culture of safety. Each unit was clean, staff was following proper infection control procedures and indicated that they are well informed of what is happening in the facility.

APPENDIX F. MVC NEWS RELEASE (OCTOBER 29, 2020)

Missouri Veterans Commission News Release

FOR IMMEDIATE RELEASE
October 29, 2020

Independent Review Team Seeks Family Comments

Independent Review Team Seeks Family Comments

JEFFERSON CITY – As an independent, external review team continues to examine operations related to COVID-19 in the Missouri Veterans Commission's seven Veterans Homes, a dedicated call-in line has been established for family members of residents in the homes.

The call-in number is (314) 552-6665 and is for veterans' family members only. The call-in line will be open through Nov. 4, 2020 only.

Family members who wish to share information with the independent review team from Armstrong Teasdale should call and speak with Brian Kaveney. Like the review itself, the call-in line is independent of the Missouri Veterans Commission and all comments related to COVID-19 from residents' family members are welcome.

On Oct. 2, Governor Mike Parson ordered the Missouri Veterans Commission to conduct an independent, external review of all seven Missouri Veterans Homes and their COVID-19 operations to assess their performance and to identify steps to improve management and prevent further COVID-19 transmission. The review began Oct. 12.

The Missouri Veterans Commission, a division of the Department of Public Safety, operates seven State Veterans Homes, five State Veterans Cemeteries, and the Veterans Services Program. The Commission is committed to honoring and serving Missouri's veterans whose dedication and sacrifices have preserved our nation and its freedoms. One mission, serving Veterans. For more information about the Missouri Veterans Commission programs, call (573) 751-3779, online at **http://www.mvc.dps.mo.gov (http://www.mvc.dps.mo.gov)**, or facebook.com/MissouriVeteransCommission.

###

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For more information, call 573-508-9194 or e-mail **(mailto:)**

APPENDIX F

APPENDIX G. PRIOR RECOMMENDATION LETTER

Brian E. Kaveney
Direct **T** 314.259.4757 **F** 314.552.4830
bkaveney@atllp.com

October 28, 2020

VIA EMAIL

ATTORNEY-CLIENT PRIVILEGED
CONFIDENTIAL

Chairman Tim Noonan
Missouri Veterans Commission
205 Jefferson Street
12th Floor Jefferson Building
Jefferson City, MO 65102
noonanstl@gmail.com

Re: Immediate Recommendations to Reduce Spread of COVID-19 in MVC Homes

Dear Chairman Noonan:

On October 12, 2020, Armstrong Teasdale LLP commenced our rapid, independent, external review for the Missouri Veterans Commissions ("MVC") pursuant to Emergency RFQ No. ERFQ30034902100586. Armstrong Teasdale is in the process of conducting its review of all Missouri Veterans Homes (the "Homes") and their COVID-19 operations to assess the Homes' performance and to identify what steps should be taken to improve their management and to prevent further COVID-19 transmission.

Based upon the interviews conducted to date at each of the Homes, I raise for your consideration the following action items that we recommend the MVC immediately consider and implement as the MVC seeks to prevent COVID-19 infections at its Homes and to prevent the spread of such infections. The following recommendations are being raised at the earliest opportunity so that the MVC and other stakeholders may work together to consider and implement these urgent recommendations, particularly for the men and women who served this country:

1. **Rapid Antigen Testing**: Our review confirms that the Homes are utilizing Abbott BinaxNOW rapid antigen tests to screen both veteran residents and staff for COVID-19 on a regular basis since they were delivered during the first week of October 2020. Rapid antigen testing is a powerful tool for mitigating the introduction and spread of COVID-19 by asymptomatic staff members. The instant results from these tests have already allowed Homes to screen out positive asymptomatic staff members, who otherwise would have worked multiple shifts during the 24-48 hour turnaround time of the traditional PCR tests. Because of the efficacy of the Abbot BinaxNOW rapid antigen tests, there is large demand for any available supply, resulting in a scarcity of these critical kits. At this time, and to the extent resources permit, we recommend the MVC prioritize securing a reliable supply of the Abbott BinaxNOW rapid antigen tests, or a similar rapid test with an equivalent or

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lower error rate, to allow the Homes to continue rapid screenings through at least April 2021. To the extent resource constraints limit the availability of the rapid tests, the MVC should develop a triage protocol to employ the available supplies for maximum protection of the Home community.

2. **Proper Optimization and Distribution of PPE**: Our review confirms that while many of the Homes currently have appropriate personal protective equipment ("PPE") readily available to treat veterans with suspected or confirmed cases of COVID-19, the stock of available PPE, including the availability of N95 respirators, has fluctuated. Due to this fluctuation, in a good faith attempt to conserve resources, some staff members have been instructed to reuse certain forms of PPE in a manner inconsistent with current Centers for Disease Control and Prevention ("CDC") recommendations. It remains unclear from early reporting, whether this issue is driven by logistical concerns or by a misapprehension of the CDC's optimizations guidelines. We recommend the MVC prioritize the acquisition of a sustainable supply chain for PPE in order to ensure a continual supply of the required protective equipment (with emphasis on N95 respirators) through at least April 2021. We also recommend the MVC assist each Home in assessing its current PPE supply and burn rate, compared against the MVC's projected reserves, in order to determine the proper optimization strategy applicable to the Home.

3. **Transfer of Veteran Residents Testing Positive**: A necessary practice in preventing the spread of COVID-19 is to separate veterans with confirmed or suspected cases of COVID-19 from the general veteran community. We recommend that any veteran who tests positive for COVID-19 be immediately transferred to an isolation area. A veteran who tests positive should not continue to reside in an area where the veteran cannot be confidently isolated from veterans who have not tested positive for COVID-19. We also recommend that the MVC prioritize assisting each Home in developing a rapid response plan in the event of a large COVID-19 outbreak among veteran residents. Special consideration should be given to circumstances where such an outbreak also coincides with significant staffing shortages due to high infection rates among the caregivers and support staff. Outbreak planning should include prior-coordination with local health officials and the Veteran's Administration hospital of jurisdiction, for circumstances where the logistical burdens of a surge in highly acute COVID-19 positive residents strains the capacity of the Home to safely care for the veteran population.

4. **Issue Press Release**: Given the publicly-reported nature of our review, we believe family members of veterans living in the Homes may be aware of our review and may have additional helpful information we should consider. For that reason, and to ensure our review appropriately considers all relevant information, we recommend the MVC immediately issue a press release notifying veterans' family members to contact Brian Kaveney at Armstrong Teasdale if the family members desire to share information with us. We have set up a dedicated call-in number for family members only. The number is 1-314-552-6665. The line will be open from October 28, 2020, through November 4, 2020.

These preliminary recommendations are raised immediately for your consideration in furtherance of our directive to identify the steps that should be taken to improve the Homes and to reduce the spread of COVID-19. We believe that immediately implementing the above recommendations will promote the safety of the veterans and staff at the Homes.

Sincerely,

Brian E. Kaveney

[1] https://mvc.dps.mo.gov/about/ (last visited November 13, 2020)
[2] COVID-19 is the official name for the disease that is causing the 2019-2020 global coronavirus outbreak, first identified in Wuhan China. The virus can spread through close contact, respiratory droplets, or touching an infected surface and then touching one's face. To date, there have been over 9 million cases and 230,000 deaths. https://www.cdc.gov/coronavirus/2019-ncov/downloads/2019-ncov-factsheet.pdf; https://covid.cdc.gov/covid-data-tracker/#cases_casesinlast7days.
[3] Dashboard Excel sheet "Daily COVID report to HQ"
[4] https://governor.mo.gov/press-releases/archive/governor-parson-announces-expansion-state-covid-19-dashboards (last visited on November 12, 2020)
[5] Interview of State epidemiologist
[6] https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/ (last visited November 13, 2020)
[7] *Id.*
[8] https://www.usnews.com/news/top-news/articles/2020-04-02/us-cdc-reports-213-144-coronavirus-cases-4-513-deaths (last visited November 13, 2020)
[9] https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days (last visited November 13, 2020)
[10] https://covid.cdc.gov/covid-data-tracker/#testing_testsperformed (last visited November 13, 2020)
[11] https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (last visited November 13, 2020)
[12] *Id.*
[13] https://governor.mo.gov/press-releases/archive/governor-parson-state-and-local-officials-confirm-first-case-covid-19-test (last visited November 13, 2020)
[14] https://governor.mo.gov/press-releases/archive/governor-parson-signs-executive-order-20-02-declaring-state-emergency (last visited November 13, 2020)
[15] https://www.stltoday.com/lifestyles/health-med-fit/coronavirus/first-covid-19-death-announced-in-missouri/article_90e696f3-4173-58c4-bb2c-992f90bd8c83.html (last visited November 13, 2020)
[16] https://governor.mo.gov/press-releases/archive/governor-parson-directs-dhss-director-require-social-distancing-statewide (last visited November 13, 2020)
[17] https://governor.mo.gov/press-releases/archive/governor-parson-issues-statewide-stay-home-missouri-order-control-contain (last visited November 13, 2020)
[18] https://governor.mo.gov/press-releases/archive/governor-parson-announces-first-phase-show-me-strong-recovery-plan-begin-may (last visited November 13, 2020);
https://governor.mo.gov/press-releases/archive/governor-parson-extends-phase-1-show-me-strong-recovery-plan-through-june-15 (last visited November 13, 2020)
[19] https://governor.mo.gov/press-releases/archive/governor-parson-announces-missouri-will-fully-reopen-enter-phase-2-recovery (last visited November 13, 2020)
[20] https://www.aarp.org/health/healthy-living/info-2020/states-mask-mandates-coronavirus.html#Missouri (last visited November 13, 2020)
[21] https://www.aarp.org/health/healthy-living/info-2020/states-mask-mandates-coronavirus.html#Missouri (last visited November 13, 2020);
https://www.arcgis.com/apps/opsdashboard/index.html#/59135fbe6eb24581b8d5dd78964ec1e4 (last visited Novem 13, 2020)
[22] https://www.nytimes.com/interactive/2020/us/missouri-coronavirus-cases.html (last visited November 16, 2020)
[23] https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (last visited November 13, 2020)
[24] https://www.jhsph.edu/covid-19/articles/covid-19-testing-understanding-the-percent-positive.html (last visited November 13, 2020)
[25] *Id.*
[26] https://showmestrong.mo.gov/public-healthcare-testing/ (last visited November 13, 2020)
[27] https://www.nytimes.com/interactive/2020/us/missouri-coronavirus-cases.html#cases (last visited November 13, 2020)
[28] https://covid.cdc.gov/covid-data-tracker/#cases_totalcases (last visited November 13, 2020) ;
https://covid.cdc.gov/covid-data-tracker/#cases_totaldeaths (last visited November 13, 2020)
[29] https://covid.cdc.gov/covid-data-tracker/#testing_totalpercentpositive (last visited November 13, 2020)
[30] https://data.cms.gov/stories/s/bkwz-xpvg (last visited November 16, 2020);
https://www.stltoday.com/news/local/metro/more-than-650-missouri-nursing-home-residents-dead-of-covid-19-as-

infection-rate-climbs/article_27ea371d-9ccd-543f-bc73-202a03bedb2e.html (last visited November 13, 2020) ; https://stlcorona.com/sites/default/assets/pdfs/resources/st-louis-county-resources-july-monthly-covid-ltc-report-08042020-0.pdf (last visited November 13, 2020); https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/ (last visited November 13, 2020)

[31] https://www.accesstocare.va.gov/Healthcare/COVID19NationalSummary (last visited November 13, 2020)

[32] https://data.cms.gov/stories/s/bkwz-xpvg (last visited November 16, 2020)

[33] *Id.*

[34] https://www.accesstocare.va.gov/Healthcare/COVID19NationalSummary (last visited November 16, 2020)

[35] Daily COVID Report to HQ – 11.3.2020 (MVC Spreadsheet)

[36] https://mvc.dps.mo.gov/about/history.php (last visited November 13, 2020)

[37] https://mvc.dps.mo.gov/index.php (last visited November 13, 2020)

[38] https://mvc.dps.mo.gov/about/ (last visited November 13, 2020)

[39] https://mvc.dps.mo.gov/news/newsitem/uuid/10a496ea-1e2a-4cb9-97fa-0d9e9383fe23 (last visited November 13, 2020)

[40] RSMo. § 42.007.5(2).

[41] RSMo. § 42.007.2

[42] *Id.*

[43] *Id.*

[44] *Id.*

[45] *Id.*

[46] RSMo. § 42.007.3.

[47] https://mvc.dps.mo.gov/about/commissioners.php (last visited November 13, 2020)

[48] RSMo § 42.012(1)

[49] *Id.*

[50] *Id.*

[51] *Id.*

[52] https://mvc.dps.mo.gov/about/execdirector.php (last visited November 13, 2020)

[53] https://mvc.dps.mo.gov/news/newsitem/uuid/da59c475-0512-434b-9f0a-bc8ca00a9ed2 (last visited November 13, 2020)

[54] https://mvc.dps.mo.gov/homes/ (last visited November 13, 2020)

[55] *Id.*

[56] *See* § 198.012.1(1), RSMo.; § 42.130, RSMo. ("[T]he provisions of sections 198.003 to 198.136 shall not apply to the Missouri Veterans' homes.").

[57] § 42.100.2, RSMo.

[58] § 42.127, RSMo.

[59] *See* 38 C.F.R. § 51.200 ("The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public."); 38 C.F.R. § 51.100(i).

[60] *See* 38 C.F.R. § 51.100(c) ("Resident Council. The facility management must establish a council of residents that meet at least quarterly. The facility management must document any concerns submitted to the management of the facility by the council.")

[61] A 2018 constitutional amendment legalizing medical marijuana in Missouri created the Missouri Veterans' Health and Care Fund, consisting of application fees and four percent tax on sales. These funds are then transferred to the MVC for its health and care services. Mo. Const. art. XIV, § 1.

[62] RSMo §§ 42.007; 42.010; 42.100

[63] RSMo § 42.100.1(1)-(8)

[64] https://oa.mo.gov/sites/default/files/FY_2020_EB_Public_Safety.pdf (last visited November 13, 2020)

[65] https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html/ (last updated April 30, 2020, last visited November 13, 2020)

[66] *Id.*

[67] *Id.*

[68] *Id.*

[69] *Id.*

[70] *Id.*

[71] *Id.*

[72] *Id.*

[73] *Id.*

[74] https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html (last visited November 13, 2020)
[75] *Id.*
[76] *Id.*
[77] *Id.*
[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html (last visited November 13, 2020)
[82] *Id.*
[83] *Id.*
[84] https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html (last visited November 13, 2020)
[85] *Id.*
[86] *Id.*
[87] https://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/ltcf.php (last visited November 13, 2020)
[88] https://www.pathwayhealth.com/about-us/ (last visited November 13, 2020)
[89] Pathway Reports
[90] Pathway Summary Overview (Mexico)
[91] Pathway Reports
[92] *Id.*
[93] *Id.*
[94] *Id.*
[95] *Id.*
[96] *Id.*
[97] http://www.cameron-mo.com/228/Missouri-Veterans-Home#:~:text=The%20Cameron%20Missouri%20Veteran's%20Home,facility%20which%20opened%20in%202000 (last visited November 13, 2020); Interview of Assistant Administrator Stephanie Whitney
[98] Interview of Assistant Administrator Stephanie Whitney
[99] Interview of Director of Social Work Daniel Leff
[100] *Id.*
[101] Interview of Director of Staff Development Monica Bonderer; Interview of Director of Nursing Ed Becker
[102] Interview of Assistant Administrator Stephanie Whitney
[103] Interview of Director of Nursing Ed Becker
[104] Interview of Assistant Administrator Stephanie Whitney
[105] *Id.*
[106] *Id.*; Interview of Director of Nursing Ed Becker
[107] Interview of Director of Nursing Ed Becker
[108] *Id.*
[109] *Id.*
[110] Interview of Assistant Administrator Stephanie Whitney
[111] Interview of Administrator David Hibler
[112] *Id.*; Interview of Assistant Administrator Stephanie Whitney
[113] Dashboard Daily COVID Report to HQ
[114] Interview of Assistant Administrator Stephanie Whitney
[115] Dashboard Daily COVID Report to HQ
[116] *Id.*
[117] *Id.*
[118] Interview of Assistant Administrator Stephanie Whitney; Interview of Director of Nursing Ed Becker; Interview of Medical Director Dr. Frederick Kiehl
[119] Interview of [redacted]
[120] *Id.*
[121] Interview of Assistant Administrator Stephanie Whitney
[122] Interview of Medical Director Dr. Frederick Kiehl
[123] Interview of family member [redacted]
[124] Interview of Medical Director Dr. Frederick Kiehl
[125] Interview of Assistant Administrator Stephanie Whitney

[126] Interview of Medical Director Dr. Frederick Kiehl
[127] *Id.*
[128] Interview of Assistant Administrator Stephanie Whitney
[129] *Id.*
[130] *Id.*
[131] Interview of Director of Social Work Daniel Leff
[132] *Id.*
[133] *Id.*
[134] *Id.*
[135] *Id.*
[136] Interview of Assistant Administrator Stephanie Whitney
[137] Interview of Director of Nursing Ed Becker
[138] Interview of Assistant Administrator Stephanie Whitney
[139] Interview of Director of Nursing Ed Becker
[140] Interview of Assistant Administrator Stephanie Whitney
[141] *Id.*
[142] *Id.*
[143] *Id.*
[144] Interview of Director of Nursing Ed Becker
[145] *Id.*
[146] Interview of Medical Director Dr. Frederick Kiehl
[147] Interview of Director of Staff Development Monica Bonderer
[148] *Id.*
[149] *Id.*; Interview of Administrator David Hibler
[150] Interview of Director of Staff Development Monica Bonderer
[151] *Id.*
[152] *Id.*
[153] Interview of Resident Council President [redacted]; Interview of Administrator David Hibler
[154] Interview of Resident Council President [redacted]; Interview of Administrator David Hibler
[155] Interview of Director of Social Work Daniel Leff
[156] Interview of Director of Human Resource for Headquarters Kristen Smith
[157] Id.
[158] Interview of Administrator David Hibler
[159] Interview of Director of Social Work Daniel Leff
[160] Interview of Food Services Manager Valerie Dredge
[161] Interview of Director of Nursing Ed Becker
[162] *Id.*
[163] *Id.*
[164] Interview of Food Services Manager Valerie Dredge
[165] Interview of Assistant Administrator Stephanie Whitney
[166] *Id.*
[167] *Id.*
[168] Interview of Assistant Administrator Buffy Huffman
[169] Interview of Human Resources Director Laura Clark
[170] *Id.*
[171] *Id.*
[172] *Id.*
[173] *Id.*
[174] *Id.*
[175] *Id.*
[176] *Id.*
[177] Pathway Report
[178] Interview of Director of Nursing Ed Becker
[179] *Id.*
[180] *Id.*
[181] Interview of Assistant Administrator Stephanie Whitney; Interview of Human Resources Director Laura Clark

[182] Interview of Human Resources Director Laura Clark
[183] *Id.*
[184] *Id.*
[185] Interview of Director of Staff Development Monica Bonderer
[186] *Id.*
[187] *Id.*
[188] *Id.*
[189] *Id.*
[190] *Id.*
[191] *Id.*
[192] *Id.*
[193] *Id.*
[194] *Id.*
[195] *Id.*
[196] *Id.*
[197] Interview of Director of Social Work Daniel Leff
[198] Interview of Assistant Administrator Stephanie Whitney
[199] *Id.*
[200] Interview of Director of Staff Development Monica Bonderer
[201] Interview of Food Services Manager Valerie Dredge
[202] Interview of Medical Director Dr. Frederick Kiehl; Interview of Director of Nursing Ed Becker
[203] Interview of Director of Environmental Services Lloyd Heckman
[204] Pathway Report
[205] Interview of Director of Environmental Services Lloyd Heckman
[206] Interview of Director of Nursing Ed Becker
[207] *Id.*
[208] *Id.*
[209] *Id.*
[210] *Id.*
[211] *Id.*
[212] Interview of Human Resources Director Laura Clark
[213] *Id.*
[214] *Id.*
[215] Interview of Director of Environmental Services Lloyd Heckman
[216] *Id.*
[217] *Id.*
[218] *Id.*
[219] *Id.*
[220] *Id.*
[221] *Id.*
[222] *Id.*
[223] *Id.*
[224] *Id.*
[225] Interview of Food Services Manager Valerie Dredge
[226] *Id.*
[227] *Id.*
[228] *Id.*
[229] *Id.*
[230] *Id.*
[231] *Id.*
[232] Interview of Assistant Administrator Stephanie Whitney
[233] Interview of Food Services Manager Valerie Dredge
[234] *Id.*
[235] Interview of Assistant Administrator Stephanie Whitney
[236] *Id.*
[237] Interview of Director of Nursing Ed Becker; Dashboard Daily COVID Report to HQ

[238] Interview of Assistant Administrator Stephanie Whitney
[239] *Id.*
[240] Interview of Assistant Administrator Stephanie Whitney; Interview of Food Services Manager Valerie Dredge
[241] Interview of Director of Nursing Ed Becker
[242] Interview of Director of Staff Development Monica Bonderer
[243] Interview of Director of Nursing Ed Becker
[244] *Id.*
[245] *Id.*
[246] *Id.*
[247] Interview of Director of Environmental Services Lloyd Heckman
[248] *Id.*
[249] Pathway Report
[250] Interview of Human Resources Director Laura Clark
[251] *Id.*
[252] *Id.*
[253] Pathway Report
[254] *Id.*
[255] *Id.*
[256] *Id.*
[257] *Id*
[258] Interview of Medical Director Dr. Frederick Kiehl
[259] *Id.*
[260] Interview of Resident Council President [redacted]
[261] *Id.*
[262] *Id.*
[263] *Id.*
[264] *Id.*
[265] *Id.*
[266] Interview of Medical Director Dr. Frederick Kiehl
[267] *Id.*
[268] Interview of Assistant Administrator Stephanie Whitney
[269] https://www.nytimes.com/interactive/2020/us/missouri-coronavirus-cases.html#clusters (last visited November 16, 2020)
[270] *Id.*
[271] https://www.covidactnow.org/us/mo/county/clinton_county?s=1295310 (last visited November 16, 2020)
[272] Interview of CNA Becky Hoover; Interview of Director of Social Services Kim Doerge; Interview of Food Services Manager Vanessa Smith; Interview of Assistant Administrator Dianne Ivy
[273] Interview of Food Services Manager Vanessa Smith
[274] Interview of Administrator Mindy Pruitt
[275] *Id.*
[276] *Id.*
[277] *Id.*
[278] *Id.*
[279] *Id.*
[280] *Id.*
[281] *Id.*
[282] Interview of Assistant Administrator Dianne Ivy
[283] Interview of Administrator Mindy Pruitt
[284] Interview of Staff Development Coordinator Katelyn Ivie
[285] Interview of Administrator Mindy Pruitt
[286] Interview of Staff Development Coordinator Katelyn Ivie
[287] Interview of Administrator Mindy Pruitt
[288] Interview of Human Resources Director Holly Luvall
[289] Interview of Staff Development Coordinator Katelyn Ivie
[290] *Id.*
[291] Interview of Administrator Mindy Pruitt

[292] Interview of Resident Council President [redacted]
[293] *Id.*
[294] "Employees Communication Cape Girardeau Timeline" – "Mindi Pruitt – Cape Girardeau"
[295] Interview of Food Services Manager Vanessa Smith
[296] *Id.*
[297] Interview of Administrator Mindy Pruitt
[298] *Id.*
[299] Interview of Assistant Administrator Dianne Ivy
[300] *Id.*
[301] Cape Girardeau Timelines
[302] A Wing COVID Map provided by Jean Sherrill
[303] *Id.*
[304] *Id.*
[305] *Id.*
[306] Pathway Report
[307] Interview of Administrator Mindy Pruitt; Interview of Medical Director Dr. Phillip Tippin
[308] Interview of Administrator Mindy Pruitt; Interview of Medical Director Dr. Phillip Tippin
[309] Interview of Administrator Mindy Pruitt
[310] Interview of Custodial Manager Janet Cook
[311] Interview of Administrator Mindy Pruitt
[312] *Id.*
[313] Interview of CNA Becky Hoover; Interview of Custodial Manager Janet Cook
[314] Interview of CNA Becky Hoover
[315] *Id.*
[316] *Id.*
[317] Interview of CNA Becky Hoover; Interview of Custodial Manager Janet Cook
[318] Interview of CNA Becky Hoover; Interview of Custodial Manager Janet Cook
[319] Interview of Custodial Manager Janet Cook
[320] Interview of CNA Becky Hoover
[321] *Id.*
[322] *Id.*
[323] *Id.*
[324] *Id.*
[325] Interview of Administrator Mindy Pruitt
[326] *Id.*
[327] *Id.*
[328] *Id.*
[329] Interview of Resident Council President [redacted]
[330] Pathway Report
[331] Interview of Director of Social Services Kim Doerge
[332] *Id.*
[333] *Id.*
[334] *Id.*
[335] *Id.*
[336] *Id.*
[337] *Id.*
[338] Interview of Resident Council President [redacted]; Interview of Director of Social Services Kim Doerge
[339] Pathway Report
[340] Interview of Administrator Mindy Pruitt
[341] *Id.*
[342] *Id.*
[343] *Id.*
[344] Interview of Assistant Administrator Dianne Ivy
[345] Interview of Administrator Mindy Pruitt
[346] *Id.*
[347] *Id.*

[348] *Id.*
[349] Interview of Resident Council President [redacted]
[350] *Id.*
[351] *Id.*
[352] Interview of Human Resources Director Holly Luvall
[353] Interview of CNA Becky Hoover
[354] *Id.*
[355] *Id.*
[356] *Id.*
[357] *Id.*
[358] *Id.*
[359] *Id.*
[360] Interview of Staff Development Coordinator Katelyn Ivie
[361] Interview of Assistant Administrator Dianne Ivy
[362] Interview of Staff Development Coordinator Katelyn Ivie
[363] *Id.*
[364] *Id.*
[365] Interview of Staff Development Coordinator Katelyn Ivie; Interview of Administrator Mindy Pruitt
[366] Interview of Staff Development Coordinator Katelyn Ivie; Interview of Custodial Manager Janet Cook
[367] Pathway Report
[368] Interview of Human Resources Director Holly Luvall
[369] Interview of CNA Becky Hoover; Interview of Staff Development Coordinator Katelyn Ivie; Interview of Human Resources Director Holly Luvall; Interview of Food Services Manager Vanessa Smith
[370] Interview of Custodial Manager Janet Cook
[371] *Id.*; Interview of Medical Director Dr. Phillip Tippin
[372] Interview of Resident Council President [redacted]
[373] Interview of Human Resources Director Holly Luvall
[374] *Id.*
[375] Interview of Assistant Administrator Dianne Ivy
[376] Pathway Report
[377] *Id.*
[378] Interview of Custodial Manager Janet Cook; Interview of Director of Social Services Kim Doerge
[379] Interview of Human Resources Director Holly Luvall
[380] Interview of Assistant Administrator Dianne Ivy
[381] *Id.*
[382] Interview of Custodial Manager Janet Cook
[383] Pathway Report
[384] Interview of Assistant Administrator Dianne Ivy
[385] *Id.*
[386] Pathway Report
[387] Interview of Assistant Administrator Dianne Ivy
[388] Interview of Custodial Manager Janet Cook; Interview of Director of Social Services Kim Doerge
[389] Interview of Assistant Administrator Dianne Ivy
[390] Interview of Director of Social Services Kim Doerge
[391] Interview of Assistant Administrator Dianne Ivy
[392] Interview of Director of Social Services Kim Doerge
[393] *Id.*
[394] *Id.*
[395] Interview of Resident Council President [redacted]
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[399] *Id.*

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[401] *Id.*
[402] Interview of Medical Director Dr. Phillip Tippin; Interview of Administrator Mindy Pruitt
[403] Interview of Assistant Administrator Dianne Ivy; Interview of Medical Director Dr. Phillip Tippin
[404] Interview of Assistant Administrator Dianne Ivy
[405] *Id.*
[406] Interview of Administrator Aliesha Edwards
[407] *Id.*
[408] *Id.*
[409] Interview of Assistant Administrator Angela Baker
[410] *Id.*
[411] *Id.*
[412] Interview of Director of Nursing Patrick Stevenson
[413] *Id.*
[414] Pathway Report
[415] *Id.*
[416] *Id.*
[417] Interview of Assistant Administrator Angela Baker
[418] *Id.*
[419] Pathway Report
[420] Interview of Social Worker Nicole Stone
[421] Interview of Director of Nursing Patrick Stevenson
[422] *Id.*
[423] Interview of Assistant Administrator Angela Baker
[424] Dashboard spreadsheet
[425] Interview of Director of Nursing Patrick Stevenson
[426] Interview of Administrator Aliesha Edwards
[427] *Id.*
[428] *Id.*
[429] *Id.*
[430] Pathway report
[431] Interview of Administrator Aliesha Edwards
[432] Interview of Director of Nursing Patrick Stevenson
[433] *Id.*
[434] *Id.*
[435] *Id.*
[436] Interview of Environmental Services Manager Teresa Ames
[437] Interview of Director of Nursing Patrick Stevenson
[438] Interview of Administrator Aliesha Edwards
[439] *Id.*
[440] *Id.*
[441] Interview of Assistant Administrator Angela Baker
[442] *Id.*
[443] Pathway Report
[444] Interview of Staff Development Director Lori Riddle
[445] *Id.*
[446] Pathway Report
[447] *Id.*
[448] *Id.*
[449] *Id.*
[450] *Id.*
[451] Interview of Director of Nursing Patrick Stevenson
[452] *Id.*
[453] *Id.*
[454] *Id.*
[455] Interview of Staff Development Director Lori Riddle

[456] Interview of Environmental Services Manager Teresa Ames
[457] Interview of Administrator Aliesha Edwards
[458] *Id.*
[459] Interview of Director of Nursing Patrick Stevenson
[460] *Id.*
[461] Pathway Report
[462] *Id.*
[463] *Id.*
[464] *Id.*
[465] *Id.*
[466] Interview of CNA Erin Paden
[467] Interview of Director of Nursing Patrick Stevenson
[468] *Id.*
[469] *Id.*
[470] Interview of Human Resources Specialist Heather Casey
[471] Interview of Administrator Aliesha Edwards
[472] *Id.*
[473] *Id.*
[474] Interview of Assistant Administrator Angela Baker
[475] Interview of Administrator Aliesha Edwards
[476] *Id.*
[477] Interview of Staff Development Director Lori Riddle
[478] *Id.*
[479] Interview of Administrator Aliesha Edwards; Interview of Staff Development Director Lori Riddle
[480] Interview of Administrator Aliesha Edwards; Interview of Staff Development Director Lori Riddle
[481] Interview of Staff Development Director Lori Riddle
[482] *Id.*
[483] Interview of CNA Erin Paden
[484] Interview of Social Worker Nicole Stone
[485] *Id.*
[486] Interview of President of Resident Council [redacted]
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[492] *Id.*
[493] Dashboard Mt. Vernon
[494] Interview of Administrator April Cutbirth
[495] Pathway Report
[496] *Id.*
[497] *Id.*
[498] *Id.*
[499] *Id.*
[500] Interview of Staff Development Coordinator Becky Williams
[501] *Id.*
[502] Interview of Environmental Services Manager Anna Myers
[503] Interview of Staff Development Coordinator Becky Williams
[504] *Id.*
[505] Interview of Administrator April Cutbirth
[506] Interview of Assistant Administrator Donna Stacye
[507] Interview of Administrator April Cutbirth

[508] *Id.*
[509] Pathway Report
[510] Dashboard
[511] Pathway Report
[512] Mt Vernon Timeline
[513] Pathway Report
[514] *Id.*
[515] Interview of Assistant Administrator Donna Stacye
[516] Interview of Administrator April Cutbirth
[517] Interview of Director of Nursing Amber Hamilton
[518] Interview of Administrator April Cutbirth
[519] Interview of Director of Nursing Amber Hamilton
[520] Interview of Administrator April Cutbirth
[521] Interview of Staff Development Coordinator Becky Williams
[522] *Id.*
[523] Interview of Administrator April Cutbirth
[524] Email from April Cutbirth dated Oct 18, 2020
[525] *Id.*
[526] *Id.*
[527] *Id.*
[528] *Id.*
[529] Interview of Assistant Administrator Donna Stacye
[530] Interview of Administrator April Cutbirth
[531] Interview of CNA Aurora Barnett
[532] *Id.*
[533] *Id.*
[534] Dashboard
[535] Interview of Director of Nursing Amber Hamilton; Pathway Report
[536] Dashboard
[537] Interview of Assistant Administrator Donna Stacye
[538] *Id.*
[539] Pathway Report
[540] *Id.*
[541] Interview of Administrator April Cutbirth
[542] *Id.*
[543] Interview of Director of Nursing Amber Hamilton
[544] *Id.*
[545] Pathway Report
[546] *Id.*
[547] *Id.*
[548] *Id.*
[549] Interview of Director of Nursing Amber Hamilton
[550] *Id.*
[551] *Id.*
[552] *Id.*
[553] Interview of Administrator April Cutbirth
[554] *Id.*
[555] Interview of Director of Nursing Amber Hamilton
[556] Interview of Human Resources Director Christine Strong
[557] *Id.*
[558] *Id.*
[559] Pathway Report
[560] *Id.*
[561] *Id.*
[562] *Id.*
[563] Interview of Administrator April Cutbirth

[564] Interview of Human Resources Director Christine Strong
[565] *Id.*
[566] *Id.*
[567] *Id.*
[568] Pathway Report
[569] *Id.*
[570] Interview of Director of Nursing Amber Hamilton
[571] Interview of CNA Aurora Barnett
[572] Interview of Staff Development Coordinator Becky Williams
[573] *Id.*
[574] *Id.*
[575] Interview of Administrator April Cutbirth
[576] *Id.*
[577] Interview of Staff Development Coordinator Becky Williams
[578] Interview of Director of Nursing Amber Hamilton
[579] *Id.*
[580] *Id.*
[581] Interview of Director of Nursing Amber Hamilton
[582] *Id.*
[583] *Id.*
[584] Interview of CNA Aurora Barnett
[585] Interview of Director of Nursing Amber Hamilton
[586] Interview of Staff Development Coordinator Becky Williams
[587] *Id.*
[588] *Id.*
[589] Interview of Administrator April Cutbirth
[590] Interview of Staff Development Coordinator Becky Williams
[591] *Id.*
[592] Pathway Report
[593] *Id.*
[594] *Id.*
[595] *Id.*
[596] *Id.*
[597] *Id.*
[598] *Id.*
[599] *Id.*
[600] *Id.*
[601] Interview of Human Resources Director Christine Strong
[602] Interview of Administrator April Cutbirth
[603] Interview of Director of Nursing Amber Hamilton
[604] Interview of Environmental Services Manager Anna Myers
[605] Interview of CNA Aurora Barnett
[606] *Id.*
[607] Interview of Assistant Administrator Donna Stacye
[608] Interview of Human Resources Director Christine Strong
[609] Interview of Assistant Administrator Donna Stacye
[610] Interview of Human Resources Director Christine Strong
[611] Interview of Director of Nursing Amber Hamilton
[612] *Id.*
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[619] Interview of Shift Supervisor Brandi Hobson
[620] *Id.*
[621] *Id.*
[622] *Id.*
[623] Pathway Report
[624] *Id.*
[625] Interview of Administrator Brittany Ritter
[626] Interview of Director of Social Services LeAnn Vogt
[627] Interview of Administrator Brittany Ritter
[628] Interview of Shift Supervisor Brandi Hobson
[629] *Id.*
[630] *Id.*
[631] *Id.*
[632] Interview of Medical Director Dr. Rachelle Gorrell
[633] Interview of Shift Supervisor Brandi Hobson
[634] *Id.*
[635] *Id.*
[636] Interview of Assistant Administrator Lorie Steen
[637] *Id.*
[638] *Id.*
[639] *Id.*
[640] *Id.*
[641] Interview of Medical Director Dr. Rachelle Gorrell
[642] *Id.*
[643] Interview of Shift Supervisor Brandi Hobson
[644] *Id.*
[645] *Id.*
[646] *Id.*
[647] Interview of Environmental Services Director Pam Bach
[648] Interview of Administrator Brittany Ritter
[649] *Id.*
[650] *Id.*
[651] *Id.*
[652] Timeline from St. James
[653] *Id.*
[654] *Id.*
[655] *Id.*
[656] *Id.*
[657] *Id.*
[658] *Id.*
[659] *Id.*
[660] Dashboard
[661] Interview of Administrator Brittany Ritter
[662] *Id.*
[663] Interview of Assistant Administrator Lorie Steen
[664] *Id.*
[665] Timeline
[666] *Id.*
[667] *Id.*.
[668] Interview of Assistant Administrator Lorie Steen
[669] *Id.*

[670] Interview of Administrator Brittany Ritter
[671] *Id.*
[672] Interview of Shift Supervisor Brandi Hobson
[673] Interview of Administrator Brittany Ritter
[674] Pathway Report
[675] Interview of Medical Director Dr. Rachelle Gorrell
[676] *Id.*
[677] Interview of Assistant Administrator Lorie Steen
[678] *Id.*
[679] *Id.*
[680] Pathway Report
[681] *Id.*
[682] *Id.*
[683] Interview of Shift Supervisor Brandi Hobson
[684] *Id.*
[685] Pathway Report
[686] Interview of Assistant Administrator Lorie Steen
[687] *Id.*
[688] *Id.*
[689] *Id.*
[690] Pathway Report
[691] *Id.*
[692] *Id.*
[693] Interview of Director of Personnel Misty Thiel
[694] *Id.*
[695] *Id.*
[696] *Id.*
[697] Interview of Staff Development Coordinator Dawn Hammerschmidt
[698] Interview of Director of Personnel Misty Thiel
[699] Interview of Staff Development Coordinator Dawn Hammerschmidt
[700] Interview of Assistant Administrator Lorie Steen
[701] *Id.*
[702] Interview of Staff Development Coordinator Dawn Hammerschmidt
[703] Pathway Report
[704] *Id.*
[705] *Id.*
[706] *Id.*
[707] *Id.*
[708] *Id.*
[709] *Id.*
[710] *Id.*
[711] *Id.*
[712] *Id.*
[713] *Id.*
[714] *Id.*
[715] *Id.*
[716] Interview of Director of Personnel Misty Thiel
[717] *Id.*
[718] *Id.*
[719] Interview of Administrator Brittany Ritter
[720] *Id.*
[721] Interview of Shift Supervisor Brandi Hobson
[722] *Id.*
[723] Interview of Administrator Brittany Ritter
[724] *Id.*
[725] Interview of Assistant Administrator Lorie Steen

[726] *Id.*
[727] *Id.*
[728] Interview of Shift Supervisor Brandi Hobson
[729] *Id.*
[730] *Id.*
[731] Interview of Director of Personnel Misty Thiel
[732] *Id.*
[733] *Id.*
[734] *Id.*
[735] Interview of Director of Social Services LeAnn Vogt
[736] Interview of Administrator Brittany Ritter
[737] *Id.*
[738] *Id.*
[739] Interview of Assistant Administrator Lorie Steen
[740] Interview of Director of Social Services LeAnn Vogt
[741] *Id.*
[742] Interview of Medical Director Dr. Rachelle Gorrell
[743] Interview of Veteran [redacted]
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[747] Interview of Director of Nursing Monica Halsey
[748] Interview of Assistant Administrator Buffy Huffman
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[751] Interview of Assistant Administrator Buffy Huffman
[752] *Id.*
[753] *Id.*
[754] *Id.*
[755] *Id.*
[756] Interview of Assistant Director of Nursing Jennifer Neisler; Interview of Medical Director Dr. Riffat Imdad.
[757] Interview of Assistant Director of Nursing Jennifer Neisler; Interview of Medical Director Dr. Riffat Imdad.
[758] Interview of Assistant Director of Nursing Jennifer Neisler; Interview of Assistant Administrator Buffy Huffman
[759] Interview of Assistant Administrator Buffy Huffman
[760] Interview of Assistant Director of Nursing Jennifer Neisler.
[761] *Id.*
[762] Interview of Assistant Administrator Buffy Huffman
[763] *Id.*
[764] Interview of Food Service Manager Lvanjia White
[765] *Id.*
[766] *Id.*
[767] *Id.*
[768] *Id.*
[769] Dashboard Daily COVID Reports to HQ.
[770] Interview of Director of Nursing Monica Halsey
[771] *Id.*
[772] *Id.*
[773] *Id.*
[774] Interview of Director of Nursing Monica Halsey; Interview of Medical Director Dr. Riffat Imdad.
[775] Dashboard Daily COVID Reports to HQ.
[776] Interview of Assistant Director of Nursing Jennifer Neisler.
[777] *Id.;* Dashboard Daily COVID Reports to HQ.
[778] *Id.*

[779] *Id.*
[780] *Id.*
[781] *Id.*
[782] *Id.*
[783] *Id.*
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[785] *Id.*
[786] *Id.*
[787] *Id.*
[788] *Id.*
[789] *Id.*
[790] *Id.*
[791] Interview of Assistant Director of Nursing Jennifer Neisler
[792] Interview of Assistant Administrator Buffy Huffman
[793] Interview of Veteran [redacted]
[794] Pathway Report
[795] Interview of Human Resources Manager Lornette Harris
[796] Interview of Assistant Administrator Buffy Huffman
[797] Interview of Director of Nursing Monica Halsey
[798] Interview of Assistant Administrator Buffy Huffman; Interview of Director of Nursing Monica Halsey
[799] Interview of Senior Clinical Caseworker Lisa Schwierjohn
[800] *Id.*
[801] Interview of Assistant Administrator Buffy Huffman
[802] *Id.*
[803] *Id.;* Pathway Report
[804] Interview of Assistant Administrator Buffy Huffman
[805] *Id.*
[806] Interview of Human Resources Manager Lornette Harris
[807] *Id.*
[808] Interview of Veteran [redacted]
[809] Interview of Director of Nursing Monica Halsey
[810] *Id.*
[811] Interview of Assistant Administrator Buffy Huffman
[812] *Id.*
[813] Interview of CNA Carolyn Jones
[814] *Id.*
[815] Interview of Assistant Administrator Buffy Huffman
[816] *Id.*
[817] *Id.*
[818] Interview of Medical Director Dr. Riffat Imdad
[819] Interview of Assistant Director of Nursing Jennifer Neisler
[820] Interview of Director of Nursing Monica Halsey
[821] *Id.*
[822] Interview of CNA Carolyn Jones
[823] *Id.*
[824] *Id.*
[825] Interview of Assistant Administrator Buffy Huffman
[826] Interview of Assistant Director of Nursing Jennifer Neisler
[827] Pathway Report
[828] Interview of Assistant Director of Nursing Jennifer Neisler
[829] Interview of Director of Nursing Monica Halsey
[830] Interview of Human Resources Manager Lornette Harris
[831] *Id.*
[832] Interview of Staff Development Coordinator Jackie Jackson
[833] *Id.*
[834] *Id.*

[835] Interview of Assistant Administrator Buffy Huffman
[836] Interview of Staff Development Coordinator Jackie Jackson
[837] *Id.*
[838] *Id.*
[839] *Id.*
[840] *Id.*
[841] Interview of Human Resources Manager Lornette Harris
[842] Pathway Report
[843] *Id.*
[844] *Id.*
[845] Interview of Veteran [redacted]
[846] *Id.*
[847] *Id.*
[848] Interview of Assistant Administrator Buffy Huffman
[849] *Id.*
[850] Interview of Senior Clinical Caseworker Lisa Schwierjohn
[851] Interview of Veteran [redacted]
[852] https://www.nytimes.com/interactive/2020/us/missouri-coronavirus-cases.html#clusters (last visited November 16, 2020)
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[854] Interview of Medical Director Dr. Riffat Imdad
[855] *Id.*
[856] Pathway Report
[857] *Id.*
[858] Interview of Director of Nursing Lisa Jewell
[859] Interview of Staff Development Coordinator Laura Weisenburger
[860] *Id.*
[861] *Id.*
[862] *Id.*
[863] Interview of Administrator Eric Endsley
[864] *Id.;* Interview of Assistant Administrator Jamie McCannon
[865] Interview of Administrator Eric Endsley
[866] Interview of Assistant Administrator Jamie McCannon
[867] *Id.*
[868] Interview of Administrator Eric Endsley
[869] *Id.*
[870] *Id.*
[871] *Id.*
[872] *Id.*
[873] *Id.*; Interview of Assistant Administrator Jamie McCannon; Interview of Director of Nursing Lisa Jewell
[874] Interview of Director of Nursing Lisa Jewell
[875] Interview of Assistant Administrator Jamie McCannon
[876] *Id.*
[877] *Id.*
[878] Daily COVID Report to HQ; Interview of Administrator Eric Endsley; Interview of Assistant Administrator Jamie McCannon
[879] Interview of Administrator Eric Endsley
[880] *Id.*
[881] *Id.*
[882] *Id.*
[883] *Id.*
[884] Interview of Director of Nursing Lisa Jewell
[885] *Id.*
[886] *Id.*
[887] Interview of Assistant Administrator Jamie McCannon
[888] Interview of Director of Nursing Lisa Jewell

[889] Interview of Social Work Director Brittney Owens
[890] *Id.*
[891] *Id.*
[892] *Id.*
[893] Interview of Environmental Services Director Emily Clark
[894] Interview of Administrator Eric Endsley
[895] *Id.*
[896] *Id.*
[897] Interview of Social Work Director Brittney Owens
[898] *Id.*
[899] Interview of Assistant Administrator Jamie McCannon
[900] Interview of Administrator Eric Endsley; Interview of Director of Nursing Lisa Jewell
[901] Interview of Administrator Eric Endsley
[902] *Id.*
[903] *Id.*
[904] *Id.*
[905] Pathway Report
[906] Interview of Staff Development Coordinator Laura Weisenburger
[907] Interview of Assistant Administrator Jamie McCannon
[908] *Id.*
[909] Interview of Administrator Eric Endsley
[910] *Id.*
[911] *Id.*
[912] *Id.*
[913] *Id.*
[914] Interview of Staff Development Coordinator Laura Weisenburger
[915] *Id.*
[916] Interview of Administrator Eric Endsley
[917] Interview of Director of Nursing Lisa Jewell
[918] *Id.*
[919] *Id.*
[920] Interview of Staff Development Coordinator Laura Weisenburger
[921] *Id.*
[922] *Id.*
[923] *Id.*
[924] *Id.*
[925] Interview of Staff Development Coordinator Laura Weisenburger; Interview of Director of Nursing Lisa Jewell
[926] Interview of Director of Nursing Lisa Jewell
[927] Interview of Administrator Eric Endsley
[928] *Id.*
[929] *Id.*
[930] Interview of Environmental Services Director Emily Clark; Interview of Director of Nursing Lisa Jewell
[931] Interview of Staff Development Coordinator Laura Weisenburger
[932] Interview of Director of Nursing Lisa Jewell
[933] Interview of Staff Development Coordinator Laura Weisenburger
[934] *Id.*
[935] Interview of Administrator Eric Endsley
[936] Interview of Environmental Services Director Emily Clark
[937] Interview of Social Work Director Brittney Owens
[938] Pathway Report
[939] Interview of Director of Nursing Lisa Jewell
[940] *Id.*
[941] Interview of Administrator Eric Endsley
[942] *Id.*
[943] *Id.*
[944] *Id.*

[945] *Id.*
[946] *Id.*
[947] *Id.*
[948] Interview of Staff Development Coordinator Laura Weisenburger
[949] *Id.*
[950] Interview of Assistant Administrator Jamie McCannon
[951] *Id.*
[952] *Id.*
[953] *Id.*
[954] Interview of Director of Nursing Lisa Jewell
[955] Interview of Administrator Eric Endsley
[956] Interview of Assistant Administrator Jamie McCannon
[957] Interview of Staff Development Coordinator Laura Weisenburger
[958] *Id.*
[959] Interview of Social Work Director Brittney Owens
[960] *Id.*
[961] *Id.*
[962] Interview of Veteran [redacted]
[963] Interview of Social Work Director Brittney Owens
[964] Interview of Veteran [redacted]
[965] *Id.*
[966] *Id.*
[967] *Id.*
[968] Interview of Assistant Administrator Jamie McCannon
[969] https://www.nytimes.com/interactive/2020/us/missouri-coronavirus-cases.html#clusters (last visited November 16, 2020)
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[971] RSMO § 42.012
[972] Interview of Executive Director COL. Paul Kirchhoff; Deputy Director Ryon Richmond; Director of Operations Melissa Skinner
[973] Interview of Director of Homes Joan Elwing
[974] Interview of Deputy Director Ryon Richmond
[975] Interview of Executive Director COL. Paul Kirchhoff
[976] *Id.*
[977] MVC COVID-19 Timeline and Communication Update Tracker
[978] *Id.*
[979] Interview of Director of Homes Joan Elwing
[980] A copy of the current iteration of the checklist can be found at the following link: https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf. (last visited November 13, 2020)
[981] Interview of Director of Operations Melissa Skinner
[982] *Id.*
[983] *Id.*
[984] *Id.*
[985] Interview of Director of Homes Joan Elwing; Interview of Assistant Administrator Angela Baker of Mexico, Missouri; Interview of Executive Director COL. Paul Kirchhoff
[986] *Id.;* Interview of Assistant Administrator Angela Baker of Mexico, Missouri; Interview of Assistant Administrator Donna Stacye of Mt. Vernon; Interview of Director of Operations Melissa Skinner
[987] Interview of Director of Operation Melissa Skinner
[988] Interview of Director of Homes Joan Elwing; Interview of Director of Operation Melissa Skinner
[989] Interview of Assistant Administrator Angela Baker of Mexico, Missouri
[990] *Id.*
[991] Interview of Director of Operations Melissa Skinner
[992] Interview of Assistant Administrator Donna Stacye of Mt. Vernon, Missouri
[993] Interview with Director of Operations Melissa Skinner; Interview with Director of Homes Joan Elwing
[994] *Id.*

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[996]https://www.kmov.com/news/covid-19-outbreak-killed-494-residents-of-st-louis-county-long-term-care-facilities/article_82c6fcb8-c95a-11ea-8c03-63002ee1f978.html (last visited on November 13, 2020)
[997]https://www.newspressnow.com/news/local_news/link-leaving-missouri-Veterans-commission-for-federal-job/article_1d3bc612-84ea-11ea-8f1f-13f0424fb1b2.html (last visited on November 13, 2020)
[998] Interview of Deputy Director Ryon Richmond
[999] Interview of Director of Homes Joan Elwing
[1000] *Id.*
[1001] Interview of Director of Operations Melissa Skinner
[1002] *Id.*
[1003] Interview of Executive Director COL. Paul Kirchhoff
[1004] *Id.*
[1005] *Id.*
[1006] Interview of Director of Homes Joan Elwing; Interview of Assistant Director of Homes Bradley Haggard
[1007] Interview of Director of Operations Melissa Skinner; Interview of Director of Homes Joan Elwing; Interview of Executive Director COL. Paul Kirchhoff; Interview of Deputy Director Ryon Richmond; Interview of Assistant Director of Homes Bradley Haggard.
[1008] Interview of Executive Director COL. Paul Kirchhoff
[1009] Interview of Director of Operations Melissa Skinner; Interview of Director of Homes Joan Elwing; Interview of Executive Director COL. Paul Kirchhoff; Interview of Deputy Director Ryon Richmond; Interview of Assistant Director of Homes Bradley Haggard; Interview of Human Resources Director Kristen Smith
[1010] MVC Timeline and Communication Tracker; Interview of Assistant Administrator Angela Baker of Mexico, Missouri
[1011] Interview of Assistant Administrator Angela Baker of Mexico, Missouri; Interview of Assistant Administrator Donna Stacye of Mt. Vernon, Missouri; Daily COVID-19 Report to Headquarters
[1012] Interview of Assistant Administrator Angela Baker of Mexico, Missouri; Interview of Assistant Administrator Donna Stacye of Mt. Vernon, Missouri; Interview of Assistant Administrator Jamie McCannon of Warrensburg, Missouri
[1013] *Id.*
[1014] Interview of Assistant Administrator Angela Baker of Mexico, Missouri
[1015] *Id.*
[1016] Interview of Director of Operations Melissa Skinner; Interview of Administrator Aliesha Edwards of Mexico, Missouri
[1017] Interview of Aliesha Edwards Administrator of Mexico, Missouri
[1018] Interview of Director of Operations Melissa Skinner
[1019] Interview of Assistant Administrator Angela Baker of Mexico, Missouri; Interview of Assistant Administrator Donna Stacye Mt. Vernon, Missouri; Interview of Assistant Administrator Jamie McCannon of Warrensburg, Missouri; Interview of Director of Homes Joan Elwing; Interview of Administrator Aliesha Edwards of Mexico, Missouri
[1020] Interview of Director of Operations Melissa Skinner; Interview of Director of Homes Joan Elwing; Interview of Executive Director COL. Paul Kirchhoff; Interview of Deputy Director Ryon Richmond; Interview of Assistant Director of Homes Bradley Haggard; Interview of Human Resources Director Kristen Smith
[1021] Interview of Director of Operations Melissa Skinner; Interview of Director of Homes Joan Elwing
[1022] Interview of Executive Director COL. Paul Kirchhoff
[1023] MVC Daily COVID-19 Report
[1024] Interview of Executive Director COL. Paul Kirchhoff
[1025] *Id.*
[1026] Interview of Director of Homes Joan Elwing; Interview of Administrator Aliesha Edwards of Mexico, Missouri
[1027] *Id.*
[1028] Interview of Director of Homes Joan Elwing
[1029] Interview of Executive Director COL. Paul Kirchhoff; Interview of Deputy Director Ryon Richmond; Interview of Human Resources Director Kristen Smith; Interview of Assistant Homes Director, Brad Haggard; Interview of Director of Homes Joan Elwing;
[1030] Interview of Assistant Director of Homes Bradley Haggard
[1031] *Id.*
[1032] *Id.*

[1033] Interview of Director of Operations Melissa Skinner; Interview of Director of Homes Joan Elwing; Interview of Executive Director COL. Paul Kirchhoff; Interview of Deputy Director Ryon Richmond; Interview of Assistant Director of Homes Bradley Haggard.
[1034] *Id.*
[1035] *E.g.*, Interview of Assistant Administrator Angela Baker of Mexico, Missouri; Interview of Director of Nursing, Amber Hamilton for Mt. Vernon, Missouri; Interview of Assistant Administrator Jamie McCannon of Warrensburg, Missouri; Interview of Administrator Aliesha Edwards of Mexico, Missouri
[1036] Interview of Assistant Administrator Angela Baker of Mexico, Missouri; Interview of Director of Nursing, Amber Hamilton of Mt. Vernon, Missouri
[1037] Interview of Assistant Administrator Angela Baker of Mexico, Missouri
[1038] Interview of Director of Operations Melissa Skinner
[1039] Interview of Director of Homes Joan Elwing
[1040] Interview of Executive Director COL. Paul Kirchhoff
[1041] Interview of Deputy Director Ryon Richmond
[1042] Interview of Director of Homes Joan Elwing
[1043] Interview of Executive Director COL. Paul Kirchhoff; Interview of Director of Operations Melissa Skinner
[1044] Interview of Director of Homes Joan Elwing
[1045] *Id.*
[1046] Interview of Executive Director COL. Paul Kirchhoff
[1047] *Id.*
[1048] *Id.*
[1049] *Id.*
[1050] *Id.*
[1051] *Id.*
[1052] Interview of Director of Operations Melissa Skinner
[1053] Interview of Director of Homes Joan Elwing
[1054] Interview of Executive Director COL. Paul Kirchhoff
[1055] Interview of Deputy Director Ryon Richmond; Interview of Director of Operations Melissa Skinner; Interview of Director of Homes Joan Elwing; Interview of Executive Director COL. Paul Kirchhoff; Interview of Assistant Director of Homes Bradley Haggard.
[1056] *Id.*
[1057] Pathway Report
[1058] Interview of Deputy Director Ryon Richmond; Interview of Director of Operations Melissa Skinner; Interview of Director of Homes Joan Elwing; Interview of Executive Director COL. Paul Kirchhoff; Interview of Assistant Director of Homes Bradley Haggard
[1059] *Id.*
[1060] Interview of Executive Director COL. Paul Kirchhoff
[1061] Interview of Director of Homes Joan Elwing
[1062] *Id.*
[1063] *Id.*
[1064] Interview of Director of Operation Melissa Skinner; Interview with Director of Homes Joan Elwing
[1065] Interview with Director of Homes Joan Elwing
[1066] Interview of Deputy Director Ryon Richmond
[1067] https://www.stltoday.com/lifestyles/health-med-fit/coronavirus/at-least-70-missouri-nursing-homes-in-st-louis-area-report-covid-19-outbreaks/article_35d9cd1a-68fe-5661-80f4-ed7ec19814d7.html (last visited on November 13, 2020); https://www.newstribune.com/news/local/story/2020/jul/18/nursing-home-coronavirus-outbreak-in-southwest-missouri-part-of-national-trend/834663/ (last visited on November 13, 2020); https://www.myleaderpaper.com/coronavirus/outbreak-of-covid-19-reported-at-eureka-nursing-home/article_504e7eba-84c6-11ea-a645-33d879389ed9.html (last visited on November 13, 2020); https://fox2now.com/news/residential-care-facilities-across-missouri-reporting-covid-19-outbreaks/ (last visited on November 13, 2020).
[1068] Interview of Deputy Director Ryon Richmond
[1069] https://governor.mo.gov/press-releases/archive/governor-parson-announces-expansion-state-covid-19-dashboards
[1070] Interview of Deputy Director Ryon Richmond
[1071] Interview of Deputy Director Ryon Richmond
[1072] Interview of Director Adam Crumbliss

[1073] Interview of Deputy Director Ryon Richmond; Interview of Director Adam Crumbliss; Interview of Director Todd Richardson
[1074] Interview of Director Todd Richardson
[1075] Interview of Director Dr. Randall Williams
[1076] Interview of Director Todd Richardson
[1077] *Id.*
[1078] Interview of Deputy Director Ryon Richmond
[1079] *Id.*
[1080] *Id*; Interview of Aaron Cluff
[1081] Interview of Director Todd Richardson
[1082] *Id.*
[1083] Interview of Director Cindy Dixon; Interview of Commissioner of Sarah Steelman; Interview of Director Todd Richardson; Interview of Director Adam Crumbliss;
[1084] Interview of Director Cindy Dixon; Interview of Commissioner of Sarah Steelman; Interview of Michelle Renkemeyer
[1085] Interview of Commissioner of Sarah Steelman
[1086] Interview of Deputy Director Ryon Richmond; Interview of Aaron Cluff
[1087] Email between Mary Menges and Ryon Richmond
[1088] Interview Deputy Director Ryon Richmond.
[1089] *Id.*
[1090] *Id.*
[1091] *Id.*
[1092] Email between Ryon Richmond and Julia LePage.
[1093] *Id.*
[1094] *Id.*; MVC Testing Tracker
[1095] *Id.*
[1096] *Id.*
[1097] Julia LePage email and PowerPoint slides
[1098] Interview of Deputy Director Ryon Richmond
[1099] *Id.*
[1100] *Id.*
[1101] Cape Girardeau Spreadsheet
[1102] *Id.*; MVC Testing Tracker
[1103] Interview of Director Todd Richardson
[1104] *Id.*
[1105] Interview of Commissioner Sarah Steelman
[1106] *Id.*
[1107] Interview of Ryon Richmond; MVC Testing Tracker documents
[1108] Home Administrator Interviews
[1109] Interview of Director Adam Crumbliss
[1110] *Id.*
[1111] Interview of Cindy Dixon
[1112] *Id.*
[1113] Interview of Commissioner Sarah Steelman
[1114] Letter dated 11/6/2020 from Ryon Richmond and Paul Kirchhoff to Armstrong Teasdale
[1115] Interview of Director of Autism Services Kerri Tesreau
[1116] *Id.*
[1117] *Id.*
[1118] *Id.*
[1119] *Id.*
[1120] *Id.*
[1121] Interview of Director Sandra Karsten
[1122] Management Call Log Entries
[1123] *Id.*
[1124] *Id.*
[1125] Interview of Director Sandra Karsten

[1126] Interview of Director Todd Richardson
[1127] *Id.*
[1128] *Id.*
[1129] *Id.*
[1130] Interview of Director Todd Richardson
[1131] Interview of Director Adam Crumbliss; Interview of Deputy Director Ryon Richmond
[1132] Interview of Director Dr. Randall Williams
[1133] *Id.*
[1134] *Id.*
[1135] *Id.*
[1136] *Id.*
[1137] Interview of Director Adam Crumbliss
[1138] *Id.*
[1139] Interview of Cindy Dixon; Interview of Commissioner Sarah Steelman
[1140] *Id.*
[1141] *Id.*
[1142] Interview of Michelle Renkemeyer
[1143] *Id.*
[1144] Interview of Executive Director COL. Paul Kirchhoff
[1145] *Id.*
[1146] *Id.*
[1147] *Id.*
[1148] *Id.*
[1149] Interview of Executive Director COL. Paul Kirchhoff; Interview of Director Sandy Karsten
[1150] Interview of Director Sandy Karsten
[1151] Interview of Michelle Renkemeyer
[1152] *Id.*
[1153] *Id.*
[1154] *Id.*
[1155] *Id.*
[1156] *Id.*
[1157] *Id.*
[1158] *Id.*
[1159] *Id.*
[1160] *Id.*
[1161] *Id.*; Excel documents provided by Michelle Renkemeyer
[1162] *See, e.g.,* the St. Louis Post Dispatch, https://www.stltoday.com/news/local/govt-and-politics/investigators-accepting-hotline-calls-from-family-members-of-residents-at-missouri-Veterans-homes/article_a94734ab-4cd2-5173-a8fa-367c991742c6.html (Oct. 29, 2020) (last visited November 13, 2020); the Rolla Daily News; https://www.therolladailynews.com/news/20201029/independent-review-team-seeking-comments-from-missouri-Veterans-homes-family-members (Oct. 29, 2020 at 4:13 PM) (last visited November 13, 2020); the Webster County Citizen, https://www.webstercountycitizen.com/news/state/article_873243fc-98b8-542b-a38a-0c974e518b0e.html (Oct. 29, 2020) (last visited November 2, 2020); and the Sedalia Democrat, https://www.sedaliademocrat.com/stories/review-team-seeks-Veterans-home-family-comments,24751 (Oct. 30, 2020 at 2:31 AM) (last visited November 13, 2020)
[1163] https://twitter.com/MOVetsComm/status/1321898925327089665 (Oct. 29, 2020 at 2:37 PM) (last visited November 13, 2020)
[1164] Interview of [redacted] Family Member
[1165] Interview of [redacted] Family Member
[1166] Interview of [redacted] Family Member
[1167] Interview of [redacted] Family Member
[1168] Interview of [redacted] Family Member; Interview of [redacted] Family Member
[1169] Interview of [redacted] Family Member
[1170] Interview of [redacted] Family Member
[1171] Interview of [redacted] Family Member
[1172] Interview of [redacted] Family Member

[1173] Interview of [redacted] Family Member
[1174] Interview of [redacted] Family Member
[1175] Interview of [redacted] Family Member
[1176] Interview of [redacted] Family Member
[1177] Interview of [redacted] Family Member
[1178] Interview of [redacted] Family Member
[1179] Interview of [redacted] Family Member
[1180] Interview of [redacted] Family Member
[1181] Interview of [redacted] Family Member; Interview of Gary Summers, Volunteer; Interview of [redacted] Family Member; Interview of [redacted] Family Member
[1182] Interview of [redacted] Family Member; Interview of [redacted] Family Member
[1183] Interview of [redacted] Family Member
[1184] Interview of [redacted] Family Member
[1185] Interview of [redacted] Family Member
[1186] Interview of [redacted] Family Member
[1187] Interview of [redacted] Family Member
[1188] Interview of [redacted] Family Member
[1189] Interview of [redacted] Family Member
[1190] Interview of [redacted] Family Member
[1191] Interview of [redacted] Family Member
[1192] Interview of [redacted] Family Member; Interview of [redacted] Family Member
[1193] Interview of [redacted] Family Member
[1194] Interview of [redacted] Family Member
[1195] *Id.*
[1196] *Id.*
[1197] Interview of [redacted] Family Member
[1198] Interview of [redacted] Family Member; Interview of [redacted] Family Member
[1199] Interview of [redacted] Family Member; Interview of [redacted] Family Member
[1200] Interview of [redacted] Family Member
[1201] Interview of [redacted] Family Member
[1202] Interview of [redacted] Family Member
[1203] Interview of [redacted] Family Member
[1204] Interview of [redacted] Family Member
[1205] *Id.*
[1206] Interview of [redacted] Family Member
[1207] *Id.*
[1208] Interview of [redacted] Family Members
[1209] Interview of [redacted] Family Member
[1210] Interview of [redacted] Family Member
[1211] Interview of [redacted] Family Member
[1212] Interview of [redacted] Family Members
[1213] Interview of [redacted], Family Member; Interview of [redacted], Family Member
[1214] *Id.*
[1215] Interview of [redacted] Family Member
[1216] Interview of [redacted] Family Member
[1217] Interview of [redacted] Family Member; Interview of [redacted], Family Members
[1218] Interview of [redacted] Family Member
[1219] Interview of [redacted] Family Member
[1220] Interview of [redacted] Family Member; [redacted], Family Member; Interview of [redacted], Family Members
[1221] Interview of [redacted], Family Member
[1222] Interview of [redacted] Family Member
[1223] Interview of [redacted] Family Member
[1224] Interview of [redacted], Family Member
[1225] *Id.*
[1226] *Id.*

[1227] Interview of [redacted], Family Member
[1228] Interview of [redacted], Family Member
[1229] Interview of [redacted], Family Member; Interview of [redacted], Family Member; Interview of [redacted] Family Member; Interview of [redacted] Family Member
[1230] Interview of [redacted], Family Member
[1231] Interview of [redacted] Family Member; Interview of [redacted] Family Member
[1232] Interview of [redacted] Family Member; Interview of [redacted], Family Member; Interview of [redacted], Family Member; Interview of [redacted] Family Member; Interview of [redacted], Family Member
[1233] Interview of [redacted] Family Member
[1234] Interview of [redacted] Family Member; Interview of [redacted], Family Member
[1235] Interview of [redacted] Nurse
[1236] *Id.*
[1237] Interview of [redacted], Family Member
[1238] Interview of [redacted], Family Members
[1239] Interview of [redacted], Family Member
[1240] Interview of [redacted], Family Member
[1241] Interview of [redacted], Family Member
[1242] *Id.*
[1243] Interview of [redacted], Family Member
[1244] Interview of [redacted], Family Member
[1245] Interview of [redacted] Family Member
[1246] Interview of [redacted], Family Member
[1247] *Id.*
[1248] *Id.*
[1249] Interview of [redacted] Family Member
[1250] Interview of [redacted], Family Member
[1251] Interview of [redacted] Family Member
[1252] Interview of [redacted] Family Member
[1253] Interview of [redacted] Veteran
[1254] Interview of [redacted] Veteran
[1255] Interview of [redacted] Family Member
[1256] Interview of [redacted] Nurse
[1257] Interview of [redacted] Family Member
[1258] Interview of [redacted] Family Member
[1259] *Id.*
[1260] Interview of [redacted] Family Member
[1261] Interview of [redacted] Family Member
[1262] Interview of [redacted] Veteran
[1263] Interview of [redacted] Family Member
[1264] Interview of [redacted] Family Member
[1265] Interview of [redacted] Family Member; Interview of [redacted] Family Member
[1266] Interview of [redacted] Family Member
[1267] Interview of [redacted] Family Members
[1268] CDC; https://coronavirus.jhu.edu/ (last visited November 13, 2020)
[1269] https://www.nytimes.com/interactive/2020/us/missouri-coronavirus-cases.html (last visited November 13, 2020)
[1270] https://apnews.com/article/67ac94d1cf08a84ff7c6bbeec2b167fa (last visited November 13, 2020); https://www.livescience.com/coronavirus-spread-us-inevitable.html (last visited November 13, 2020)
[1271] https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html (last visited November 13, 2020)
[1272] https://www.stltoday.com/news/local/state-and-regional/missouri-nursing-homes-record-more-than-1-400-covid-19-deaths-accounting-for-nearly-half/article_07da8864-778f-561e-9788-21d04c1df02a.html (last visited November 13, 2020)
[1273] https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/outbreaks.html (last visited November 13, 2020)
[1274] Interview of State Epidemiologist Dr. George Turabelidze
[1275] https://www.livescience.com/coronavirus-spread-us-inevitable.html (last visited November 13, 2020)
[1276] Interview of State Epidemiologist Dr. George Turabelidze

[1277] Interview of Director of Homes Joan Elwing
[1278] Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus; https://www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-hospital-checklist.html (last visited November 13, 2020); Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings; https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html (last visited November 13, 2020); Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF); https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html (last visited November 13, 2020); Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings (novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf)
[1279] Interview of State Epidemiologist Dr. George Turabelidze
[1280] Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus; https://www.cdc.gov/coronavirus/2019-ncov/hcp/hcp-hospital-checklist.html (last visited November 13, 2020)
[1281] Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings; https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html (last visited November 13, 2020)
[1282] Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF); https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fhealthcare-facilities%2Fprevent-spread-in-long-term-care-facilities.html (last visited November 13, 2020)
[1283] Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings (novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf)
[1284] Interview of Director of Homes Joan Elwing
[1285] Pathway Report
[1286] Interview of Mexico Staff Development Director Lori Riddle; Interview of Warrensburg Staff Development Coordinator Laura Weisenburger; Interview of Mt. Vernon CNA Aurora Barnett
[1287] *Id.*
[1288] *Id.*
[1289] Interview of State Epidemiologist Dr. George Turabelidze
[1290] Interview of Director of Homes Joan Elwing
[1291] Interview of State Epidemiologist Dr. George Turabelidze
[1292] *Id.*
[1293] *Id.*
[1294] Interview of Director of Operations Melissa Skinner
[1295] *Id.*
[1296] Interview of CNA Becky Hoover; Interview of Custodial Manager Janet Cook
[1297] Interview of Director of Homes Joan Elwing
[1298] Interview of State Epidemiologist Dr. George Turabelidze
[1299] Interview of Director of Homes Joan Elwing; Interview of Director of Nursing and Infection Prevention Jean Sherrill
[1300] Pathway Report
[1301] Interview of Director of Operations Melissa Skinner
[1302] Interview of State Epidemiologist Dr. George Turabelidze
[1303] Pathway Report (Cameron Home)
[1304] Pathway Report (Cape Girardeau Home)
[1305] Interview of Sandra Karsten
[1306] "The MVC administratively reports to the Department of Public Safety (DPS)." State of Missouri, Emergency Request for Quote (RFQ), "Independent External Investigation: COVID Exposure and Reporting" (Oct. 7, 2020) at § 1.2.1. At various times, individuals referred to the MVC as a "holding company." DPS "comprises eight different agencies (including two commissions) and six separate programs all committed to ensuring the safety of the citizens of Missouri." *Id.* at § 1.2.2.
[1307] Interview of [redacted] Family Member
[1308] Interview of [redacted] Family Member
[1309] Interview of [redacted] Family Member
[1310] https://www.nytimes.com/2020/10/30/us/nursing-homes-isolation-virus.html (last visited November 13, 2020)

Armstrong Teasdale

COVID-19 OUTBREAK AT MISSOURI VETERANS HOMES