

---

State of Illinois  
Office of the Auditor General

---



Performance Audit of the

**State's Response to the  
COVID-19 Outbreak at the  
LaSalle Veterans' Home**

May 5, 2022

---

**Frank J. Mautino**  
*Auditor General*

---

You can obtain reports by contacting:

Office of the Auditor General  
Iles Park Plaza  
740 E. Ash  
Springfield, IL 62703

217-782-6046 or TTY: 1-888-261-2887

OR

This Audit Report and a Report Digest are also available on the worldwide web at  
<http://www.auditor.illinois.gov>

SPRINGFIELD OFFICE:  
ILES PARK PLAZA  
740 EAST ASH • 62703-3154  
PHONE: 217/782-6046  
FAX: 217/785-8222 • TTY: 888/261-2887  
FRAUD HOTLINE: 1-855-217-1895



CHICAGO OFFICE:  
MICHAEL A. BILANDIC BLDG. • SUITE S-900  
160 NORTH LASALLE • 60601-3103  
PHONE: 312/814-4000  
FAX: 312/814-4006  
FRAUD HOTLINE: 1-855-217-1895

OFFICE OF THE AUDITOR GENERAL  
FRANK J. MAUTINO

*To the Legislative Audit Commission, the Speaker  
and Minority Leader of the House of Representatives,  
the President and Minority Leader of the Senate, the  
members of the General Assembly, and the  
Governor:*

This is our report of the performance audit of the State's response to the COVID-19 outbreak at the LaSalle Veterans' Home.

The audit was conducted pursuant to House Resolution Number 62. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Sections 3-14 of the Illinois State Auditing Act.

**SIGNED ORIGINAL ON FILE**

FRANK J. MAUTINO  
Auditor General

Springfield, Illinois  
May 2022





Performance Audit of the

## State's Response to the COVID-19 Outbreak at the LaSalle Veterans' Home

### Background:

On April 28, 2021, the Illinois House of Representatives adopted House Resolution Number 62, which directed the Office of the Auditor General to conduct a performance audit of the State's response to the management of the COVID-19 outbreak at the LaSalle Veterans' Home (see Appendix A). The outbreak at the LaSalle Veterans' Home occurred in late October 2020, when COVID-19 cases were trending up statewide. Also, the outbreak occurred prior to the COVID-19 vaccine. Based on tests administered prior to the end of October 2020, 13 residents and staff (8 residents and 5 staff) tested positive. According to the Department of Public Health (IDPH), by November 4, 2020, 57 residents and staff (46 residents and 11 staff) had tested positive for COVID-19. By the end of November 2020, 203 total positive cases had been identified at the LaSalle Home. According to IDPH, in total, between October 23, 2020 and December 9, 2020, 109 of the Home's 128 residents (85%) and 88 of the Home's 231 staff (38%) had tested positive for COVID-19.

### Key Findings:

- Although the Illinois Department of Public Health (IDPH) officials were informed of the increasing positive cases almost on a daily basis by the Illinois Department of Veterans' Affairs (IDVA) Chief of Staff, IDPH did not identify and respond to the seriousness of the outbreak. It was the IDVA Chief of Staff who ultimately had to request assistance. The IDVA Chief of Staff inquired about a site visit and about rapid tests (November 9th), and inquired about getting antibody treatments (November 11th) for LaSalle Veterans' Home residents. From the documents reviewed, IDPH officials did not offer any advice or assistance as to how to slow the spread at the Home, offer to provide additional rapid COVID-19 tests, and were unsure of the availability of the antibody treatments for long-term care settings prior to being requested by the IDVA Chief of Staff.
- The outbreak at the LaSalle Veterans' Home occurred at a time when COVID-19 cases were trending up statewide. Positive cases in Region 2 (where the LaSalle Home is located) increased from 12,108 in October 2020 to 37,825 in November 2020, an increase of 212.4 percent. Also, the outbreak occurred prior to the COVID-19 vaccine. Prior to the outbreak that began at the end of October 2020, only six staff members had tested positive for COVID-19. Even though the LaSalle Home had designated areas for isolation and quarantine, once the virus entered the Home, it spread very rapidly.
- The time it took to receive staff COVID-19 testing results from the IDPH lab was lengthened by the collection method used by the LaSalle Home. The Home tested staff over a three day period. As a result, new tests of staff collected on November 3rd, 4th, and 5th were not delivered to the IDPH lab until Thursday, November 5th, even though the first two staff members from the outbreak were found to be positive by Sunday, November 1st. The IDPH lab published the majority of the test results on either Friday or Saturday. Therefore, the delay in getting testing results was primarily due to the collection method used by the LaSalle Home. Additionally, the testing method, collecting tests over three days, was not in compliance with the facility's policy, which allowed for testing over two days.
- IDVA provided auditors with new infection prevention policies on June 17, 2021, which were drafted with the assistance of IDPH, which were officially implemented on April 23, 2021. The purpose of these policies was to establish a comprehensive and integrated infection prevention and control program at all Illinois veterans' homes. A system-level Infection Prevention and Control Committee was tasked with standardizing policies and procedures and was required to oversee infection prevention at the Illinois veterans' homes. These policies also updated infection prevention training requirements for staff at Illinois veterans' homes.

- The LaSalle Veterans’ Home implemented several infrastructure improvements during FY20 and FY21 as a result of the COVID-19 pandemic and outbreak at the Home. Prior to the outbreak, external firms were commissioned to design and build airborne infection isolation rooms at IDVA Homes, including the LaSalle Home. The construction of the isolation rooms was initiated in March of 2020 and operational by May 23, 2020. Payments made for the construction of the isolation rooms totaled \$1,057,470. In total, the cost for all infrastructure improvements from March 2020 through June 2021 totaled \$1,162,719.
- The State expended approximately \$3.4 million between FY20 and FY21 as a result of the COVID-19 pandemic at the LaSalle Veterans’ Home. According to documentation provided by IDPH and IDVA, expenditures included PPE, infrastructure improvements, and COVID-19 testing for both the COVID-19 pandemic as a whole and the outbreak at the LaSalle Home that began in late October 2020. Auditors concluded that the outbreak did not significantly add to the Home’s overall COVID-19-related costs during FY20 and FY21.
- The Department of Human Services’ Office of the Inspector General (DHS OIG) investigation reported that the significance of the outbreak was not being meaningfully tracked by the IDVA Chief of Staff. In fact, auditors found the Chief of Staff provided detailed information to IDPH that was used by the Director of IDPH in her daily COVID-19 briefings. IDPH and the First Assistant Deputy Governor for Health & Human Services were provided detailed emails of COVID-19 positive cases and related deaths for each of the four State veterans’ homes by IDVA on November 2nd, 3rd, 4th, 5th, 6th, 9th, 10th, 12th, and 13th. The primary finding of the DHS OIG report, which indicated the “absence of any standard operating procedures in the event of a COVID-19 outbreak,” was flawed. Auditors identified hundreds of pages of guidance provided by IDPH and by the Centers for Disease Control. In addition, COVID-19 policies were formulated by IDVA specifically for the LaSalle Veterans’ Home as well as a Continuity of Operations Plan that was reviewed by Illinois Emergency Management Agency and was provided to IDPH back in March 2020.

***Key Recommendations:***

The audit report contains three recommendations:

- IDVA should ensure each of its Veterans' Homes have policies and procedures in place that mandate timely testing of its residents and employees during COVID-19 outbreaks, and should ensure that residents and employees are tested according to the policy.
- IDPH should:
  - clearly define its role in relation to monitoring COVID-19 outbreaks at Illinois Veterans’ Homes; and
  - develop policies and procedures that clearly identify criteria which mandate IDPH intervention at Veterans’ Homes during an outbreak of COVID-19.
- IDVA should ensure that:
  - the IDVA Director works with the Department of Public Health and the Governor’s office during COVID-19 outbreaks to advocate for the health, safety, and welfare of the veterans who reside in the Homes under IDVA’s care; and
  - the Senior Home Administrator position is filled and the duties of the position include monitoring and providing guidance to the Veterans’ Homes during COVID-19 outbreaks.

This performance audit was conducted by the staff of the Office of the Auditor General.

## Report Digest

On April 28, 2021, the Illinois House of Representatives adopted House Resolution Number 62, which directed the Office of the Auditor General to conduct a performance audit of the State's response to the management of the COVID-19 outbreak at the LaSalle Veterans' Home. The Resolution contained six specific determinations. Our assessment of these determinations is shown in **Digest Exhibit 1.** (pages 1-2)

Digest Exhibit 1  
**ASSESSMENT OF AUDIT DETERMINATIONS**

Determination from Audit Resolution	Auditor Assessment
<p><i>The response of the Department of Veterans' Affairs to the outbreak of COVID-19 in 2020 at the LaSalle Veterans' Home, including the recommendations made in the November 13, 2020 site visit by the Illinois Department of Public Health and the Department's actions to address those recommendations. (Note: the site visit was conducted on November 12, 2020, not November 13, 2020)</i></p>	<ul style="list-style-type: none"> <li>• Four positive COVID-19 cases were identified at the LaSalle Veterans’ Home by Sunday, November 1, 2020. These four cases included two residents and two staff members. These four cases were reported by the IDVA Chief of Staff to the IDPH State Medical Officer and the First Assistant Deputy Governor for Health &amp; Human Services on the afternoon of November 1, 2020. Auditors determined that although IDPH officials were informed of the increasing positive cases almost on a daily basis by the IDVA Chief of Staff, IDPH did not identify and respond to the seriousness of the outbreak. It was the IDVA Chief of Staff who ultimately had to request assistance. The Chief of Staff inquired about a site visit and about rapid tests (November 9th), and inquired about getting antibody treatments (November 11th) for LaSalle Veterans’ Home residents. From the documents reviewed, IDPH officials did not offer any advice or assistance as to how to slow the spread at the Home, offer to provide additional rapid COVID-19 tests, and were unsure of the availability of the antibody treatments for long-term care settings prior to being requested by the IDVA Chief of Staff. (pages 27-51)</li> </ul>
<p><i>The type, cost, and timing of any infrastructure or other building improvements intended to contain the further spread of COVID-19 or prevent its reoccurrence at the LaSalle Veterans' Home.</i></p>	<ul style="list-style-type: none"> <li>• The LaSalle Veterans’ Home implemented several infrastructure improvements during FY20 and FY21 as a result of the COVID-19 pandemic and outbreak at the Home. Prior to the outbreak, external firms were commissioned to design and build airborne infection isolation rooms at IDVA Homes, including the LaSalle Home. According to IDVA, the construction of the isolation rooms was initiated in March 2020 and operational by May 23, 2020. Payments made for the construction of the isolation rooms totaled \$1,057,470. In total, the cost for all infrastructure improvements from March 2020 through June 2021 totaled \$1,162,719. (pages 78-79)</li> </ul>
<p><i>The nature of changes made by the Department in operating protocols and staff</i></p>	<ul style="list-style-type: none"> <li>• IDVA provided auditors with new infection prevention policies on June 17, 2021, which were drafted with the</li> </ul>

*training thereon, intended to contain the further spread of COVID-19 or prevent its reoccurrence at the LaSalle Veterans' Home.*

assistance of the Illinois Department of Public Health, which were officially implemented on April 23, 2021. The purpose of these policies was to establish a comprehensive and integrated infection prevention and control program at all Illinois veterans' homes. A system-level Infection Prevention and Control Committee was tasked with standardizing policies and procedures and was required to oversee infection prevention at the Illinois veterans' homes. These policies also updated infection prevention training requirements for staff at Illinois veterans' homes. (pages 67-73)

*The nature and extent of monitoring conducted by the Department to determine whether the improvements and protocols put in place are effective to ensure the safety of residents and staff at the LaSalle Veterans' Home.*

- The LaSalle Veterans' Home has been monitored through the IDPH survey process since November 2020. Additionally, IDVA hired consultants to review the protocols at the homes in order to identify any additional recommendations to prevent further outbreaks. IDVA also hired additional consultants to review the HVAC systems at the homes. The Interagency Infection Prevention Project report from March 9, 2021, noted that repeated site visits to the LaSalle Veterans' Home showed substantial improvement in infection prevention practices. (pages 74-76)

*The amount of State moneys received and the amount of State moneys expended by IDPH or any other State agency during State fiscal years 2020 and 2021 to address the COVID-19 outbreaks at the LaSalle Veterans' Home.*

- The State expended approximately \$3.4 million between FY20 and FY21 as a result of the COVID-19 pandemic at the LaSalle Veterans' Home. According to documentation provided by IDPH and IDVA, expenditures included PPE, infrastructure improvements, and COVID-19 testing for both the COVID-19 pandemic as a whole and the outbreak at the LaSalle Home that began in late October 2020. Auditors concluded that the outbreak did not significantly add to the Home's overall COVID-19-related costs during FY20 and FY21. (pages 77-80)

*To the extent information is available, whether the LaSalle Veterans' Home has been the subject of any reviews since 2015 to determine its compliance with applicable laws and regulations with regard to the care of its residents and, if so, the results of those reviews.*

- The LaSalle Veterans' Home was surveyed by IDPH as well as the U.S. Department of Veterans Affairs. Since 2015, the LaSalle Veterans' Home has been the subject of 22 IDPH surveys. Non-compliance was identified in two surveys both following the November 2020 COVID-19 outbreak. One, from November 2020, found non-compliance related to written policies related to all services provided and policies for investigating, controlling, and preventing infections. The other, from March 2021, found the facility failed to prevent abuse, failed to report potential abuse immediately, failed to immediately remove the staff member from contact with residents after a report of potential abuse, and failed to follow their policy to immediately examine a resident and immediately suspend the accused staff member for two of the three residents reviewed. (pages 81-83)

Source: OAG assessment of the audit determinations contained in House Resolution Number 62.



## Background

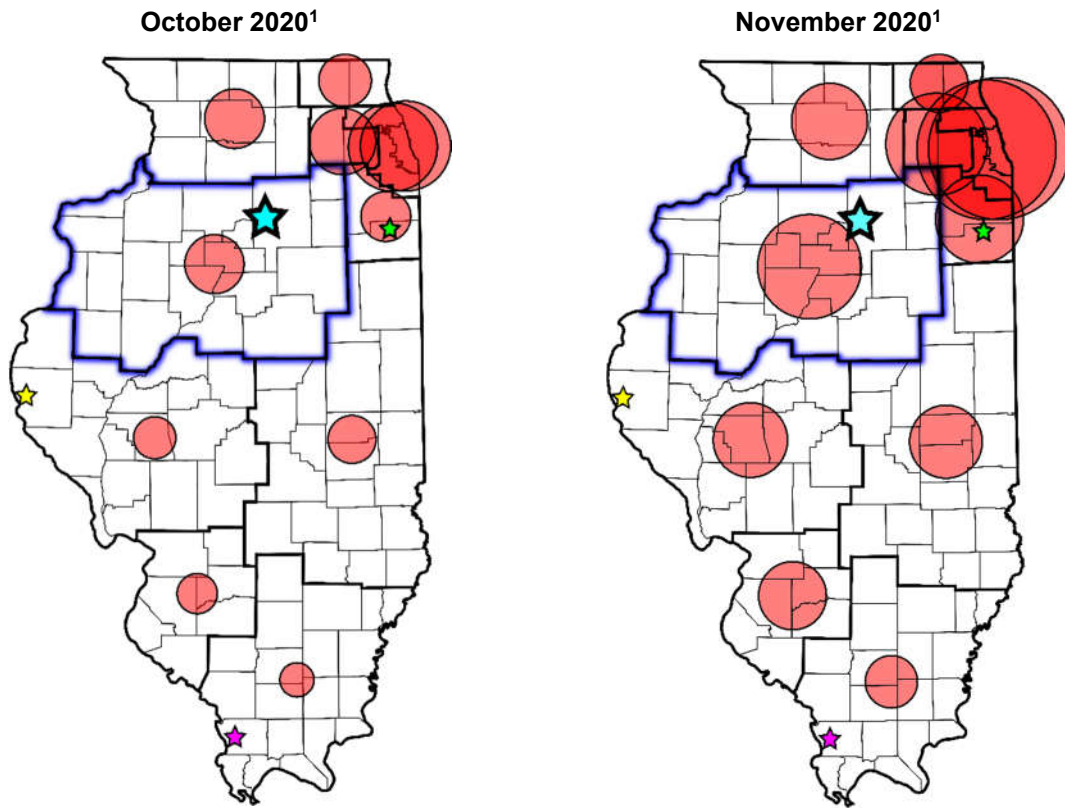
The Illinois Department of Public Health (IDPH) announced the first case of COVID-19 in Illinois on January 24, 2020, and the spouse of the individual was the second confirmed case on January 30, 2020. These were the first two known cases of Illinois residents to test positive. By March 5, 2020, Illinois had five confirmed cases. On March 9, 2020, Governor Pritzker issued a Disaster Proclamation for Illinois.

By April 1, 2020, IDPH reported a total of 6,980 positive cases and 141 COVID-19 related deaths. On October 31, 2020, the number of positive cases increased to its then highest one day total, 7,899. Beginning on November 6, 2020, IDPH began reporting both confirmed and probable cases. Consequently, more than 7,000 previously unreported probable cases were added to the November 5, 2020 total cases. On November 7, 2020, the daily positive cases increased to 12,438. (pages 3-4)


## COVID-19 Cases in Region 2

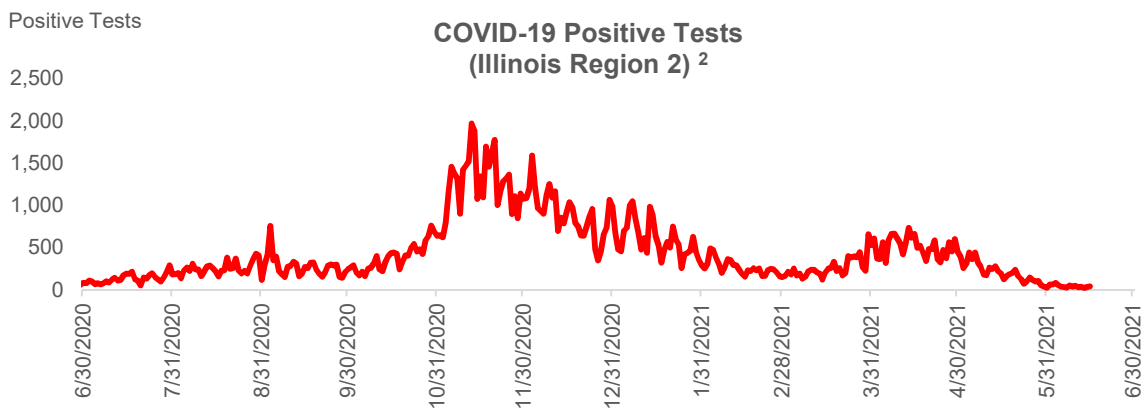
The Illinois Veterans' Home LaSalle is in LaSalle County, which is located in COVID-19 Region 2 (North-Central). In November 2020, there was a drastic increase in COVID-19 cases compared to the previous months. Positive cases in Region 2 increased from 12,108 in October 2020 to 37,825 in November 2020, an increase of **212.4 percent**. Cases began to increase near the end of October 2020 in Region 2 which mirrored the increase in cases throughout the State. **Digest Exhibit 2** graphically depicts the increased cases in Region 2 compared to the other 10 Regions. Further, the Exhibit shows the daily positive case counts for Region 2. (pages 4-6)

Digest Exhibit 2  
**INCREASE IN COVID-19 CASES IN REGION 2 COMPARED TO OTHER ILLINOIS REGIONS**  
 October and November 2020



**IDVA Veterans' Homes**

			
LaSalle	Manteno	Quincy	Anna



Notes:  
<sup>1</sup> Circle size indicates regional quantity of positive COVID-19 tests.  
<sup>2</sup> Region 2 contains the LaSalle Veterans' Home (outlined in blue).  
 Source: Auditor analysis of Illinois Department of Public Health data.

## COVID-19 Outbreak at the LaSalle Veterans' Home

The outbreak at the LaSalle Veterans' Home occurred at a time when COVID-19 cases were trending up statewide. Also, the outbreak occurred prior to the COVID-19 vaccine. Prior to the outbreak that began at the end of October 2020, only six staff members had tested positive for COVID-19.

Even though the LaSalle Home had designated areas for isolation and quarantine, once the virus entered the Home, it spread very rapidly. According to documentation provided by the LaSalle Veterans' Home, the first resident was positive on October 23, 2020. This was followed by another resident and two staff on October 27, 2020. Based on tests administered prior to the end of October 2020, 13 residents and staff (8 residents and 5 staff) tested positive. Clearly there was a verified outbreak and by November 4, 2020, according to IDPH, 57 residents and staff (46 residents and 11 staff) had tested positive for COVID-19. By the end of November 2020, 203 total positive cases had been identified at the LaSalle Veterans' Home. According to IDPH, **in total, between October 23, 2020 and December 9, 2020, 109 of the Home's 128 residents (85%) and 88 of the Home's 231 staff (38%) had tested positive for COVID-19.** (pages 10-12)

## Resident Deaths at the LaSalle Veterans' Home

In total, 36 residents of the LaSalle Veterans' Home died due to COVID-19. The deaths occurred between November 7, 2020 and January 1, 2021. Positive cases increased rapidly during the first week of November 2020. By November 15, 2020, 17 residents had lost their lives from COVID-19 at the LaSalle Home.

Auditors compared the deaths to the date these 36 residents tested positive for COVID-19. Four residents that lost their lives from COVID-19 were positive before November 2, 2020. We determined that of the 35 residents that tested positive for COVID-19 on November 2, 2020, 15 died from the virus. Additionally, all but four residents who died were positive prior to the date of the IDPH site visit on November 12, 2020. (page 13)

## Guidance Provided to the LaSalle Veterans' Home

At the beginning of the pandemic, in March 2020, the LaSalle Veterans' Home already had general infection control policies and procedures in place to prevent the spread of illness and disease. On April 19, 2020, guidance was issued on notifying residents, family, and staff of positive test results in a facility. As the CDC updated its recommendations, IDPH updated its guidance. IDPH also began weekly educational webinars for long-term care staff beginning in March 2020. Additional guidance was also provided to the Home through August 2020.

IDPH changed its rules for skilled nursing facilities three times between May and October 2020. The first, in May, required facility-wide testing of staff and residents when experiencing an outbreak or when ordered by IDPH or the local health department. The second, in July, added specific CDC infection control guidelines that facilities had to follow. In October, the third change added a

testing requirements based on the COVID-19 positivity rate in the county. It appears the LaSalle Home complied with these updated requirements.

Documentation shows that the LaSalle Veterans’ Home administration did disseminate the information received from IDPH to the senior staff and department heads. In some cases, documentation indicates that employees were asked to sign a statement which indicated that they received information from their supervisor or department head.

In early March 2020, IDVA was required to submit Continuity of Operations Plans to both the Illinois Emergency Management Agency (IEMA) and IDPH. IEMA reviewed the plans and responded that “a common theme among Continuity of Operations Plans is that they are structured for impact to physical locations and do not take into account staffing shortages.” (pages 17-20)

### **COVID-19 Testing during the Outbreak at the LaSalle Veterans’ Home**

The time it took to receive staff COVID-19 testing results from the IDPH lab was lengthened by the collection method used by the LaSalle Home. The Home tested staff over a three day period. As a result, new tests of staff collected on November 3rd, 4th, and 5th were not delivered to the IDPH lab until Thursday, November 5th, even though the first two staff members from the outbreak were found to be positive by Sunday, November 1st. The IDPH lab published the majority of the test results on either Friday or Saturday. Therefore, the delay in getting testing results was primarily due to the collection method used by the LaSalle Home. Additionally, the testing method, collecting tests over three days, **was not in compliance with the facility’s policy, which allowed for testing over two days.**

*Auditors recommend that IDVA should ensure each of its Veterans’ Homes have policies and procedures in place that mandate timely testing of its residents and employees during COVID-19 outbreaks, and should ensure that residents and employees are tested according to the policy.* (pages 21-26)

### **COVID-19 Outbreak Response at the LaSalle Veterans’ Home**

Auditors determined that four positive COVID-19 cases were identified at the LaSalle Veterans’ Home by Sunday, November 1, 2020. These four cases included two residents and two staff members. These four cases were reported by the IDVA Chief of Staff to the IDPH State Medical Officer and the First Assistant Deputy Governor for Health & Human Services on the afternoon of November 1, 2020.

Twelve days later, an email on November 13th from the IDVA Chief of Staff reported **83 total (82 current) residents, 93 (88 current) staff** with positive cases, **11 resident deaths**, and 3 residents and 1 employee hospitalized.

Auditors reviewed emails and documentation and conducted meetings and determined that although IDPH officials were informed of the increasing positive cases almost on a daily basis, IDPH did not identify and respond to the seriousness of the outbreak. It was the IDVA Chief of Staff who ultimately had to request assistance. The Chief of Staff inquired about a site visit and about rapid

tests (November 9th), and inquired about getting antibody treatments (November 11th) for LaSalle Veterans’ Home residents. From the documents reviewed, IDPH officials did not offer any advice or assistance as to how to slow the spread at the Home, offer to provide additional rapid COVID-19 tests, and were unsure of the availability of the antibody treatments for long-term care settings prior to being requested by the IDVA Chief of Staff.

It wasn’t until the November 11th, when the IDPH State Medical Officer noted that she spoke to the IDPH Chief of Staff and he told her the Governor was very concerned and wanted IDPH to visit the Home that a site visit by IDPH was scheduled. The site visit was conducted the following day.

*Auditors recommend that IDPH should: clearly define its role in relation to monitoring COVID-19 outbreaks at Illinois Veterans’ Homes; and develop policies and procedures that clearly identify criteria which mandate IDPH intervention at Veterans’ Homes during an outbreak of COVID-19.*

*Auditors also recommend IDVA should ensure that: the IDVA Director works with the Department of Public Health and the Governor’s office during COVID-19 outbreaks to advocate for the health, safety, and welfare of the veterans who reside in the Homes under IDVA’s care; and the Senior Home Administrator position is filled and the duties of the position include monitoring and providing guidance to the Veterans’ Homes during COVID-19 outbreaks.* (pages 27-40)

**Timeline of the 2020 LaSalle Veterans’ Home COVID-19 Outbreak**

**Digest Exhibit 3** is a detailed timeline of the 2020 LaSalle Veterans’ Home COVID-19 outbreak. The Exhibit summarizes various communication by IDVA, IDPH, and LaSalle Veterans’ Home officials. (pages 41-51)

Digest Exhibit 3 2020 LASALLE VETERANS’ HOME COVID-19 OUTBREAK TIMELINE	
Illinois Department of Veterans’ Affairs (IDVA)	Illinois Department of Public Health (IDPH)
Sunday, November 1, 2020 (1 <sup>st</sup> COVID-19 Communication to IDPH)	
1:59 PM	The IDVA Chief of Staff emailed IDPH staff including the State Medical Officer and copied the First Assistant Deputy Governor for Health & Human Services that the LaSalle Veterans’ Home had <b>2 residents</b> and <b>2 staff</b> test positive. It was noted that 4 more residents were tested and that all residents would be tested in the morning.
2:51 PM	The LaSalle Veterans’ Home Administrator emailed staff that there were 2 residents and 2 employees who had tested for COVID-19. She requested that staff “continue to be diligent with infection control precautions.” She also stated that “everyone needs to take breaks responsibly – maintain social distancing.” Further she asked staff to “not sit together in your vehicles to smoke or visits, no potlucks in the break rooms on the wings.” She instructed that staff in close proximity with a co-worker to both wear masks. In the email, she also stated “ <b>We must stop this outbreak in its tracks!</b> Please take this seriously – it is important to keeping our Veterans safe and healthy!”
2:58 PM	The LaSalle Veterans’ Home Infection Control Nurse informed the LaSalle County Health Department of the outbreak. The Infection Control Nurse noted that the Home would begin weekly testing of residents and continue weekly staff testing. It was further noted that staff would continue

	to wear surgical masks, face shields, and other additional PPE and that staff would be monitored for temperatures and symptoms 3 times a shift and residents would be monitored each shift.
3:10 PM	The LaSalle County Health Department emailed the LaSalle Home’s Infection Control Nurse, the Director of Nursing, and LaSalle Home Administrator asking for a line list, the total number of staff, the total number of residents, and the total people tested.
<b>Monday, November 2, 2020</b>	
7:42 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and requested census information along with the number of COVID positive residents and staff, the number of COVID deaths, and the number of outstanding tests. It was also asked if there were any difficulties with PPE or testing.
7:44 AM	The LaSalle Home Administrator replied to the Health System Specialist that they were having an outbreak and that she would get back to her later in the day when she knew more. She noted that it was affecting both residents and staff.
8:45 AM	The IDVA Chief of Staff emailed the “IDVA Homes Report” to various IDVA, IDPH, and Governor’s office staff, which included the Director of Veterans’ Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: “Note: Outbreak at LaSalle” and reported <b>10 positive residents</b> (one recovered) and <b>8 positive staff</b> . One non-symptomatic hospitalization was also reported.
9:35 AM	The IDVA Labor Relations Administrator emailed the IDVA Chief of Staff noting that they needed to get the Director’s signature on the Testing Policy.
9:38 AM	The IDVA Chief of Staff emailed the COVID-19 Testing Policy to the IDVA Director and her Assistant for signature and requested that it have “today’s date please.”
9:41 AM	The IDVA Director’s Assistant returned the signed Testing Policy to the IDVA Chief of Staff.
9:58 AM	The IDVA Chief of Staff emailed the Testing Policy to the IDVA Labor Relations Administrator and to the IDVA General Counsel and asked to have it placed with other policies on SharePoint.
10:09 AM	The LaSalle County Health Department emailed numerous pieces of guidance documents to the LaSalle Home’s Infection Control Nurse and LaSalle Home Administrator.
10:32 AM	The LaSalle Home’s Infection Control Nurse emailed the COVID positive line list to the LaSalle County Health Department. The line list showed 10 positive residents and 3 positive staff.
12:26 PM	The LaSalle Home Administrator emailed staff and asked to order antigen test supplies.
12:30 PM	The LaSalle Home Administrator emailed the IDVA Chief of Staff that currently there were 11 positive residents with one additional in isolation awaiting the result from a PCR test. It was also noted that there were 3 positive employees with 2 pending test results.
12:31 PM	The IDVA Chief of Staff asked the Administrator if all 11 were from the West wing.
12:33 PM	The LaSalle Home Administrator responded to the IDVA Chief of Staff that all but one were from the West wing, the other is from the North West wing.
12:47 PM	The LaSalle County Health Department notified the IDPH Communicable Disease Control Section Chief that they were notified the night before of 3 positive cases and now 10 more this morning along with 2 hospitalizations. The LaSalle County Health Department noted that they sent all current guidance.
12:53 PM	The email from the LaSalle County Health Department was forwarded to the IDPH Director and the State Medical Officer.
2:44 PM	The State Medical Officer replied to the IDVA Chief of Staff’s email from the previous day at 1:59 PM. The State Medical Officer stated “Thank you [REDACTED] – it sounds as if you are taking all of the appropriate steps.”
2:46 PM	The State Medical Officer forwarded the LaSalle County Health Department email to the IDPH Director and noted that the IDVA Chief of Staff notified the First Assistant Deputy Governor and that it sounded like he was taking “all of the appropriate steps.”
2:48 PM	The IDVA Public Information Officer emailed the two Communications Directors at the Governor’s office and reported the outbreak at the LaSalle Veterans’ Home. The email noted that 11 residents and 3 employees tested positive.
2:55 PM	The IDVA Chief of Staff emailed the State Medical Officer that there were 11 residents and 3 staff with COVID. He noted that all but one were from the West wing and all residents had been swabbed and were at the lab in Chicago. Additionally, he noted that the employees would be tested “today/tomorrow” and would be delivered to the lab on Wednesday.

4:06 PM	IDPH Siren Notification issued for Region 2; as of November 4, 2020, long-term care facilities must suspend indoor visitation and off-site outings.
4:57 PM	The LaSalle Home Administrator emailed the IDVA Labor Relations Administrator and copied the IDVA Chief of Staff and reported 11 positive residents (2 were in the hospital) and 2 additional residents were in isolation pending test results. There were also 5 staff positives with 11 in quarantine with exposure or symptoms.
8:58 PM	The First Assistant Deputy Governor for Health & Human Services emailed the IDVA Chief of Staff and asked, “Do you need any extra support from DPH re LaSalle? Have you been able to connect with the State Medical Officer?”
<b>Tuesday, November 3, 2020</b>	
7:34 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and asked for the total census, the numbers of tests, the number of COVID positive residents and staff, the number of tests outstanding, the number of COVID related deaths, and also any areas of difficulty.
8:47 AM	The IDVA Chief of Staff responded to the First Assistant Deputy Governor noting “I can’t think of anything specific we need at LaSalle. You’ll see shortly, it’s not improving though. I have traded emails with the State Medical Officer on getting a call with the administrators and her team but we haven’t locked in on a date/time yet.”
9:03 AM	The IDVA Chief of Staff emailed the “IDVA Homes Report” to various IDVA, IDPH, and Governor’s office staff, which included the Director of Veterans’ Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there were a total of <b>13 residents (12 current)</b> and <b>10 staff (5 current)</b> with positive cases as well as 3 residents hospitalized.
10:02 AM	The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting that all tests were at the lab. It was also reported that the total census was 128 and there were 12 positive residents and 5 positive staff.
10:36 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and asked the following: <ul style="list-style-type: none"> <li>• Are any of the 12 residents who tested positive experiencing symptoms?</li> <li>• Were the 12 residents who tested positive on the same unit?</li> <li>• Were the staff on the same unit?</li> <li>• I’m guessing positive staff are quarantining for 14 days, can you confirm?</li> <li>• How are you isolating the residents?</li> </ul>
12:04 PM	The LaSalle Home Administrator responded to the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting that all 12 experienced symptoms, residents were from the same unit but were now seeing symptoms elsewhere, one nurse from the west seemed to be the source, positive staff were quarantining for 10 days with the last 24 hours being symptom free, and residents were isolated in the negative pressure wing.
4:51 PM	The LaSalle Home Administrator emailed supervisory staff and asked them to pass the email and an attached family update letter on to their staff. The email noted there were now 22 positive residents and 7 positive employees. The Administrator stated: “Please, keep your chins up, keep working hard. We will get through this! This team is amazing! This virus is ruthless and tenacious and it never rests so don’t look down on our efforts – we held on a LONG time! Illinois is full of hot spots – not one region in the state is not in some level of mitigation again for increased positivity rates or hospitalization. Don’t give up! We still have to fight back and push this virus back out of our doors. During this outbreak, all staff should be wearing their masks and face shields at all times when in the building. If you are in an office position, you can remove them when you are at your desk. Additionally, all staff should restrict movement within the building. If you need someone in an office, call them – do not go to the office. All residents are again quarantined to their rooms, so if you do not have to see a resident, you should not be on a residential wing. Take your breaks alone – it is a small sacrifice we can make. Continue to follow all infection control guidance from us and from Public Health both here and at home. If you have any questions or concerns, please call me. Thank you for all you do. Thank you for not giving up. Thank you for taking care of our Veterans – they need us now more than ever!”
5:33 PM	The LaSalle Home Administrator responded to the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting they ended the day with 22 positive residents, who were all moved to isolation in negative pressure rooms, and there were 7 positive staff.

5:33 PM	The LaSalle Home Administrator emailed the Daily Report to the IDVA Chief of Staff. The Report showed that there were 22 positive residents and 7 positive staff.
<b>Wednesday, November 4, 2020</b>	
7:59 AM	The LaSalle Home Infection Control Nurse emailed the current COVID positive line list to the LaSalle County Health Department. The list contained the names of 20 residents and 7 staff.
8:30 AM	The IDVA Chief of Staff emailed the “IDVA Homes Report” to various IDVA, IDPH, and Governor’s office staff, which included the Director of Veterans’ Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there was a total of <b>23 total (22 current) residents</b> and <b>12 (7 current) staff</b> with positive cases as well as 3 residents hospitalized.
3:56 PM	The LaSalle County Health Department emailed the LaSalle Home’s Infection Control Nurse and provided information which outlined guidelines for asymptomatic exposed healthcare workers to work under modified quarantine. The email stated “as soon as they show symptoms or tested positive, they were out for a 10 day isolation. Any staff under modified quarantine needs to understand that they’re only allowed to work and go home. No grocery stores, no friend’s houses, etc.”
4:37 PM	The LaSalle Home Administrator emailed the Daily Report to the IDVA Chief of Staff. The Report showed that there were <b>36 positive residents and 8 positive staff</b> .
<b>Thursday, November 5, 2020</b>	
7:47 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and asked if the facility had PPE and if there were any staffing concerns. It was indicated that during the Manteno outbreak, Manteno received help for staff issues from IDPH. The Specialist also asked whether 3 were still hospitalized.
8:46 AM	The IDVA Chief of Staff emailed the “IDVA Homes Report” to various IDVA, IDPH, and Governor’s office staff, which included the Director of Veterans’ Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there were a total of <b>45 total (44 current) residents</b> and <b>14 (9 current) staff</b> with positive cases as well as 3 residents hospitalized. He noted that employee tests would be “dropping today.”
9:08 AM	An IDPH Siren Notification was issued on Ventilation Systems Guidance During COVID-19.
9:30 AM	The LaSalle Home Administrator responded to the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting they couldn’t get a lead on true medical “N95s” and the stock was “critically low.” It was also reported that staffing was getting challenging and that they would let them know if they need anything else. Finally, it was reported that there were 44 residents and 8 staff positive and staff samples were being sent to the “Chicago IDPH lab today.”
10:37 AM	The LaSalle Home’s Director of Nursing emailed the Home’s Infection Control Nurse and asked, “What do you think about having West staff wear full PPE since they are the hot spot, and we will be expanding over to West B hall?”
10:53 AM	The LaSalle Home’s Infection Control Nurse responded to the Director of Nursing’s PPE question stating, “Might as well.”
12:43 PM	The LaSalle Home’s Infection Control Nurse emailed the COVID positive line list to the LaSalle County Health Department. The line list showed 44 positive residents and 11 positive staff.
3:53 PM	The LaSalle Home Administrator emailed supervisory staff stating the following: “Hi all! It is has been quite a whirlwind this week! I have heard “wildfire” a lot this week and it’s a pretty accurate description of our current circumstances. As of the time I’m typing this, we have 48 positive residents and 11 positive staff members. If you have been a direct exposure to anyone, you have been contacted. At this point, staffing is critical so we are utilizing critical infrastructure guidelines – this means that if you are not symptomatic, but are a known exposure, we can ask you to continue to work. If at any time you become symptomatic, you report it immediately and go home. Everyone, whether exposed or not, should already be monitoring themselves for symptoms at least 3 times each shift. I keep a log of my temps and symptoms in my office and you should all have the same. Staff on the floor/other departments log per their department rules. The key is that we are ALL doing it at least 3 times each shift. I do not want anyone to underestimate any symptoms. Please report them immediately and you will go home and contact your own physician for next steps. This does not mean that we sent you home so you automatically get COVID pay. It has to be because you are a known 1st hand exposure or you are COVID positive yourself. And both of these have to have documentation to support. As always if you have any questions or



	concerns, please let me know. Thank you for your continued hard work and dedication to our Veterans!”
5:30 PM	The LaSalle Home Administrator emailed the Daily Report to the IDVA Chief of Staff. The Report showed that there were <b>48 positive residents and 12 positive staff</b> . There were 195 staff and 90 resident tests still pending.
5:31 PM	The LaSalle Home Administrator responded to the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting 48 residents and 12 staff were positive and 3 residents were hospitalized.
<b>Friday, November 6, 2020</b>	
9:02 AM	The IDVA Chief of Staff emailed the “IDVA Homes Report” to various IDVA, IDPH, and Governor’s office staff, which included the Director of Veterans’ Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there were a total of <b>49 total (48 current) residents</b> and <b>17 (12 current) staff</b> with positive cases as well as 3 residents hospitalized. He also noted that there were 282 tests pending (192 staff and 90 residents).
11:05 AM	IDVA officials responded to a media inquiry about the LaSalle outbreak. The response noted the 49 residents and 17 staff testing positive for COVID. It further noted that those positive were being isolated and monitored for symptom and all families had been notified.
3:17 PM	The LaSalle Home’s Infection Control Nurse emailed the LaSalle Home Administrator, the Director and Assistant Director of Nursing, and other supervisory staff that currently there were 54 quarantined employees.
3:47 PM	The LaSalle Home’s Dietary Manager emailed the LaSalle Home Administrator that she was not aware that the A Hall of the West wing was now being used for isolation. The Dietary Manager also indicated that the Home’s Infection Control Nurse was not aware either.
4:43 PM	The IDVA Chief of Staff emailed the IDPH Public Health Educator that there were issues with their data and he might not have an update until “nearly noon tomorrow.”
6:11 PM	The State Medical Officer emailed the IDVA Chief of Staff about trying to set up weekly IDPH/IDVA COVID-19 meetings. Monday afternoon meetings were proposed.
7:03 PM	The IDPH Public Health Educator replied to the IDVA Chief of Staff that the IDPH Director hadn’t been requiring them to report on weekends, “unless there are major changes.”
<b>Saturday, November 7, 2020</b>	
9:32 AM	The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting “Overnight we got several more results. We do not have all employee back yet, but our staffing is now critical. Currently 60 positive residents and 43 employees. Four of those residents are in the hospital.”
11:34 AM	IDVA Chief of Staff emailed IDPH Lab Manager and copied the State Medical Officer noting there was a “major outbreak” at the LaSalle Home. He noted that half of the residents were positive based on the prior week’s testing and that nearly 1/3 of the staff were positive. He noted that they were testing that day and were planning to send 67 more tests for residents on Sunday morning and asked if the lab was still open from 8 AM to 8 PM.
11:38 AM	The IDVA Chief of Staff emailed the IDPH Public Health Educator that LaSalle had 31 employees come back positive overnight. He noted specifically, “We’re currently at <b>60 residents and 43 employees positive</b> . We still have 101 employees tests pending (the Chicago lab is really slow). We will be re-testing all the negative residents again and sending to the Springfield lab tomorrow”
11:50 AM	The IDVA Chief of Staff emailed the IDVA Public Information Officer and the two Communications Directors at the Governor’s office and copied the Deputy Governor, the First Assistant Deputy Governor, the IDVA Director and Assistant Director, and the IDVA Labor Relations Administrator and informed them of the increase in positive residents from 48 to 60 and employees from 12 to 43. He further noted that there were four residents hospitalized and they were waiting for over 100 employee tests to come back from the IDPH lab.
11:52 AM	The IDPH Lab Manager replied to IDVA Chief of Staff and the State Medical Officer that the lab was open from 10-2 and noted, “We do have a bit of a backlog but we will get to them as soon as we can.”
2:14 PM	The IDPH Public Health Educator replied to the IDVA Chief of Staff that she would let the Director’s office know about the increase in positive residents and employees noted in the 11:38 AM email.

Sunday, November 8, 2020	
7:01 AM	The LaSalle Home Administrator emailed the IDVA Chief of Staff reporting that 2 residents had passed.
10:40 AM	The IDVA Chief of Staff emailed the IDVA Public Information Officer and the two Communications Directors at the Governor’s office and copied the Deputy Governor, the First Assistant Deputy Governor, the IDVA Director and Assistant Director, and the IDVA Labor Relations Administrator and informed them of the 2 resident deaths and that he believed there were some additional positives.
10:44 AM	The IDVA Chief of Staff emailed the State Medical Officer and copied the First Assistant Deputy Governor for Health & Human Services and noted the deaths of 2 residents. He also noted that there were still 4 in the hospital.
11:30 AM	The IDVA Chief of Staff emailed the IDPH Public Health Educator and reported that tomorrow’s report would include 2 COVID positive resident deaths at LaSalle and another 18 staff positives. There were now 59 residents and 61 employees positive.
1:13 PM	The State Medical Officer emailed IDVA Chief of Staff that <b>she was sorry to hear about the deaths and thanked him for letting her know.</b>
1:41 PM	The IDPH Public Health Educator responded to the IDPH Chief of Staff and noted, “Wow, this poor facility. I will pass this on to the director’s office.”
7:57 PM	The LaSalle Home Administrator emailed the IDVA Chief of Staff reporting that an additional resident passed.
9:01 PM	The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital and reported a census of 125, 59 positive residents (3 hospitalized), and 65 positive employees. Three resident deaths over the last 24 hours were also reported.
9:27 PM	The LaSalle Home Administrator emailed supervisory staff stating the following: “I’m looking back through emails and notes for the past few days and realize I have not sent one of these updates since Thursday. I am sorry for that. Our reality is very different today than Thursday. Currently, we have 59 residents who are positive for COVID – 3 of them are in the hospital. Sadly, 3 Veterans have died in the last 24 hours. We have 65 employees who are positive for COVID. And I know others are not feeling well. This puts our staffing in a critical situation. A new letter will go to families, residents, and all of you tomorrow. Right now, we have resident tests at the lab for processing and I am checking for results frequently. Tomorrow, we are testing all employees again – I hope you all can get there. This is so important and the sooner we get you all tested, the sooner we get results. Do everything you can to be here, please. When your results go to the lab, it can take 72 hours for those results to be released. On our normal testing schedule, you could test on Tuesday and the sample is not even delivered to the lab until Thursday. This is very frustrating, I know, and it causes a great deal of anxiety. I understand the wait can be miserable, so I will do my best to answer your calls or texts. Please know that if your result comes back positive, I WILL CALL YOU, no matter what time it is. So if you don’t get that call, your results are either negative or incomplete. The bad news is, this virus has hit us hard all at once. The good news is, the wave should recede in about a week. We just have to hang on. Keep doing your best, keep showing up – all for the Veterans who need us now more than ever. If you have a skill that can be used to care for them, please use it. We need ALL HANDS ON DECK to make it through this. As always, if you have any questions, please let me know. I am here to support you any way that I can. <b>redacted</b> is my cell number and you can check in with me any time. THANK YOU, THANK YOU, THANK YOU for ALL you are doing and the many hours you are giving.”
Monday, November 9, 2020	
8:28 AM	The IDVA Public Information Officer emailed the IDVA Chief of Staff and asked if there was anything new happening.
8:29 AM	The IDVA Chief of Staff responded to the IDVA Public Information Officer, “Yes. Coming soon, more staff, more residents and another death.”
8:51 AM	The IDVA Chief of Staff emailed the State Medical Officer and asked for guidance on BinaxNOW rapid tests.
9:00 AM	The State Medical Officer emailed point-of-care antigen testing guidance and asked if they could begin recurring meeting later that day at 1:00.
9:06 AM	The IDVA Chief of Staff emailed the “IDVA Homes Report” to various IDVA, IDPH, and Governor’s office staff, which included the Director of Veterans’ Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there

	were a total of <b>63 total (59 current) residents</b> and <b>70 (65 current) staff</b> with positive cases. He reported <b>3 deaths</b> as well as 3 residents hospitalized. He also noted that there were 66 tests pending (65 staff and 1 resident).
10:35 AM	The IDVA General Counsel emailed the IDVA Chief of Staff and asked what was being done about staffing at LaSalle.
10:36 AM	The LaSalle Home’s Infection Control Nurse emailed the LaSalle County Health Department informing them of 3 deaths over the weekend.
10:55 AM	The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital and reported they were working through staffing issues and at that point were not requesting any additional staff.
10:59 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital responded to the LaSalle Home Administrator asking, “[W]ould you like a[n] infection control consultation?”
12:55 PM	The LaSalle Home Administrator replied to the Health System Specialist to the Associate Director from the Hines Veterans Hospital question about an infection control consultation and stated, “I think that would be a good thing.”
12:56 PM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital responded to the LaSalle Home Administrator, “I will get that moving.”
2:18 PM	An email from the IDVA Chief of Staff responding to media questions was shared with the Deputy Governor, the First Assistant Deputy Governor, the communications and public information officers from the Governor’s office and IDVA. The email noted 67 employees and 64 residents (over 1/2) were positive with COVID. It also noted 3 resident deaths.
2:30 PM	The Deputy Governor for Health & Human Services emailed the IDVA Chief of Staff, the First Assistant Deputy Governor, and the communications and public information officers from the Governor’s office and IDVA the following inclusions to the previous email: <ul style="list-style-type: none"> <li>• They are doing no more admitting, no visitors as of Friday.</li> <li>• In addition to regular PCR testing to DPH labs, they are also going to ramp up the use of more antigen faster time tests.</li> <li>• They have segregated staff and residents into the covid wing who are positive.</li> <li>• Reinforced all of the safety measures to employees for their personal lives.</li> <li>• They also have 3 residents currently hospitalized.</li> </ul>
2:33 PM	The Deputy Governor for Health & Human Services emailed IDPH’s Chief of Testing and the IDVA Chief of Staff and copied the IDPH Chief of Staff requesting that BinaxNOW tests be shipped “asap” to DVA homes with prioritization being LaSalle.
3:15 PM	The LaSalle Home Administrator emailed the IDVA Chief of Staff and the IDVA Public Information Officer and discussed questions from families. The theme of the questions was related to how the Home was continuing to take care of residents with so many sick staff members. The email noted: many are working overtime; other departments are helping with what they are able to; some staff who are not having serious symptoms are working as able in the isolation unit; and 69 is a large number, but our total number of employees is over 200 and not all of the positives are nursing staff.
3:48 PM	A LaSalle Home staff member emailed an updated room roster to the Home management and noted that this list is “fluid” but “people have been talking all day about how they don’t know where people went, they cannot keep track of things, etc.”
5:12 PM	The IDPH Chief of Testing replied to the Deputy Governor’s 2:33 PM email that “we can make that happen.”
5:37 PM	The IDVA Chief of Staff emailed the LaSalle Home Administrator that they would receive two batches of 640 antigen tests.
5:44 PM	The IDVA Chief of Staff emailed the IDPH Chief of Testing and specifically asked that, per their earlier conversation, two cases of antigen tests (one asap and one to follow) be sent to the LaSalle Home.
6:33 PM	The IDPH Chief of Testing emailed the IDVA Chief of Staff noting that they would get the tests in tomorrow’s shipment.
6:39 PM	The Illinois Association of County Veterans Assistance Commissions, Kane County, emailed the IDVA Director and Assistant Director and offered to help collecting PPE, transporting supplies, collecting needed items for residents, or whatever else within their capabilities.

8:59 PM	The IDVA Chief of Staff emailed the IDVA Director regarding the Kane County email and noted: “Thank him for the outreach. We’re honestly good on PPE and supplies. I think anything they can do to promote the communities around our homes to follow the mitigations is the more helpful.”
9:08 PM	The IDVA Assistant Director replied to Kane County: “Thank you very much for the offer. We truly appreciate you reaching out and offering assistance. We will keep you in mind as we continue to work through all of our options and contingencies at LVH.”
9:10 PM	The IDVA Chief of Staff emailed the State Medical Officer and copied the IDVA Director, the Deputy Governor, the First Assistant Deputy Governor, and the IDPH Chief of Staff about the LaSalle Home. His email stated the following: <b><u>the virus had moved “very aggressively” through the Home and he wanted to see if the State Medical Officer thought it would be beneficial for one of her staff to visit and “advise review” if there are additional mitigations they should be doing.</u></b>
<b>Tuesday, November 10, 2020</b>	
6:32 AM	A Hines Manager from the Infection Control Section emailed the LaSalle Home Administrator and asked about setting up a time to speak late in the day to see how they could assist.
7:32 AM	The LaSalle Home’s Infection Control Nurse emailed the LaSalle Home Administrator and the LaSalle Director and Assistant Director of Nursing a copy of the current line list which showed a total of 72 residents and 69 staff that were positive for COVID-19.
7:58 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and asked for the total census, the numbers of tests, the number of COVID positive residents and staff, the number of tests outstanding, the number of COVID related deaths, and also any areas of difficulty.
8:31 AM	The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting the total census was 122 and there were 64 positive residents (6 deaths and 4 currently hospitalized), 69 positive staff, and 2 resident and 140 staff tests out.
8:57 AM	The LaSalle Home Administrator emailed the IDVA Chief of Staff and reported there were 64 positive residents, 69 positive staff, 3 residents in the hospital, and 6 deaths.
9:10 AM	The LaSalle Home’s Infection Control Nurse emailed the LaSalle County Health Department and noted there were 3 additional deaths in the last 24 hours.
9:26 AM	The IDVA Chief of Staff emailed the “IDVA Homes Report” to various IDVA, IDPH, and Governor’s office staff, which included the Director of Veterans’ Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated that there were a total of <b>68 total (64 current) residents</b> and <b>70 (65 current) staff</b> with positive cases. He reported <b>6 total deaths</b> as well as 4 residents and 1 staff hospitalized.
9:34 AM	The LaSalle Home Administrator emailed the Director and Assistant Director of Nursing and the Infection Control Nurse and noted that the Home’s Medical Director was planning to come in that morning to meet with them. They were to discuss staffing and moves after isolation.
10:15 AM	The IDVA Chief of Staff emailed the IDPH Public Health Educator and clarified that there were 3 deaths on the previous day’s report and 3 more overnight for a total of 6.
12:42 PM	The First Assistant Deputy Governor emailed the IDVA Chief of Staff to “Please call me asap.”
1:04 PM	The LaSalle Home Administrator emailed the IDVA Chief of Staff and the IDVA Public Information Officer noting “I am going to be calling all the families and I need some ideas for how to handle these questions please.”
1:26 PM	The LaSalle Home Administrator emailed supervisory staff stating the following: “These are sad days at IVHL. We have lost 6 Veterans to this awful virus. I know we all mourn together and I want to tell you all how sorry I am for your loss. I know these Veterans become family when they are here and this is just so much loss in a short period of time. I am working with IDVA to have some assistance for us to cope with this and I hope you will all continue to be supportive of your co-workers as they travel this journey as well. We will get through this together. As always, if you have any questions, concerns, or just need someone to shout at/cry at whatever, I am here for you.”
<b>Wednesday, November 11, 2020</b>	
9:05 AM	The State Medical Officer emailed the IDVA Chief of Staff responding to his request to possibly have IDPH staff visit the LaSalle Veterans’ Home. The State Medical Officer responded, “yes, certainly,” and noted that she had copied two infection preventionists who could help. She asked in the email whether one of the preventionists would be able to visit.

9:05 AM	An automatic reply was returned that one of the preventionists was out of the office for Veterans Day.
10:36 AM	The IDPH Chief of Staff emailed the State Medical Officer and the IDPH Communicable Disease Control Section Chief and asked them to arrange for one of the infection control specialists to “be at IVHL tomorrow, Friday at the latest.”
10:37 AM	The State Medical Officer emailed the IDPH Chief of Staff and responded that “this is already underway.”
10:43 AM	The IDVA Chief of Staff emailed the State Medical Officer and copied the Deputy Governor and First Assistant Deputy Governor, noting that the Medical Director at the LaSalle facility was asking about trying to obtain monoclonal antibody treatments.
10:45 AM	The IDPH Chief of Staff emailed the State Medical Officer asking her to call him regarding his previous email about getting an infection control specialist on site.
10:46 AM	The IDVA Chief of Staff emailed the State Medical Officer and copied the Deputy Governor and First Assistant Deputy Governor, noting that the Medical Director was told there were 6,500 doses (of monoclonal antibody treatments) sent to the State and asked if any would be available for the veterans’ homes.
10:46 AM	The State Medical Officer emailed IDPH Chief of Staff noting that an Infection Control Consultant was working on the situation that morning with the local health department. The State Medical Officer stated that she would share the findings and recommendations when she received them.
11:29 AM	The LaSalle Veterans’ Home’s Infection Control Nurse emailed the LaSalle Home Administrator and the Infection Control Consultant the current line list. The list showed 81 residents and 74 staff with COVID-19.
11:34 AM	The LaSalle Veterans’ Home’s Infection Control Nurse emailed the line list to the LaSalle County Health Department and reported another resident death.
11:37 AM	The Infection Control Consultant emailed the State Medical Officer and the IDVA Chief of Staff that she spoke to the LaSalle Veterans’ Home Infection Control Nurse and the LaSalle Home Administrator. It was noted that the outbreak was large and came on rather quickly. It was reported that staffing was tight, their supply of PPE was adequate, employees were wearing full COVID PPE throughout the entire building, the facility was using KN95 masks in non-COVID rooms and fit tested N95 respirators in COVID rooms, negative pressure rooms were being used for residents who were actively coughing. The Consultant concluded that the “processes being done are sound” and that the [Infection Control Nurse] at the Home will reach out with any questions, and “at this time feels they are doing okay and doesn’t feel the need for someone to visit.” The Consultant stated: “Just feels like it came on quickly and hoping it will calm down just as quick. I will reach out in a day or two and see if he has additional needs.”
11:59 AM	The State Medical Officer emailed the Infection Control Consultant and IDVA Chief of Staff and asked the Consultant if she had “a sense for how the outbreak got so large so quickly?” The State Medical Officer also noted that she spoke to the IDPH Chief of Staff and he told her the Governor was very concerned and wanted IDPH to visit the Home.
12:11 PM	The Infection Control Consultant emailed the State Medical Officer and provided the names of two individuals who might be able to go conduct a site visit.
1:05 PM	The IDPH Communicable Disease Control Section Chief emailed the State Medical Officer that one of the preventionists was able to go as early as tomorrow (November 12, 2020).
1:58 PM	The LaSalle Home Administrator emailed the Infection Control Nurse and the Director and Assistant Director of Nursing and stated “We can bring people back early from quarantine if they are well enough OR have positive staff work if they are well enough, but we need to go through our local health department, give names of the employees to them and get documented approval. I would say the employee name, positive test date, symptom onset date (if different) and current symptom status.”
2:01 PM	The IDVA Chief of Staff replied to the 11:59 AM email from the State Medical Officer which noted “the sooner the better” and there were 12 more positive employees from the tests from yesterday. He also stated: “Not exactly sustainable but I’m thinking about doing antigen tests at shift changes.”
2:06 PM	The State Medical Officer emailed IDVA Chief of Staff that the IDPH Infection Control Coordinator would be at the Home tomorrow.
2:16 PM	The State Medical Officer responded to the IDVA Chief of Staff and copied the Deputy Governor and the First Assistant Deputy Governor regarding the monoclonal antibody treatments and stated: “Interesting question. Let me look into this – I am checking also with our CDC medical consultant.”

4:10 PM	The LaSalle Home Administrator emailed the family update letter to the IDVA Chief of Staff, the IDVA Public Information Officer, and a few other staff and copied the IDVA Director and Assistant Director. The letter reported: “Since the beginning of the crisis we have had a total of 81 positive residents and 88 positive employees. Unfortunately, seven (7) of those residents who tested positive have passed away. We are following the latest medical guidance and are working with state, federal and local health officials to ensure the continued care for all of our residents and testing and protection of anyone potentially exposed.”
8:32 PM	The First Assistant Deputy Governor emailed the IDVA Chief of Staff and copied the IDVA Director and the Deputy Governor and asked when IDPH was sending someone and who were they sending.
8:34 PM	The IDVA Chief of Staff responded that someone would be there tomorrow and mentioned the IDPH Infection Control Coordinator and possibly the State Medical Officer.
<b>Thursday, November 12, 2020</b>	
7:48 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and asked for the total census, the numbers of tests out, total number of deaths, and number of COVID positive residents and staff. It was also asked if they had any PPE, staffing, or testing difficulties.
7:52 AM	The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting that when she left the night before there were 74 positive residents (3 in the hospital), and 88 positive staff. The census was reported to be 121.
7:55 AM	The IDPH Communicable Disease Control Section Chief emailed the LaSalle County Health Department informing that IDPH would be onsite arriving shortly after noon.
7:55 AM	The Hines Infection Control Manager emailed the LaSalle Home Administrator that her arrival time was 9:15-9:30.
7:58 AM	The LaSalle Home Administrator responded to the Hines Infection Control Manager that IDPH would also be there.
8:00 AM	The LaSalle Home’s Infection Control Nurse emailed the LaSalle County Health Department and copied the LaSalle Home Administrator and the Director and Assistant Director of Nursing informing them of 2 deaths over the last 24 hours.
9:24 AM	The IDVA Chief of Staff emailed the “IDVA Homes Report” to various IDVA, IDPH, and Governor’s office staff, which included the Director of Veterans’ Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there were a total of <b>73 positive residents</b> and <b>88 positive staff</b> . He reported <b>9 total deaths</b> as well as 3 residents and 1 employee hospitalized.
1:28 PM	The IDVA Chief of Staff emailed the State Medical Officer and copied the Deputy Governor and First Assistant Deputy Governor and asked if there were any thoughts on the monoclonal antibody treatments.
1:37 PM	The First Assistant Deputy Governor responded to the 1:28 PM email and noted that she added the IDPH Chief of Staff and that “the feds are in the early stages of distributing this and it will first go to hospitals. DPH is currently working out a distribution process. I don’t think the state has even received any yet.”
1:46 PM	The State Medical Officer responded to the IDVA Chief of Staff, the IDPH Chief of Staff, the First Assistant Deputy Governor, and the Deputy Governor regarding the monoclonal antibody treatment and noted that they were exploring the possibility with the CDC.
1:54 PM	The IDPH Chief of Staff responded that he was working on it and “this stuff is just coming out.” He also noted there were “certain limiting parameters for its use.”
2:36 PM	The IDVA Chief of Staff emailed the State Medical Officer a general timeline of the outbreak. He also noted that the daily report was sent to the Illinois Department of Public Health, the U.S. Department of Veterans Affairs, and the Illinois Emergency Management Agency. The timeline was as follows:  <b>“October 27/28</b> – Regular employee testing was conducted and sent to the lab on October 29 <sup>th</sup> <b>October 31</b> – Overnight, a resident was sent to the local hospital for non-covid related issue. The hospital administered an antigen test which indicated the resident was positive. <b>Nov 1</b> – Administrator was notified; in turn notified COS. Direction was given to test all residents and deliver to the lab 11/2. Visitation was suspended and the admission was postponed; Reinforced all of the safety measures to employees for their personal lives.

	<p><b>Nov 2</b> – Antigen tests administered on residents showing symptoms with several testing positive as well as employees testing outside the facility positive. All positive residents moved to the West side of building into negative pressure wing.</p> <p><b>Nov 3</b> – First positive resident PCR tests coming back – 22 residents, 7 staff</p> <p><b>Nov 4</b> – 14 additional resident antigen test positive</p> <p><b>Nov 5</b> – additional resident positives</p> <p><b>Nov 6</b> – another round of staff tests shipped 48 residents; 18 staff positive</p> <p><b>Nov 7</b> – Two residents pass; multiple staff positives received.</p> <p><b>Nov 8</b> – Resident passes Current count 59 residents, 64 staff</p> <p><b>Nov 9</b> – more results - 66 resident, 69 employees two residents pass; retesting (PCR) of residents</p> <p><b>Nov 10</b> – Two residents pass – USDVA conducts call with facility to review policies/protocols. Request made for DPH onsite visit.</p> <p><b>Nov 11</b> – DPH conducts call with facility to review policies/protocols. DPH and USDVA schedule onsite visits. Additional residents and employees positive 82 residents (minus 7 deceases – 75 active) and 88 employees positive</p> <p><b>Nov 12</b> – two residents pass (total 9)”</p>
3:26 PM	The IDVA Chief of Staff emailed an updated template for the daily report to the four veterans’ homes.
4:04 PM	The LaSalle Home Administrator provided an updated family letter that reported a total of 82 positive residents and 89 positive staff. It also noted 10 resident deaths.
5:29 PM	<p>The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting that: “Last night to today we lost 3 more residents. I have all of that information below. Our census is 118. Today we have 89 positive staff and 72 positive residents, 6 of whom are in the hospital. (An increase of 2 positive cases)</p> <p>[The Infection Manager] was here today and it was great to hear from her – she is so knowledgeable! We discovered that the dispensers on our walls do not have alcohol-based hand sanitizer. We do have, and have had, the correct kind of hand sanitizer out for use, but these wall mounted ones need to be replaced. We received antigen tests today from IDPH and have started doing testing on staff at the start of their shift. We just did our first round – oncoming and outgoing at 3 p.m. and no positive results were revealed.”</p>
6:00 PM	The IDPH Division Chief of Emergency Medical Services and Highway Safety emailed the State Medical Officer, the IDPH Chief of Staff, the Deputy Governor, and the First Assistant Deputy Governor and noted the State had been allocated 6,380 vials of the (monoclonal antibody) treatment and they were waiting on a survey from health systems and hospitals, due the next day, to determine the allocation methodology.
8:51 PM	The IDPH Chief of Staff emailed the State Medical Officer and asked if she had received any feedback from the site visit.
9:25 PM	The State Medical Officer responded to the IDPH Chief of Staff that the “source of the outbreak appears to be staff complacency.” She noted staff had not been wearing masks or social distancing and had been gathering in the parking lot and in the lunch room, and socializing.
<b>Friday, November 13, 2020</b>	
7:35 AM	The State Medical Officer emailed IDPH Director and provided her with an update on the outbreak at LaSalle and noted the draft site visit report would be coming out later in the day. The State Medical Officer noted that the IDVA Chief of Staff told her that the veterans’ homes were all located in parts of the state where they were not taking the virus seriously.
9:05 AM	<p>The IDPH Infection Control Coordinator emailed the site visit report to the State Medical Officer and the IDPH Communicable Disease Control Section Chief. First, it was noted that the LaSalle Home Administrator and the local health department reported that delays and barriers to mitigation were due to asymptomatic residents and staff as well as the lengthy testing turnaround time. Contributing factors included:</p> <ul style="list-style-type: none"> <li>• delayed implementation of mitigation efforts with contact tracing, exclusion, and testing of residents and staff;</li> <li>• delay in receiving test results;</li> </ul>

	<ul style="list-style-type: none"> <li>• delay in contact tracing to identify close contacts to be excluded, tested and quarantine when initial cases were identified;</li> <li>• staff gatherings outside of facility- Halloween party off grounds hosted and attended by multiple staff;</li> <li>• staff self reporting and ignoring minor symptoms;</li> <li>• as observed staff congregating and not adhering to social distancing; and</li> <li>• ineffective substance for hand hygiene.</li> </ul> <p>The report also noted that overall the facility was very receptive and the veterans are being well cared for by the nursing staff. The Infection Control Coordinator noted, “the dedication to the health, safety and well-being of the Veterans was obvious via my personal observation and interviews. The staff is devastated by the loss of their Veterans. It is also important to note that some of the veterans had prior directives regarding resuscitation.”</p>
9:16 AM	<p>The IDVA Chief of Staff emailed the “IDVA Homes Report” to various IDVA, IDPH, and Governor’s office staff, which included the Director of Veterans’ Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health &amp; Human Services. The email stated: that there were a total of <b>83 total (82 current) residents and 93 (88 current) staff</b> with positive cases. He reported <b>11 total deaths</b> as well as 3 residents and 1 employee hospitalized.</p>

**COVID-19 Site Visits at the LaSalle Veterans’ Home**

An initial site visit was conducted by the U. S. Department of Veterans Affairs in collaboration with IDPH on November 12, 2020. Additionally, IDPH conducted a follow-up site visit on November 17, 2020. Following these initial site visits, investigations were also conducted by the Department of Human Services Office of the Inspector General and by the Illinois Department of Labor, Division of Occupational Safety and Health.

The November 12th initial site visit identified issues in the following areas: insufficient staff and visitor screening; the timeliness of receiving testing results; limited housekeeping which included use of the wrong hand sanitizer; negative pressure rooms which failed qualitative tissue testing; and improper PPE usage.

The November 17th follow-up visit identified improvements in the following areas: contingency capacity strategies for staffing were in place; all staff providing direct resident care were wearing disposable face shields, gowns, masks, and head and foot coverings; the Home discontinued the use of Viri-Masks; wall-mounted dispensers which previously contained an alcohol-free hand sanitizer were empty and were labeled “Do not use;” screenings for symptoms were conducted verbally and face-to face; and PCR tests for staff were being done at weekly intervals on Mondays, Tuesdays, and Wednesdays and were scheduled to begin testing twice per week at the time of the visit. The Home had also initiated daily pre-shift testing with BinaxNOW COVID-19 lateral flow antigen test cards. (pages 52-56)

**DHS Office of the Inspector General Investigation at the LaSalle Veterans’ Home**

On April 26, 2021, the Illinois Department of Human Services’ Office of Inspector General (DHS OIG) released a report summarizing its investigation of the fall 2020 COVID-19 outbreak at the LaSalle Veterans’ Home. The Governor requested the DHS OIG conduct an investigation into the outbreak at the Home, and the DHS OIG retained a law firm to assist it in investigating the circumstances surrounding the outbreak and with drafting its report.



**The DHS OIG relied heavily on testimonial evidence from interviews to support its findings, as is evident by the numerous quotes and testimonial evidence presented throughout the report.** Interviews were conducted with personnel from both IDVA and IDPH. The report stated that the interviews revealed concerns about the Home’s operations and leadership in the months before the outbreak, revealing operational deficiencies and unpreparedness, including: the absence of any outbreak plans and insufficient COVID-19 policies; a failure to communicate with, train, and educate staff members concerning COVID-19 policies; and repeated non-compliance with personal protective equipment (PPE) and infection control protocols. The report also concluded that the inadequate response by the LaSalle Home was due to corresponding failures in the executive leadership at IDVA and there was a relaxing of quarantine policy at the LaSalle Veterans’ Home for residents returning from St. Margaret’s Hospital sometime during the summer of 2020.

**Pursuant to the Intergovernmental Agreement entered into with IDVA, the Department of Human Services (DHS), and the Office of the Governor, the scope of the DHS OIG investigation was narrow and focused specifically on IDVA officials and LaSalle Veterans’ Home management.** Additionally, since the DHS OIG relied heavily on interviews to support its findings, auditors attempted to identify documentary evidence to corroborate the DHS OIG report’s findings. Auditors found that the documentation collected from IDPH, IDVA, and the LaSalle Veterans’ Home was contrary to many of the statements used by the DHS OIG to reach its conclusions.

The DHS OIG investigation reported that the significance of the outbreak was not being meaningfully tracked by the IDVA Chief of Staff. **In fact, auditors found the Chief of Staff provided detailed information to IDPH that was used by the Director of IDPH in her daily COVID-19 briefings.** IDPH and the First Assistant Deputy Governor for Health & Human Services were provided detailed emails of COVID-19 positive cases and related deaths for each of the four State veterans’ homes by IDVA on November 2nd, 3rd, 4th, 5th, 6th, 9th, 10th, 12th, and 13th.

Further, the primary finding of the DHS OIG report, which indicated the “absence of any standard operating procedures in the event of a COVID-19 outbreak,” was also flawed. **Auditors identified hundreds of pages of guidance provided by IDPH and by the CDC.** In addition, COVID-19 policies were formulated by IDVA specifically for the LaSalle Veterans’ Home as well as a Continuity of Operations Plan that was reviewed by IEMA and was provided to IDPH back in March 2020. Also, the LaSalle County Health Department provided IDPH COVID-19 specific policies to the LaSalle Home on November 2nd, at the beginning of the outbreak. Additionally, according to the current Director of Nursing at the Home, binders with policies and specific guidance were available at each nursing station. Many of these policies required general infection control that was already in place at the time and would have been standard practice for healthcare professionals who work in congregate care settings.

**The DHS OIG concluded that the lack of policies and procedures “was a significant contributing factor to the Home’s failure to contain the virus.”**

Auditors identified numerous policies and procedures. Therefore, there was no evidence to support that a lack of policies and procedures resulted in a failure to contain the virus. The virus hit the Home very quickly with a large number of residents and staff positive within a few days. As a result, it was unclear whether non-adherence to policy caused the virus to spread so quickly or whether the rapid spread was due to other factors. These factors include: a rumored outside gathering of employees; a Halloween parade at the LaSalle Home; or possibly the high positivity rate during that time in the community. An additional potential cause may have been that guidelines during that time did not require rapid COVID-19 testing prior to entering the Home; therefore, asymptomatic staff possibly carried the virus into the Home from the community unknowingly. (pages 57-64)

### **Illinois Occupational Safety and Health Investigation**

A complaint was filed with the Illinois Department of Labor, Division of Occupational Safety and Health (IL OSHA) alleging the management at the LaSalle Veterans’ Home was forcing COVID-19 positive employees (mainly nurses) to still come to work. As a result, a review was conducted and determined that seven employees worked on certain days between November 6, 2020, and November 13, 2020, after testing positive for COVID-19. According to IDVA, all seven employees were asymptomatic when they worked. IDVA noted that the LaSalle Veterans’ Home followed Centers for Disease Control (CDC) guidelines to ensure that the seven employees maintained safety precautions including wearing PPE, working only in COVID-19 positive units, using separate entrances and exits to avoid contact with others, and using separate bathrooms and break areas.

IL OSHA sent a letter to IDVA on December 15, 2020, informing the agency that based on the response and information provided the case would be officially closed. (pages 65- 66)

### **Changes to Policies as a Result of COVID-19 at Illinois Veterans’ Homes**

Following site visits to the LaSalle Veterans’ Home on November 12, 2020, and November 17, 2020, as a result of a COVID-19 outbreak at the Home the same month, a collaboration of the Illinois Department of Veterans’ Affairs, Illinois Department of Public Health, and the Veterans’ Integrated Service Network 12 of the U. S. Department of Veterans Affairs created the Interagency Infection Prevention Project, whose purpose was to support an integrated and comprehensive response to COVID-19 at Illinois veterans’ homes. An initial site visit was conducted at the LaSalle Veterans’ Home on November 12, 2020, in response to the COVID-19 outbreak occurring at the Home. Subsequent announced site visits took place on November 24, 2020, and January 4, 2021, while unannounced site visits took place on November 17th and December 14, 2020.

The Interagency Infection Prevention Project drafted a report on March 9, 2021, summarizing its recommendations for addressing COVID-19 at Illinois veterans’ homes. According to the Interagency Infection Prevention Project status report, IDVA had begun implementing changes to better contain COVID-19 at all of its veterans’ homes. The team found that the Illinois Department of Veterans’ Affairs had embraced and adopted numerous recommendations from the integrated project assessment, and repeated site visits to the veterans’ homes have documented substantial improvement in infection prevention practices. The team also found that the last resident associated with the late October 2020 outbreak at the LaSalle Veterans’ Home tested positive on November 23, 2020. The next resident to test positive was on March 1, 2021, when one resident tested positive without symptoms as a result of weekly testing.

The Illinois Department of Veterans’ Affairs’ new policies for its Infection Prevention Project established updated training requirements for Illinois veterans’ homes’ staff. Additionally, new policies identified the responsibilities of specific positions within the new framework and implanted a specific training and continuing professional development program for the Illinois Department of Veterans’ Affairs and Illinois veterans’ homes staff.

According to the Illinois veterans’ homes updated policies effective April 23, 2021, all newly hired and current staff are required to receive infection prevention training upon hire and at least annually. Staff at the Illinois veterans’ homes were required to complete the Centers for Medicare and Medicaid Services trainings at the recommendation of the Illinois Department of Public Health. In addition, the Department noted that LaSalle Home staff were provided in-service training in March 2021. (pages 67-73)

### **Monitoring at the LaSalle Veterans’ Home Post-COVID-19 Outbreak**

The LaSalle Veterans’ Home has been monitored through the IDPH survey process since November 2020. Additionally, IDVA hired consultants to review the protocols at the Homes in order to identify any additional recommendations to prevent further outbreaks. IDVA also hired additional consultants to review the HVAC systems at the Homes.

A separate committee was created to provide quality assurance reviews of the LaSalle Home operations. The first meeting was conducted on February 25, 2021. According to IDVA, the committee has already recommended improvements at the Home, and will provide the foundation for implementing drills for the new policies.

The Interagency Infection Prevention Project Report from March 9, 2021, noted that repeated site visits to the LaSalle Veterans’ Home showed substantial improvement in infection prevention practices. At the LaSalle Veterans’ Home, the last new resident case associated with the facility’s November outbreak tested positive on November 23, 2020. There were no further positive tests among LaSalle residents until March 1, 2021, when one resident tested positive without symptoms during the weekly PCR surveillance. Positive cases in staff at the LaSalle Veterans’ Home also improved, with 11 employees testing positive in the

first quarter of 2021 at the time of the report, compared to 102 positive staff members in the fourth quarter of 2020. The report notes that, in December 2020, immunization became an essential tool in suppressing transmission of COVID-19. As of February 11, 2021, 95.4 percent of residents and 56.4 percent of staff at the LaSalle Veterans' Home had either received at least one dose of the vaccine or were scheduled to receive the first dose. (pages 74-76)

### **LaSalle Veterans' Home COVID-19 Costs**

The State expended approximately \$3.4 million between FY20 and FY21 as a result of the COVID-19 pandemic at the LaSalle Veterans' Home. According to documentation provided by IDPH and IDVA, expenditures included PPE, infrastructure improvements, and COVID-19 testing for both the COVID-19 pandemic as a whole and the outbreak at the LaSalle Home that began in late October 2020. Auditors concluded that the outbreak did not significantly add to the Home's overall COVID-19-related costs during FY20 and FY21. Additionally, because the amount of monthly overtime hours and costs incurred by LaSalle Veterans' Home staff fluctuated throughout FY20 (after the COVID-19 pandemic began in March 2020) and FY21, it was difficult for auditors to determine which overtime hours and costs were COVID-19-related and which were usual standard overtime costs. **Digest Exhibit 4** summarizes the costs incurred by the State for the LaSalle Veterans' Home as a result of the COVID-19 pandemic from March 2020 through June 2021. (pages 77-80)

Digest Exhibit 4  
**COSTS INCURRED BY THE STATE FOR THE LASALLE VETERANS’ HOME  
 FOR THE COVID-19 PANDEMIC**  
 For the Period March 2020 Through June 2021

Fiscal Year	Calendar Month/Year	Personal Protective Equipment (PPE) <sup>2</sup>	Infrastructure Improvements	COVID-19 Testing <sup>3</sup>	Total Costs Outbreak and Pandemic
<b>FY20</b>	March 2020	\$44,412	-	-	\$44,412
	April 2020	\$143,380	-	-	\$143,380
	May 2020	\$19,376	\$59,683	\$42,439	\$121,499
	June 2020	\$2,388	-	\$44,425	\$46,813
<b>FY21</b>	July 2020	\$88,789	\$29,841	\$56,133	\$174,763
	August 2020	\$41,108	\$7,799	\$141,325	\$190,232
	September 2020	\$5,898	-	\$110,384	\$116,282
	October 2020	\$20,266	-	\$123,659	\$143,925
	November 2020	\$55,867	-	\$114,669	\$170,537
	December 2020	\$11,159	-	\$118,746	\$129,905
	January 2021	\$37,311	\$993,923	\$129,722	\$1,160,956
	February 2021	\$21,523	\$7,369	\$141,638	\$170,530
	March 2021	\$9,825	-	\$181,569	\$191,394
	April 2021	\$7,350	\$64,104	\$167,875	\$239,330
	May 2021	\$15,024	-	\$178,642	\$193,666
	June 2021	\$12,778	-	\$122,196	\$134,973
<b>Totals<sup>1</sup></b>		<b>\$536,456</b>	<b>\$1,162,719</b>	<b>\$1,673,421</b>	<b>\$3,372,596</b>

Notes:

- <sup>1</sup> Totals may not add due to rounding.
- <sup>2</sup> The CDC defines PPE as personal protective equipment, which includes respirators or facemasks, eye protection (goggles or face shields), gloves, and gowns.
- <sup>3</sup> COVID-19 expenditures incurred by IDPH.

Source: Illinois Department of Public Health information and Illinois Department of Veterans’ Affairs.

**Reviews Since 2015**

The LaSalle Veterans’ Home was surveyed by IDPH as well as the U. S. Department of Veterans Affairs (USDVA). Since 2015, the LaSalle Veterans’ Home has been the subject of 22 IDPH surveys. Non-compliance was identified in two surveys both following the November 2020 COVID-19 outbreak. One, from November 2020, found non-compliance related to written policies related to all services provided and policies for investigating, controlling, and preventing infections. The other, from March 2021, found the facility failed to prevent abuse, failed to report potential abuse immediately, failed to immediately remove the staff member from contact with residents after a report of potential abuse, and failed to follow its policy to immediately examine a resident and immediately suspend the accused staff member for two of the three residents reviewed.

Non-compliance has been identified in 3 of the 5 annual surveys conducted by the USDVA since 2015. None of the issues identified were related to infectious diseases or infection control. (pages 81-83)

## Audit Recommendations

The audit report contains three recommendations. Two recommendations were directed to the Department of Veterans' Affairs and one was directed to the Department of Public Health. The Departments agreed with the recommendations. The complete responses from the Departments are included in this report as Appendix E.

This performance audit was conducted by the staff of the Office of the Auditor General.

**SIGNED ORIGINAL ON FILE**

---

JOE BUTCHER  
Division Director

This report is transmitted in accordance with Sections 3-14 and 3-15 of the Illinois State Auditing Act.

**SIGNED ORIGINAL ON FILE**

---

FRANK J. MAUTINO  
Auditor General

FJM:SAW

## Contents

Report Highlights	
Report Digest	iii
Introduction	1
Background	3
Illinois Veterans' Home at LaSalle	9
COVID-19 Outbreaks in Other IDVA Facilities	15
Guidance Provided to the LaSalle Veterans' Home	17
COVID-19 Testing during the Outbreak at the LaSalle Veterans' Home	21
COVID-19 Outbreak Response at the LaSalle Veterans' Home	27
COVID-19 Site Visits at the LaSalle Veterans' Home	52
DHS OIG Investigation at the LaSalle Veterans' Home	57
Illinois Occupational Safety and Health Investigation	65
Changes to Policies as a Result of COVID-19 at Illinois Veterans' Homes	67
Monitoring at the LaSalle Veterans' Home Post-COVID-19 Outbreak	74
LaSalle Veterans' Home COVID-19 Costs	77
Reviews Since 2015	81
Appendix A – House Resolution Number 62	85
Appendix B – Audit Scope and Methodology	87
Appendix C – IDVA Homes Report Emails	90
Appendix D – IDVA Chief of Staff Response	100
Appendix E – Agency Responses	108
<b>Recommendations</b>	
Recommendation 1 – COVID-19 Testing	25
Recommendation 2 – COVID-19 Monitoring and Policies	35
Recommendation 3 – Veterans' Affairs Management	39





## Introduction

On April 28, 2021, the Illinois House of Representatives adopted House Resolution Number 62, which directed the Office of the Auditor General to conduct a performance audit of the State's response to the management of the COVID-19 outbreak at the LaSalle Veterans' Home. The audit was to specifically include, but not be limited to, the following determinations:

1. The response of the Department of Veterans' Affairs to the outbreak of COVID-19 in 2020 at the LaSalle Veterans' Home, including the recommendations made in the November 13, 2020 site visit by the Illinois Department of Public Health and the Department's actions to address those recommendations;
2. The type, cost, and timing of any infrastructure or other building improvements intended to contain the further spread of COVID-19 or prevent its reoccurrence at the LaSalle Veterans' Home;
3. The nature of changes made by the Department in operating protocols and staff training thereon, intended to contain the further spread of COVID-19 or prevent its reoccurrence at the LaSalle Veterans' Home;
4. The nature and extent of monitoring conducted by the Department to determine whether the improvements and protocols put in place are effective to ensure the safety of residents and staff at the LaSalle Veterans' Home;
5. The amount of State moneys received and the amount of State moneys expended by IDPH or any other State agency during State fiscal years 2020

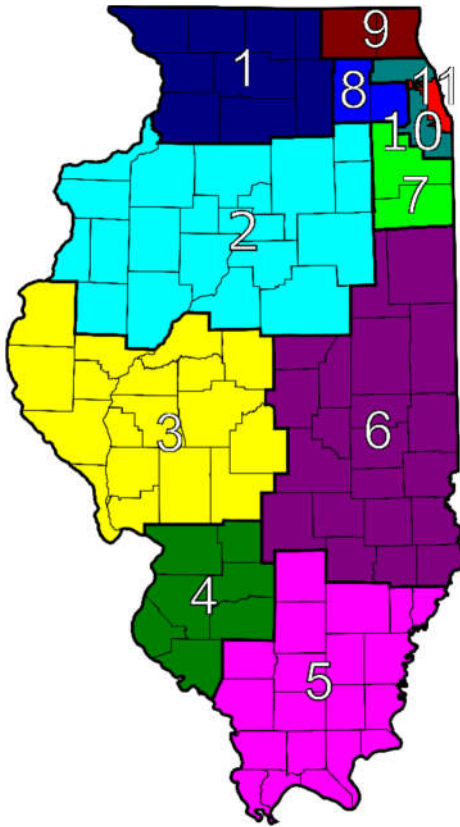
and 2021 to address the COVID-19 outbreaks at the LaSalle Veterans' Home;  
and

6. To the extent information is available, whether the LaSalle Veterans' Home has been the subject of any reviews since 2015 to determine its compliance with applicable laws and regulations with regard to the care of its residents and, if so, the results of those reviews.

## Background

The Illinois Department of Public Health (IDPH) announced the first case of COVID-19 in Illinois on January 24, 2020, and the spouse of the individual was the second confirmed case on January 30, 2020. These were the first two known cases of Illinois residents to test positive. By March 5, 2020, Illinois had five confirmed cases. On March 9, 2020, Governor Pritzker issued a Disaster Proclamation for Illinois.

Exhibit 1  
ILLINOIS' COVID-19 REGIONS



Source: Illinois Department of Public Health.

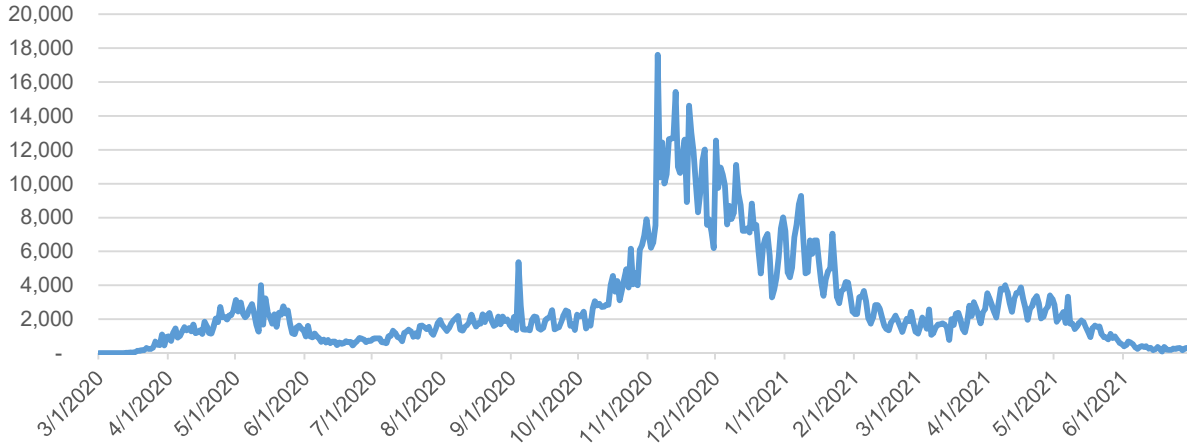
On July 15, 2020, Governor Pritzker and the Illinois Department of Public Health announced a new COVID-19 mitigation plan. According to the plan, mitigations were applied on a regional basis and were based on the Emergency Medical Services Regions that guide IDPH in its statewide public health work. The plan noted that expanding to 11 regions allows for a more granular approach in this phase of the response to COVID-19. According to the press release, these new regions followed county lines to account for counties that were in more than one Emergency Medical Services Region. The 11 COVID-19 regions are shown in **Exhibit 1**.

### Cases of COVID-19 in Illinois

By April 1, 2020, IDPH reported a total of 6,980 positive cases and 141 COVID-19 related deaths. On October 31, 2020, the number of positive cases increased to its then highest one day total, 7,899. Beginning on November 6, 2020, IDPH began reporting both confirmed and probable cases. Consequently, more than 7,000 previously unreported probable cases were added to the November 5, 2020 total cases. On November 7, 2020, the daily positive cases increased to

12,438. **Exhibit 2** shows the number of positive COVID-19 cases reported by IDPH by day from March 1, 2020, through June 30, 2021.

**Exhibit 2**  
**ILLINOIS' COVID-19 CASES BY DAY**  
 March 1, 2020 through June 30, 2021



Note: To align with the national case definition, beginning on November 6, 2020, IDPH began reporting both confirmed and probable cases. Consequently, 7,673 previously unreported probable cases were added to the data on November 5, 2020.

Source: Illinois Department of Public Health.

**COVID-19 Cases in Region 2**

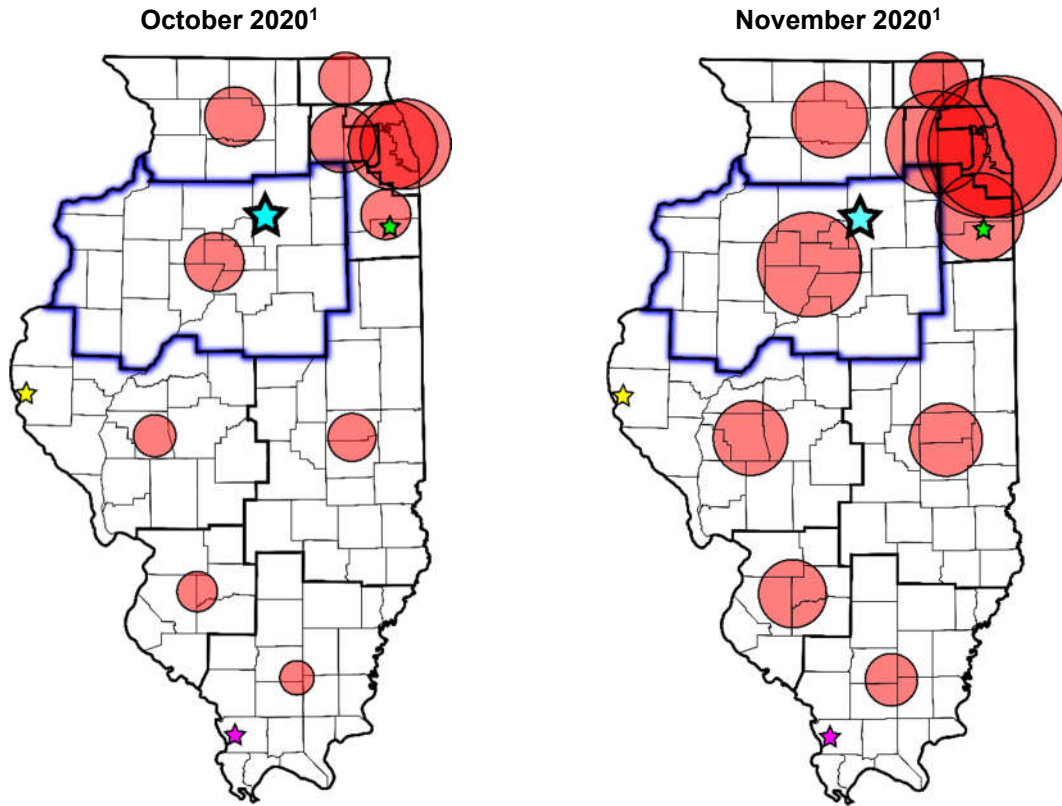
The Illinois Veterans' Home LaSalle is in LaSalle County, which is located in COVID-19 Region 2 (North-Central). Region 2 includes the following 20 counties: Bureau; Fulton; Grundy; Henderson; Henry; Kendall; Knox; LaSalle; Livingston; Marshall; McDonough; McLean; Mercer; Peoria; Putnam; Rock Island; Stark; Tazewell; Warren; and Woodford.

In November 2020, there was a drastic increase in COVID-19 cases compared to the previous months. Cases began to increase near the end of October 2020 in Region 2 which mirrored the increase in cases throughout the State. **Exhibit 3** graphically depicts the increased cases in Region 2 compared to the other 10 Regions. Further, the Exhibit shows the daily positive case counts for Region 2, where the LaSalle Veterans' Home is located.

To further illustrate the increased positive cases, and the severity of the increase in Region 2, **Exhibit 4** shows the changes in COVID-19 cases for all Regions for October, November, and December 2020. Clearly, Region 2 experienced a large percent increase in November, which occurred at approximately the same time as the outbreak at the LaSalle Home. Positive cases in Region 2 increased from 12,108 in October 2020 to 37,825 in November 2020, an increase of **212.4 percent**.

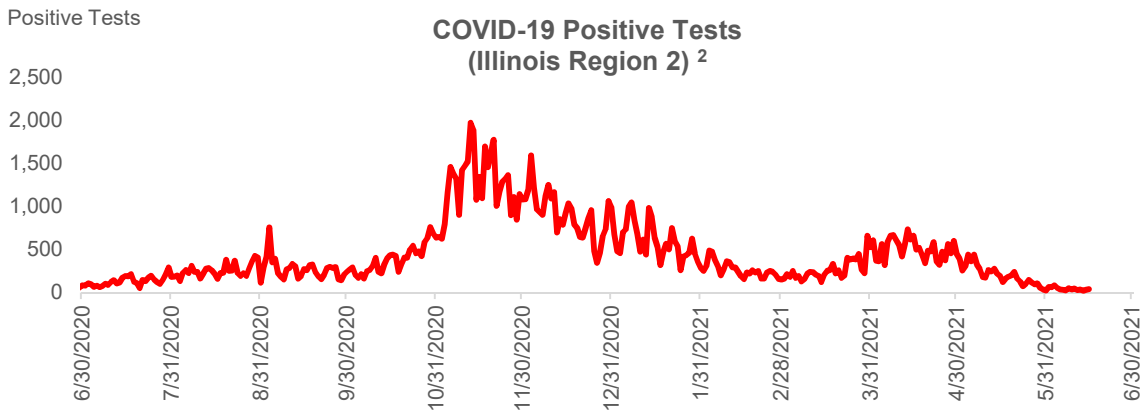
Positive cases in Region 2 increased from 12,108 in October 2020 to 37,825 in November 2020, an increase of **212.4 percent**.

**Exhibit 3**  
**INCREASE IN COVID-19 CASES IN REGION 2 COMPARED TO OTHER ILLINOIS REGIONS**  
 October and November 2020



**IDVA Veterans' Homes**

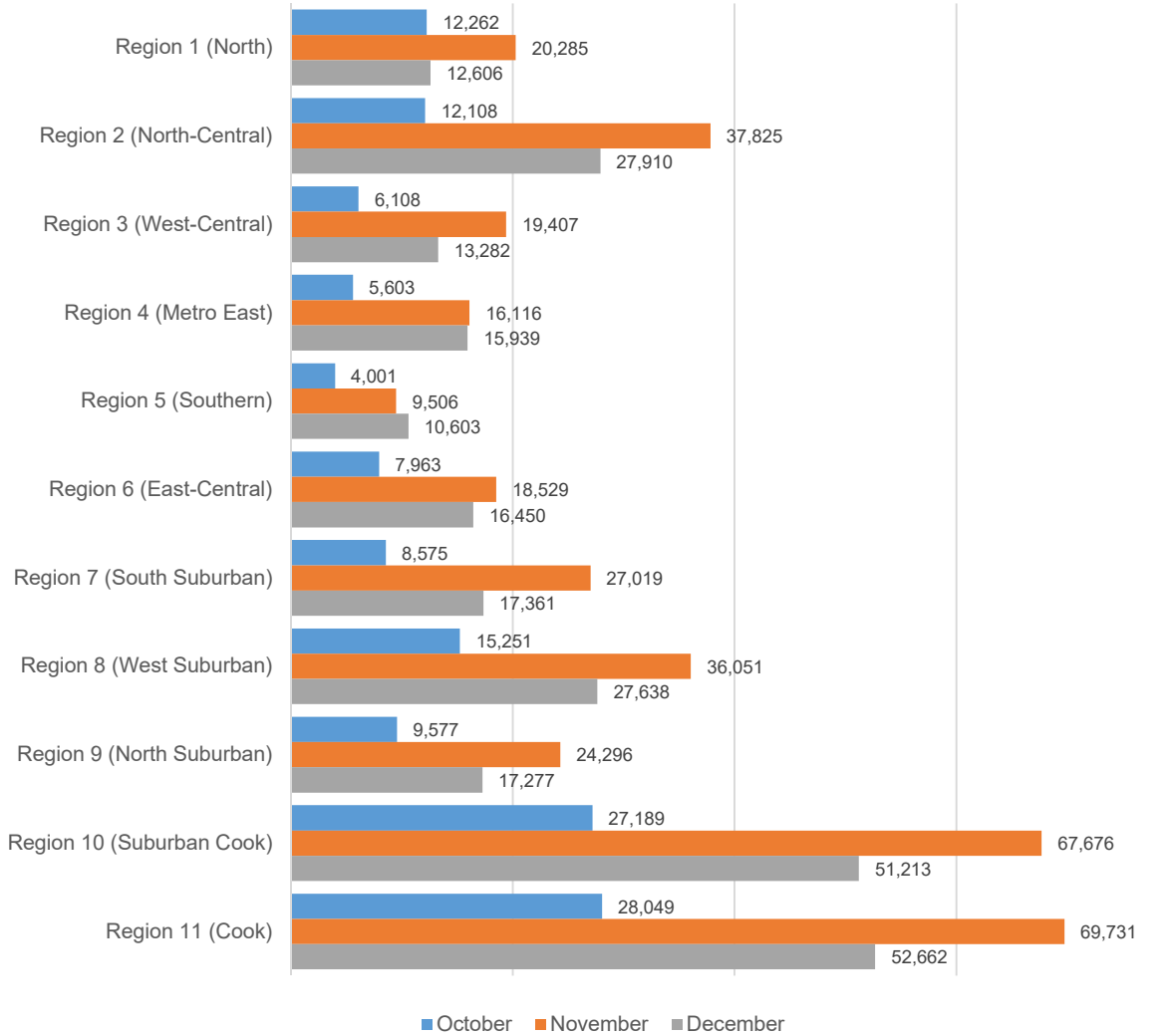
- ★  
LaSalle
- ★  
Manteno
- ★  
Quincy
- ★  
Anna



Notes:  
 1 Circle size indicates regional quantity of positive COVID-19 tests.  
 2 Region 2 contains the LaSalle Veterans' Home (outlined in blue).

Source: Auditor analysis of Illinois Department of Public Health data.

**Exhibit 4**  
**ILLINOIS' COVID-19 POSITIVE CASES BY COVID-19 REGION**  
 October/November/December 2020



Source: Illinois Department of Public Health.

**Long-Term Care Facilities in Illinois**

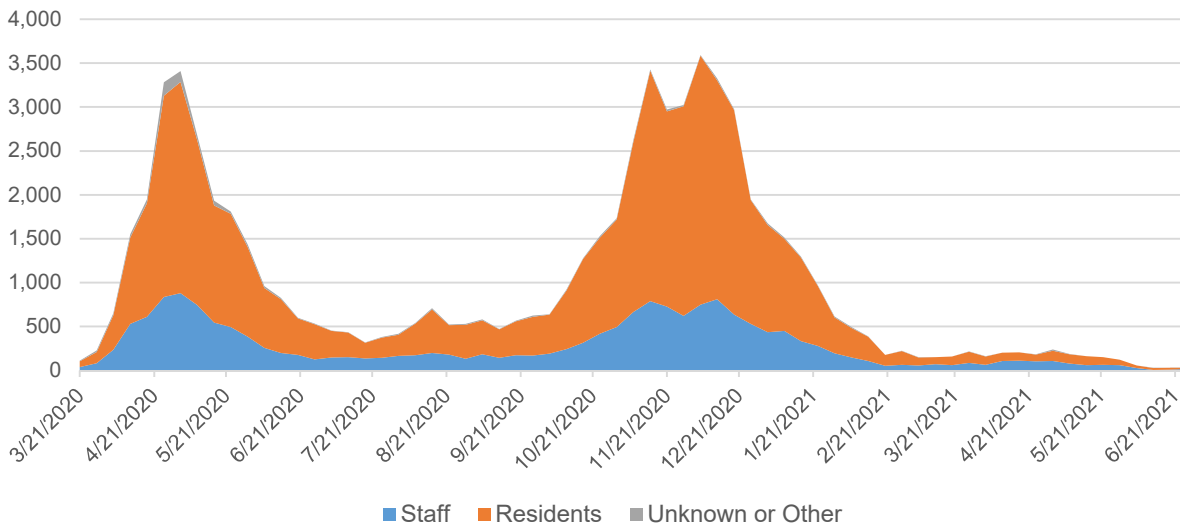
The first case in a long-term care facility was on March 13, 2020. According to IDPH, COVID-19 cases and deaths surged in the community and in long-term care facilities, peaking in May 2020. IDPH’s long-term care response, listed on its website, focused on increasing testing capacity, providing personal protective equipment, and working with facilities and local health departments to ensure that the core principals of infection prevention were put into practice. IDPH contracted with healthcare organizations to perform onsite long-term care infection prevention evaluations and COVID-19 testing. Emergency rules were

issued at the end of May 2020, which required long-term care facilities to perform testing during outbreaks.

According to IDPH, the U.S. Department of Health and Human Services sent point-of-care antigen tests (rapid tests) to long-term care facilities across the nation. IDPH ensured that all long-term care facilities had adequate supplies of the tests and, following the Centers for Medicare and Medicaid Services' lead, required routine testing of all staff. These tests were to help long-term care facility staff identify infected asymptomatic individuals who could inadvertently spread the virus to residents and co-workers.

**Exhibit 5** shows the COVID-19 cases in long-term care facilities in Illinois between March 21, 2020, and June 26, 2021. The numbers clearly show two distinct peaks in long-term care facilities. In both instances, residents and staff were affected. The increased cases in long-term care facilities in November and December 2020 occurred at a time when there was an overall increase in cases statewide, as seen in Exhibit 2. Additionally, the weeks with the largest number of cases in long-term care facilities during the second wave began with the week ending November 7, 2020, where 2,622 cases were reported followed by 3,427 the following week. The long-term care facility numbers peaked for the week ending December 5, 2020, with 3,593 cases.

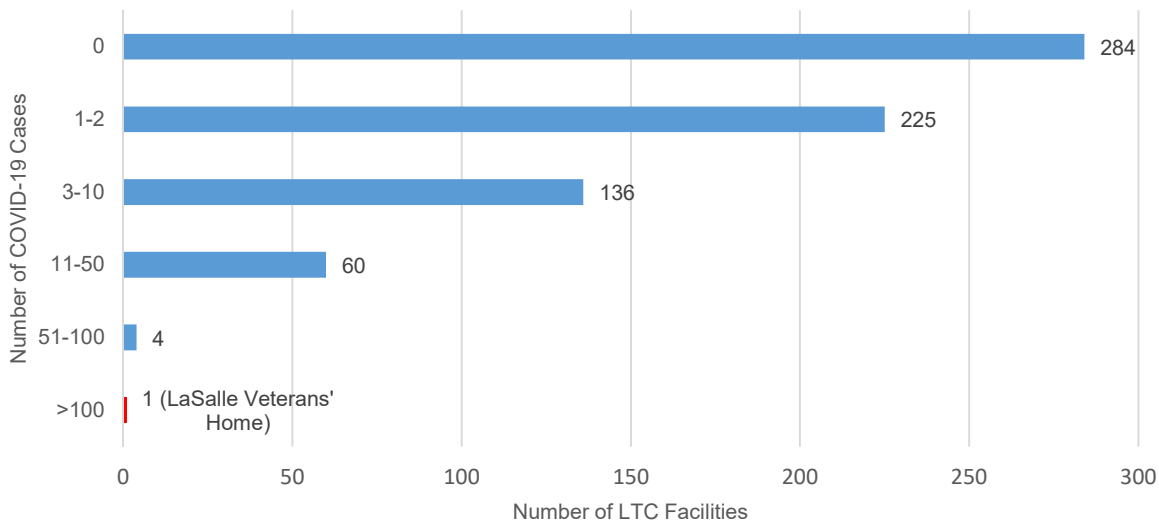
**Exhibit 5**  
**WEEKLY ILLINOIS LONG-TERM CARE FACILITY COVID-19 CASES**  
 The week ending March 21, 2020 through the week of June 26, 2021



Source: Illinois Department of Public Health.

Auditors reviewed a report titled “IDVA Home Reports” created by the Illinois Department of Veterans’ Affairs (IDVA) Chief of Staff during the first week of November 2020 and determined that there were COVID-19 outbreaks at the Homes in LaSalle, Quincy, and Manteno. The outbreak at LaSalle was much larger than in the other two Homes. Auditors then compared the outbreak at the LaSalle Veterans’ Home with the long-term care facilities throughout Illinois. According to IDPH data, for the week ending November 8, 2020, the LaSalle Veterans’ Home had the highest number of total COVID-19 cases (including both residents and staff) in all of Illinois’ long-term care facilities at the time. Of the 710 long-term care facilities in Illinois, 645 (91%) had 10 cases or fewer, with 284 (40%) of the facilities having zero cases. Five of the facilities had greater than 50 cases, with the LaSalle Veterans’ Home being the only facility with greater than 100 cases, with 134 total cases. **Exhibit 6** shows the distribution of cases by the number of positive cases and lists the five facilities which had more than 50 total cases during the week ending November 8, 2020.

**Exhibit 6**  
**DISTRIBUTION OF COVID-19 CASES IN ILLINOIS’ LONG-TERM CARE FACILITIES**  
 For the Week Ending November 8, 2020



Facility Name	County	Total Cases	Resident Cases	Staff Cases
LaSalle Veterans’ Home <sup>1</sup>	LaSalle	134	68	66
Heritage Health-Pana <sup>2</sup>	Christian	90	53	37
River View Rehab Center <sup>2</sup>	Kane	81	47	34
Joliet Terrace <sup>2</sup>	Will	61	49	12
Marigold Rehabilitation HCC <sup>2</sup>	Knox	55	33	22

Notes: <sup>1</sup> Certified by the U.S. Department of Veterans’ Affairs.

<sup>2</sup> Certified by the U.S. Centers for Medicare & Medicaid Services.

Source: National Healthcare Safety Network data provided by the Illinois Department of Public Health.



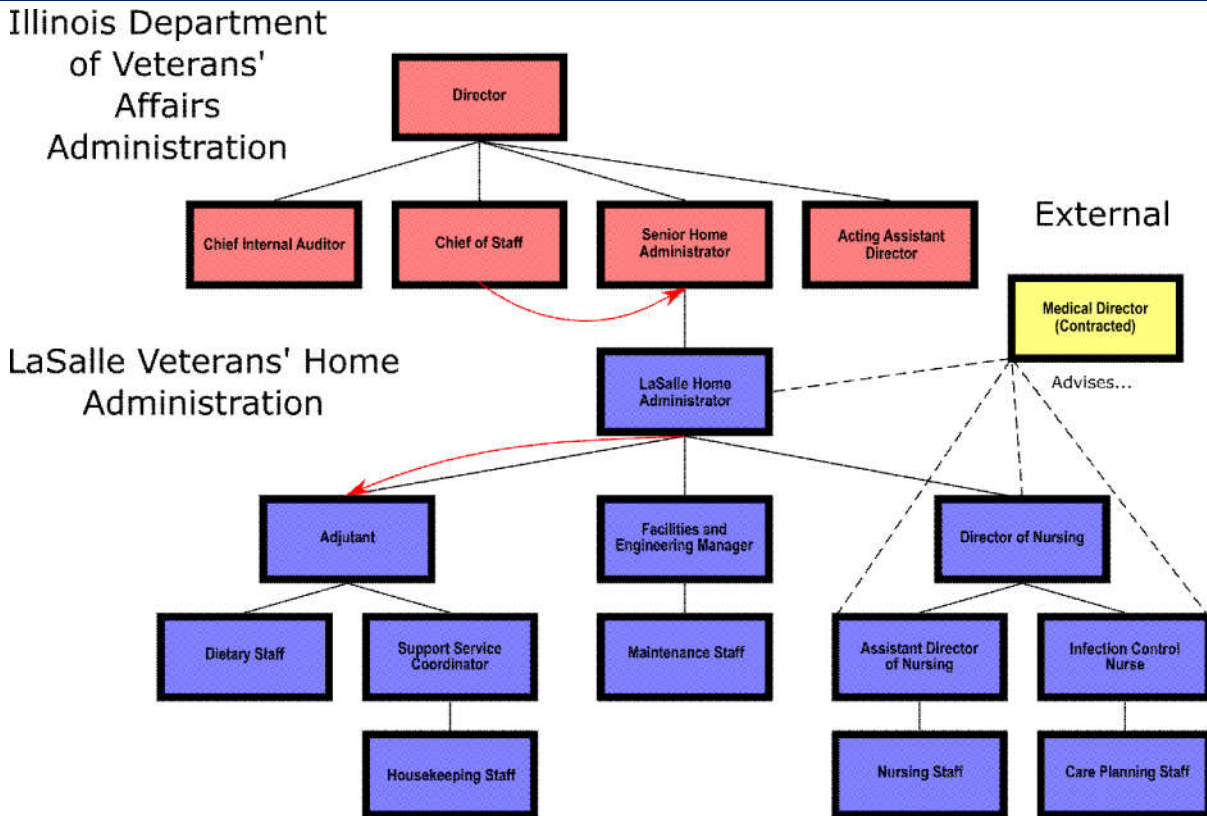
## Illinois Veterans' Home at LaSalle

The Illinois Veterans' Home at LaSalle opened in December 1990 and is located in LaSalle, Illinois. The capacity of the original construction was 120 beds. In January 2009, an additional 80 beds were added. The LaSalle Veterans' Home provides skilled nursing services for veterans. It can provide care for up to 190 veterans, which may include 40 veterans with special needs. On November 1, 2020, the resident census at the LaSalle Veterans' Home was 128, which included 3 residents that were out of the Home.

On November 1, 2020, the resident census at the LaSalle Veterans' Home was 128, which included 3 residents that were out of the Home.

Veterans' Homes in Illinois are run by IDVA; in November 2020, there were four Illinois Veterans' Homes operating with a fifth Home being built in Chicago. These Homes are staffed with professionals who provide long-term skilled care and services to residents. **Exhibit 7** shows the organization chart for IDVA for the LaSalle Veterans' Home as of November 2020.

Exhibit 7  
**LASALLE VETERANS' HOME ORGANIZATION CHART**  
 As of November 2020



Note: The red arrows indicate that the Chief of Staff was performing the duties of the Senior Home Administrator, and the LaSalle Home Administrator was performing the duties of the Adjutant.

Source: Auditor created from Illinois Department of Veterans' Affairs data.

The Veterans' Homes are licensed by IDPH and are certified by the U.S. Department of Veterans Affairs Medical Center. Hines VA Hospital is the Veterans Affairs Medical Center for the LaSalle Veterans' Home.

**COVID-19 Outbreak at the LaSalle Veterans' Home**

The outbreak at the LaSalle Veterans' Home occurred at a time when COVID-19 cases were trending up statewide. Also, the outbreak occurred prior to the COVID-19 vaccine. Prior to the outbreak that began at the end of October 2020, only six staff members had tested positive for COVID-19.

Even though the LaSalle Home had designated areas for isolation and quarantine, once the virus entered the Home, it spread very rapidly. **Exhibit 8** shows the layout of the LaSalle Veterans' Home and identifies the quarantine areas, the employee entrance, and where employee screenings were conducted.

According to documentation provided by the LaSalle Veterans' Home, the first resident was positive on October 23, 2020. This was followed by another resident and two staff on October 27, 2020. Based on tests administered prior to the end of October 2020, 13 residents and staff (8 residents and 5 staff) tested positive.

In total, between October 23, 2020, and December 9, 2020, 109 of the Home's 128 residents (85%) and 88 of the Home's 231 staff (38%) had tested positive for COVID-19.

Clearly there was a verified outbreak and by November 4, 2020, according to IDPH, 57 residents and staff (46 residents and 11 staff) had tested positive for COVID-19. By the end of November 2020, 203 total positive cases had been identified at the LaSalle Veterans' Home. **According to IDPH, in total, between October 23, 2020, and December 9, 2020, 109 of the Home's 128 residents (85%) and 88 of the Home's 231 staff (38%) had tested positive for COVID-19.**

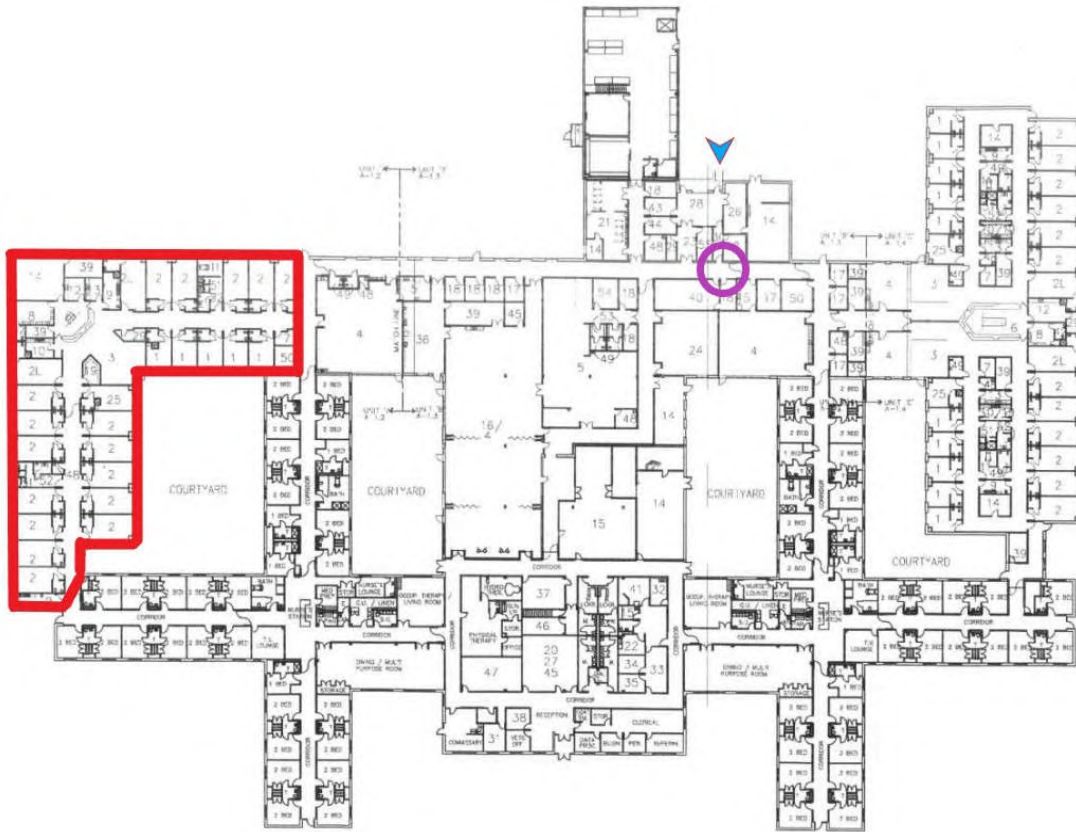
**TYPES OF COVID-19 TESTS**

**Antigen Test (Rapid Test)** - a low cost point-of-care test approved by the U.S. Food and Drug Administration for detecting SARS-CoV-2 viral proteins, providing results in approximately 15 minutes.

**PCR Test** - a laboratory-based test used to detect the genetic material of the SARS-CoV-2 virus, often used to confirm an antigen test because it is considered the most sensitive test for the virus.

Source: Illinois Department of Public Health.

**Exhibit 8  
FLOOR PLAN OF THE LASALLE VETERANS' HOME**

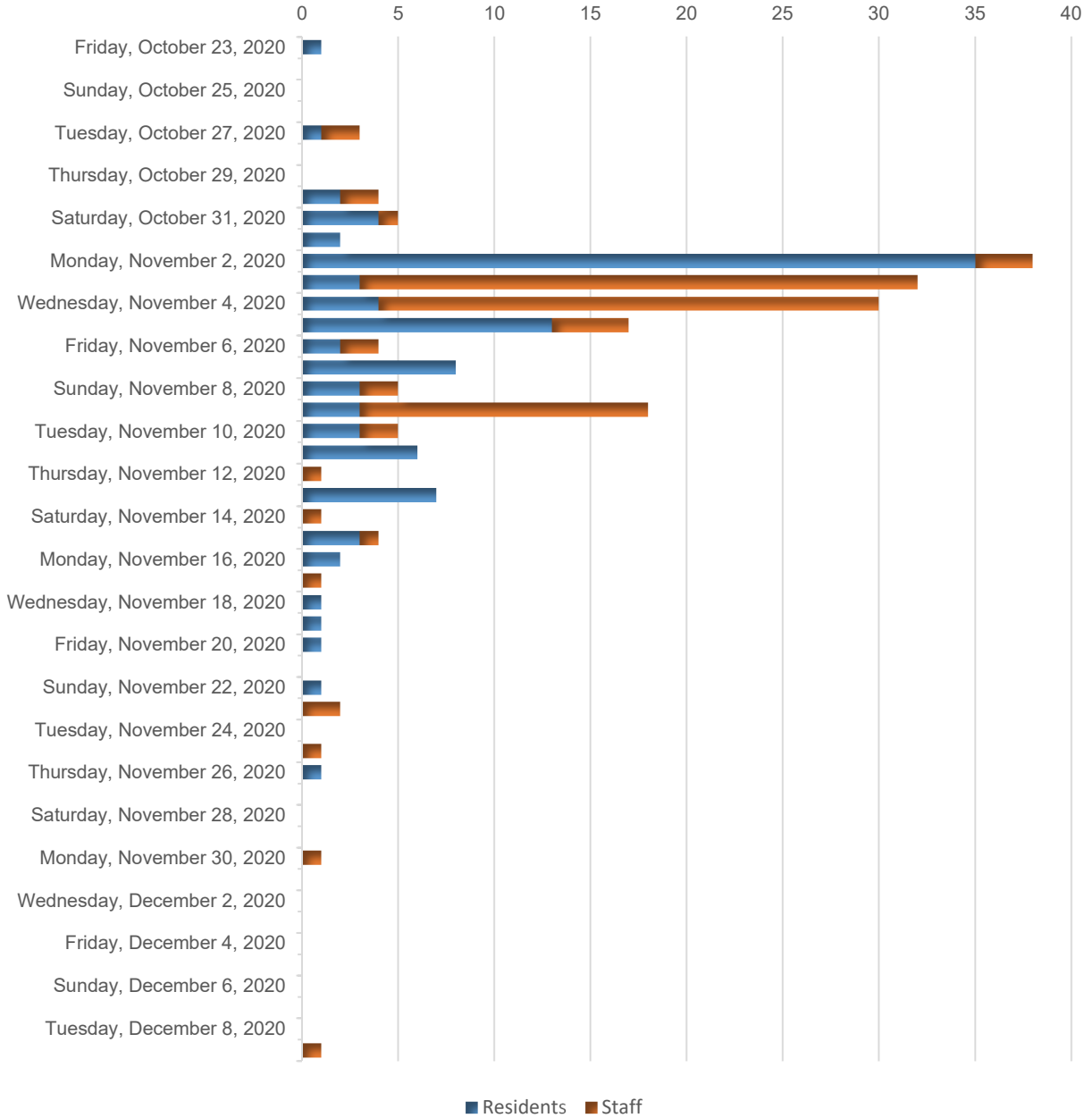


Note: The red area represents the 17 isolation beds (upper right of the red area) and the 27 quarantine beds (lower left of the red area) following the late October 2020 outbreak. The blue arrow was the employee entrance and the purple circle identifies the area where employee screenings were conducted.

Source: Illinois Veterans' Home at LaSalle.

**Exhibit 9** shows the date of positive tests from the onset of the outbreak on October 23, 2020, through December 9, 2020. The Exhibit depicts the date the positive COVID-19 tests were administered and not the date the test results were received.

**Exhibit 9**  
**LASALLE VETERANS' HOME POSITIVE CASE TEST DATES FOR RESIDENTS AND STAFF<sup>1,2</sup>**  
 October 23, 2020 through December 9, 2020



**Notes:**

<sup>1</sup> In some instances, IDVA considered the positive date to be the date of symptom onset.

<sup>2</sup> Depicts the date the positive COVID-19 tests were administered and not the date the test results were received.

Source: Data provided by the Illinois Veterans' Home at LaSalle.

### Resident Deaths at the LaSalle Veterans' Home

In total, 36 residents of the LaSalle Veterans' Home died due to COVID-19. The deaths occurred between November 7, 2020, and January 1, 2021. As shown earlier in this report, positive cases increased rapidly during the first week of November 2020. By November 15, 2020, 17 residents had lost their lives from COVID-19 at the LaSalle Home.

Auditors compared the deaths to the date these 36 residents tested positive for COVID-19. Four residents that lost their lives from COVID-19 were positive

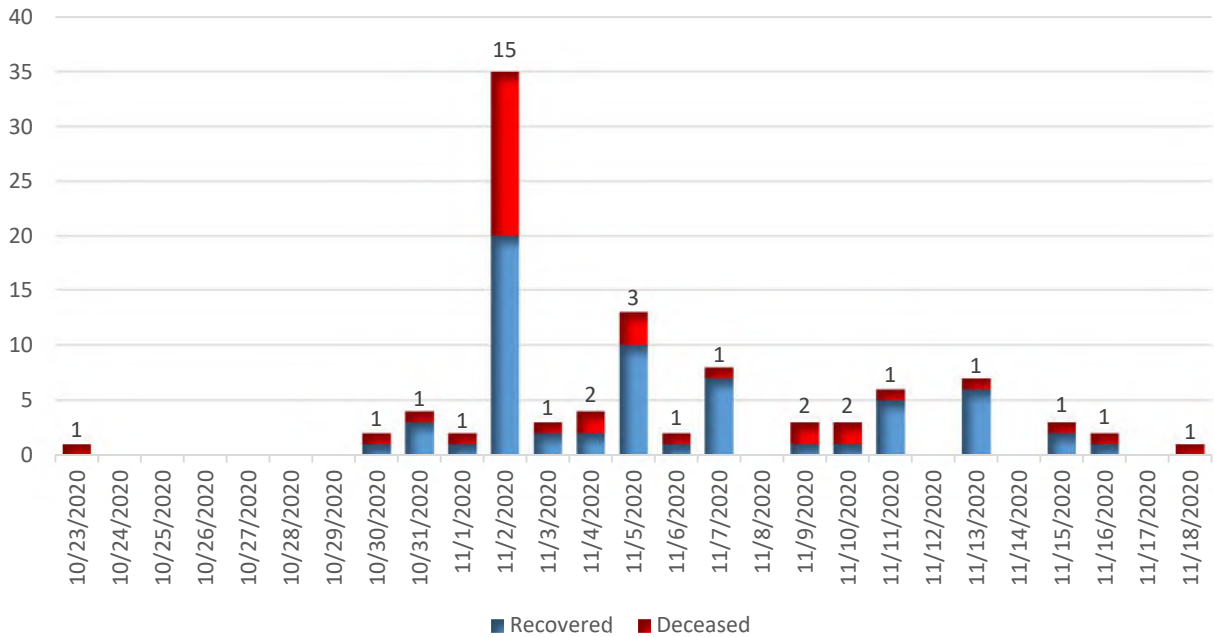
We determined that of the 35 residents that tested positive for COVID-19 on November 2, 2020, 15 died from the virus.

before November 2, 2020. We determined that of the 35 residents that tested positive for COVID-19 on November 2, 2020, 15 died from the virus.

Additionally, all but four residents who died were positive **prior to the date of the IDPH site visit** on

November 12, 2020. **Exhibit 10** shows the number of residents that died based on the date the COVID-19 test was administered.

Exhibit 10  
**LASALLE VETERANS' HOME RESIDENT STATUS BY POSITIVE TEST DATE<sup>1</sup>**  
 For the 36 Deceased Residents from the 2020 Outbreak at the LaSalle Veterans' Home

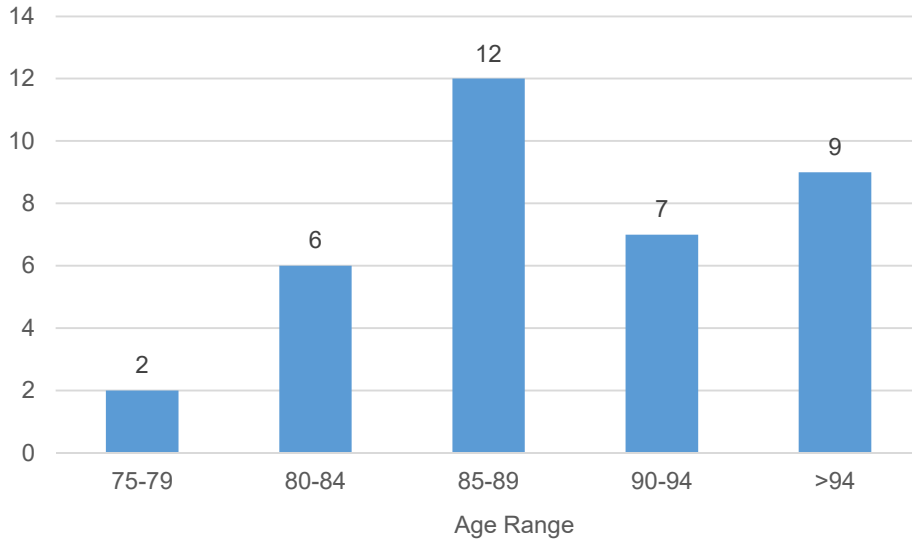


Note: <sup>1</sup> Depicts the date the positive COVID-19 tests were administered and not the date the test results were received.

Source: Illinois Department of Veterans' Affairs.

**Exhibit 11** examines the age of the 36 LaSalle Veterans' Home residents that died after having COVID-19. The average age of the deceased residents was 89.6 years old. One-third of the deceased residents were in the 85 to 89 age range. No LaSalle Veterans' Home staff died as a result of the COVID-19 outbreak at the home.

Exhibit 11  
**AGE OF THE DECEASED LASALLE VETERANS' HOME RESIDENTS**  
 For the 36 Deceased Residents from the 2020 Outbreak at the LaSalle Veterans' Home

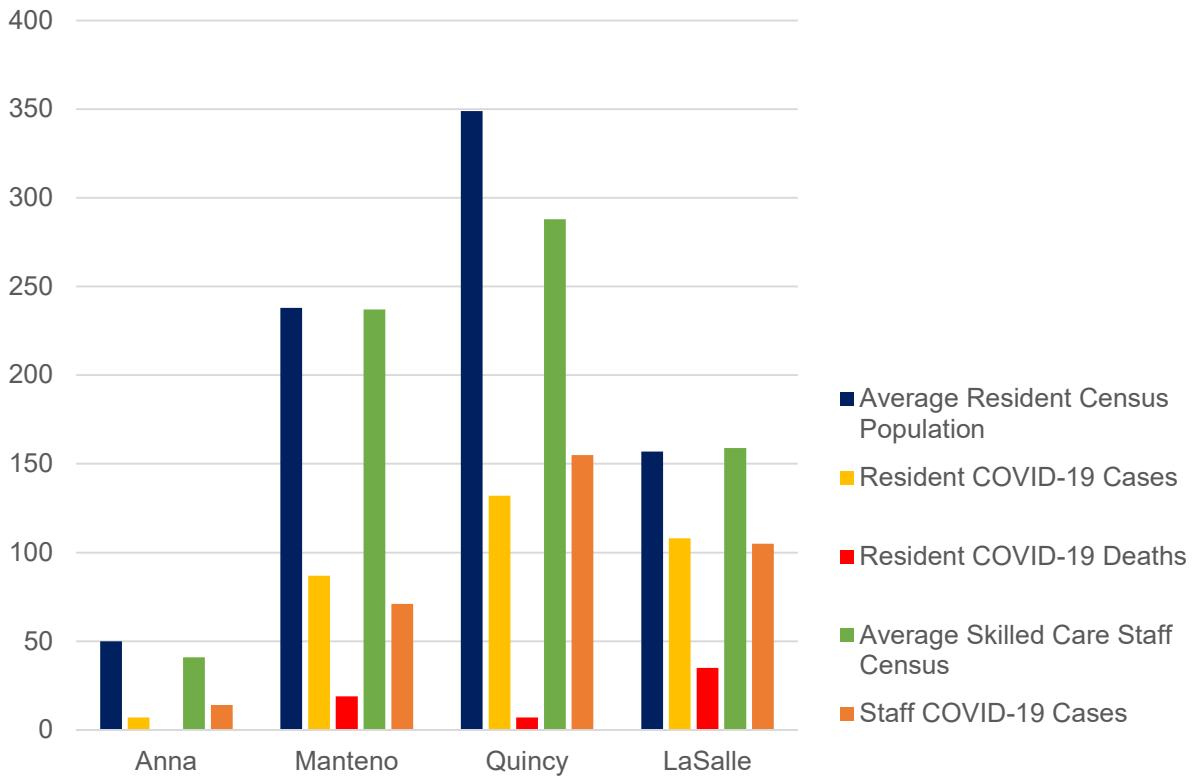


Source: Illinois Department of Veterans' Affairs.

## COVID-19 Outbreaks in Other IDVA Facilities

In 2020, all four IDVA-administered Veterans' Homes experienced COVID-19 cases at various points in time. However, unlike the other three larger veterans' homes, Anna only had a small number of cases. The Manteno, Quincy, and LaSalle Veterans' Homes experienced significant outbreaks in which both residents and staff tested positive and experienced a significant number of resident deaths. **Exhibit 12** shows IDVA resident and staff census, COVID-19 cases, and COVID-19 related deaths by facility during 2020.

Exhibit 12  
**IDVA VETERANS' HOMES RESIDENT AND STAFF CENSUS, COVID-19 CASES, AND COVID-19 RELATED DEATHS<sup>1</sup>**  
 During 2020



Note: <sup>1</sup> Average Resident Population and Average Skilled Care Staff Census are based on fiscal year 2020 (7/1/2019 through 6/30/2020).

Source: Auditor prepared from Illinois Department of Veterans' Affairs data.

**Anna** - On May 12, 2020, IDVA announced a COVID-19 outbreak at the Anna Veterans' Home. There were 5 residents (out of an average resident population of 50 in FY20) and 1 staff with positive cases. There were more positive cases, mainly for staff, later in 2020. In total, there were 7 residents and 14 staff with positive cases and no deaths during 2020.

**Manteno** - The Manteno Veterans' Home experienced its first COVID-19 outbreak starting May 9, 2020, which became the first outbreak of COVID-19 within IDVA facilities. During the first outbreak, 50 residents contracted COVID-19, 30 staff members contracted the disease, and ultimately 15 residents died. The Manteno Veterans' Home experienced additional, less severe outbreaks starting on October 21, 2020, and continued to have COVID-19 cases throughout the year. As a result, 87 residents tested positive for COVID-19 and resulted in 19 deaths during 2020. Additionally, in total, 71 staff tested positive for COVID-19 during 2020 and there were no associated staff deaths.

**Quincy** - The Quincy Veterans' Home experienced its first COVID-19 outbreak beginning on July 6, 2020. There were 31 staff cases (mostly among dietary staff), 15 resident cases, and 1 resident death as a result of this outbreak. The Quincy Veterans' Home experienced another outbreak beginning November 4, 2020. During 2020, the Quincy Veterans' Home reported a total of 132 resident cases, 155 staff cases, and 7 deaths.

**LaSalle** - The LaSalle Veterans' Home, as discussed throughout this report, experienced a significant COVID-19 outbreak in November 2020. The LaSalle Veterans' Home is unique in that it is the only IDVA Veterans' Home contained within a single building. For example, the Manteno Veterans' Home has residents spread out over five separate buildings, and the Quincy Veterans' Home is spread out over a 210 acre campus with multiple residential care buildings.



## Guidance Provided to the LaSalle Veterans' Home

In March 2020, the LaSalle Veterans' Home already had general infection control policies and procedures in place to prevent the spread of illness and disease. These policies included many areas where IDPH would eventually issue additional COVID-specific guidance. Additional COVID-19 policies were issued beginning in March 2020. IDPH began to issue guidance for healthcare workers and facilities specific to COVID-19, based on information from the Centers for Disease Control (CDC). IDPH also issued guidance specifically for local health departments throughout the State. There was guidance on infection control strategies (which included use of masks, gowns, gloves, and other personal protective equipment (PPE) as well as cleaning and disinfection guidance), screening of visitors, healthcare personnel contact tracing, monitoring, and work restrictions. On April 19, 2020, guidance was issued on notifying residents, family, and staff of positive test results in a facility. As the CDC updated its recommendations, IDPH updated its guidance. IDPH also began weekly educational webinars for long-term care staff beginning in March 2020. Additional guidance was also provided to the Home through August 2020.

IDPH also changed its rules for skilled nursing facilities three times between May and October 2020. The first, in May, required facility-wide testing of staff and residents when experiencing an outbreak or when ordered by IDPH or the local health department. The second, in July, added specific CDC infection control guidelines that facilities had to follow. In October, the third change added testing requirements based on the COVID-19 positivity rate in the county. However, the LaSalle Veterans' Home is not covered under the rules for skilled care nursing facilities; it is covered under the Veterans' Home Code. Nevertheless, it appears the LaSalle Home complied with these updated requirements.

In early March 2020, IDVA was required to submit Continuity of Operations Plans to both the Illinois Emergency Management Agency (IEMA) and IDPH. IEMA reviewed the plans and responded that "a common theme among Continuity of Operations Plans is that they are structured for impact to physical locations and do not take into account staffing shortages." IEMA offered templates for updating the Continuity of Operations Plans to address this shortcoming. As a result, IDVA hired a consultant to help update the plans and resubmit them to IEMA. According to IDPH officials, Infection Prevention staff reviewed the Continuity of Operations Plan.

---

At the beginning of the pandemic, in March 2020, the LaSalle Veterans' Home already had general infection control policies and procedures in place to prevent the spread of illness and disease. These policies included many areas where IDPH would eventually issue additional COVID-specific guidance, including hand washing, sterile and non-sterile glove use, employee infection guidelines, handling of infectious medical waste, airborne and droplet isolation, use of masks, and cleaning and disinfection.

In March 2020, IDPH began to issue guidance for healthcare workers and facilities specific to COVID-19, based on information from the CDC. IDPH also issued guidance specifically for local health departments throughout the State. There was guidance on infection control strategies (which included use of masks, gowns, gloves, and other personal protective equipment (PPE) as well as cleaning

and disinfection guidance), screening of visitors, healthcare personnel contact tracing, monitoring, and work restrictions. On April 19, 2020, guidance was issued on notifying residents, family, and staff of positive test results in a facility. As the CDC updated its recommendations, IDPH updated its guidance. IDPH also began weekly educational webinars for long-term care staff beginning in March 2020. **Exhibit 13** shows the guidance received by the LaSalle Veterans' Home from either IDPH or the local health department before the outbreak in late October 2020.

**Exhibit 13  
GUIDANCE RECEIVED BY THE LASALLE VETERANS' HOME  
PRIOR TO THE LATE OCTOBER 2020 OUTBREAK**

<b>Guidance Issued</b>	<b>Date</b>
CMS (Centers for Medicare and Medicaid Services) guidance on COVID Prevention/Control in Nursing Homes (visitation guidance)	March 13, 2020
IDPH Long-Term Care Facility Guidance for Coronavirus (COVID19)	March 2020
IDPH COVID-19 Update - Webinar	March 18, 2020
IDPH Guidance for donning/doffing PPE During Cluster of COVID-19 Infections	March 18, 2020
IDPH Interim Guidance for Work Exclusion and Monitoring Recommendations for Healthcare Setting and EMS	March 19, 2020
IDPH Long-Term Care Guidance	March 20, 2020
IDPH Control Measures for Long-Term Care Facility with Symptomatic Patient	March 23, 2020
IDPH SIREN - State Expanding Lab Testing	March 27, 2020
IDPH SIREN - Communicating about COVID in Congregate Settings (Long-Term Care Facilities)	April 19, 2020
IDPH Interim Guidance for COVID-19 Resident Monitoring Protocol Long-Term Care Facilities	April 20, 2020
CMS Guidance - Nursing Home Reopening Recommendations for State and Local Officials	May 18, 2020
IDPH Updated Interim Guidance: COVID-19 Testing and Response Strategy in Licensed Long-Term Care Facilities	May 28, 2020
IDPH Updated Interim Guidance for Nursing Homes and Other Long-Term Care Facilities and Programs: Phased Reopening	August 7, 2020
IDPH Webinar on Situational guidance	August 19, 2020

Source: OAG prepared from information provided by the DHS Office of the Inspector General and the LaSalle County Health Department.

According to documentation reviewed, the LaSalle Veterans' Home received much of this guidance directly from IDPH or from the local public health department when it was issued and also participated in some of the weekly webinars. As IDPH instituted requirements or changed guidance, there is evidence that the LaSalle Veterans' Home changed its procedures to follow the requirements. For example, on April 16, 2020, when IDPH required employee

temperatures be taken and employees attest that they had no COVID-like symptoms before starting a shift, the LaSalle Veterans' Home instituted the practice. Then, on May 4, 2020, the Home added requirements for temperature checks at mid-shift and end of shift when IDPH revised its requirements.

IDPH also changed its rules for skilled nursing facilities three times between May and October 2020. The first, in May, required facility-wide testing of staff and residents when experiencing an outbreak or when ordered by IDPH or the local health department. The second, in July, added specific CDC infection control guidelines that facilities had to follow. In October, the third change added testing requirements based on the COVID-19 positivity rate in the county. However, the LaSalle Veterans' Home is not under the rules for skilled nursing care facilities; it is covered under the Veterans' Home Code. It appears the LaSalle Home complied with these updated requirements.

Guidance on the use of PPE was included in the initial information sent out by IDPH in March 2020, and was included in many of the subsequent bulletins and informational seminars.

Guidance on the use of PPE was included in the initial information sent out by IDPH in March 2020, and was included in many of the subsequent bulletins and informational seminars. A staff training at the Home in April 2020 used CDC guidance on the use of PPE in healthcare settings. The guidance said that the PPE used depended on the type of exposure anticipated, appropriateness for the task, and fit. For expanded precautions, guidance recommended

the following:

- contact precautions – gown and gloves for contact with patient or care environment;
- droplet precautions – surgical masks within three feet of patient; and
- airborne infection isolation – particulate respirator (N95 mask).

IDPH issued more detailed guidance on PPE in June 2020. The guidance discussed the use of face protection, eye protection, gown, and gloves in units where COVID-19 was suspected or confirmed and units where no COVID-19 was suspected. In a COVID-19 positive unit, the required PPE was a facemask or N95 mask; face shield or goggles; gowns (ideally disposed of or laundered after each use but not to be worn in common areas); and gloves for each patient interaction. For non-COVID units, a surgical mask was required unless an N95 respirator was warranted, such as for a patient with a cough. Gloves were also required, but gowns were to be reserved for the COVID unit, especially if supplies were low. Other PPE tips included extended use of PPE, such as using the PPE for an extended period of time before removing it between residents; used PPE should not leave the building; staff should not wear used PPE while eating and drinking; and if a new resident case is identified, staff should wear all recommended PPE (masks, eye protection, gowns, and gloves) for the care of all residents on the affected floor. Although this guidance was dated June 2020 and was included in an IDPH webinar in July 2020, auditors could not determine whether this

Documentation shows that the LaSalle Veterans' Home administration did disseminate the information received from IDPH to the senior staff and department heads.

guidance was received by the Home before November 2, 2020, when the LaSalle County Health Department sent it via email.

Documentation shows that the LaSalle Veterans' Home administration did disseminate the information received from IDPH to the senior staff and department heads. In some cases, documentation indicates that employees

were asked to sign a statement which indicated that they received information from their supervisor or department head. One unit even conducted several training sessions for staff that included the proper use of PPE (covered in multiple sessions), equipment cleaning, employee screenings, and lab procedures when doing bloodwork for COVID-19 testing.

### **Continuity of Operations Plan**

In early March 2020, IDVA was required by the Governor's office to submit Continuity of Operations Plans to both IEMA and IDPH. IEMA reviewed the plans and responded that "a common theme among Continuity of Operations Plans is that they are structured for impact to physical locations and do not take into account staffing shortages." IEMA offered templates for updating the Continuity of Operations Plans to address this shortcoming. As a result, IDVA hired a consultant to help update the plans and resubmit them to IEMA. According to IDPH officials, Infection Prevention Staff reviewed the Continuity of Operations Plan.

## COVID-19 Testing during the Outbreak at the LaSalle Veterans' Home

The time it took to receive staff COVID-19 testing results from the IDPH lab was lengthened by the collection method used by the LaSalle Home. The Home tested staff over a three day period. As a result, new tests of staff collected on November 3rd, 4th, and 5th were not delivered to the IDPH lab until Thursday, November 5th, even though the first two staff members from the outbreak were found to be positive by Sunday, November 1st. The IDPH lab published the majority of the test results on either Friday or Saturday. Therefore, the delay in getting testing results was primarily due to the collection method used by the LaSalle Home. Additionally, the testing method, collecting tests over three days, **was not in compliance with the facility's policy, which allowed for testing over two days.**

There were a total 194 staff who were tested either on November 3rd, 4th, or 5th. In total, 45 of the 194 staff tested were positive. Results of positive tests were published beginning on November 6th. For the 45 positives, 16 were published on the 6th, 28 were published on the 7th, and 1 was published on the 8th. If these staff members were asymptomatic, they likely worked during that time period. It is also likely the multi-day testing method used contributed to the length of the outbreak because asymptomatic positive staff continued to work during that time, potentially exposing co-workers and residents.

Resident testing was more straightforward. Resident tests were usually collected on a single day and then sent to the IDPH lab. No employees or residents tested positive during testing the week prior, so residents were not tested during the week of October 25-31, 2020. By November 1st, however, two residents had tested positive. Residents were tested on November 2nd, at the beginning of the outbreak, and results were received November 4th and 5th, which was an average of 2.5 days to receive the results from the IDPH lab.

Recurring testing of employees and residents for the presence of COVID-19 at the LaSalle Veterans' Home began in June 2020 following an order from the Director of IDVA. Prior to that time, the Home had tested both residents and staff in early May 2020.

In response to an emergency rule adopted by IDPH in May 2020, both IDVA and the LaSalle Veterans' Home developed testing policies. The Home's policy, which was dated June 10, 2020, and was submitted to IDPH, stated that universal testing would be done of all staff on a bi-weekly basis unless otherwise designated by the local health department or IDPH. Facility-wide re-testing of residents was not necessary if no new cases or symptomatic individuals were identified; however, it would be warranted in outbreak situations. Further, the policy stated that staff testing would be done over 2 days and resident testing should be completed in the same day.

The IDVA testing policy was in place but was not formally approved until November 2, 2020, one day after IDVA was notified of the LaSalle outbreak. The policy states testing of residents is to be done at least every four weeks and employees are to be tested at least every two weeks, with testing every three to seven days in the event of an outbreak. The testing may also be more frequent than the minimum depending on the transmission rates in the community or State. Any employee without a valid medical condition who does not report for testing

or verbally refuses testing is subject to disciplinary action, including discharge; residents who refuse testing are to be placed in transmission-based precautions according to CDC/IDPH guidelines.

Documentation shows that the LaSalle Home followed this policy, even before it was effective, testing both residents and employees weekly through August 2020, then testing employees weekly and residents monthly. In the weeks just prior to the outbreak, the Home said it was testing residents weekly in response to isolated employee positive tests, which is even more frequently than is required by IDVA policy. However, the Home did not test residents the last week of October, which was the week the outbreak began. After the outbreak began, documentation shows the Home tested employees and residents at least every seven days according to IDVA policy.

**Exhibit 14** shows the frequency of testing both residents and staff at the LaSalle Home between October 20, 2020, and November 20, 2020. The Exhibit also shows when test results were posted by the IDPH lab to an online system the Veterans' Home could access. The COVID-19 testing conducted on October 27-29, 2020, identified the first two positive employees related to this outbreak.

### Testing of Staff

The time it took to receive staff COVID-19 testing results from the IDPH lab was lengthened by the collection method used by the LaSalle Home. As shown in the Exhibit, at times, the Home tested staff over a three day period. As a result, new tests of staff collected on November 3rd, 4th, and 5th, were not delivered to the IDPH lab until Thursday, November 5th, even though the first two staff members from the outbreak were found to be positive by Sunday, November 1st. The IDPH lab published the majority of the test results on either Friday or Saturday. Thus, due to the delayed testing collection methodology, it took approximately a week to receive staff testing results during a known outbreak. Therefore, the delay in getting testing results was primarily due to the collection method used by the LaSalle Home.

There were a total 193 staff who were tested either on November 3rd, 4th, or 5th. In total, 45 of the 193 staff tested positive. Results of positive tests were published beginning on November 6th. For the 45 positives, 16 were published on the 6th, 28 were published on the 7th, and 1 was published on the 8th. If these staff members were asymptomatic, they likely worked during that time period. It is also likely the multi-day testing method used contributed to the length of the outbreak because asymptomatic positive staff continued to work during that time, potentially exposing co-workers and residents. Additionally it appears that the testing method, collecting tests over three days, was not in compliance with the facility's policy, which allowed for testing over two days.

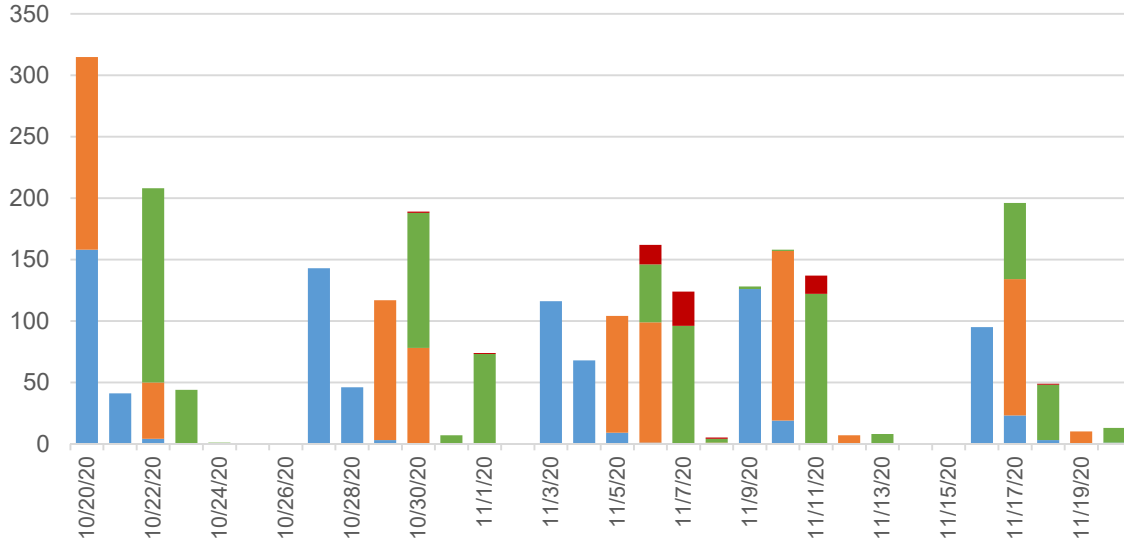
### Testing of Residents

Resident testing was more straightforward. As shown in the Exhibit, resident tests were collected on a single day and then sent to the lab. No employees or residents tested positive during testing the week prior, so residents were not tested

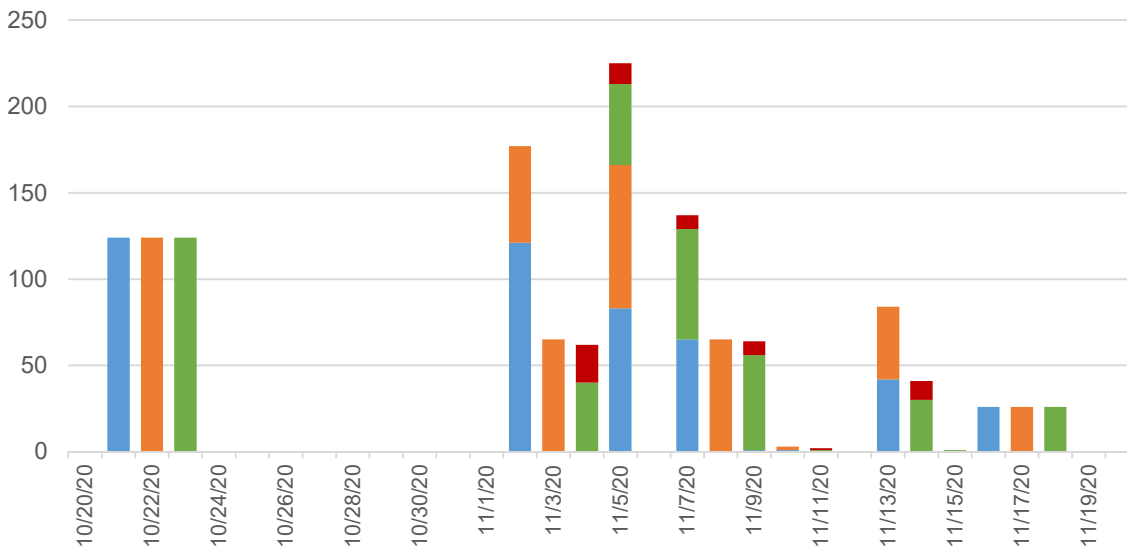
during the week of October 25-31, 2020. By November 1st, however, two residents had tested positive. One tested positive at the hospital and the other through an antigen test. Residents were tested on November 2nd, at the beginning of the outbreak, and results were received November 4th and 5th, which was an average of 2.5 days to receive the results from the IDPH lab. As the number of positive residents increased, the number of resident tests collected decreased, since only negative residents needed to be tested.

Exhibit 14  
**STAFF AND RESIDENT COVID-19 TESTING AND RESULTS<sup>1, 2</sup>**  
 2020 Outbreak at the LaSalle Veterans' Home

**STAFF TESTING**



**RESIDENT TESTING**



■ Tests Collected ■ Tests Submitted ■ Negative Results Published ■ Positive Results Published

Notes:

<sup>1</sup> Results were only those processed by the IDPH lab.

<sup>2</sup> The date the tests were submitted to the lab was the date the tests were scanned in by the lab and not the date the tests were delivered to the lab.

Source: Illinois Department of Veterans' Affairs.



**COVID-19 Testing**

**RECOMMENDATION NUMBER**

**1**

*The Illinois Department of Veterans' Affairs should ensure each of its Veterans' Homes have policies and procedures in place that mandate timely testing of its residents and employees during COVID-19 outbreaks, and should ensure that residents and employees are tested according to the policy.*

**IDVA Response:** IDVA agrees with this recommendation. Even though IDVA is not a Centers for Medicare and Medicaid Services (“CMS”) facility, IDVA followed the CMS guidance for testing and the Illinois Department of Public Health (IDPH) Guidance for Nursing Homes and Other Long-Term Care Facilities and Programs. Prior to the COVID-19 outbreak, in October 2020, IDVA staff were tested weekly, and the residents were tested every other week. The interim IDPH guidance from October 21, 2020, referenced that testing was based on the county positivity rate, and this rate was based on CMS data. IDVA was testing staff in accordance with the positivity rate the week before the outbreak. The residents were not tested that last week in October 2020, because the Illinois Veterans' Home at LaSalle (IVHL) was not in outbreak status, nor were there any staff positives, and the residents had been tested the week before (the week of October 20, 2021) with no positives.

Regarding the collection of tests, IVHL typically attempted to deliver tests every day or every other day to the IDPH laboratory. For the week of November 2, 2020, IVHL had already collected the first round of testing on the residents by Monday, November 2, 2020, and those tests were pending at the Chicago laboratory. On November 3rd and 4th, IVHL then did their round of testing on its staff. There is an e-mail from the IDVA Chief of Staff (COS), dated November 2, 2020, to IDPH that stated IVHL planned on delivering the tests to the laboratory on Wednesday (November 4, 2020). The COS also referenced the residents were swabbed, and those tests were pending at the IDPH Chicago laboratory. In the daily report from the COS dated November 3, 2020, he referenced that staff would be tested that day, and in his daily report from November 4, 2020, he stated, “Staff tests dropping today.” On November 5, 2020, IVHL did a second round of testing on the residents and tested a small number of employees that were not caught on November 3rd and 4th.

Generally, with IVHL’s testing schedule, the staff tests should have been ready to be delivered to the IDPH laboratory on November 4, 2020. However, it appears that the tests were not delivered on Wednesday (November 4, 2020). At that time, there were issues with the IDPH Chicago laboratory being overwhelmed since the Springfield lab was temporarily closed. During the beginning of the outbreak, the timing of collection and delivery of tests appears to be an isolated incident due to the circumstances with the laboratories.

After the outbreak began in November 2020, IDVA worked with the United States Department of Veterans’ Affairs (USDVA) and IDPH and adjusted its PCR testing of staff from weekly to twice a week (every 3-4 days) and on November 13, 2020, implemented daily pre-shift antigen testing for staff. IDVA continues to test in this manner when in outbreak status, regardless of vaccination status.

During the outbreak, there were residents that IVHL did not send to the hospital for further treatment due to the wishes of their Powers of Attorney(POA)/families. The Medical Director and his staff had specific conversations with the residents’ POAs/families about whether they would allow IVHL to send the residents to the hospital for further care. These conversations were documented in the residents’ records. Monoclonal antibody treatments were new, and the supply was limited during the outbreak at IVHL. These treatments were primarily administered at hospitals. Nonetheless, IVHL was able to obtain monoclonal antibody treatments through the Medical Director and his hospital, and under the Medical Director’s medical supervision, residents, who met the treatment criteria and agreed to the use, were provided with this treatment beginning in November 2020.

Prior to the testing policy being signed on November 1, 2020, IDVA was waiting on the Illinois Department of Central Management Services (CMS) Labor Relations Bureau to provide guidance for employees that refused to test as IDVA needed to be able to enforce testing through the disciplinary

process. CMS Labor issued a memorandum on October 28, 2020, outlining the guidelines for testing at the 24-hour facilities, and how to handle refusals to test through disciplinary measures. The IDVA policy was finalized and signed within days after receipt of this memorandum.

IDVA continued to follow the Centers for Medicare and Medicaid Services and IDPH guidance for testing up and until IDVA implemented a new written policy, HOM-25 COVID-19 Testing Plan, on April 23, 2021, with the assistance of Dr. Avery Hart from IDPH. This policy was again updated on November 22, 2021. Per the policy, IDVA collects staff and resident samples within a 24-hour period and designates an extra day to collect samples from staff who are not available for testing for reasons such as scheduled absences. Testing of staff and residents is done regardless of vaccination status. Due to COVID-19 guidance continuing to evolve, IDVA monitors changes with CDC, CMS, and IDPH guidance in order to update its policies.

---

## COVID-19 Outbreak Response at the LaSalle Veterans' Home (Determination 1)

Auditors determined that four positive COVID-19 cases were identified at the LaSalle Veterans' Home by Sunday, November 1, 2020. These four cases included two residents and two staff members. These four cases were reported by the IDVA Chief of Staff to the IDPH State Medical Officer and the First Assistant Deputy Governor for Health & Human Services on the afternoon of November 1, 2020.

Twelve days later, an email on November 13th from the IDVA Chief of Staff reported **83 total (82 current) residents, 93 (88 current) staff** with positive cases, **11 resident deaths**, and 3 residents and 1 employee hospitalized.

Auditors reviewed emails and documentation and conducted meetings and determined that although IDPH officials were informed of the increasing positive cases almost on a daily basis, IDPH did not identify and respond to the seriousness of the outbreak. It was the IDVA Chief of Staff who ultimately had to request assistance. The Chief of Staff inquired about a site visit and about rapid tests (November 9th), and inquired about getting antibody treatments (November 11th) for LaSalle Veterans' Home residents. From the documents reviewed, IDPH officials did not offer any advice or assistance as to how to slow the spread at the Home, offer to provide additional rapid COVID-19 tests, and were unsure of the availability of the antibody treatments for long-term care settings prior to being requested by the IDVA Chief of Staff.

It wasn't until November 11th, when the IDPH State Medical Officer noted that she spoke to the IDPH Chief of Staff and he told her the Governor was very concerned and wanted IDPH to visit the Home that a site visit by IDPH was scheduled. The site visit was conducted the following day.

---

House Resolution Number 62 asked auditors to determine the response of the Department of Veterans' Affairs to the outbreak of COVID-19 in 2020 at the LaSalle Veterans' Home. To address this determination, auditors reviewed policies, procedures, guidelines, and actions taken by various agencies. These include: the Illinois Department of Veterans' Affairs; the Illinois Department of Public Health; the Governor's office; the LaSalle County Health Department; and the U.S. Department of Veterans' Affairs (USDVA). Auditors requested and received all emails from IDPH and IDVA officials from the beginning of the LaSalle outbreak (October 23, 2020) through the site visit conducted by IDPH and the USDVA on November 12, 2020.

Auditors determined that four positive COVID-19 cases were identified at the LaSalle Veterans' Home by Sunday, November 1, 2020. These four cases included two residents and two staff members. These four cases were reported by the IDVA Chief of Staff to several individuals including the IDPH State Medical Officer and the First Assistant Deputy Governor for Health & Human Services on the afternoon of November 1, 2020.

After the identification of the initial four positive cases, the agencies listed above had differing responses to the outbreak. The following will summarize the key

responses by each agency over the next 11 days. Additionally, **Exhibit 15** summarizes the 2020 LaSalle Veterans' Home COVID-19 Outbreak Timeline.

### **LaSalle County Health Department**

According to LaSalle County Health Department officials, historically, they have had little to no involvement with outbreaks at Veterans' Homes as they were typically handled by the Illinois Department of Public Health. Since sometime around March or April 2020, due to the COVID-19 pandemic, they said they began to work with the Veterans' Home. Officials noted that LaSalle County had 19-20 long-term care facilities, and much of their role during the COVID-19 pandemic had been sending updated guidance from IDPH and the CDC to the long-term care facilities, including the Veterans' Home.

According to LaSalle County officials, they were notified of the outbreak at the LaSalle Veterans' Home on November 1, 2020, and contacted the Home and requested information on the number of residents and staff and the number of people tested. They also requested a line list that would show the number of residents and staff positive. It was also noted that LaSalle County notified the Illinois Department of Public Health on November 2, 2020, of the outbreak. According to County officials, IDPH had already been notified of the outbreak and it was accepted that IDPH would take the lead role in handling the outbreak and conducting a site visit. The County was to collect information and enter the information into IDPH's database.

On November 2, 2020, the LaSalle County Health Department emailed guidance to the LaSalle Home. This included line list and family letter examples, PPE guidance, cleaning and disinfection tips, COVID-19 testing guidance, resident monitoring protocols, and asymptomatic resident monitoring guidance. Additionally, numerous links were provided to CDC guidance related to testing, preventing the spread in long-term care facilities, staff seminars for cleaning, monitoring residents, keeping COVID-19 out, and PPE lessons.

On November 4, 2020, County Health Department officials emailed information which outlined guidelines for asymptomatic exposed healthcare workers to work under modified quarantine. The email stated "as soon as they show symptoms or tested positive, they were out for a 10 day isolation. Any staff under modified quarantine needs to understand that they're only allowed to work and go home. No grocery stores, no friend's houses, etc."

County officials were notified by the LaSalle Veterans' Home numerous times regarding the status of the outbreak.

### **United States Department of Veterans Affairs (USDVA) - Hines**

The officials from the USDVA at Hines provided the most guidance and conducted the bulk of all monitoring of the outbreak at the LaSalle Veterans' Home. On November 2, 2020, the Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and requested census information along with the number of COVID-19 positive residents and staff, the number of COVID-19 deaths, and the

number of outstanding tests. She also asked if the Home was having difficulties with PPE or testing. The LaSalle Home Administrator responded on November 3rd that there were 12 positive residents and 5 staff. She also reported that all resident tests were at the lab and the census was 128. Questions and exchanges between the LaSalle Home Administrator and the Health System Specialist to the Associate Director from the Hines Veterans Hospital occurred routinely over the next several days. There were discussions on November 2nd, 3rd, 5th, 7th, 8th, 9th, 10th, and 12th.

On November 5th, the Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and asked if the facility had PPE and if there were any staffing concerns. On November 9th, the Health System Specialist to the Associate Director from the Hines Veterans Hospital responded to the LaSalle Home Administrator asking “would you like a[n] infection control consultation?” The Home Administrator agreed that a consultation would be a good thing. Ultimately, the U.S. Department of Veterans Affairs would send the Manager of the Infection Control Section for Hines on site to conduct a visit. The USDVA report was used by IDPH as the IDPH Infection Control Coordinator was on site the same day.

### **The Office of the Governor**

The Deputy Governor for Health & Human Services and First Assistant Deputy Governor may not have realized the significance of the outbreak at the LaSalle Veterans' Home as the virus continued to progress through the Home. It wasn't until the Governor requested that someone go on site, more than 10 days after the outbreak began, that significant action was taken.

According to the Deputy Governor for Health & Human Services, the response to the outbreak was her responsibility. It was also overseen by her assistant, the First Assistant Deputy Governor. Auditors interviewed the Deputy Governor and she stated that her office thought that the leadership at IDVA and the Home were communicating and taking actions regarding the employees under their responsibility to ensure things were being done.

The Deputy Governor said that she had tried to figure out which day she had been informed of the outbreak but she could not pinpoint an exact day. She thought that it was likely the 3rd or 4th of November, but could not recall an exact date. Further, she believed that the IDVA Director was involved in operations during the outbreak and that the IDVA Chief of Staff was in contact with the IDPH State Medical Officer. Auditors requested exact dates of meetings or discussions related to the outbreak and the only documentation of a meeting was for a scheduled weekly meeting with IDVA on November 4th. After our interview and our review of email documentation provided by the Department of Innovation and Technology (DoIT), auditors could not document when the Deputy Governor was notified of the outbreak or when she had meetings or discussions with IDVA and IDPH officials regarding the outbreak at the LaSalle Veterans' Home. The first email we saw from the Deputy Governor from the information provided to auditors was on November 9th.

Auditors received the November 1, 2020, email documentation of the initial outbreak notice sent out by the IDVA Chief of Staff. The official at the Governor's office that received the email was the First Assistant Deputy Governor. Following the initial outbreak notice, the IDVA Chief of Staff sent out "IDVA Home Reports" to the First Assistant Deputy Governor on November 2nd, 3rd, 4th, 5th, 6th, 9th, 10th, 12th, and 13th.

On November 2, 2020, the First Assistant Deputy Governor emailed the IDVA Chief of Staff and asked "Do you need any extra support from DPH re LaSalle? Have you been able to connect with the State Medical Officer?" The following day, the IDVA Chief of Staff responded "I can't think of anything specific we need at LaSalle. You'll see shortly, it's not improving though. I have traded emails with the State Medical Officer on getting a call with the administrators and her team but we haven't locked in on a date/time yet."

As the IDVA Chief of Staff continued to report the increasing number of cases, auditors could not identify any further communications from the Governor's office until November 9th, when the Deputy Governor responded to the IDVA Chief of Staff in response to media questions following the first resident deaths. By this time, there were 67 staff and 64 residents positive with COVID-19. There also had been 3 resident deaths.

Additionally, on November 9th, the Deputy Governor for Health & Human Services emailed IDPH's Chief of Testing and the IDVA Chief of Staff and copied the IDPH Chief of Staff requesting that BinaxNOW tests be shipped "asap" to DVA homes with prioritization being LaSalle. Later on the 9th, the IDVA Chief of Staff emailed the State Medical Officer and copied the IDVA Director, the Deputy Governor, the First Assistant Deputy Governor, and the IDPH Chief of Staff about the LaSalle Home. His email stated the following: the virus had moved "very aggressively" through the LaSalle Home and he wanted to see if the State Medical Officer thought it would be beneficial for one of her staff to visit and "advise review" if there are additional mitigations they should be doing.

In an email on November 11, 2020, the IDPH State Medical Officer noted to the IDVA Chief of Staff and the Infection Control Consultant that she spoke to the IDPH Chief of Staff who told her the Governor was very concerned and wanted IDPH to visit the LaSalle Home. This was 22 minutes after a decision was made by the Infection Control Consultant for IDPH that the "processes being done are sound" and that the infection specialist at the LaSalle Home will reach out with any questions, and "at this time feels they are doing okay and doesn't feel the need for someone to visit." The Consultant stated: "Just feels like it came on quickly and hoping it will calm down just as quick. I will reach out in a day or two and see if he has additional needs." Therefore, it appears that without intervention by Governor Pritzker, a site visit would not have been conducted for several more days.

## Illinois Department of Public Health

The Illinois Department of Public Health did not act on the significant outbreak at the LaSalle Veterans' Home during the first week of November, even though it was the largest outbreak in any of the State's congregate care facilities. Although

The Illinois Department of Public Health did not act on the significant outbreak at the LaSalle Veterans' Home during the first week of November, even though it was the largest outbreak in any of the State's congregate care facilities.

IDPH officials were informed of the increasing positive cases almost on a daily basis, there was no action taken. The number of cases increased rapidly from 4 on November 1st to 53 on November 5th. By November 9th, there had been no effort by IDPH to reach out to the Home to provide assistance, solutions, or to determine the cause of the large outbreak, even though there were now 64 residents and 67 staff positive with COVID-19.

It also appeared that the IDVA Chief of Staff kept IDPH officials apprised of the increasing severity of the outbreak, requested assistance, inquired about additional rapid tests, and inquired about getting antibody treatments for LaSalle Veterans' Home residents. From the documents reviewed, management at IDPH did not offer any advice or assistance as to how to slow the spread at the Home, offer to provide additional rapid COVID-19 tests, and were unsure of the availability of the antibody treatments for long-term care settings prior to being requested by the IDVA Chief of Staff, even though the State had been allocated 6,380 vials of monoclonal antibodies, which could have been used to treat positive residents.

### Monday, November 2, 2020

The IDVA Chief of Staff reported an increase in positive cases (10 resident and 8 staff) to IDPH staff including the State Medical Officer and copied the First Assistant Deputy Governor. Later that day, the State Medical Officer responded to the email from the previous day and thanked the Chief of Staff and noted that it sounded "as if you are taking all of the appropriate steps." It is unclear how this determination that appropriate steps were being taken was reached since the number of positive cases appeared to increase by 350 percent in one day.

### Tuesday, November 3, 2020

This was Election Day, a State holiday. The IDVA Home Report sent by the IDVA Chief of Staff listed a total of 13 residents and 10 staff with positive cases as well as 3 residents hospitalized. There were few communications that day, likely due to the holiday. However, that evening, the LaSalle Home Administrator emailed the IDVA Chief of Staff that there were now 22 positive residents and 7 positive staff. This was emailed to the State Medical Officer the following morning.

### Thursday, November 5, 2020

The IDVA Chief of Staff reported an increase in positive cases (44 residents and 9 staff) to IDPH staff including the State Medical Officer and copied the First Assistant Deputy Governor. Auditors did not identify any further contact or guidance provided by IDPH that day.

**Saturday, November 7, 2020**

The IDVA Chief of Staff emailed the IDPH Public Health Educator that LaSalle had 31 employees come back positive overnight. He noted that currently 60 residents (nearly 1/2) and 43 employees (nearly 1/3) were positive. He also noted there were still 101 employee tests pending and that the Chicago lab was really slow, and they would be re-testing all the negative residents again and sending to the Springfield lab tomorrow. The IDPH Public Health Educator replied to the IDVA Chief of Staff that she would let the Director's office know about the increase in positive residents and employees.

**Sunday, November 8, 2020**

The IDVA Chief of Staff emailed the State Medical Officer and copied the First Assistant Deputy Governor and noted the deaths of two residents. He also noted that there were still four in the hospital. The response from the State Medical Officer was that she was sorry to hear about the deaths and thanked him for letting her know.

The IDVA Chief of Staff also informed the IDPH Public Health Educator that tomorrow's report would include two COVID-19 positive resident deaths and another 18 positive staff cases. He reported that there were now 59 residents and 61 employees positive. The Public Health Educator responded that she would pass it on to the Director's office.

**Monday, November 9, 2020**

The IDVA Chief of Staff emailed the State Medical Officer and asked for guidance on BinaxNOW rapid tests. The State Medical Officer provided point-of-care antigen testing guidance and asked if they could begin recurring meetings later that day at 1:00.

Late in the evening, the IDVA Chief of Staff emailed the State Medical Officer and copied IDVA Director, the Deputy Governor, First Assistant Deputy Governor, and the IDPH Chief of Staff about the LaSalle Home. He noted the virus had moved "very aggressively" through the LaSalle Home and he wanted to see if the State Medical Officer thought it would be beneficial for one of her staff to visit and "advise review" if there were additional mitigations they should be doing.

Late in the evening, the IDVA Chief of Staff emailed the State Medical Officer and copied the IDVA Director, the Deputy Governor, the First Assistant Deputy Governor, and the IDPH Chief of Staff about the LaSalle Home. He noted the virus had moved "very aggressively" through the LaSalle Home and he wanted to see if the State Medical Officer thought it would be beneficial for one of her staff to visit and "advise review" if there were additional mitigations they should be doing.

**Tuesday, November 10, 2020**

The IDVA Chief of Staff emailed the "IDVA Homes Report" to various IDVA, IDPH, and Governor's office staff, which included the Director of Veterans' Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there were a total of 68 total (64 current) residents and 70 (65 current) staff with positive cases. He reported 6 total deaths as well as 4 residents and 1 staff hospitalized.



### Wednesday, November 11, 2020

The State Medical Officer emailed the IDVA Chief of Staff responding to his November 9, 2020 request to possibly have IDPH staff visit the LaSalle Veterans' Home. The State Medical Officer responded "yes, certainly," and noted that she copied two infection preventionists who could help. She asked in the email whether one of the preventionists would be able to visit. The IDPH Chief of Staff emailed the State Medical Officer and the IDPH Communicable Disease Control Section Chief and asked them to arrange for one of the infection control specialists to "be at IVHL tomorrow, Friday at the latest."

The IDPH Infection Control Consultant emailed the State Medical Officer and the IDVA Chief of Staff noting that she spoke to the LaSalle Veterans' Home infection specialist and the Home's administrator. It was noted that the outbreak was large and came on rather quickly. It was reported that staffing was tight, their supply of PPE was adequate, employees were wearing full COVID PPE throughout the entire building, the facility was using KN95 masks in non-COVID rooms and fit tested N95 respirators in COVID rooms, and negative pressure rooms were being used for residents who were actively coughing. The Consultant concluded that the "processes being done are sound" and that the infection specialist at the LaSalle Home would reach out with any questions, and "at this time feels they are doing okay and doesn't feel the need for someone to visit." The Consultant stated: "Just feels like it came on quickly and hoping it will calm down just as quick. I will reach out in a day or two and see if he has additional needs."

Therefore, it appears that the decision was made to wait before conducting a site visit at LaSalle. It wasn't until the State Medical Officer also noted that she spoke

It wasn't until the State Medical Officer also noted that she spoke to the IDPH Chief of Staff and he told her the Governor was very concerned and wanted IDPH to visit the LaSalle Home that a site visit by IDPH was scheduled. In approximately two hours, the State Medical Officer reported to the IDPH Chief of Staff that a preventionist would be visiting the Home the following day.

to the IDPH Chief of Staff and he told her the Governor was very concerned and wanted IDPH to visit the LaSalle Home that a site visit by IDPH was scheduled. In approximately two hours, the State Medical Officer reported to the IDPH Chief of Staff that a preventionist would be visiting the Home the following day.

Also on this day, the IDVA Chief of Staff inquired with the State Medical Officer, the Deputy Governor, and the First Assistant Deputy Governor, noting that the Medical Director at the LaSalle facility was asking about trying to obtain monoclonal antibody treatments.

The State Medical Officer responded to the IDVA Chief of Staff and copied the Deputy Governor and the First Assistant Deputy Governor regarding the monoclonal antibody treatments and stated: "Interesting question. Let me look into this – I am checking also with our CDC medical consultant."

### Thursday, November 12, 2020

A site visit was conducted by the IDPH Infection Control Consultant and the consultant from the USDVA. The visit resulted in an official report written by the USDVA (which is discussed later in this report).

The IDVA Chief of Staff asked the State Medical Officer, the First Assistant Deputy Governor, and the Deputy Governor on their thoughts related to the monoclonal antibody treatments. The First Assistant Deputy Governor responded and noted that she added the IDPH Chief of Staff and that “the feds are in the early stages of distributing this and it will first go to hospitals. IDPH is currently working out a distribution process. I don’t think the state has even received any yet.” The IDPH Chief of Staff responded that he was working on it and “this stuff is just coming out.” He also noted there were “certain limiting parameters for its use.”

At 6:00 PM, the IDPH Division Chief of Emergency Medical Services and Highway Safety emailed the State Medical Officer, the IDPH Chief of Staff, the Deputy Governor, and the First Assistant Deputy Governor, noting the State had been allocated 6,380 vials of the treatment and they were waiting on a survey from health systems and hospitals, due the next day, to determine the allocation methodology.

Finally, at the end of the day, following the results from the site visit, the IDPH State Medical Officer reported to the IDPH Chief of Staff that the “source of the outbreak appears to be staff complacency.” She noted staff had not been wearing masks or social distancing. She also noted staff had been socializing and gathering in the parking lot and in the lunch room.

### **Conclusion**

The Illinois Department of Public Health was notified of the increasing number of COVID-19 cases at the LaSalle Veterans’ Home beginning on November 1, 2020, and did not identify and respond to the seriousness of the outbreak. The Illinois Department of Public Health’s mission statement is to protect the health and wellness of the people of Illinois through the prevention, health promotion, regulation, and the control of disease and injury. The Department of Public Health Act (20 ILCS 2305/2(a)) states that IDPH has general supervision of the interests of the health and lives of the people of the State. The statute also grants IDPH the “supreme authority” in matters of quarantine and isolation, and may declare and enforce quarantine and isolation when none exists, and may modify or relax quarantine and isolation when it has been established. Therefore, it was the responsibility of IDPH to provide guidance and monitoring to protect the residents at the LaSalle Veterans’ Home. To ensure a COVID-19 outbreak of this magnitude does not occur again at a Veterans’ Home, IDPH should clearly define its role in relation to monitoring COVID-19 outbreaks at Illinois veterans’ homes, and should develop policies and procedures that clearly identify criteria which mandate IDPH intervention at veterans’ homes during an outbreak of COVID-19.

**COVID-19 Monitoring and Policies**

**RECOMMENDATION  
NUMBER  
2**

- The Illinois Department of Public Health should:*
- *clearly define its role in relation to monitoring COVID-19 outbreaks at Illinois Veterans' Homes; and*
  - *develop policies and procedures that clearly identify criteria which mandate IDPH intervention at Veterans' Homes during an outbreak of COVID-19.*

**IDPH Response:** IDPH accepts this recommendation.

The Illinois Department of Public Health (IDPH) is evaluating its role in relation to the State of Illinois Veterans Homes, specifically how IDPH can strengthen its ability to provide guidance and support to these homes, as well as other congregate facilities, during a pandemic or other infectious disease outbreak.

This written response will address the Office of the Auditor General's (OAG) Audit Report (Report) on the Illinois Veteran's Home at LaSalle (IVH - LaSalle) fall 2020 COVID-19 outbreak, describing how IDPH has modified its operations to ensure effective communication and collaboration with the Illinois Department of Veteran's Affairs (IDVA) leadership.

**Note:** Due to its length, the Department's complete response to this recommendation is shown in Appendix E.

**Illinois Department of Veterans' Affairs**

The IDVA Chief of Staff notified the IDPH State Medical Officer and the First Assistant Deputy Governor of the first four cases of COVID-19 at the LaSalle Veterans' Home on November 1, 2020. Additionally on November 1st, the LaSalle Home Administrator emailed her staff informing them of the 2 resident and 2 staff cases.

The LaSalle Home Infection Control Nurse also informed the LaSalle County Health Department of the outbreak. The Infection Control Nurse noted that the Home would begin weekly testing of residents and continue weekly staff testing. It was further noted that staff would continue to wear surgical masks, face shields, and other additional PPE and that staff would be monitored for temperatures and symptoms 3 times a shift and residents would be monitored each shift.

**Communications within the LaSalle Veterans' Home**

Auditors found evidence that the LaSalle Veterans' Home Administrator emailed supervisory staff every few days during the outbreak. Emails were sent on November 1st, 3rd, 5th, 8th, and 10th. The emails contained the following information:

**Sunday, November 1st**

The email noted that there were 2 residents and 2 employees who had tested positive for COVID-19. It requested that staff "continue to be diligent with infection control precautions" and stated that "everyone needs to take breaks responsibly – maintain social distancing." Further, the email asked staff to "not sit together in your vehicles to smoke or visits, no potlucks in the break rooms on

the wings.” It instructed staff in close proximity with a co-worker to both wear masks. The email also stated **“We must stop this outbreak in its tracks! Please take this seriously – it is important to keeping our Veterans safe and healthy!”**

### Tuesday, November 3rd

The email asked supervisory staff to pass the email and an attached family update letter on to their staff. The email noted there were now 22 positive residents and 7 positive employees. The Administrator stated:

*Please, keep your chins up, keep working hard. We will get through this! This team is amazing!*

*This virus is ruthless and tenacious and it never rests so don't look down on our efforts – we held on a LONG time! Illinois is full of hot spots – not one region in the state is not in some level of mitigation again for increased positivity rates or hospitalization.*

*Don't give up! We still have to fight back and push this virus back out of our doors.*

*During this outbreak, all staff should be wearing their masks and face shields at all times when in the building. If you are in an office position, you can remove them when you are at your desk. Additionally, all staff should restrict movement within the building. If you need someone in an office, call them – do not go to the office. All residents are again quarantined to their rooms, so if you do not have to see a resident, you should not be on a residential wing. Take your breaks alone – it is a small sacrifice we can make. Continue to follow all infection control guidance from us and from Public Health both here and at home.*

*If you have any questions or concerns, please call me.*

*Thank you for all you do. Thank you for not giving up. Thank you for taking care of our Veterans – they need us now more than ever!*

### Thursday, November 5th

The email to supervisory staff stated the following:

*Hi all! It is has been quite a whirlwind this week! I have heard “wildfire” a lot this week and it's a pretty accurate description of our current circumstances. As of the time I'm typing this, we have 48 positive residents and 11 positive staff members. If you have been a direct exposure to anyone, you have been contacted. At this point, staffing is critical so we are utilizing critical infrastructure guidelines – this means that if you are not symptomatic, but are a known exposure, we can ask you to continue to work. If at any time you become symptomatic, you report it immediately and go home. Everyone, whether exposed or not, should already be monitoring themselves for symptoms at least 3 times each shift. I keep a log of my temps and symptoms in my office and you should all have the same. Staff on the floor/other departments log per their department rules. The key is that we are ALL doing it at least 3 times each shift.*

*I do not want anyone to underestimate any symptoms. Please report them immediately and you will go home and contact your own physician for next steps. This does not mean that we sent you home so you automatically get COVID pay. It has to be because you are a known 1st hand exposure or you are COVID positive yourself. And both of these have to have documentation to support.*

*As always if you have any questions or concerns, please let me know. Thank you for your continued hard work and dedication to our Veterans!*

### **Sunday, November 8th**

The email to supervisory staff stated the following:

*I'm looking back through emails and notes for the past few days and realize I have not sent one of these updates since Thursday. I am sorry for that. Our reality is very different today than Thursday.*

*Currently, we have 59 residents who are positive for COVID – 3 of them are in the hospital. Sadly, 3 Veterans have died in the last 24 hours.*

*We have 65 employees who are positive for COVID. And I know others are not feeling well. This puts our staffing in a critical situation.*

*A new letter will go to families, residents, and all of you tomorrow. Right now, we have resident tests at the lab for processing and I am checking for results frequently. Tomorrow, we are testing all employees again – I hope you all can get there. This is so important and the sooner we get you all tested, the sooner we get results. Do everything you can to be here, please.*

*When your results go to the lab, it can take 72 hours for those results to be released. On our normal testing schedule, you could test on Tuesday and the sample is not even delivered to the lab until Thursday. This is very frustrating, I know, and it causes a great deal of anxiety. I understand the wait can be miserable, so I will do my best to answer your calls or texts. Please know that if your result comes back positive, I WILL CALL YOU, no matter what time it is. So if you don't get that call, your results are either negative or incomplete.*

*The bad news is, this virus has hit us hard all at once. The good news is, the wave should recede in about a week. We just have to hang on. Keep doing your best, keep showing up – all for the Veterans who need us now more than ever. If you have a skill that can be used to care for them, please use it. We need ALL HANDS ON DECK to make it through this.*

*As always, if you have any questions, please let me know. I am here to support you any way that I can. **Redacted** is my cell number and you can check in with me any time. THANK YOU, THANK YOU, THANK YOU for ALL you are doing and the many hours you are giving.*

**Tuesday, November 10th**

The email to supervisory staff stated the following:

*These are sad days at IVHL. We have lost 6 Veterans to this awful virus. I know we all mourn together and I want to tell you all how sorry I am for your loss. I know these Veterans become family when they are here and this is just so much loss in a short period of time. I am working with IDVA to have some assistance for us to cope with this and I hope you will all continue to be supportive of your co-workers as they travel this journey as well.*

*We will get through this together. As always, if you have any questions, concerns, or just need someone to shout at/cry at whatever, I am here for you.*

**Illinois Department of Veterans' Affairs Management**

Based on our review of emails during the span of the outbreak, there was very little if any communication from the IDVA Director to anyone related to the outbreak. There was no evidence provided that showed the Director had any communications or involvement related to the LaSalle outbreak. This includes communication with the Administrator of the LaSalle Home, the IDVA Chief of Staff, officials from IDPH, or the Governor's office, including the First Assistant Deputy Governor or Deputy Governor who oversees the Health and Human Service agencies in Illinois. There was no documentation to support the Director was monitoring the situation or advocating for the health, safety, and welfare of the veterans who reside in the Homes under her care with IDPH and the Governor's office. Neither the Director nor any other IDVA official requested assistance from IDPH or the Governor's office early in the outbreak, which may have prompted assistance, thus slowing the spread of COVID-19.

What were referred to as "IDVA Home Reports" were sent by the IDVA Chief of Staff to the IDPH State Medical Officer and to the First Assistant Deputy Governor on November 2nd, 3rd, 4th, 5th, 6th, 9th, 10th, 12th, and 13th.

Almost all communication from IDVA with the LaSalle Home, the Governor's office, and IDPH was from the IDVA Chief of Staff. Auditors found evidence that the Chief of Staff provided continued communication to the Governor's office, the Illinois Emergency Management Agency, the U.S. Department of Veterans Affairs, and IDPH officials related to the increasing cases at the LaSalle Home. Auditors also identified continued

communication between the LaSalle Home Administrator and the U.S. Department of Veterans Affairs.

As noted above, the majority of all external communication related to the outbreak was originated by the Chief of Staff at IDVA. What were referred to as "IDVA Home Reports" were sent by the IDVA Chief of Staff to the IDPH State Medical Officer and to the First Assistant Deputy Governor on November 2nd, 3rd, 4th, 5th, 6th, 9th, 10th, 12th, and 13th (see Appendix C). The Chief of Staff also sent emails to IDPH requesting a site visit and for information on rapid tests on November 9th, and requested information on the monoclonal antibody treatments on November 11th. Auditors identified very little communication with

questions on operations or offering help or suggestions on how to slow the spread of the virus by officials from either the Governor's office or from IDPH.

**Senior Home Administrator Position**

During the outbreak, IDVA had not filled the Senior Home Administrator position. According to IDVA officials, the position was filled in November 2021, after being vacant for several years. The Senior Home Administrator position requires a nursing home license. According to documentation reviewed by auditors, including findings by the DHS OIG, the IDVA Chief of Staff made all decisions related to the outbreak at the LaSalle Veterans' Home. As such, the Chief of Staff was making all decisions related to the outbreak that may have been out of the area of his expertise.

However, our review of emails and documentation showed that the Chief of Staff was timely and attentive to all questions related to the outbreak at LaSalle. He also kept officials at IDPH informed of the severity of the outbreak. The Chief of Staff also requested help from IDPH, requested additional rapid tests from IDPH, and asked IDPH about the availability of antibody treatments. None of these were offered by IDPH prior to the Chief of Staff making the requests. If IDVA had a Senior Home Administrator, these requests possibly could have been made sooner and the decisions made by the LaSalle Home could have been monitored by a licensed administrator.

As noted above in the section outlining the actions by the USDVA, constant communication occurred and help was offered to the LaSalle Home. This type of communication and monitoring should be conducted by the Senior Home Administrator if future outbreaks of COVID-19 occur.

Veterans' Affairs Management	
<p><b>RECOMMENDATION NUMBER</b></p> <p style="font-size: 2em; font-weight: bold;">3</p>	<p><i>The Illinois Department of Veterans' Affairs should ensure that:</i></p> <ul style="list-style-type: none"> <li>• <i>the IDVA Director works with the Department of Public Health and the Governor's office during COVID-19 outbreaks to advocate for the health, safety, and welfare of the veterans who reside in the Homes under IDVA's care; and</i></li> <li>• <i>the Senior Home Administrator position is filled and the duties of the position include monitoring and providing guidance to the Veterans' Homes during COVID-19 outbreaks.</i></li> </ul>

**IDVA Response:** IDVA agrees with these recommendations. For nearly all of 2021 and until recently, the Director participated in daily calls with the senior leaders and Home Administrators. While recently adjusted to twice weekly, the morning calls with the Home Administrators and Senior Home Administrator still continue in which they discuss COVID updates at each respective home. The Director or his designee also communicates with the Governor's Office and IDPH when there are COVID updates at any of the homes involving topics such as significant outbreaks, changes in visitation, testing, and PPE. Additionally, there are bi-monthly calls with IDPH in which the Director, Senior Home Administrator, the Home Administrators and other senior leaders discuss COVID issues and new guidance. Since the outbreak in November of 2020, IDPH has made numerous site visits to the veterans' homes for consultation purposes related to COVID mitigation and infection prevention.

On November 16, 2021, the Senior Home Administrator (SHA) position was filled. As stated above, the SHA hosts twice weekly calls with the Home Administrators to discuss COVID issues/updates, and also hosts the bi-monthly phone calls with IDPH. The SHA also monitors and reviews the homes' policies for updates. In order to supplement assistance for the SHA, each home has an Infection Control Preventionist, and IDVA recently hired a Senior Home Infection Preventionist to oversee the infection prevention positions at all of the homes. The Senior Home Infection Preventionist starts employment on May 2, 2022.



**Timeline of the 2020 LaSalle Veterans' Home COVID-19 Outbreak**

The following Exhibit is a detailed timeline of the 2020 LaSalle Veterans' Home COVID-19 outbreak. The Exhibit summarizes various communication by IDVA, IDPH, and LaSalle Veterans' Home officials.

Exhibit 15 2020 LASALLE VETERANS' HOME COVID-19 OUTBREAK TIMELINE	
Illinois Department of Veterans' Affairs (IDVA)	Illinois Department of Public Health (IDPH)
<b>Sunday, November 1, 2020 (1<sup>st</sup> COVID-19 Communication to IDPH)</b>	
1:59 PM	The IDVA Chief of Staff emailed IDPH staff including the State Medical Officer and copied the First Assistant Deputy Governor for Health & Human Services that the LaSalle Veterans' Home had <b>2 residents</b> and <b>2 staff</b> test positive. It was noted that 4 more residents were tested and that all residents would be tested in the morning.
2:51 PM	The LaSalle Veterans' Home Administrator emailed staff that there were 2 residents and 2 employees who had tested for COVID-19. She requested that staff "continue to be diligent with infection control precautions." She also stated that "everyone needs to take breaks responsibly – maintain social distancing." Further she asked staff to "not sit together in your vehicles to smoke or visits, no potlucks in the break rooms on the wings." She instructed that staff in close proximity with a co-worker to both wear masks. In the email, she also stated " <b>We must stop this outbreak in its tracks!</b> Please take this seriously – it is important to keeping our Veterans safe and healthy!"
2:58 PM	The LaSalle Veterans' Home Infection Control Nurse informed the LaSalle County Health Department of the outbreak. The Infection Control Nurse noted that the Home would begin weekly testing of residents and continue weekly staff testing. It was further noted that staff would continue to wear surgical masks, face shields, and other additional PPE and that staff would be monitored for temperatures and symptoms 3 times a shift and residents would be monitored each shift.
3:10 PM	The LaSalle County Health Department emailed the LaSalle Home's Infection Control Nurse, the Director of Nursing, and LaSalle Home Administrator asking for a line list, the total number of staff, the total number of residents, and the total people tested.
<b>Monday, November 2, 2020</b>	
7:42 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and requested census information along with the number of COVID positive residents and staff, the number of COVID deaths, and the number of outstanding tests. It was also asked if there were any difficulties with PPE or testing.
7:44 AM	The LaSalle Home Administrator replied to the Health System Specialist that they were having an outbreak and that she would get back to her later in the day when she knew more. She noted that it was affecting both residents and staff.
8:45 AM	The IDVA Chief of Staff emailed the "IDVA Homes Report" to various IDVA, IDPH, and Governor's office staff, which included the Director of Veterans' Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: "Note: Outbreak at LaSalle" and reported <b>10 positive residents</b> (one recovered) and <b>8 positive staff</b> . One non-symptomatic hospitalization was also reported.
9:35 AM	The IDVA Labor Relations Administrator emailed the IDVA Chief of Staff noting that they needed to get the Director's signature on the Testing Policy.
9:38 AM	The IDVA Chief of Staff emailed the COVID-19 Testing Policy to the IDVA Director and her Assistant for signature and requested that it have "today's date please."
9:41 AM	The IDVA Director's Assistant returned the signed Testing Policy to the IDVA Chief of Staff.
9:58 AM	The IDVA Chief of Staff emailed the Testing Policy to the IDVA Labor Relations Administrator and to the IDVA General Counsel and asked to have it placed with other policies on SharePoint.
10:09 AM	The LaSalle County Health Department emailed numerous pieces of guidance documents to the LaSalle Home's Infection Control Nurse and LaSalle Home Administrator.
10:32 AM	The LaSalle Home's Infection Control Nurse emailed the COVID positive line list to the LaSalle County Health Department. The line list showed 10 positive residents and 3 positive staff.

12:26 PM	The LaSalle Home Administrator emailed staff and asked to order antigen test supplies.
12:30 PM	The LaSalle Home Administrator emailed the IDVA Chief of Staff that currently there were 11 positive residents with one additional in isolation awaiting the result from a PCR test. It was also noted that there were 3 positive employees with 2 pending test results.
12:31 PM	The IDVA Chief of Staff asked the Administrator if all 11 were from the West wing.
12:33 PM	The LaSalle Home Administrator responded to the IDVA Chief of Staff that all but one were from the West wing, the other is from the North West wing.
12:47 PM	The LaSalle County Health Department notified the IDPH Communicable Disease Control Section Chief that they were notified the night before of 3 positive cases and now 10 more this morning along with 2 hospitalizations. The LaSalle County Health Department noted that they sent all current guidance.
12:53 PM	The email from the LaSalle County Health Department was forwarded to the IDPH Director and the State Medical Officer.
2:44 PM	The State Medical Officer replied to the IDVA Chief of Staff's email from the previous day at 1:59 PM. The State Medical Officer stated "Thank you [REDACTED] – it sounds as if you are taking all of the appropriate steps."
2:46 PM	The State Medical Officer forwarded the LaSalle County Health Department email to the IDPH Director and noted that the IDVA Chief of Staff notified the First Assistant Deputy Governor and that it sounded like he was taking "all of the appropriate steps."
2:48 PM	The IDVA Public Information Officer emailed the two Communications Directors at the Governor's office and reported the outbreak at the LaSalle Veterans' Home. The email noted that 11 residents and 3 employees tested positive.
2:55 PM	The IDVA Chief of Staff emailed the State Medical Officer that there were 11 residents and 3 staff with COVID. He noted that all but one were from the West wing and all residents had been swabbed and were at the lab in Chicago. Additionally, he noted that the employees would be tested "today/tomorrow" and would be delivered to the lab on Wednesday.
4:06 PM	IDPH Siren Notification issued for Region 2; as of November 4, 2020, long-term care facilities must suspend indoor visitation and off-site outings.
4:57 PM	The LaSalle Home Administrator emailed the IDVA Labor Relations Administrator and copied the IDVA Chief of Staff and reported 11 positive residents (2 were in the hospital) and 2 additional residents were in isolation pending test results. There were also 5 staff positives with 11 in quarantine with exposure or symptoms.
8:58 PM	The First Assistant Deputy Governor for Health & Human Services emailed the IDVA Chief of Staff and asked, "Do you need any extra support from DPH re LaSalle? Have you been able to connect with the State Medical Officer?"
<b>Tuesday, November 3, 2020</b>	
7:34 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and asked for the total census, the numbers of tests, the number of COVID positive residents and staff, the number of tests outstanding, the number of COVID related deaths, and also any areas of difficulty.
8:47 AM	The IDVA Chief of Staff responded to the First Assistant Deputy Governor noting "I can't think of anything specific we need at LaSalle. You'll see shortly, it's not improving though. I have traded emails with the State Medical Officer on getting a call with the administrators and her team but we haven't locked in on a date/time yet."
9:03 AM	The IDVA Chief of Staff emailed the "IDVA Homes Report" to various IDVA, IDPH, and Governor's office staff, which included the Director of Veterans' Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there were a total of <b>13 residents (12 current)</b> and <b>10 staff (5 current)</b> with positive cases as well as 3 residents hospitalized.
10:02 AM	The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting that all tests were at the lab. It was also reported that the total census was 128 and there were 12 positive residents and 5 positive staff.
10:36 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and asked the following: <ul style="list-style-type: none"> <li>• Are any of the 12 residents who tested positive experiencing symptoms?</li> <li>• Were the 12 residents who tested positive on the same unit?</li> <li>• Were the staff on the same unit?</li> </ul>

	<ul style="list-style-type: none"> <li>• I'm guessing positive staff are quarantining for 14 days, can you confirm?</li> <li>• How are you isolating the residents?</li> </ul>
12:04 PM	The LaSalle Home Administrator responded to the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting that all 12 experienced symptoms, residents were from the same unit but were now seeing symptoms elsewhere, one nurse from the west seemed to be the source, positive staff were quarantining for 10 days with the last 24 hours being symptom free, and residents were isolated in the negative pressure wing.
4:51 PM	The LaSalle Home Administrator emailed supervisory staff and asked them to pass the email and an attached family update letter on to their staff. The email noted there were now 22 positive residents and 7 positive employees. The Administrator stated: "Please, keep your chins up, keep working hard. We will get through this! This team is amazing! This virus is ruthless and tenacious and it never rests so don't look down on our efforts – we held on a LONG time! Illinois is full of hot spots – not one region in the state is not in some level of mitigation again for increased positivity rates or hospitalization. Don't give up! We still have to fight back and push this virus back out of our doors. During this outbreak, all staff should be wearing their masks and face shields at all times when in the building. If you are in an office position, you can remove them when you are at your desk. Additionally, all staff should restrict movement within the building. If you need someone in an office, call them – do not go to the office. All residents are again quarantined to their rooms, so if you do not have to see a resident, you should not be on a residential wing. Take your breaks alone – it is a small sacrifice we can make. Continue to follow all infection control guidance from us and from Public Health both here and at home. If you have any questions or concerns, please call me. Thank you for all you do. Thank you for not giving up. Thank you for taking care of our Veterans – they need us now more than ever!"
5:33 PM	The LaSalle Home Administrator responded to the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting they ended the day with 22 positive residents, who were all moved to isolation in negative pressure rooms, and there were 7 positive staff.
5:33 PM	The LaSalle Home Administrator emailed the Daily Report to the IDVA Chief of Staff. The Report showed that there were 22 positive residents and 7 positive staff.
<b>Wednesday, November 4, 2020</b>	
7:59 AM	The LaSalle Home Infection Control Nurse emailed the current COVID positive line list to the LaSalle County Health Department. The list contained the names of 20 residents and 7 staff.
8:30 AM	The IDVA Chief of Staff emailed the "IDVA Homes Report" to various IDVA, IDPH, and Governor's office staff, which included the Director of Veterans' Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there was a total of <b>23 total (22 current) residents</b> and <b>12 (7 current) staff</b> with positive cases as well as 3 residents hospitalized.
3:56 PM	The LaSalle County Health Department emailed the LaSalle Home's Infection Control Nurse and provided information which outlined guidelines for asymptomatic exposed healthcare workers to work under modified quarantine. The email stated "as soon as they show symptoms or tested positive, they were out for a 10 day isolation. Any staff under modified quarantine needs to understand that they're only allowed to work and go home. No grocery stores, no friend's houses, etc."
4:37 PM	The LaSalle Home Administrator emailed the Daily Report to the IDVA Chief of Staff. The Report showed that there were <b>36 positive residents and 8 positive staff</b> .
<b>Thursday, November 5, 2020</b>	
7:47 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and asked if the facility had PPE and if there were any staffing concerns. It was indicated that during the Manteno outbreak, Manteno received help for staff issues from IDPH. The Specialist also asked whether 3 were still hospitalized.
8:46 AM	The IDVA Chief of Staff emailed the "IDVA Homes Report" to various IDVA, IDPH, and Governor's office staff, which included the Director of Veterans' Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there were a total of <b>45 total (44 current) residents</b> and <b>14 (9 current) staff</b> with positive cases as well as 3 residents hospitalized. He noted that employee tests would be "dropping today."
9:08 AM	An IDPH Siren Notification was issued on Ventilation Systems Guidance During COVID-19.
9:30 AM	The LaSalle Home Administrator responded to the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting they couldn't get a lead on true medical "N95s" and the stock was "critically low." It was also reported that staffing was getting challenging and

	that they would let them know if they need anything else. Finally, it was reported that there were 44 residents and 8 staff positive and staff samples were being sent to the "Chicago IDPH lab today."
10:37 AM	The LaSalle Home's Director of Nursing emailed the Home's Infection Control Nurse and asked, "What do you think about having West staff wear full PPE since they are the hot spot, and we will be expanding over to West B hall?"
10:53 AM	The LaSalle Home's Infection Control Nurse responded to the Director of Nursing's PPE question stating, "Might as well."
12:43 PM	The LaSalle Home's Infection Control Nurse emailed the COVID positive line list to the LaSalle County Health Department. The line list showed 44 positive residents and 11 positive staff.
3:53 PM	The LaSalle Home Administrator emailed supervisory staff stating the following: "Hi all! It is has been quite a whirlwind this week! I have heard "wildfire" a lot this week and it's a pretty accurate description of our current circumstances. As of the time I'm typing this, we have 48 positive residents and 11 positive staff members. If you have been a direct exposure to anyone, you have been contacted. At this point, staffing is critical so we are utilizing critical infrastructure guidelines – this means that if you are not symptomatic, but are a known exposure, we can ask you to continue to work. If at any time you become symptomatic, you report it immediately and go home. Everyone, whether exposed or not, should already be monitoring themselves for symptoms at least 3 times each shift. I keep a log of my temps and symptoms in my office and you should all have the same. Staff on the floor/other departments log per their department rules. The key is that we are ALL doing it at least 3 times each shift. I do not want anyone to underestimate any symptoms. Please report them immediately and you will go home and contact your own physician for next steps. This does not mean that we sent you home so you automatically get COVID pay. It has to be because you are a known 1st hand exposure or you are COVID positive yourself. And both of these have to have documentation to support. As always if you have any questions or concerns, please let me know. Thank you for your continued hard work and dedication to our Veterans!"
5:30 PM	The LaSalle Home Administrator emailed the Daily Report to the IDVA Chief of Staff. The Report showed that there were <b>48 positive residents and 12 positive staff</b> . There were 195 staff and 90 resident tests still pending.
5:31 PM	The LaSalle Home Administrator responded to the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting 48 residents and 12 staff were positive and 3 residents were hospitalized.
<b>Friday, November 6, 2020</b>	
9:02 AM	The IDVA Chief of Staff emailed the "IDVA Homes Report" to various IDVA, IDPH, and Governor's office staff, which included the Director of Veterans' Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there were a total of <b>49 total (48 current) residents</b> and <b>17 (12 current) staff</b> with positive cases as well as 3 residents hospitalized. He also noted that there were 282 tests pending (192 staff and 90 residents).
11:05 AM	IDVA officials responded to a media inquiry about the LaSalle outbreak. The response noted the 49 residents and 17 staff testing positive for COVID. It further noted that those positive were being isolated and monitored for symptom and all families had been notified.
3:17 PM	The LaSalle Home's Infection Control Nurse emailed the LaSalle Home Administrator, the Director and Assistant Director of Nursing, and other supervisory staff that currently there were 54 quarantined employees.
3:47 PM	The LaSalle Home's Dietary Manager emailed the LaSalle Home Administrator that she was not aware that the A Hall of the West wing was now being used for isolation. The Dietary Manager also indicated that the Home's Infection Control Nurse was not aware either.
4:43 PM	The IDVA Chief of Staff emailed the IDPH Public Health Educator that there were issues with their data and he might not have an update until "nearly noon tomorrow."
6:11 PM	The State Medical Officer emailed the IDVA Chief of Staff about trying to set up weekly IDPH/IDVA COVID-19 meetings. Monday afternoon meetings were proposed.
7:03 PM	The IDPH Public Health Educator replied to the IDVA Chief of Staff that the IDPH Director hadn't been requiring them to report on weekends, "unless there are major changes."
<b>Saturday, November 7, 2020</b>	
9:32 AM	The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting "Overnight we got several more results. We do not have

	all employee back yet, but our staffing is now critical. Currently 60 positive residents and 43 employees. Four of those residents are in the hospital.”
11:34 AM	IDVA Chief of Staff emailed IDPH Lab Manager and copied the State Medical Officer noting there was a “major outbreak” at the LaSalle Home. He noted that half of the residents were positive based on the prior week’s testing and that nearly 1/3 of the staff were positive. He noted that they were testing that day and were planning to send 67 more tests for residents on Sunday morning and asked if the lab was still open from 8 AM to 8 PM.
11:38 AM	The IDVA Chief of Staff emailed the IDPH Public Health Educator that LaSalle had 31 employees come back positive overnight. He noted specifically, “We’re currently at <b>60 residents and 43 employees positive</b> . We still have 101 employees tests pending (the Chicago lab is really slow). We will be re-testing all the negative residents again and sending to the Springfield lab tomorrow”
11:50 AM	The IDVA Chief of Staff emailed the IDVA Public Information Officer and the two Communications Directors at the Governor’s office and copied the Deputy Governor, the First Assistant Deputy Governor, the IDVA Director and Assistant Director, and the IDVA Labor Relations Administrator and informed them of the increase in positive residents from 48 to 60 and employees from 12 to 43. He further noted that there were four residents hospitalized and they were waiting for over 100 employee tests to come back from the IDPH lab.
11:52 AM	The IDPH Lab Manager replied to IDVA Chief of Staff and the State Medical Officer that the lab was open from 10-2 and noted, “We do have a bit of a backlog but we will get to them as soon as we can.”
2:14 PM	The IDPH Public Health Educator replied to the IDVA Chief of Staff that she would let the Director’s office know about the increase in positive residents and employees noted in the 11:38 AM email.
<b>Sunday, November 8, 2020</b>	
7:01 AM	The LaSalle Home Administrator emailed the IDVA Chief of Staff reporting that 2 residents had passed.
10:40 AM	The IDVA Chief of Staff emailed the IDVA Public Information Officer and the two Communications Directors at the Governor’s office and copied the Deputy Governor, the First Assistant Deputy Governor, the IDVA Director and Assistant Director, and the IDVA Labor Relations Administrator and informed them of the 2 resident deaths and that he believed there were some additional positives.
10:44 AM	The IDVA Chief of Staff emailed the State Medical Officer and copied the First Assistant Deputy Governor for Health & Human Services and noted the deaths of 2 residents. He also noted that there were still 4 in the hospital.
11:30 AM	The IDVA Chief of Staff emailed the IDPH Public Health Educator and reported that tomorrow’s report would include 2 COVID positive resident deaths at LaSalle and another 18 staff positives. There were now 59 residents and 61 employees positive.
1:13 PM	The State Medical Officer emailed IDVA Chief of Staff that <b>she was sorry to hear about the deaths and thanked him for letting her know.</b>
1:41 PM	The IDPH Public Health Educator responded to the IDPH Chief of Staff and noted, “Wow, this poor facility. I will pass this on to the director’s office.”
7:57 PM	The LaSalle Home Administrator emailed the IDVA Chief of Staff reporting that an additional resident passed.
9:01 PM	The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital and reported a census of 125, 59 positive residents (3 hospitalized), and 65 positive employees. Three resident deaths over the last 24 hours were also reported.
9:27 PM	The LaSalle Home Administrator emailed supervisory staff stating the following: “I’m looking back through emails and notes for the past few days and realize I have not sent one of these updates since Thursday. I am sorry for that. Our reality is very different today than Thursday. Currently, we have 59 residents who are positive for COVID – 3 of them are in the hospital. Sadly, 3 Veterans have died in the last 24 hours. We have 65 employees who are positive for COVID. And I know others are not feeling well. This puts our staffing in a critical situation. A new letter will go to families, residents, and all of you tomorrow. Right now, we have resident tests at the lab for processing and I am checking for results frequently. Tomorrow, we are testing all employees again – I hope you all can get there. This is so important and the sooner we get you all tested, the sooner we get results. Do everything you can to be here, please. When your results go to the lab, it can take 72 hours for those results to be released. On our normal testing schedule, you could test on

	Tuesday and the sample is not even delivered to the lab until Thursday. This is very frustrating, I know, and it causes a great deal of anxiety. I understand the wait can be miserable, so I will do my best to answer your calls or texts. Please know that if your result comes back positive, I WILL CALL YOU, no matter what time it is. So if you don't get that call, your results are either negative or incomplete. The bad news is, this virus has hit us hard all at once. The good news is, the wave should recede in about a week. We just have to hang on. Keep doing your best, keep showing up – all for the Veterans who need us now more than ever. If you have a skill that can be used to care for them, please use it. We need ALL HANDS ON DECK to make it through this. As always, if you have any questions, please let me know. I am here to support you any way that I can. [redacted] is my cell number and you can check in with me any time. THANK YOU, THANK YOU, THANK YOU for ALL you are doing and the many hours you are giving.”
<b>Monday, November 9, 2020</b>	
8:28 AM	The IDVA Public Information Officer emailed the IDVA Chief of Staff and asked if there was anything new happening.
8:29 AM	The IDVA Chief of Staff responded to the IDVA Public Information Officer, “Yes. Coming soon, more staff, more residents and another death.”
8:51 AM	The IDVA Chief of Staff emailed the State Medical Officer and asked for guidance on BinaxNOW rapid tests.
9:00 AM	The State Medical Officer emailed point-of-care antigen testing guidance and asked if they could begin recurring meeting later that day at 1:00.
9:06 AM	The IDVA Chief of Staff emailed the “IDVA Homes Report” to various IDVA, IDPH, and Governor’s office staff, which included the Director of Veterans’ Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there were a total of <b>63 total (59 current) residents</b> and <b>70 (65 current) staff</b> with positive cases. He reported <b>3 deaths</b> as well as 3 residents hospitalized. He also noted that there were 66 tests pending (65 staff and 1 resident).
10:35 AM	The IDVA General Counsel emailed the IDVA Chief of Staff and asked what was being done about staffing at LaSalle.
10:36 AM	The LaSalle Home’s Infection Control Nurse emailed the LaSalle County Health Department informing them of 3 deaths over the weekend.
10:55 AM	The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital and reported they were working through staffing issues and at that point were not requesting any additional staff.
10:59 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital responded to the LaSalle Home Administrator asking, “[W]ould you like a[n] infection control consultation?”
12:55 PM	The LaSalle Home Administrator replied to the Health System Specialist to the Associate Director from the Hines Veterans Hospital question about an infection control consultation and stated, “I think that would be a good thing.”
12:56 PM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital responded to the LaSalle Home Administrator, “I will get that moving.”
2:18 PM	An email from the IDVA Chief of Staff responding to media questions was shared with the Deputy Governor, the First Assistant Deputy Governor, the communications and public information officers from the Governor’s office and IDVA. The email noted 67 employees and 64 residents (over 1/2) were positive with COVID. It also noted 3 resident deaths.
2:30 PM	The Deputy Governor for Health & Human Services emailed the IDVA Chief of Staff, the First Assistant Deputy Governor, and the communications and public information officers from the Governor’s office and IDVA the following inclusions to the previous email: <ul style="list-style-type: none"> <li>• They are doing no more admitting, no visitors as of Friday.</li> <li>• In addition to regular PCR testing to DPH labs, they are also going to ramp up the use of more antigen faster time tests.</li> <li>• They have segregated staff and residents into the covid wing who are positive.</li> <li>• Reinforced all of the safety measures to employees for their personal lives.</li> <li>• They also have 3 residents currently hospitalized.</li> </ul>
2:33 PM	The Deputy Governor for Health & Human Services emailed IDPH’s Chief of Testing and the IDVA Chief of Staff and copied the IDPH Chief of Staff requesting that BinaxNOW tests be shipped “asap” to DVA homes with prioritization being LaSalle.

3:15 PM	The LaSalle Home Administrator emailed the IDVA Chief of Staff and the IDVA Public Information Officer and discussed questions from families. The theme of the questions was related to how the Home was continuing to take care of residents with so many sick staff members. The email noted: many are working overtime; other departments are helping with what they are able to; some staff who are not having serious symptoms are working as able in the isolation unit; and 69 is a large number, but our total number of employees is over 200 and not all of the positives are nursing staff.
3:48 PM	A LaSalle Home staff member emailed an updated room roster to the Home management and noted that this list is "fluid" but "people have been talking all day about how they don't know where people went, they cannot keep track of things, etc."
5:12 PM	The IDPH Chief of Testing replied to the Deputy Governor's 2:33 PM email that "we can make that happen."
5:37 PM	The IDVA Chief of Staff emailed the LaSalle Home Administrator that they would receive two batches of 640 antigen tests.
5:44 PM	The IDVA Chief of Staff emailed the IDPH Chief of Testing and specifically asked that, per their earlier conversation, two cases of antigen tests (one asap and one to follow) be sent to the LaSalle Home.
6:33 PM	The IDPH Chief of Testing emailed the IDVA Chief of Staff noting that they would get the tests in tomorrow's shipment.
6:39 PM	The Illinois Association of County Veterans Assistance Commissions, Kane County, emailed the IDVA Director and Assistant Director and offered to help collecting PPE, transporting supplies, collecting needed items for residents, or whatever else within their capabilities.
8:59 PM	The IDVA Chief of Staff emailed the IDVA Director regarding the Kane County email and noted: "Thank him for the outreach. We're honestly good on PPE and supplies. I think anything they can do to promote the communities around our homes to follow the mitigations is the more helpful."
9:08 PM	The IDVA Assistant Director replied to Kane County: "Thank you very much for the offer. We truly appreciate you reaching out and offering assistance. We will keep you in mind as we continue to work through all of our options and contingencies at LVH."
9:10 PM	The IDVA Chief of Staff emailed the State Medical Officer and copied the IDVA Director, the Deputy Governor, the First Assistant Deputy Governor, and the IDPH Chief of Staff about the LaSalle Home. His email stated the following: <b><u>the virus had moved "very aggressively" through the Home and he wanted to see if the State Medical Officer thought it would be beneficial for one of her staff to visit and "advise review" if there are additional mitigations they should be doing.</u></b>
<b>Tuesday, November 10, 2020</b>	
6:32 AM	A Hines Manager from the Infection Control Section emailed the LaSalle Home Administrator and asked about setting up a time to speak late in the day to see how they could assist.
7:32 AM	The LaSalle Home's Infection Control Nurse emailed the LaSalle Home Administrator and the LaSalle Director and Assistant Director of Nursing a copy of the current line list which showed a total of 72 residents and 69 staff that were positive for COVID-19.
7:58 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and asked for the total census, the numbers of tests, the number of COVID positive residents and staff, the number of tests outstanding, the number of COVID related deaths, and also any areas of difficulty.
8:31 AM	The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting the total census was 122 and there were 64 positive residents (6 deaths and 4 currently hospitalized), 69 positive staff, and 2 resident and 140 staff tests out.
8:57 AM	The LaSalle Home Administrator emailed the IDVA Chief of Staff and reported there were 64 positive residents, 69 positive staff, 3 residents in the hospital, and 6 deaths.
9:10 AM	The LaSalle Home's Infection Control Nurse emailed the LaSalle County Health Department and noted there were 3 additional deaths in the last 24 hours.
9:26 AM	The IDVA Chief of Staff emailed the "IDVA Homes Report" to various IDVA, IDPH, and Governor's office staff, which included the Director of Veterans' Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated that there were a total of <b>68 total (64 current) residents</b> and <b>70 (65 current) staff</b> with positive cases. He reported <b>6 total deaths</b> as well as 4 residents and 1 staff hospitalized.

9:34 AM	The LaSalle Home Administrator emailed the Director and Assistant Director of Nursing and the Infection Control Nurse and noted that the Home's Medical Director was planning to come in that morning to meet with them. They were to discuss staffing and moves after isolation.
10:15 AM	The IDVA Chief of Staff emailed the IDPH Public Health Educator and clarified that there were 3 deaths on the previous day's report and 3 more overnight for a total of 6.
12:42 PM	The First Assistant Deputy Governor emailed the IDVA Chief of Staff to "Please call me asap."
1:04 PM	The LaSalle Home Administrator emailed the IDVA Chief of Staff and the IDVA Public Information Officer noting "I am going to be calling all the families and I need some ideas for how to handle these questions please."
1:26 PM	The LaSalle Home Administrator emailed supervisory staff stating the following: "These are sad days at IVHL. We have lost 6 Veterans to this awful virus. I know we all mourn together and I want to tell you all how sorry I am for your loss. I know these Veterans become family when they are here and this is just so much loss in a short period of time. I am working with IDVA to have some assistance for us to cope with this and I hope you will all continue to be supportive of your co-workers as they travel this journey as well. We will get through this together. As always, if you have any questions, concerns, or just need someone to shout at/cry at whatever, I am here for you."
<b>Wednesday, November 11, 2020</b>	
9:05 AM	The State Medical Officer emailed the IDVA Chief of Staff responding to his request to possibly have IDPH staff visit the LaSalle Veterans' Home. The State Medical Officer responded, "yes, certainly," and noted that she had copied two infection preventionists who could help. She asked in the email whether one of the preventionists would be able to visit.
9:05 AM	An automatic reply was returned that one of the preventionists was out of the office for Veterans Day.
10:36 AM	The IDPH Chief of Staff emailed the State Medical Officer and the IDPH Communicable Disease Control Section Chief and asked them to arrange for one of the infection control specialists to "be at IVHL tomorrow, Friday at the latest."
10:37 AM	The State Medical Officer emailed the IDPH Chief of Staff and responded that "this is already underway."
10:43 AM	The IDVA Chief of Staff emailed the State Medical Officer and copied the Deputy Governor and First Assistant Deputy Governor, noting that the Medical Director at the LaSalle facility was asking about trying to obtain monoclonal antibody treatments.
10:45 AM	The IDPH Chief of Staff emailed the State Medical Officer asking her to call him regarding his previous email about getting an infection control specialist on site.
10:46 AM	The IDVA Chief of Staff emailed the State Medical Officer and copied the Deputy Governor and First Assistant Deputy Governor, noting that the Medical Director was told there were 6,500 doses (of monoclonal antibody treatments) sent to the State and asked if any would be available for the veterans' homes.
10:46 AM	The State Medical Officer emailed IDPH Chief of Staff noting that an Infection Control Consultant was working on the situation that morning with the local health department. The State Medical Officer stated that she would share the findings and recommendations when she received them.
11:29 AM	The LaSalle Veterans' Home's Infection Control Nurse emailed the LaSalle Home Administrator and the Infection Control Consultant the current line list. The list showed 81 residents and 74 staff with COVID-19.
11:34 AM	The LaSalle Veterans' Home's Infection Control Nurse emailed the line list to the LaSalle County Health Department and reported another resident death.
11:37 AM	The Infection Control Consultant emailed the State Medical Officer and the IDVA Chief of Staff that she spoke to the LaSalle Veterans' Home Infection Control Nurse and the LaSalle Home Administrator. It was noted that the outbreak was large and came on rather quickly. It was reported that staffing was tight, their supply of PPE was adequate, employees were wearing full COVID PPE throughout the entire building, the facility was using KN95 masks in non-COVID rooms and fit tested N95 respirators in COVID rooms, negative pressure rooms were being used for residents who were actively coughing. The Consultant concluded that the "processes being done are sound" and that the [Infection Control Nurse] at the Home will reach out with any questions, and "at this time feels they are doing okay and doesn't feel the need for someone to visit." The Consultant stated: "Just feels like it came on quickly and hoping it will calm down just as quick. I will reach out in a day or two and see if he has additional needs."



11:59 AM	The State Medical Officer emailed the Infection Control Consultant and IDVA Chief of Staff and asked the Consultant if she had “a sense for how the outbreak got so large so quickly?” The State Medical Officer also noted that she spoke to the IDPH Chief of Staff and he told her the Governor was very concerned and wanted IDPH to visit the Home.
12:11 PM	The Infection Control Consultant emailed the State Medical Officer and provided the names of two individuals who might be able to go conduct a site visit.
1:05 PM	The IDPH Communicable Disease Control Section Chief emailed the State Medical Officer that one of the preventionists was able to go as early as tomorrow (November 12, 2020).
1:58 PM	The LaSalle Home Administrator emailed the Infection Control Nurse and the Director and Assistant Director of Nursing and stated “We can bring people back early from quarantine if they are well enough OR have positive staff work if they are well enough, but we need to go through our local health department, give names of the employees to them and get documented approval. I would say the employee name, positive test date, symptom onset date (if different) and current symptom status.”
2:01 PM	The IDVA Chief of Staff replied to the 11:59 AM email from the State Medical Officer which noted “the sooner the better” and there were 12 more positive employees from the tests from yesterday. He also stated: “Not exactly sustainable but I’m thinking about doing antigen tests at shift changes.”
2:06 PM	The State Medical Officer emailed IDVA Chief of Staff that the IDPH Infection Control Coordinator would be at the Home tomorrow.
2:16 PM	The State Medical Officer responded to the IDVA Chief of Staff and copied the Deputy Governor and the First Assistant Deputy Governor regarding the monoclonal antibody treatments and stated: “Interesting question. Let me look into this – I am checking also with our CDC medical consultant.”
4:10 PM	The LaSalle Home Administrator emailed the family update letter to the IDVA Chief of Staff, the IDVA Public Information Officer, and a few other staff and copied the IDVA Director and Assistant Director. The letter reported: “Since the beginning of the crisis we have had a total of 81 positive residents and 88 positive employees. Unfortunately, seven (7) of those residents who tested positive have passed away. We are following the latest medical guidance and are working with state, federal and local health officials to ensure the continued care for all of our residents and testing and protection of anyone potentially exposed.”
8:32 PM	The First Assistant Deputy Governor emailed the IDVA Chief of Staff and copied the IDVA Director and the Deputy Governor and asked when IDPH was sending someone and who were they sending.
8:34 PM	The IDVA Chief of Staff responded that someone would be there tomorrow and mentioned the IDPH Infection Control Coordinator and possibly the State Medical Officer.
<b>Thursday, November 12, 2020</b>	
7:48 AM	The Health System Specialist to the Associate Director from the Hines Veterans Hospital emailed the LaSalle Home Administrator and asked for the total census, the numbers of tests out, total number of deaths, and number of COVID positive residents and staff. It was also asked if they had any PPE, staffing, or testing difficulties.
7:52 AM	The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting that when she left the night before there were 74 positive residents (3 in the hospital), and 88 positive staff. The census was reported to be 121.
7:55 AM	The IDPH Communicable Disease Control Section Chief emailed the LaSalle County Health Department informing that IDPH would be onsite arriving shortly after noon.
7:55 AM	The Hines Infection Control Manager emailed the LaSalle Home Administrator that her arrival time was 9:15-9:30.
7:58 AM	The LaSalle Home Administrator responded to the Hines Infection Control Manager that IDPH would also be there.
8:00 AM	The LaSalle Home’s Infection Control Nurse emailed the LaSalle County Health Department and copied the LaSalle Home Administrator and the Director and Assistant Director of Nursing informing them of 2 deaths over the last 24 hours.
9:24 AM	The IDVA Chief of Staff emailed the “IDVA Homes Report” to various IDVA, IDPH, and Governor’s office staff, which included the Director of Veterans’ Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there were a total of <b>73 positive residents</b> and <b>88 positive staff</b> . He reported <b>9 total deaths</b> as well as 3 residents and 1 employee hospitalized.

1:28 PM	The IDVA Chief of Staff emailed the State Medical Officer and copied the Deputy Governor and First Assistant Deputy Governor and asked if there were any thoughts on the monoclonal antibody treatments.
1:37 PM	The First Assistant Deputy Governor responded to the 1:28 PM email and noted that she added the IDPH Chief of Staff and that "the feds are in the early stages of distributing this and it will first go to hospitals. DPH is currently working out a distribution process. I don't think the state has even received any yet."
1:46 PM	The State Medical Officer responded to the IDVA Chief of Staff, the IDPH Chief of Staff, the First Assistant Deputy Governor, and the Deputy Governor regarding the monoclonal antibody treatment and noted that they were exploring the possibility with the CDC.
1:54 PM	The IDPH Chief of Staff responded that he was working on it and "this stuff is just coming out." He also noted there were "certain limiting parameters for its use."
2:36 PM	<p>The IDVA Chief of Staff emailed the State Medical Officer a general timeline of the outbreak. He also noted that the daily report was sent to the Illinois Department of Public Health, the U.S. Department of Veterans' Affairs, and the Illinois Emergency Management Agency. The timeline was as follows:</p> <p><b>"October 27/28</b> – Regular employee testing was conducted and sent to the lab on October 29<sup>th</sup></p> <p><b>October 31</b> – Overnight, a resident was sent to the local hospital for non-covid related issue. The hospital administered an antigen test which indicated the resident was positive.</p> <p><b>Nov 1</b> – Administrator was notified; in turn notified COS. Direction was given to test all residents and deliver to the lab 11/2. Visitation was suspended and the admission was postponed; Reinforced all of the safety measures to employees for their personal lives.</p> <p><b>Nov 2</b> – Antigen tests administered on residents showing symptoms with several testing positive as well as employees testing outside the facility positive. All positive residents moved to the West side of building into negative pressure wing.</p> <p><b>Nov 3</b> – First positive resident PCR tests coming back – 22 residents, 7 staff</p> <p><b>Nov 4</b> – 14 additional resident antigen test positive</p> <p><b>Nov 5</b> – additional resident positives</p> <p><b>Nov 6</b> – another round of staff tests shipped 48 residents; 18 staff positive</p> <p><b>Nov 7</b> – Two residents pass; multiple staff positives received.</p> <p><b>Nov 8</b> – Resident passes Current count 59 residents, 64 staff</p> <p><b>Nov 9</b> – more results - 66 resident, 69 employees two residents pass; retesting (PCR) of residents</p> <p><b>Nov 10</b> – Two residents pass – USDVA conducts call with facility to review policies/protocols. Request made for DPH onsite visit.</p> <p><b>Nov 11</b> – DPH conducts call with facility to review policies/protocols. DPH and USDVA schedule onsite visits. Additional residents and employees positive 82 residents (minus 7 deceases – 75 active) and 88 employees positive</p> <p><b>Nov 12</b> – two residents pass (total 9)"</p>
3:26 PM	The IDVA Chief of Staff emailed an updated template for the daily report to the four Veterans' Homes.
4:04 PM	The LaSalle Home Administrator provided an updated family letter that reported a total of 82 positive residents and 89 positive staff. It also noted 10 resident deaths.
5:29 PM	<p>The LaSalle Home Administrator emailed the Health System Specialist to the Associate Director from the Hines Veterans Hospital noting that: "Last night to today we lost 3 more residents. I have all of that information below. Our census is 118. Today we have 89 positive staff and 72 positive residents, 6 of whom are in the hospital. (An increase of 2 positive cases)</p> <p>[The Infection Manager] was here today and it was great to hear from her – she is so knowledgeable! We discovered that the dispensers on our walls do not have alcohol-based hand sanitizer. We do have, and have had, the correct kind of hand sanitizer out for use, but these wall mounted ones need to be replaced. We received antigen tests today from IDPH and have started doing testing on staff at the start of their shift. We just did our first round – oncoming and outgoing at 3 p.m. and no positive results were revealed."</p>

6:00 PM	The IDPH Division Chief of Emergency Medical Services and Highway Safety emailed the State Medical Officer, the IDPH Chief of Staff, the Deputy Governor, and the First Assistant Deputy Governor and noted the State had been allocated 6,380 vials of the (monoclonal antibody) treatment and they were waiting on a survey from health systems and hospitals, due the next day, to determine the allocation methodology.
8:51 PM	The IDPH Chief of Staff emailed the State Medical Officer and asked if she had received any feedback from the site visit.
9:25 PM	The State Medical Officer responded to the IDPH Chief of Staff that the “source of the outbreak appears to be staff complacency.” She noted staff had not been wearing masks or social distancing and had been gathering in the parking lot and in the lunch room, and socializing.
<b>Friday, November 13, 2020</b>	
7:35 AM	The State Medical Officer emailed IDPH Director and provided her with an update on the outbreak at LaSalle and noted the draft site visit report would be coming out later in the day. The State Medical Officer noted that the IDVA Chief of Staff told her that the Veterans’ Homes were all located in parts of the state where they were not taking the virus seriously.
9:05 AM	<p>The IDPH Infection Control Coordinator emailed the site visit report to the State Medical Officer and the IDPH Communicable Disease Control Section Chief. First, it was noted that the LaSalle Home Administrator and the local health department reported that delays and barriers to mitigation were due to asymptomatic residents and staff as well as the lengthy testing turnaround time. Contributing factors included:</p> <ul style="list-style-type: none"> <li>• delayed implementation of mitigation efforts with contact tracing, exclusion, and testing of residents and staff;</li> <li>• delay in receiving test results;</li> <li>• delay in contact tracing to identify close contacts to be excluded, tested and quarantine when initial cases were identified;</li> <li>• staff gatherings outside of facility- Halloween party off grounds hosted and attended by multiple staff;</li> <li>• staff self reporting and ignoring minor symptoms;</li> <li>• as observed staff congregating and not adhering to social distancing; and</li> <li>• ineffective substance for hand hygiene.</li> </ul> <p>The report also noted that overall the facility was very receptive and the veterans are being well cared for by the nursing staff. The Infection Control Coordinator noted, “the dedication to the health, safety and well-being of the Veterans was obvious via my personal observation and interviews. The staff is devastated by the loss of their Veterans. It is also important to note that some of the veterans had prior directives regarding resuscitation.”</p>
9:16 AM	The IDVA Chief of Staff emailed the “IDVA Homes Report” to various IDVA, IDPH, and Governor’s office staff, which included the Director of Veterans’ Affairs, the IDPH State Medical Officer, and the First Assistant Deputy Governor for Health & Human Services. The email stated: that there were a total of <b>83 total (82 current) residents and 93 (88 current) staff</b> with positive cases. He reported <b>11 total deaths</b> as well as 3 residents and 1 employee hospitalized.

## COVID-19 Site Visits at the LaSalle Veterans' Home

An initial site visit was conducted by the U.S. Department of Veterans Affairs in collaboration with IDPH on November 12, 2020. Additionally, IDPH conducted a follow-up site visit on November 17, 2020. Following these initial site visits, investigations were also conducted by the Department of Human Services' Office of the Inspector General (DHS OIG) and by the Illinois Department of Labor (IDOL), Division of Occupational Safety and Health (OSHA).

The November 12th initial site visit identified issues in the following areas: insufficient staff and visitor screening; the timeliness of receiving testing results; limited housekeeping which included use of the wrong hand sanitizer; negative pressure rooms which failed qualitative tissue testing; and improper PPE usage.

The November 17th follow-up visit identified improvements in the following areas: contingency capacity strategies for staffing were in place; all staff providing direct resident care were wearing disposable face shields, gowns, masks, and head and foot coverings; the Home discontinued the use of Viri-Masks; wall-mounted dispensers which previously contained an alcohol-free hand sanitizer were empty and were labeled "Do not use;" screenings for symptoms were conducted verbally and face-to-face; and PCR tests for staff were being done at weekly intervals on Mondays, Tuesdays, and Wednesdays and were scheduled to begin testing twice per week at the time of the visit. The Home had also initiated daily pre-shift testing with BinaxNOW COVID-19 lateral flow antigen test cards.

House Resolution Number 62 asked auditors to determine the response of the Department of Veterans' Affairs to the outbreak of COVID-19 in 2020 at the LaSalle Veterans' Home. The Resolution also asked auditors to include the recommendations made in the November 13, 2020 site visit by the Illinois Department of Public Health and the Department of Veterans' Affairs actions to address those recommendations. However, auditors determined that the initial site visit was conducted by the U.S. Department of Veterans Affairs in collaboration with IDPH on November 12, 2020, not on November 13th. Additionally, IDPH conducted a follow-up site visit on November 17, 2020. Following these initial site visits, investigations were also conducted by the DHS OIG and by the IDOL OSHA. The following sections summarize these investigations.

### **Veterans Integrated Service Network 12 (VISN 12) Infection Control Visit (November 12, 2020)**

The VA Great Lakes Health Care System, Veterans Integrated Service Network 12 (VISN 12) Infection Control lead and a representative from IDPH performed a one-day, onsite consultation at the LaSalle Veterans' Home on November 12, 2020. According to the report from the visit, during the consultation, the Infection Control nurse explained COVID-19 processes and practices and escorted the VISN 12 lead and IDPH representative to observe staff and resident behaviors. The report contained multiple assessments of the LaSalle Veterans' Home's procedures:

- **Staff and Visitor Screening**
  - ✓ **Findings** - the screening process for all entering the facility through the main entrance was adequate for non-outbreak circumstances. This included posted signage and a controlled entry point, with appropriate symptoms and exposure-related questions listed on a form that is recorded by the visitor. This also included active temperature monitoring. However, the staff entry used a different form which did not list all of the screening questions and there were no staff stationed at the entry at the time of the visit.
  - ✓ **Recommendations** - an active review of relevant symptoms should be done for both visitors and staff, which should include having someone ask the screening questions. Additionally, critical staffing shortage strategies should be reviewed in coordination with IDPH, administration, and Infection Control staff to ensure appropriate actions are taken for quarantine, isolation, or return-to-work.
- **COVID-19 Testing**
  - ✓ **Findings** - there were issues getting tests back in a timely manner due to the Springfield lab being closed at the beginning of the outbreak. As a result, the report noted it was difficult to recognize an outbreak “when results trickle in.”
  - ✓ **Recommendations** - the LaSalle Veterans’ Home should administer a PCR test on all staff every three days and that 100 percent of staff should be tested on a single day (not spread out over several days). IDPH also suggested that a point of care antigen test can be used to screen staff prior to beginning a work shift; however, IDPH stated that this should not be substituted for the PCR tests.
- **Point of Care Testing**
  - ✓ **Findings** - the Abbott BinaxNOW point of care testing system was brought online at the Home after it was delivered at the end of the day on November 13, 2020. The manufacturer of this system indicates that a timeframe of the first seven days of symptom onset is when it is effective as it loses its correlative accuracy with its PCR counterparts.
  - ✓ **Recommendations** - the report suggests that the BinaxNOW system would be better utilized for serial testing, as opposed to the PCR tests which are better for providing a “point in time” snapshot. The LaSalle Veterans’ Home should use the BinaxNOW tests within a minute of obtaining a sample, and build this into the process and policy/procedure for testing. The LaSalle Veterans’ Home should also follow up positive tests and clinical symptoms/suspicion of COVID-19 with molecular/PCR testing. If a resident is clinically symptomatic, testing should be repeated 48-72 hours after a negative PCR test while maintaining isolation precautions. The LaSalle Veterans’ Home

should develop algorithms for this process along with the medical director and in consultation with the health department.

- **Environment of Care**

- ✓ **Findings** - the facility was “very clean.” There was no dust, debris, or soiled surfaces in common areas or resident rooms. Resident rooms were organized and medication and nutrition rooms were sanitary. Housekeeping staff provided a checklist for regular terminal cleaning of resident rooms and were able to appropriately describe their process.

The report also found there was recently added use of UV light disinfection to the protocols. Other findings in the report included: limited housekeeping could create an inadequacy of terminal cleaning after residents are moved; large undated containers of bleach in the janitor’s closet; and the use of alcohol-free foam hand sanitizer found in all mounted dispensers.

- ✓ **Recommendations** - the LaSalle Veterans’ Home should develop a written standard operating procedure/policy for use of UV light disinfection. The report also recommended ensuring the appropriate amount of time elapses for the room to settle after a positive patient is moved before placing another patient in the room, which could exceed 90 minutes.

It was recommended that the LaSalle Veterans’ Home place alcohol-based hand sanitizer pumps in all clinical areas, as the alcohol-free hand sanitizer that was being used was not found to be an effective agent against COVID-19.

- **Ventilation**

- ✓ **Findings** - single-patient rooms connected by an adjoining bathroom raise an additional concern for COVID-19 transmission. Ventilation observed in some of the resident rooms was manually turned on and only fed the very far end of the room. Investigators were not able to determine if recirculated air went through a filter in the wall unit, and if so, what level filter and how often was it changed. The report also noted very little air movement near the entry of the room.

Viri-Masks were provided to IDPH to determine their appropriateness for use as PPE.

Positive patient negative pressure room doors were left open due to “fall-risk.” It was also observed that the pressure monitors did not alarm when doors open which disrupt the pressurization in the room. It was also observed that the negative pressure rooms failed “qualitative tissue testing.”

- ✓ **Recommendations** - discontinue use of the Viri-Masks in the clinical setting where N95 respirators are required for PPE until the

appropriateness can be evaluated. The report recommended that the supply of N95 masks should be evaluated and the LaSalle Veterans' Home should replenish and maintain a contingency supply to support heightened PPE requirements/recommendations for outbreak management.

It was suggested that single-patient rooms connected by adjoining bathrooms should be considered as a dual-occupancy room as it pertains to contact tracing and placement decisions.

The report recommended that the facility arrange a discussion with the vendor who set up the negative pressure, and follow-up in-servicing on the function of the negative pressure and how to assess based on the configuration and equipment.

- **Staff Management and Infection Control Practices**

- ✓ **Findings** - investigators observed various instances of improper PPE usage including: staff in full PPE walking through the administrative area; three staff without masks eating less than six feet apart in the kitchen; and staff touching patients and surfaces without changing gloves or performing hand hygiene.
- ✓ **Recommendations** - a series of PPE practices for staff should be strictly adhered to and reinforced, including wearing respiratory and eye protection, changing N95 respirators at least daily, refraining from wearing gowns in the common areas of non-COVID units, and changing gloves/performing proper hand hygiene after specific tasks.

The report also recommended that management advise staff to take a series of additional precautions, such as: refraining from changing into scrubs until entering the building; wearing freshly-laundered work attire daily; staggering breaks while refraining from smoking in groups outside or in vehicles; consuming food only in designated areas after proper hand hygiene is performed and with proper social distancing; avoiding social gatherings outside of work; ensuring sanitary practices with cell phones and other electronics; and having a pair of shoes that are facility-dedicated and changed for work if possible.

IDPH requested that, during the time period while attempting to reach containment, each unit be treated as an individual “bubble”, and that staff should not be floated between units if possible and cleaning staff and equipment should be dedicated to the COVID units. IDPH also recommended that EPA-approved disinfectant wipes be made available in all areas where staff works, handles equipment, or takes breaks.

### **IDPH Follow-up Visit (November 17, 2020)**

On November 17, 2020, an Infection Control Coordinator from IDPH conducted a follow-up visit to the LaSalle Home. The report documented the following observations made during the visit:

- LaSalle Veterans' Home officials stated that contingency capacity strategies for staffing were in place and that critical capacity strategies were not required at the time of the visit. At the time of the visit, 36 furloughed and quarantined staff had returned to duty.
- All staff providing direct resident care were wearing disposable face shields, gowns, masks, and head and foot coverings. All COVID unit staff were wearing NIOSH-approved, fit-tested N95 respirators.
- The recommendation that was made on November 12th to discontinue use of Viri-Masks was followed.
- The facility had multiple free-standing pump bottles of alcohol-based hand rub, at or near the wall-mounted dispensers, throughout the facility and the wall-mounted dispensers which previously contained an alcohol-free hand sanitizer were empty and were labeled "Do not use."
- Screenings for symptoms were conducted verbally and face-to face, with a staff member positioned at the entry point to perform both the symptom screen and the temperature screen. This follows the recommendation from the initial visit.
- PCR tests for staff were being done at weekly intervals on Mondays, Tuesdays, and Wednesdays and were scheduled to begin testing twice per week at the time of the visit. The Home had also initiated daily pre-shift testing with BinaxNOW COVID-19 lateral flow antigen test cards.

The report contained two recommendations. They were as follows:

- Continue both pre-shift rapid antigen testing of all staff and twice-weekly PCR testing for at least 14 days and until transmission has dropped dramatically; further recommendations on adjustment of test frequency will follow at that time.
- Begin daily rapid antigen testing of residents who have not been detected as COVID-positive, but who have potentially been exposed to infected staff or residents, for 10-14 days after exposure.



## DHS OIG Investigation at the LaSalle Veterans' Home

On April 26, 2021, the Illinois Department of Human Services' Office of Inspector General (DHS OIG) released a report summarizing its investigation of the fall 2020 COVID-19 outbreak at the LaSalle Veterans' Home. The Governor requested the DHS OIG conduct an investigation into the outbreak at the Home, and the DHS OIG retained a law firm to assist it in investigating the circumstances surrounding the outbreak and with drafting its report.

**The DHS OIG relied heavily on testimonial evidence from interviews to support its findings, as is evident by the numerous quotes and testimonial evidence presented throughout the report.** Interviews were conducted with personnel from both IDVA and IDPH. The report stated that the interviews revealed concerns about the Home's operations and leadership in the months before the outbreak, revealing operational deficiencies and unpreparedness, including: the absence of any outbreak plans and insufficient COVID-19 policies; a failure to communicate with, train, and educate staff members concerning COVID-19 policies; and repeated non-compliance with personal protective equipment (PPE) and infection control protocols. The report also concluded that the inadequate response by the LaSalle Home was due to corresponding failures in the executive leadership at IDVA and there was a relaxing of quarantine policy at the LaSalle Veterans' Home for residents returning from St. Margaret's Hospital sometime during the summer of 2020.

**Pursuant to the Intergovernmental Agreement entered into with IDVA, the Department of Human Services (DHS), and the Office of the Governor, the scope of the DHS OIG investigation was narrow and focused specifically on IDVA officials and LaSalle Veterans' Home management.** Additionally, since the DHS OIG relied heavily on interviews to support its findings, auditors attempted to identify documentary evidence to corroborate the DHS OIG report's findings. Auditors found that the documentation collected from IDPH, IDVA, and the LaSalle Veterans' Home was contrary to many of the statements used by the DHS OIG to reach its conclusions.

The DHS OIG investigation reported that the significance of the outbreak was not being meaningfully tracked by the IDVA Chief of Staff. **In fact, auditors found the Chief of Staff provided detailed information to IDPH that was used by the Director of IDPH in her daily COVID-19 briefings.** IDPH and the First Assistant Deputy Governor for Health & Human Services were provided detailed emails of COVID-19 positive cases and related deaths for each of the four State Veterans' Homes by IDVA on November 2nd, 3rd, 4th, 5th, 6th, 9th, 10th, 12th, and 13th. These emails are shown in Appendix C of this report.

Further, the primary finding of the DHS OIG report, which indicated the "absence of any standard operating procedures in the event of a COVID-19 outbreak," was also flawed. **Auditors identified hundreds of pages of guidance provided by IDPH and by the CDC.** In addition, COVID-19 policies were formulated by IDVA specifically for the LaSalle Veterans' Home as well as a Continuity of Operations Plan that was reviewed by IEMA and was provided to IDPH back in March 2020. Also, the LaSalle County Health Department provided IDPH COVID-19 specific policies to the LaSalle Home on November 2nd, at the beginning of the outbreak. Additionally, according to the current Director of Nursing at the Home, binders with policies and specific guidance were available at each nursing station. Many of these policies required general infection control that was already in place at the time and would have been standard practice for healthcare professionals who work in congregate care settings.

**The DHS OIG concluded that the lack of policies and procedures “was a significant contributing factor to the Home’s failure to contain the virus.”** Auditors identified numerous policies and procedures. Therefore, there was no evidence to support that a lack of policies and procedures resulted in a failure to contain the virus. The virus hit the Home very quickly with a large number of residents and staff positive within a few days. As a result, it was unclear whether non-adherence to policy caused the virus to spread so quickly or whether the rapid spread was due to other factors. These factors include: a rumored outside gathering of employees; a Halloween parade at the LaSalle Home; or possibly the high positivity rate during that time in the community. An additional potential cause may have been that guidelines during that time did not require rapid COVID-19 testing prior to entering the Home; therefore, asymptomatic staff possibly carried the virus into the Home from the community unknowingly.

Per an Intergovernmental Agreement entered into in December 2020, between the Office of the Governor of the State of Illinois, the Illinois Department of Veterans’ Affairs, the Illinois Department of Human Services (DHS), and the DHS OIG, an investigation was to be completed to look at the conduct, policies,

According to the Department of Human Services Act (20 ILCS 1305/1-17), the DHS OIG is created to investigate and report upon allegations of the abuse, neglect, or financial exploitation of individuals receiving services within mental health facilities, developmental disabilities facilities, and community agencies operated, licensed, funded, or certified by the Department of Human Services, but not licensed or certified by any other State agency.

procedures, protocols, and safeguards employed by IDVA, its staff, and supervisors, in connection with the operation of the Illinois Veterans’ Home in LaSalle in the wake of the national pandemic. According to the Department of Human Services Act (20 ILCS 1305/1-17), the DHS OIG is created to investigate and report upon allegations of the abuse, neglect, or financial exploitation of individuals receiving services within mental health facilities, developmental disabilities facilities, and community agencies operated, licensed, funded, or certified by the Department of Human Services, but not licensed or certified by any other State agency.

On April 26, 2021, DHS OIG released a report summarizing its investigation of the fall 2020 COVID-19 outbreak at the LaSalle Veterans’ Home. The Governor requested the DHS OIG conduct an investigation into the outbreak at the LaSalle Home, and the DHS OIG retained a law firm to assist it in investigating the circumstances surrounding the outbreak and with drafting its report.

The investigation into the late October 2020 COVID-19 outbreak at the LaSalle Veterans’ Home included analyzing COVID-19 data, trends, and protocol in the Home and assessing IDVA’s response to the outbreak in order to discover any lapses in protocol and employee compliance with applicable rules and regulations. This was accomplished by reviewing hundreds of documents. In addition, the DHS OIG interviewed 29 individuals including staff from the following areas: administrative; infection control; nursing; medical; social work; housekeeping; and environmental services. The DHS OIG relied heavily on testimonial evidence from these interviews to support its findings, as is evident by the numerous quotes and testimonial evidence presented throughout the report. Interviews were also conducted with personnel from both IDVA and IDPH. The report noted “the

quoted language represents the best approximation of what was stated by the witness and is intended to convey the substance of the communication.”

The report stated that the interviews revealed concerns about the Home’s operations and leadership in the months before the outbreak, revealing operational deficiencies and unpreparedness, including:

- **the absence of any outbreak plans and insufficient COVID-19 policies** - Based on testimonial evidence, the report stated that the LaSalle Home lacked any formal preparedness and response plan related to COVID-19 as of October 2020, despite transmission risks and rising cases in the surrounding community being well understood by that point. In addition, testimonial evidence from the report indicated there was a relaxing of the quarantine requirement for veterans returning from appointments at St. Margaret’s Hospital and a lack of oversight or standard for employee screening processes which both contributed to the COVID-19 outbreak.
- **a failure to communicate with, train, and educate staff members concerning COVID-19 policies** - Based on testimonial evidence, the report concluded that during the pandemic, policies at the LaSalle Home were disseminated in various manners, including bulletin board postings, signage, policy binders, and emails. Using testimonial evidence, the report concluded:
  - the Home conducted daily meetings with some supervisors; however, the meetings were stratified among staff and eventually stopped occurring in the summer of 2020;
  - there was frustration over the poor communication between staff and management;
  - there were inconsistent sources of communication, which led to increased uncertainty regarding the most current policies;
  - that many staff did not have a State email account and were not aware of policy binders and bulletin board updates;
  - that training on COVID-19 policies was inconsistent in form, substance, and frequency;
  - the Infection Control Nurse inadequately performed duties, which included inadequate training of nurses and a lack of contact tracing;
  - the Infection Control Nurse was given too many duties to effectively manage; and
  - that communication and training issues were made more difficult by the relationship dynamics among staff, department supervisors, and the management team within the Home; and that communication and interpersonal issues between staff and supervisors placed the Home in a difficult position to implement COVID-19 policies.
- **repeated non-compliance with personal protective equipment (PPE) and infection control protocols** - Based on testimonial evidence, the report

concluded that during the initial days of the outbreak, the management team requested that multiple staff members report to work or complete a shift after testing positive for COVID-19 if they were not experiencing symptoms. The report also stated that, based on testimonial evidence, IDPH observed non-compliance with masking and social distancing at the Home.

The report also concluded the inadequate response by the Home was due to corresponding failures in the executive leadership at IDVA. Among these failures, based on staff testimonies, were the consolidation of too many responsibilities in one person due to vacant positions; the failure to delegate and assign clear responsibilities; the failure to learn from previous outbreaks at long-term care facilities, including other Illinois veterans' homes; the failure to effectively communicate; and the failure to identify, seek, or accept external resources. The shortfalls in the Home's operations noted above, as well as the issues described with leadership of IDVA, were identified as the root causes that contributed to the size and severity of the outbreak within the Home.

The investigation concluded there was a relaxing of quarantine policy at the LaSalle Veterans' Home for residents returning from St. Margaret's Hospital sometime during the summer of 2020. It is unclear how the DHS OIG determined this relaxing occurred other than through testimonial evidence. Auditors followed up on this with the current Director of Nursing, who was the Assistant Director of Nursing during the outbreak, and she indicated that the policy was not relaxed. Additionally, she provided auditors with notes from a quality assurance meeting conducted at the Home on September 28, 2020. The document supports that the Home's Medical Director wanted the policy relaxed; however, the Home Administrator denied the request and noted:

*ER and hospitalization will still quarantine, prolonged dentist appts will also require quarantine; Quarantine will happen if resident is at an appt with family.*

The Inspector General made numerous recommendations aimed at correcting the operational deficiencies found in the Home so that a future outbreak of this severity could be avoided. To address the issue of inadequate policies and training of personnel, the Inspector General recommended a series of changes at the LaSalle Veterans' Home and IDVA, including the following:

- create centralized policies and develop outbreak drills and stress tests;
- educate staff on the importance of quality infection control for any infection;
- integrate the standards for long-term care facilities, at least in part, into the Veterans' Home Code;
- develop an infection control task force or committee within the Home;
- establish and clearly communicate thresholds for when IDPH visits the Home;
- provide a suitable independent outlet for escalating internal complaints;

- create temporary positions or consultancies to ensure essential positions do not remain unfilled;
- require one Veterans Advisory Council member to be appointed by IDPH; and
- adopt recommendations of the 2019 health and safety audit and succeeding interagency memo (dated March 9, 2021) as soon as possible.

The 2019 health and safety audit, conducted by the consulting firm Tetra Tech, Inc., recommended the Homes implement an overarching standardized policy structure and provide more opportunities for hands-on and refresher training (this report was not specific to the LaSalle Veterans' Home). The DHS OIG report recommended IDVA incorporate the recommendations made in 2019, in addition to the recommendations made in the March 9, 2021 interagency memo. These recommendations included: reorganizing infection prevention as a standardized, coordinating effort across the organization; expanding system capacities for infection prevention; better education for infection control staff, and preparing them to be interdisciplinary team members; strengthening staff-wide training; monitoring adherence to policy and procedure and promoting active, shared staff participation; and engaging top management directly with frontline staff.

The DHS OIG report concluded that failures in the LaSalle Home and IDVA's preparation and response to COVID-19 contributed to the size of the outbreak.

The DHS OIG report concluded that failures in the LaSalle Home and IDVA's preparation and response to COVID-19 contributed to the size of the outbreak. Further, inadequate leadership and structure within the Home and IDVA resulted in the Home's failure to adequately meet the increased expectations caused by the COVID-19 pandemic. As a result, the DHS OIG

emphasized the importance of well-developed infection control procedures within long-term facilities in order to more appropriately manage and appreciate any infectious disease threatening veterans and staff.

### Office of the Auditor General's Review of the DHS OIG Report

The scope of the investigation was narrow and focused specifically at IDVA officials and LaSalle Veterans' Home management. The investigation was to look at the conduct, policies, procedures, protocols, and safeguards employed by IDVA, its staff, and supervisors, in connection with its operation of the Illinois

The focus was solely on IDVA and did not include a review of other Departments, such as IDPH. As a result, the findings in the DHS OIG report did not provide a complete account of the response to the outbreak at the LaSalle Veterans' Home.

Veterans' Home in LaSalle in the wake of the national pandemic. The focus was solely on IDVA and did not include a review of other Departments, such as IDPH. As a result, the findings in the DHS OIG report did not provide a complete account of the response to the outbreak at the LaSalle Veterans' Home.

Additionally, the Comptroller General of the United States Governmental Accountability Office (GAO) notes that testimonial evidence may be useful in interpreting or corroborating documentary or physical information, and documentary evidence may be used to help verify, support, or challenge

testimonial evidence. Since the DHS OIG relied heavily on testimonial evidence from interviews to support its findings, auditors attempted to identify documentary evidence to corroborate the DHS OIG report's findings. Auditors found that the documentation collected from IDPH, IDVA, and the LaSalle Veterans' Home was contrary to many of the statements used by the DHS OIG to reach its conclusions.

One conclusion from the DHS OIG investigation was that the significance of the outbreak was not being meaningfully tracked by the IDVA Chief of Staff. In fact, the Chief of Staff provided detailed information to IDPH that was used by the Director of IDPH in her daily COVID-19 briefings.

One conclusion from the DHS OIG investigation was that the significance of the outbreak was not being meaningfully tracked by the IDVA Chief of Staff. In fact, the Chief of Staff provided detailed information to IDPH that was used by the Director of IDPH in her daily COVID-19 briefings. IDPH and the First Assistant Deputy Governor for Health & Human Services were provided detailed emails of COVID-19 positive cases and related deaths for each of the four State Veterans' Homes by IDVA on November 2nd,

3rd, 4th, 5th, 6th, 9th, 10th, 12th, and 13th. These emails are shown in Appendix C of this report. Additionally, according to the Chief of Staff, daily reports were also sent to the U.S. Department of Veterans' Affairs and daily calls were conducted with the Illinois Emergency Management Agency. It is unclear how the DHS OIG concluded that the information was not meaningfully tracked since the data was provided to officials within State government who had the knowledge, means, and experience to provide assistance to the LaSalle Veterans' Home.

Further, the primary finding of the DHS OIG report, which indicated the "absence of any standard operating procedures in the event of a COVID-19 outbreak," was also flawed. There were hundreds of pages of guidance provided by IDPH and by the CDC. In addition, according to the IDPH State Medical Officer, a COVID-19 testing and response plan was formulated by IDVA specifically for the LaSalle Veterans' Home on June 10, 2020. A Continuity of Operations Plan was also completed that was reviewed by IEMA and was provided to IDPH back in March 2020.

Further, the primary finding of the DHS OIG report, which indicated the "absence of any standard operating procedures in the event of a COVID-19 outbreak," was also flawed. There were hundreds of pages of guidance provided by IDPH and by the CDC. In addition, according to the IDPH State Medical Officer, a COVID-19 testing and response plan was formulated by IDVA specifically for the LaSalle Veterans' Home on June 10, 2020. A Continuity of Operations Plan was also completed that was reviewed by IEMA and was provided to IDPH back in March 2020. Also, the LaSalle County Health Department provided IDPH COVID-19 specific policies to the LaSalle Home on November 2nd, at the beginning of the outbreak.

Additionally, according to the current Director of Nursing at the Home, binders with policies and specific guidance were available at each nursing station. Many of these policies required general infection control that was already in place at the time and would have been standard practice for healthcare professionals who work in congregate care settings. As such, according to the current LaSalle Veterans' Home Director of Nursing, these policies were not new.

The DHS OIG investigation report contained contradictory language related to the existence of policies, procedures, and guidelines for LaSalle staff. It was noted that the Home did not have comprehensive policies and plans. The report also stated that there were no standard operating procedures. However, later in the report, it was noted that the Home had “numerous sources of communication” which led to inconsistent messaging. The DHS OIG additionally reported that there was policy made available through the use of bulletin boards, in policy binders, by email (for those that had email), and in some cases, direct phone calls. The issue the DHS OIG had was that these policies were not communicated by an “all-staff meeting.” As a result, it was reported that staff felt “left in the dark” because staff members were not present at the supervisors’ meetings with the management team. However, while auditors found that policies and plans were present during the outbreak at the Home, the DHS OIG concluded that there was an issue with how these policies and plans were disseminated to the staff. Since there was a pandemic where social distancing was required, large meetings of staff would likely not have been appropriate. It appears that LaSalle Home management used numerous methods of communication in an attempt to ensure that all staff received the necessary information.

The DHS OIG investigation reported the lack of preventative pre-outbreak N95 respirator usage as an issue, despite the lack of CDC and IDPH guidance indicating that such would be expected, effective, or even reasonable. The CDC and IDPH guidelines provided criteria for situations where N95 respirators should be used. These guidelines required N95s for personnel working directly with residents known or suspected to be carrying COVID-19, and those personnel involved with aerosol generating procedures. As such, it was not recommended that everyone use a N95 respirator at all times at the time the outbreak began at the Home. In fact, CDC guidance advised against such a practice due to supply shortages and suggested optimizing the stock of N95 respirators in the event of an outbreak.

The OIG concluded that the lack of policies and procedures “was a significant contributing factor to the Home’s failure to contain the virus.” Auditors identified numerous policies and procedures. Therefore, there was no evidence to support that a lack of policies and procedures resulted in a failure to contain the virus. The virus hit the Home very quickly with a large number of residents and staff positive within a few days. As a result, it was unclear whether non-adherence to policy caused the virus to spread so quickly or whether the rapid spread was due to other factors. These factors include: a rumored outside gathering of employees; a Halloween parade at the LaSalle Home; or possibly the high positivity rate during that time in the community. Auditors obtained pictures of the parade and Halloween activities from October 30, 2020, where residents and some staff were unmasked. Since the virus is invisible, and several days may pass after exposure before symptoms develop, the origin of the virus at the Home may never be determined. It is likely that the high positivity rate in the community during that time period was a significant contributor. An additional potential cause may have been that guidelines during that time did not require rapid

COVID-19 testing prior to entering the Home; therefore, asymptomatic staff possibly carried the virus into the Home from the community unknowingly.

Based on tests completed by November 4th, 115 residents and staff (52 residents and 63 staff) eventually tested positive once results were received. That is 58 percent of all the residents and staff that tested positive between October 23rd and December 9th.

Based on tests completed by November 4th, 115 residents and staff (52 residents and 63 staff) eventually tested positive once results were received. That is 58 percent of all the residents and staff that tested positive between October 23rd and December 9th. Based on CDC guidelines, it is likely that these 52 residents and 63 staff may have already been exposed to the virus when the first four cases were identified by November 1st. The Home managed to keep the virus out for

months with the policies it had in place. Therefore, a lack of policies was not likely the cause. According to the current Director of Nursing, the Home had protocols to handle cases of COVID-19, but they were untested and did not anticipate having that many cases all at once. There were more cases than isolation/quarantine beds available. Additionally, there also was a sudden increase in COVID-19 positivity among staff that was not foreseen by anyone.

#### **Response provided by the Former IDVA Chief of Staff**

Auditors contacted the former IDVA Chief of Staff to get his opinion on the OIG investigation as well as some general questions regarding the outbreak at the LaSalle Veterans' Home.

The former Chief of Staff's general conclusion regarding the DHS OIG report was that it "made a significant number of assumptions and bold declarations of opinion without the benefit of any substance to understand how the author formed the opinion." He also noted the DHS OIG chose not to report that each of the facilities initiated a Continuity of Operations Plan to address the pandemic. A Continuity of Operations Plan for each facility was circulated to the Illinois Emergency Management Agency and the Illinois Department of Public Health. According to the former Chief of Staff, IEMA provided feedback, but IDPH did not. He also noted that at no time did anyone indicate the policy was insufficient.

The former Chief of Staff's complete unedited response related to the DHS OIG investigation, COVID-related training at the LaSalle Home, the IDPH response to the outbreak, his duties as Chief of Staff, and other questions are shown in Appendix D of this report. Auditors did not attempt to verify all of the statements made by the former Chief of Staff.



## Illinois Occupational Safety and Health Investigation

A complaint was filed with the Illinois Department of Labor, Division of Occupational Safety and Health (IL OSHA) alleging the management at the LaSalle Veterans' Home was forcing COVID-19 positive employees (mainly nurses) to still come to work. As a result, a review was conducted and determined that seven employees worked on certain days between November 6, 2020, and November 13, 2020, after testing positive for COVID-19. According to IDVA, all seven employees were asymptomatic when they worked. IDVA noted that the LaSalle Veterans' Home followed CDC guidelines to ensure that the seven employees maintained safety precautions including wearing PPE, working only in COVID-19 positive units, using separate entrances and exits to avoid contact with others, and using separate bathrooms and break areas.

OSHA sent a letter to IDVA on December 15, 2020, informing the agency that based on the response and information provided the case would be officially closed.

On November 17, 2020, the Illinois Department of Labor and Illinois Occupational Safety and Health wrote to IDVA reporting that a complaint was received alleging the following health hazard(s) related to COVID-19 at the LaSalle Veterans' Home:

*During the last 2 weeks the veteran home's management has been making the employees (mainly nursing staff) who test positive for COVID, still come to work. Some staff have said they have been forced to and some staff say it's voluntary, but they fear retaliation later if they don't come to work. Management is putting staff and Veteran lives in danger by forcing employees to come to work sick.*

As a result of this complaint, IL OSHA noted in the letter to IDVA that it would be conducting an off-site investigation. IL OSHA asked IDVA to perform a "self-audit" of the alleged hazardous conditions and make any necessary corrections or modifications to protect employee health within five business days of the date of the letter. A subsequent letter was sent to IDVA by the IL OSHA on December 2, 2020, extending the deadline for IDVA's response to December 9, 2020.

IDVA responded to the letter from the IL DOL and IL OSHA on December 9, 2020. IDVA noted in its response that IDVA had followed guidelines from the CDC and IDPH since the beginning of the pandemic. Further, IDVA stated that staff had been provided full PPE and in-service training on how to use this equipment. The training also included steps staff could take in their personal lives to stay safe. Additionally, IDVA noted it had tested employees as needed consistent with IDPH and CDC guidelines.

While IDVA stated it instructed employees to not come to work if they were having symptoms or tested positive for COVID-19, IDVA also noted that the unprecedented nature of the pandemic and the vulnerability of residents in IDVA's full-time care necessitated IDVA to develop detailed mitigation plans to protect the health and safety of residents and staff of the homes and to plan for emergency situations caused by a surge in positive cases. As a result, the homes' plans adopted CDC guidance which recommended that if a facility is

experiencing a staffing crisis because there was no longer enough staff to provide safe patient care, a facility could allow suspected or confirmed positive employees to return to work if they are “well enough and willing to work.” IDVA noted that the CDC guidance outlined particular restrictions if this “last resort” measure was implemented. These restrictions stated that such employees should be restricted from contact with severely immunocompromised patients, should perform their job duties away from others to the greatest extent possible, and should only provide direct care to patients who are confirmed to be COVID-positive. Furthermore, employees would be directed to wear appropriate PPE.

IDVA stated it conducted an initial review that of the COVID-19 positive employees who worked at the LaSalle Veterans’ Home once the outbreak began in late October 2020 and determined that seven employees worked on certain days between November 6, 2020, and November 13, 2020, after testing positive for COVID-19. According to IDVA, all seven employees were asymptomatic when they worked. IDVA noted that the LaSalle Veterans’ Home followed CDC guidelines to ensure that the seven employees maintained safety precautions including wearing PPE, working only in COVID-19 positive units, using separate entrances and exits to avoid contact with others, and using separate bathrooms and break areas.

IDVA included in its response how direct and non-direct care staff that continued to work after testing positive for COVID-19 were managed, and the results of employee testing during the height of the outbreak at the LaSalle Home. Additionally, IDVA stated that it continued to work with outside entities to develop additional mitigation strategies for all of its veterans’ homes.

IDVA stated it began consulting with a medical consultant for IDPH, to assist with COVID-19 guidance, and also implemented personnel changes at the LaSalle Veterans’ Home, including appointing the Assistant Director as interim Administrator and the Assistant Director of Nursing as the Acting Director of Nursing. Finally, IDVA noted that the Department of Human Services’ Office of the Inspector General had undertaken an independent investigation into the outbreak to identify any lapses in protocols as well as supervisor and employee compliance with rules.

Upon receipt of IDVA’s response to IL OSHA’s request for a self-audit into the alleged hazardous conditions that took place during the November 2020 COVID-19 outbreak at the LaSalle Veterans’ Home, IL OSHA sent a letter to IDVA on December 15, 2020, informing the agency that based on the response and information provided the case would be officially closed.

## Changes to Policies as a Result of COVID-19 at Illinois Veterans' Homes (Determination 3)

Following site visits to the LaSalle Veterans' Home on November 12, 2020, and November 17, 2020, as a result of a COVID-19 outbreak at the Home the same month, a collaboration of the Illinois Department of Veterans' Affairs, Illinois Department of Public Health, and the Veterans' Integrated Service Network 12 of the U.S. Department of Veterans Affairs created the Interagency Infection Prevention Project, whose purpose was to support an integrated and comprehensive response to COVID-19 at Illinois veterans' homes. An initial site visit was conducted at the LaSalle Veterans' Home on November 12, 2020, in response to the COVID-19 outbreak occurring at the Home. Subsequent announced site visits took place on November 24, 2020, and January 4, 2021, while unannounced site visits took place on November 17th and December 14, 2020.

The Interagency Infection Prevention Project drafted a report on March 9, 2021, summarizing its recommendations for addressing COVID-19 at Illinois veterans' homes. According to the Integrated Infection Prevention Project status report, IDVA had begun implementing changes to better contain COVID-19 at all of its veterans' homes. The team found that the Illinois Department of Veterans' Affairs had embraced and adopted numerous recommendations from the integrated project assessment, and repeated site visits to the veterans' homes have documented substantial improvement in infection prevention practices. The team also found that the last resident associated with the late October 2020 outbreak at the LaSalle Veterans' Home tested positive on November 23, 2020. The next resident to test positive was on March 1, 2021, when one resident tested positive without symptoms as a result of weekly testing.

The Illinois Department of Veterans' Affairs' new policies for its Infection Prevention Project established updated training requirements for Illinois veterans' home staff. Additionally, new policies identified the responsibilities of specific positions within the new framework and implanted a specific training and continuing professional development program for the Illinois Department of Veterans' Affairs and Illinois veterans' homes staff.

According to the Illinois veterans' homes updated policies effective April 23, 2021, all newly hired and current staff are required to receive infection prevention training upon hire and at least annually. Staff at the Illinois veterans' homes were required to complete the Centers for Medicare and Medicaid Services trainings at the recommendation of the Illinois Department of Public Health. In addition, the Department noted that LaSalle Home staff were provided in-service training in March 2021.

---

House Resolution Number 62 asked auditors to determine the nature of changes made by the Department in operating protocols and staff training thereon, intended to contain the further spread of COVID-19 or prevent its reoccurrence at the LaSalle Veterans' Home. Auditors requested documentation from the Illinois Department of Veterans' Affairs on June 9, 2021, to support the nature of changes made by the Department in operating protocols and staff training thereon, intended to contain the further spread of COVID-19 or prevent its reoccurrence at the LaSalle Veterans' Home.

## Changes Made in Operating Protocols at the LaSalle Veterans' Home as a Result of COVID-19

Auditors reviewed documentation provided related to changes in policies and operating protocols at the LaSalle Veterans' Home. Following site visits to the LaSalle Veterans' Home on November 12, 2020, and November 17, 2020, as a result of a COVID-19 outbreak at the Home the same month, a collaboration of the Illinois Department of Veterans' Affairs, Illinois Department of Public Health, and the Veterans' Integrated Service Network 12 of the U.S. Department of Veterans Affairs created the Interagency Infection Prevention Project, whose purpose was to support an integrated and comprehensive response to COVID-19 at Illinois veterans' homes.

The Interagency Infection Prevention Project drafted a report on March 9, 2021, summarizing its recommendations for addressing COVID-19 at Illinois veterans' homes. The report was released to supplement the Illinois Department of Veterans' Affairs biannual departmental report submitted to the General Assembly, which by statute, must include information on any epidemic reported at a veterans' home and action taken to eradicate the spread of communicable disease during the reporting period. Delays in implementing a general standardized policy structure, which was recommended by a Health and Safety audit conducted in 2019 pursuant to Executive Order 2019-04, allowed the project to work on a comprehensive, system-wide quality improvement project for COVID-19 response and for general infection control policies as a whole. The Interagency Infection Prevention Project was given the following objectives:

- Review current policies, procedures, and practice relating to COVID-19 response at each facility; identify issues for which corrective action is needed;
- Assist each site with development of a COVID-19 corrective action plan for each action item identified and monitor execution of action plan, including at least one mock inspection;
- Assist in creating a framework of standardized policies to address COVID-19 at IDVA homes; and
- Consult as needed with specialists who could identify any engineering controls and/or structural changes needed to reduce potential transmission of COVID-19 within the facility.

An initial site visit was conducted at the LaSalle Veterans' Home on November 12, 2020, in response to the COVID-19 outbreak occurring at the Home. Subsequent announced site visits took place on November 24, 2020, and January 4, 2021, while unannounced site visits took place on November 17, 2020, and December 14, 2020. Suggestions for program enhancements based on the Infection Control Assessment and Response tool were made during the initial visits. The areas reviewed by the tool are shown in **Exhibit 16**.

The Interagency Infection Prevention Project team utilized a standardized, structured tool based on the Infection Control Assessment and Response developed by the CDC to systemically assess each Home's infection prevention

and control practices and to guide quality improvement activities by addressing identified gaps based upon current CDC guidance. According to the Interagency Infection Prevention Project status report released on March 9, 2021, the Illinois Department of Veterans' Affairs has begun implementing changes to better contain COVID-19 at all of the IDVA veterans' homes. The Interagency Infection Prevention Project had three primary objectives for its IDVA home visits and this subsequent status report:

- identify COVID-related issues for which corrective action is needed at the site;
- assist the site with development of a corrective action plan for each issue identified; and
- monitor execution of the plan.

There are seven sections of the CDC Infection Control Assessment and Response tool that assess infection prevention and control practices, which were updated to focus on infection prevention and control practices specific to COVID-19. The Interagency Infection Prevention Project team appended two additional sections to the Infection Control Assessment and Response tool related to vaccination plans and respiratory protection.

The team found that the Illinois Department of Veterans' Affairs had embraced and adopted numerous recommendations from the interagency project assessment, and repeated site visits to the veterans' homes have documented substantial improvement in infection prevention practices. The team also found that the last resident associated with the late October 2020 outbreak at the LaSalle Veterans' Home tested positive on November 23, 2020. The next resident to test positive was on March 1, 2021, when one resident tested positive without symptoms as a result of weekly testing.

**Exhibit 16** summarizes the program enhancements for the LaSalle Veterans' Home from the Infection Control Assessment and response found in the March 9, 2021, Interagency Infection Prevention Project status report.

Exhibit 16

**INTERAGENCY INFECTION PREVENTION PROJECT SUMMARY OF INFECTION CONTROL**

**ASSESSMENT & RESPONSE – LaSalle Veterans' Home**

Program Enhancement Observed as of March 9, 2021

Infection Control Assessment and Response Section	Program Enhancement <u>Suggested</u> (November 12, 2020)	Program Enhancement <u>Observed</u> (January 4, 2021)
Section 1: Facility Demographics & Critical Infrastructure	<ul style="list-style-type: none"> <li>Establish infection preventionist position: at least one person with 1.0 Full-time employee dedicated infection preventionist hours; direct report to administration.</li> <li>Collaborate with other larger Illinois Department of Veterans' Affairs sites and local health department.</li> <li>Utilize private quarantine/isolation rooms when space available.</li> </ul>	<ul style="list-style-type: none"> <li>Infection preventionist is working directly with administrator and Director of Nursing.</li> <li>Collaboration is occurring on a weekly basis with other Illinois Department of Veterans' Affairs sites; also, closer relationship with local health department now since working together on vaccine.</li> <li>Private quarantine/isolation are being used.</li> </ul>
Section 2: Personal Protective Equipment (PPE)	<ul style="list-style-type: none"> <li>Ensure availability of personal protective equipment at all point of care.</li> <li>Monitor personal protective equipment donning and doffing.</li> <li>Train and verify competency for personal protective equipment use.</li> <li>Standardize signage.</li> </ul>	<ul style="list-style-type: none"> <li>Personal protective equipment readily available and supply monitored.</li> <li>Routine checks are occurring.</li> <li>Education and competency completed and ongoing.</li> <li>Signage standardized.</li> </ul>
Section 3: Hand Hygiene (HH)	<ul style="list-style-type: none"> <li>Use Centers for Disease Control-recommended alcohol-based hand sanitizer</li> <li>Educate and competency hand hygiene.</li> <li>Audit and document hand hygiene observations.</li> </ul>	<ul style="list-style-type: none"> <li>Centers for Disease Control-recommended alcohol-based hand sanitizer is at point of care including inside resident rooms.</li> <li>In-service training with return demonstration is completed to validate competency and practice.</li> <li>Auditing and documenting hand hygiene observations.</li> </ul>
Section 4: Environmental Services	<ul style="list-style-type: none"> <li>Ensure Environmental Protection Agency list N cleaner/disinfectants are at all points of care.</li> <li>Increase in ready-to-use formulations (e.g., bleach).</li> <li>Implement routine environmental rounding of units and buildings.</li> <li>Monitor and audit processes and supply of product.</li> <li>Ensure interdisciplinary access to products for cleaning/disinfecting at point of care (not locked away with limited access; consider door keypads).</li> </ul>	<ul style="list-style-type: none"> <li>List N products available at point of care.</li> <li>Active, routine rounding and monitoring of practice with just in time training to ensure correct use, continued supply of products at point of care.</li> </ul>

Exhibit 16  
**INTERAGENCY INFECTION PREVENTION PROJECT SUMMARY OF INFECTION CONTROL ASSESSMENT & RESPONSE – LaSalle Veterans' Home**  
 Program Enhancement Observed as of March 9, 2021

Infection Control Assessment and Response Section	Program Enhancement <u>Suggested</u> (November 12, 2020)	Program Enhancement <u>Observed</u> (January 4, 2021)
Section 5: Infection Prevention and Control Policies	<ul style="list-style-type: none"> <li>Standardize infection prevention policies with a system-wide interdisciplinary committee.</li> <li>Implement Centers for Medicare and Medicaid Services Quality Assurance Performance Improvement Project</li> </ul>	<ul style="list-style-type: none"> <li>Started to standardize policies and procedures.</li> </ul>
Section 6: Resident Related Infection Prevention & Control Policies	<ul style="list-style-type: none"> <li>Review resident teaching and education re: Hand hygiene, social distancing, mask use, reporting symptoms, group activities, visitation restrictions, and use of isolation and quarantine.</li> <li>Explore enhancement of vendor electronic health records system to enable documentation of pertinent negatives from COVID-specific symptom screening.</li> </ul>	<ul style="list-style-type: none"> <li>Residents wearing masks and social distancing, no group activities.</li> <li>Charting by exception with emphasis on symptoms screening.</li> <li>Work with electronic health records system vendor to establish prompts and alerts.</li> </ul>
Section 7: SARS CoV-2 Testing	<ul style="list-style-type: none"> <li>Increase frequency and type of testing.</li> <li>Include daily antigen point of care testing and routine PCR.</li> </ul>	<ul style="list-style-type: none"> <li>Testing frequency exceeds Centers for Disease Control and Prevention /Centers for Medicare and Medicaid Services /Illinois Department of Public Health recommendations.</li> </ul>
Section 8: Vaccination Plan	<ul style="list-style-type: none"> <li>Work with Illinois Department of Veterans' Affairs and local health department.</li> </ul>	<ul style="list-style-type: none"> <li>95% of residents vaccinated.</li> <li>Actively working to vaccinate staff.</li> </ul>
Section 9: Respiratory Protection	<ul style="list-style-type: none"> <li>Continue fit testing plan in partnership with local health department.</li> </ul>	<ul style="list-style-type: none"> <li>Working with local health department.</li> </ul>

Source: Illinois Department of Veterans' Affairs.

IDVA provided auditors with new infection prevention policies on June 17, 2021, which were drafted with the assistance of the Illinois Department of Public Health, which were officially implemented on April 23, 2021. These policies were in response to the program enhancements described in **Exhibit 16**. The purpose of these policies was to establish a comprehensive and integrated infection prevention and control program at all Illinois veterans' homes. A system-level Infection Prevention and Control Committee was tasked with standardizing policies and procedures and was required to oversee infection prevention at the Illinois veterans' homes. These policies also updated infection prevention training requirements for staff at Illinois veterans' homes.

## Changes Made in Staff Training and Compliance Monitoring at the LaSalle Veterans' Home as a Result of COVID-19

Auditors reviewed documentation provided related to changes in staff training at the LaSalle Veterans' Home in the aftermath of the late October 2020 COVID-19 outbreak at the Home. The IDVA's new policies for its Infection Prevention Program established updated training requirements for Illinois veterans' home staff. Additionally, new policies identified the responsibilities of specific positions within the new framework and implanted a specific training and continuing professional development program for IDVA and Illinois veterans' home staff.

According to the Illinois veterans' homes' updated policies effective April 23, 2021, all newly hired and current staff are required to receive infection prevention training upon hire and at least annually. According to the updated policies:

- frontline clinical staff and management are required to received targeted trainings on hand hygiene, personal protective equipment, symptom screening and monitoring, cleaning, cohorting, and caring for residents with dementia during a pandemic;
- management staff are required to receive additional training in the areas of infection prevention, emergency preparedness and surge capacity, addressing emotional health of residents and staff, telehealth for nursing homes, and vaccine delivery system preparation;
- environmental staff are required to undergo targeted environmental service training in the areas of infection prevention, personal protective equipment, chemical safety, and disinfection procedures for surface cleaning; and
- infection preventionists are required to receive progressive training and professional development.

According to IDVA, changes in staff training related to COVID-19 were delineated per the emergency rule for 77 Ill. Adm. Code 340.1390. Staff at the Illinois veterans' homes were required to complete the Centers for Medicare and Medicaid Services trainings at the recommendation of IDPH. In addition, IDVA noted that LaSalle Home staff were provided in-service training in March 2021. IDVA provided a checklist showing which LaSalle Veterans' Home staff completed the training.

The updated infection prevention program implemented by IDVA also included a framework for self-assessment, self-monitoring, and quality improvement. Within the overall system-wide framework for infection prevention, each Illinois veterans' home is required to periodically (at least annually) conduct a thorough self-assessment of its infection prevention and control effort using one or more standardized assessment tools. Each Illinois veterans' home is also required to continuously monitor its compliance with infection practice through three ways: interdisciplinary rounds by veterans' home executive leadership; infection preventionist rounds; and focused audits. Each home shall also utilize standard



tools for quality assurance and performance improvement to close identified gaps in infection prevention practice.

## Monitoring at the LaSalle Veterans' Home Post-COVID-19 Outbreak (Determination 4)

The LaSalle Veterans' Home has been monitored through the IDPH survey process since November 2020. Additionally, IDVA hired consultants to review the protocols at the homes in order to identify any additional recommendations to prevent further outbreaks. IDVA also hired additional consultants to review the HVAC systems at the homes.

A separate committee was created to provide quality assurance reviews of the LaSalle Home operations. The first meeting was conducted on February 25, 2021. According to IDVA, the committee has already recommended improvements at the Home, and will provide the foundation for implementing drills for the new policies.

The Interagency Infection Prevention Project report from March 9, 2021, noted that repeated site visits to the LaSalle Veterans' Home showed substantial improvement in infection prevention practices. At the LaSalle Veterans' Home, the last new resident case associated with the facility's November outbreak tested positive on November 23, 2020. There were no further positive tests among LaSalle residents until March 1, 2021, when one resident tested positive without symptoms during the weekly PCR surveillance. Positive cases in staff at the LaSalle Veterans' Home also improved, with 11 employees testing positive in the first quarter of 2021 at the time of the report, compared to 102 positive staff members in the fourth quarter of 2020. The report notes that, in December 2020, immunization became an essential tool in suppressing transmission of COVID-19. As of February 11, 2021, 95.4 percent of residents and 56.4 percent of staff at the LaSalle Veterans' Home had either received at least one dose of the vaccine or were scheduled to receive the first dose.

House Resolution Number 62 asked auditors to determine the nature and extent of the monitoring conducted by IDVA to determine whether the improvements and protocols put in place are effective to ensure the safety of the residents and staff at the LaSalle Veterans' Home. According to IDVA, the LaSalle Veterans' Home was monitored consistently through the IDPH survey process since November 2020. Additionally, IDVA hired consultants to review the protocols at the homes in order to identify any additional recommendations to prevent further outbreaks. IDVA also hired additional consultants to review the HVAC systems at the Homes.

A separate committee was created to provide quality assurance reviews of the LaSalle Home operations. The first meeting was conducted on February 25, 2021. According to IDVA, the committee has already recommended improvements at the LaSalle Home, and will provide the foundation for implementing drills for the new policies.

### Interagency Infection Prevention Project Report (March 9, 2021)

On March 9, 2021, the Interagency Infection Prevention Project report was released by the medical consultant hired by the Department of Public Health. The Interagency Infection Prevention Project was formed when IDVA requested that IDPH and VISN 12 assist them in a comprehensive, system-wide quality

improvement project for COVID-19 response in late November 2020. The goals of the Interagency Infection Prevention Project were to:

- review current policies, procedures, and practice relating to COVID-19 response at each facility;
- assist each site with development of a COVID-19 corrective action plan;
- assist in creating a framework of standardized policies to address COVID-19 at IDVA Homes; and
- consult with specialists who could identify any structural/engineering changes needed to reduce potential transmission of COVID-19 within the facilities.

### **Recommendations to the Illinois Department of Veterans' Affairs**

The Interagency Infection Prevention Project identified a series of strengths that were found in the Illinois veterans' homes, as well as a series of recommended enhancements that build on the strengths identified. The strengths identified by the Interagency Infection Prevention Project were as follows:

- staff members at all levels of the organization place residents and their family members at the center of care;
- key resources are available, including sufficient front-line staffing, PPE, cleaning and disinfecting products, and point-of-care testing supplies, providing the basics for an effective infection prevention and control response; and
- willingness and readiness of veterans' homes to engage in an active pandemic response using an interdisciplinary approach that has included administration, nursing, infection preventionists, front line staff, and public health authorities.

The recommended enhancements were as follows:

- **Reorganize Infection Prevention for Veterans' Homes as a Coordinated Multi-Site Effort, Rather than the Independent Efforts of Individual Facilities** - this includes standardizing system-wide policies, procedures, and practices for infection prevention; standardizing supplies and equipment for environmental services; and creating a position for a Senior Infection Preventionist, as well as a system-wide Infection Prevention Committee.
- **Expand System Capacity for Infection Prevention** - this includes setting staff levels based on CDC recommendations and promoting regionally based linkages with infection preventionists and communicable disease leads at jurisdictional VA Medical Centers and local health departments.
- **Position Infection Preventionists to be Conveners, Coordinators, and Communicators for Interdisciplinary Team Efforts** - this includes aligning reporting relationships with their interdisciplinary role and responsibility, promoting professional development of infection preventionists by strengthening engagement with the Association for Professionals in Infection

Control and Epidemiology, and considering joining the AHRQ ECHO National Nursing Home COVID-19 Action Network.

- **Strengthen Staff-Wide Training** - this includes expanding structured in-service training, adding a layer of deeper training for managers, and emphasizing competency-based training techniques.
- **Monitor Adherence to Policy and Procedure to Identify and Correct Gaps in a Timely Manner** - this includes direct observation of practice by infection preventionists and supervisory staff; interdisciplinary rounds on all shifts; and regular, systemic, participatory audits, sharing results with staff.
- **Engage Top Management Directly with Front-Line Staff Through Interdisciplinary Team Rounds for Infection Prevention** - this includes creating a safe space in which to elicit facility-wide and unit-specific concerns from staff, engaging in collaborative problem-solving, promoting partnerships across disciplines, and cultivating a culture of clinical excellence among front-line staff.

### Progress

The report noted that repeated site visits to the Veterans' Home showed substantial improvement in infection prevention practices. At the LaSalle Veterans' Home, the last new resident case associated with the facility's November outbreak tested positive on November 23, 2020. There were no further positive tests among LaSalle residents until March 1, 2021, when one resident tested positive without symptoms during the weekly PCR surveillance. Positive cases in staff at the LaSalle Veterans' Home also improved, with 11 employees testing positive in the first quarter of 2021 at the time of the report, compared to 102 positive staff members in the fourth quarter of 2020. The report notes that, in December 2020, immunization became an essential tool in suppressing transmission of COVID-19. As of February 11, 2021, 95.4 percent of residents and 56.4 percent of staff at the LaSalle Veterans' Home had either received at least one dose of the vaccine or were scheduled to receive the first dose.

### Transition to In-House Infection Prevention

According to the report, IDVA has been highly receptive and responsive to recommendations from the interagency project team. The report states that one or more members of the Interagency Infection Prevention Project team will remain available for timely, day-to-day consultation, and the Interagency Infection Prevention Project has encouraged the leadership teams to attend the ongoing Long-Term Care Q&A teleconference series on infection prevention. The report also states, after IDVA hires a senior infection preventionist at the system level and further develops its infection prevention workforce at the facility level, the staff within the Department will be ready to handle most issues internally.

## LaSalle Veterans' Home COVID-19 Costs (Determinations 2 and 5)

The State expended approximately \$3.4 million between FY20 and FY21 as a result of the COVID-19 pandemic at the LaSalle Veterans' Home. According to documentation provided by IDPH and IDVA, expenditures included PPE, infrastructure improvements, and COVID-19 testing for both the COVID-19 pandemic as a whole and the outbreak at the LaSalle Home that began in late October 2020. Auditors concluded that the outbreak did not significantly add to the Home's overall COVID-19-related costs during FY20 and FY21. Additionally, because the amount of monthly overtime hours and costs incurred by LaSalle Veterans' Home staff fluctuated throughout FY20 (after the COVID-19 pandemic began in March 2020) and FY21, it was difficult for auditors to determine which overtime hours and costs were COVID-19-related and which were usual standard overtime costs.

House Resolution Number 62 asked auditors to determine the type, cost, and timing of any infrastructure or other building improvements intended to contain the further spread of COVID-19 or prevent its reoccurrence at the LaSalle Veterans' Home. In addition, House Resolution Number 62 asked auditors to determine the amount of State moneys received and the amount of State moneys expended by IDPH or any other State agency during State fiscal years 2020 and 2021 to address the COVID-19 outbreaks at the LaSalle Veterans' Home.

### LaSalle Home Funding and State Money Received in FY20 and FY21

The LaSalle Veterans' Home is overseen by IDVA, and licensed by IDPH. The LaSalle Home is primarily appropriated money through its own fund, the "LaSalle Veterans' Home Fund." As a result of the COVID-19 pandemic, the Home was specifically appropriated additional money under the appropriation name "Ordinary and Contingent Expenses – COVID19."

According to IDPH, it did not make any statutory fund transfers to the LaSalle Home. However, IDPH did note that transfers were made by IEMA from the State Coronavirus Urgent Remediation Emergency Fund. In addition, IDVA stated it was reimbursed for COVID expenses pursuant to the CARES Act. IDVA provided documentation that shows transfers were made to IDVA from the Governor's office of Management and Budget (GOMB) transfer account. IDVA noted this was transferred to IDVA after GOMB received a request for reimbursement.

The State Coronavirus Urgent Remediation Emergency Fund was established to receive federal funds from the Coronavirus Relief Fund or from any other federal fund pursuant to a provision of federal law. IEMA and IDPH have spending authority from the fund. Based on documentation provided by IDPH and IDVA, the LaSalle Veterans' Home Fund received two statutory transfers during the audit period, one on November 6, 2020 in the amount of \$655,108.86 and another on December 1, 2020 in the amount of \$284,265.52. In total, the LaSalle Veterans' Home received \$939,374.38.

## LaSalle Home State Money Expended and Infrastructure Improvements

The State expended approximately \$3.4 million between FY20 and FY21 as a result of the COVID-19 pandemic at the LaSalle Veterans' Home. According to documentation provided by IDPH and IDVA, expenditures included PPE, infrastructure improvements, and COVID-19 testing for both the COVID-19 pandemic as a whole and the outbreak at the LaSalle Home that began in late October 2020. The CDC defines PPE as personal protective equipment, which includes respirators or facemasks, eye protection (goggles or face shields), gloves, and gowns. Auditors limited the scope of costs incurred by the LaSalle Veterans' Home to include items that fit this definition.

The LaSalle Veterans' Home implemented several infrastructure improvements during FY20 and FY21 as a result of the COVID-19 pandemic and outbreak at the Home. Prior to the outbreak, external firms were commissioned to design and build airborne infection isolation rooms at IDVA Homes, including the LaSalle Home. According to IDVA, the construction of the isolation rooms was initiated in March of 2020 and operational by May 23, 2020. Payments made for the construction of the isolation rooms totaled \$1,057,470.

On December 18, 2020, a certified engineering and consulting firm conducted an assessment to improve air quality at the LaSalle Home. A report was published by the external firm on March 5, 2021. The objective of the assessment was to determine the most effective immediate measures to improve air quality at IDVA homes. Specific to the LaSalle Veterans' Home, the firm recommended the LaSalle Home utilize HEPA filters with UV disinfection in non-isolation resident rooms and for outdoor air intakes, as well as ensure demand controlled ventilation be disabled. The firm reported that facility maintenance at the LaSalle Veterans' Home had already addressed the firm's filter recommendations, and had made a decision to install UV disinfection throughout the home as a result. The cost for the assessment conducted at the LaSalle Veterans' Home totaled \$7,369.

**Exhibit 17** summarizes the costs incurred by the State for the LaSalle Veterans' Home as a result of the COVID-19 pandemic from March 2020 through June 2021. The Home was continuously supplied with PPE and was routinely conducting COVID-19 testing since the beginning of the pandemic. In addition, infrastructure improvements were already being implemented prior to the onset of the COVID-19 outbreak at the Home. Therefore, auditors concluded that the outbreak, which began in late October 2020, did not significantly add to the Home's overall COVID-19-related costs during FY20 and FY21.

Exhibit 17  
**COSTS INCURRED BY THE STATE FOR THE LASALLE VETERANS' HOME  
 FOR THE COVID-19 PANDEMIC**  
 For the Period March 2020 Through June 2021

Fiscal Year	Calendar Month/Year	Personal Protective Equipment (PPE) <sup>2</sup>	Infrastructure Improvements	COVID-19 Testing <sup>3</sup>	Total Costs Outbreak and Pandemic
<b>FY20</b>	March 2020	\$44,412	-	-	\$44,412
	April 2020	\$143,380	-	-	\$143,380
	May 2020	\$19,376	\$59,683	\$42,439	\$121,499
	June 2020	\$2,388	-	\$44,425	\$46,813
<b>FY21</b>	July 2020	\$88,789	\$29,841	\$56,133	\$174,763
	August 2020	\$41,108	\$7,799	\$141,325	\$190,232
	September 2020	\$5,898	-	\$110,384	\$116,282
	October 2020	\$20,266	-	\$123,659	\$143,925
	November 2020	\$55,867	-	\$114,669	\$170,537
	December 2020	\$11,159	-	\$118,746	\$129,905
	January 2021	\$37,311	\$993,923	\$129,722	\$1,160,956
	February 2021	\$21,523	7,369	\$141,638	\$170,530
	March 2021	\$9,825	-	\$181,569	\$191,394
	April 2021	\$7,350	\$64,104	\$167,875	\$239,330
	May 2021	\$15,024	-	\$178,642	\$193,666
	June 2021	\$12,778	-	\$122,196	\$134,973
<b>Totals<sup>1</sup></b>		<b>\$536,456</b>	<b>\$1,162,719</b>	<b>\$1,673,421</b>	<b>\$3,372,596</b>

Notes:

<sup>1</sup> Totals may not add due to rounding.

<sup>2</sup> The CDC defines PPE as personal protective equipment, which includes respirators or facemasks, eye protection (goggles or face shields), gloves, and gowns.

<sup>3</sup> COVID-19 expenditures incurred by IDPH.

Source: Illinois Department of Public Health information and Illinois Department of Veterans' Affairs.

**Overtime Hours and Costs During FY20 and FY21**

Auditors assessed the amount of overtime hours and associated expenses incurred by staff at the LaSalle Veterans' Home as a result of both the COVID-19 pandemic, and specifically during November 2020, which is generally the time of the COVID-19 outbreak at the Home. Auditors requested overtime costs or costs for any contractual employees for the LaSalle Veterans' Home from IDVA. Because the amount of monthly overtime hours and costs incurred by LaSalle Veterans' Home staff fluctuated throughout FY20 (after the COVID-19 pandemic began in March 2020) and FY21, it was difficult for auditors to determine which overtime hours and costs were COVID-19-related and which were usual standard overtime costs.

Exhibit 18  
**LASALLE VETERANS' HOME MONTHLY  
 STAFF OVERTIME HOURS AND COSTS<sup>1</sup>**  
 For the Period March 2020 Through June 2021

Month/Year	Overtime Hours by Month	Overtime Costs by Month <sup>1</sup>
March 2020	3,549	\$118,871
April 2020	2,717	\$96,329
May 2020	3,333	\$135,451
June 2020	3,993	\$145,358
July 2020	2,741	\$113,186
August 2020	3,376	\$141,741
September 2020	2,547	\$105,453
October 2020	2,436	\$102,400
November 2020 <sup>2</sup>	3,826	\$144,040
December 2020	1,817	\$67,956
January 2021	1,549	\$60,748
February 2021	2,014	\$75,086
March 2021	2,966	\$112,253
April 2021	2,615	\$93,434
May 2021	3,040	\$116,226
June 2021	3,402	\$130,758
<b>Totals<sup>3</sup></b>	<b>45,919</b>	<b>\$1,759,290</b>

Notes:

- <sup>1</sup> Auditors were unable to separate normal overtime from overtime as a result of COVID-19.
- <sup>2</sup> November 2020 generally reflects the time period the COVID-19 outbreak took place at the LaSalle Veterans' Home.
- <sup>3</sup> Totals may not add due to rounding.

Source: Illinois Department of Veterans' Affairs.

IDVA provided auditors with overtime reports for the LaSalle Veterans' Home from March 2020 through June 2021. Since the COVID-19 pandemic began in Illinois in March 2020, LaSalle Veterans' Home staff worked approximately 45,919 total hours of overtime for a total cost of nearly \$1.8 million. Based on the information provided, the lowest overtime amount LaSalle Home staff worked was 1,549 hours for a cost of \$60,748 in January 2021. At the highest, LaSalle Home staff worked 3,993 hours for a cost of \$145,358. During the late fall 2020 COVID-19 outbreak at the LaSalle Home, which occurred during November, staff at the Home worked 3,826 hours of overtime for a total cost of \$144,040. Auditors also determined the following for the Home since the beginning of the pandemic:

- the average amount of overtime hours worked per month was 1,913;
- the average cost of overtime expended per month was \$109,956; and
- the average cost per hour of overtime was \$38.

**Exhibit 18** summarizes monthly overtime hours and associated costs at the LaSalle Home between March 2020 and June 2021.



## Reviews Since 2015 (Determination 6)

The LaSalle Veterans' Home was surveyed by IDPH as well as the U.S. Department of Veterans' Affairs (USDVA). Since 2015, the LaSalle Veterans' Home has been the subject of 22 IDPH surveys. Non-compliance was identified in two surveys both following the November 2020 COVID-19 outbreak. One, from November 2020, found non-compliance related to written policies related to all services provided and policies for investigating, controlling, and preventing infections. The other, from March 2021, found the facility failed to prevent abuse, failed to report potential abuse immediately, failed to immediately remove the staff member from contact with residents after a report of potential abuse, and failed to follow their policy to immediately examine a resident and immediately suspend the accused staff member for two of the three residents reviewed.

Non-compliance has been identified in 3 of the 5 annual surveys conducted by the USDVA since 2015. None of the issues identified were related to infectious diseases or infection control.

House Resolution Number 62 asked auditors to determine whether the LaSalle Veterans' Home has been the subject of any reviews since 2015 to determine its compliance with applicable laws and regulations with regard to the care of its residents. According to IDVA, the LaSalle Veterans' Home is surveyed by IDPH as well as the USDVA. Since 2015, the LaSalle Veterans' Home has been the subject of 22 IDPH surveys.

Of the 22 IDPH surveys, two found non-compliance:

- **November 23, 2020** - IDPH found that the LaSalle Home was not meeting the requirements set forth by Section 340.1300 and Section 340.1335 of the Illinois Administrative Code. Section 340.1300 requires that the facility have written policies and procedures governing all services provided by the facility, and that these written policies be followed in operating the facility. Section 340.1335 requires that policies and procedures for investigating, controlling, and preventing infections in the facility should be established and followed. IDPH found that the LaSalle Home did not meet these requirements, as it failed to disinfect monitoring equipment in between resident use for three of the five residents reviewed.
- **March 26, 2021** - IDPH found that the LaSalle Home was not meeting the requirements set forth by Section 340.1300 and Section 340.1440 of the Illinois Administrative Code. Section 340.1440 requires that the facility not abuse or neglect a resident, and if a facility employee or agent becomes aware of abuse or neglect of a resident then it must be immediately reported to the facility administrator. If an employee of the facility is, based on credible evidence, suspected to be the perpetrator of abuse, the employee must be immediately barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution, or disciplinary action. Based on interviews and record reviews, the facility failed to prevent abuse, failed to report potential abuse immediately, failed to immediately remove the staff member from contact with residents after a report of potential abuse, and failed to follow its policy to immediately examine a resident and

immediately suspend the accused staff member for two of the three residents reviewed.

In addition to the surveys conducted by IDPH, the LaSalle Veterans' Home has also been subject to five annual surveys by the USDVA since 2015. Of the five surveys, three of them found non-compliance:

- **October 29, 2015**

- ✓ **38 CFR 51.70 (c)(6)** requires that the facility management must purchase a surety bond, or otherwise provide assurance satisfactory to the Under Secretary for Health, to assure the security of all personal funds of residents deposited with the facility. While the LaSalle Home was self-insured through the State of Illinois, the report says that the LaSalle Home did not have a surety bond and did not have an alternative method of assurance approved by the Under Secretary of Health. The report noted that IDVA was in the process of seeking approval of its self-insurance plan. The survey recommended that the LaSalle Home aggressively follow up with the Under Secretary for Health to ensure immediate resolution and if the report were to be denied, then the LaSalle Home would need to ensure a surety bond is established.
- ✓ **38 CFR 51.120 (n)** requires that facility management ensure that medication errors are identified and reviewed on a timely basis and that strategies for preventing medication errors and adverse reactions are implemented. The USDVA found that the LaSalle Home failed to prevent a medication error for 1 of the 27 sampled residents.
- ✓ **38 CFR 51.200 (a)** requires that the facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. The USDVA found that the LaSalle Home did not meet this requirement as the LaSalle Home failed to provide complete sprinkler coverage of the facility. The report noted this deficient practice affected 4 of the 14 smoke compartments, as well as 60 residents.

- **October 19, 2017**

- ✓ **38 CFR 51.200 (a)** requires that the facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public. The USDVA found that the LaSalle Home failed to install a fire sprinkler system that provided complete coverage. The report noted that the deficient practice affected one of the 14 smoke compartments.
- ✓ **38 CFR 51.200 (b)** requires that an emergency electrical power system must be provided to supply enough power to illuminate all exit signs, lighting required for exiting the facility, fire alarms, medical gas alarms, emergency communication systems, and illumination for generator tasks. This system must be in accordance with NFPA 99, NFPA 101, the Life Safety Code, and the Health Care Facilities Code. The NFPA is the

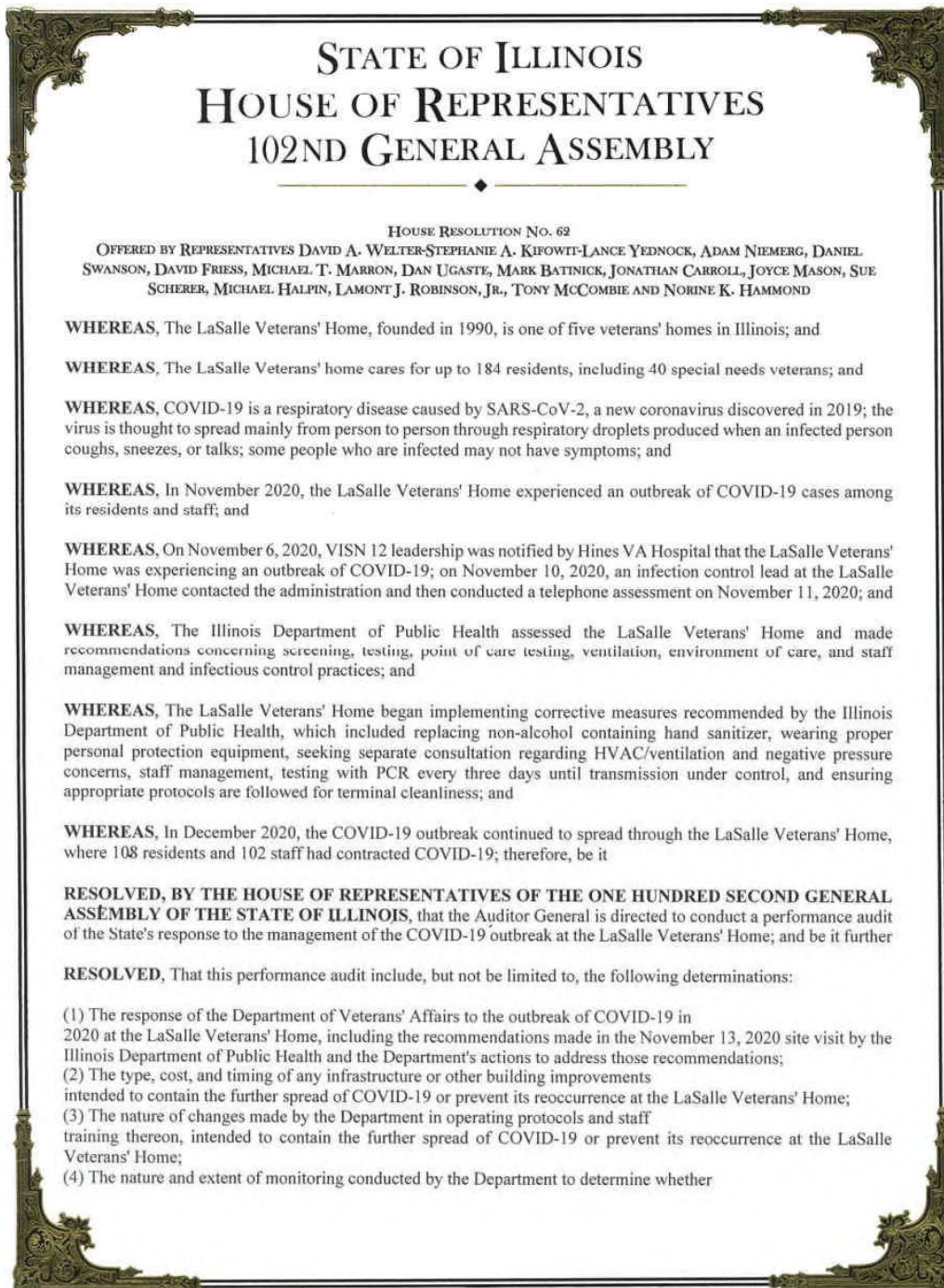
National Fire Protection Association. The USDVA found that the LaSalle Home could not provide documented weekly inspection reports of the emergency generators for the weeks of December 18, 2016, and March 9, 2017, as required by NFPA 101.

- **October 17, 2019:**
  - ✓ **38 CFR 51.120 (h)** requires that, if the LaSalle Home does not employ a qualified professional person to furnish a specific service to be provided by the facility, management must have that service furnished to residents by a person or agency outside the facility under a written agreement. This agreement must specify that the LaSalle Home management assumes responsibility for obtaining services that meet professional standards and timeliness of the services. The USDVA found that this requirement was only provisionally met, as the LaSalle Home had a veteran utilizing outside dialysis; however there was no contract between the LaSalle Home and the dialysis facility at the time.



## Appendix A

## House Resolution Number 62



the improvements and protocols put in place are effective to ensure the safety of residents and staff at the LaSalle Veterans' Home;

(5) The amount of State moneys received and the amount of State moneys expended by IDPH or any other State agency during State fiscal years 2020 and 2021 to address the COVID-19 outbreaks at the LaSalle Veterans' Home; and

(6) To the extent information is available, whether the LaSalle Veterans' Home has been the subject of any reviews since 2015 to determine its compliance with applicable laws and regulations with regard to the care of its residents and, if so, the results of those reviews; and be it further

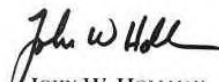
**RESOLVED**, That the Illinois Department of Veterans' Affairs, the Illinois Department of Public Health, the Office of the Governor, and any other State agency or other entity or person that may have information relevant to this audit cooperate fully and promptly with the Auditor General's Office; and be it further

**RESOLVED**, That the Auditor General is best equipped to conduct an investigation given their understanding of the policies and procedures associated with an outbreak response by the Departments of Public Health and Veterans' Affairs and the recommendations made in the 2019 Performance Audit; and be it further


**RESOLVED**, That the Auditor General commence this audit as soon as practical and report its findings and recommendations upon completion in accordance with the provisions of Section 3-14 of the Illinois State Auditing Act; and be it further

**RESOLVED**, That a suitable copy of this resolution be delivered to the Auditor General.

Adopted by the House of Representatives on April 28, 2021.

  
JOHN W. HOLLMAN  
CLERK OF THE HOUSE



  
EMANUEL "CHRIS" WELCH  
SPEAKER OF THE HOUSE

## Appendix B

### Audit Scope and Methodology

This performance audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310. Audit standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives found in House Resolution Number 62.

The audit objectives were delineated by House Resolution Number 62, which directed the Office of the Auditor General to conduct a performance audit of the State's response to the management of the COVID-19 outbreak at the LaSalle Veterans' Home. The Resolution contained six specific determinations (see Appendix A).

In conducting this audit, auditors reviewed management controls and assessed risk related to the audit's objectives. A risk assessment was conducted to identify areas that needed closer examination. We examined the five components of internal control – control environment, risk assessment, control activities, information and communication, and monitoring – along with the underlying principles. We considered all five components to be significant to the audit objectives and did not identify any significant weaknesses in those controls.

Auditors reviewed COVID-19 guidelines from the Centers for Disease Control and the Illinois Department of Public Health (IDPH). Auditors also reviewed policies and procedures, investigative reports, emails, visitor logs, training guidelines, medical records from the LaSalle Veterans' Home, Department of Human Services' Office of the Inspector General (DHS OIG) interviews of LaSalle Veterans' Home staff, and other documents provided by various sources.

Specific documents related to the LaSalle outbreak were requested from the Illinois Department of Veterans' Affairs (IDVA) and IDPH. Additional documents were also requested from the DHS OIG, the LaSalle County Health Department, and the Office of the Governor. Auditors met with IDVA officials to gain an overview of the agency and an understanding of how the outbreak at the LaSalle Veterans' Home began, the response to the outbreak, and to request information. Auditors met with representatives from the DHS Inspector General, the Deputy Governor over Health and Human Services, the Chief Counsel and Deputy Chief Counsel for the Governor, officials from IDVA and IDPH, the LaSalle Veterans' Home Administrator and the Director of Nursing, and officials from the LaSalle County Health Department.

Auditors were provided a large amount of information from IDVA and IDPH. Additional information was provided by the LaSalle County Health Department. After working with the Governor's office, emails from individuals from IDVA

and IDPH were provided for the time period of the outbreak at LaSalle. These emails were reviewed and were used to create a timeline of the communications during the outbreak at LaSalle.

Due to active outbreaks at the LaSalle Veterans' Home during the audit, on site visits of the LaSalle Home were not conducted by auditors. Additionally, several individuals employed at IDVA during the LaSalle Home COVID-19 outbreak were no longer employed by the State. As a result, with the exception of the former Chief of Staff, these individuals were not interviewed. These individuals include the former IDVA Director, and the LaSalle Veterans' Home Administrator, Director of Nursing, and Infectious Disease Nurse.



The dates of the Exit Conferences and the principal attendees for IDVA, IDPH, and the DHS OIG are noted below:

<b>IDVA Exit Conference</b>		<b>April 11, 2022</b>
<b>Agency</b>	<b>Name and Title</b>	
Illinois Department of Veterans' Affairs	<ul style="list-style-type: none"> <li>• Terry Prince, Director</li> <li>• Anthony Vaughn, Assistant Director</li> <li>• Melissa Black, Chief of Staff</li> <li>• Brittany Hawkins, General Counsel</li> <li>• Matt Eddington, Assistant General Counsel</li> </ul>	
Illinois Office of the Auditor General	<ul style="list-style-type: none"> <li>• Scott Wahlbrink, Senior Audit Manager</li> <li>• Bill Helton, Audit Manager</li> <li>• Geoff Piehl, Audit Supervisor</li> <li>• Michael Haskins, Audit Staff</li> <li>• Ryan Rizner, Audit Staff</li> </ul>	
<b>IDPH Exit Conference</b>		<b>April 14, 2022</b>
<b>Agency</b>	<b>Name and Title</b>	
Illinois Department of Public Health	<ul style="list-style-type: none"> <li>• Justin DeWitt, Chief of Staff</li> <li>• Laura Vaught, Chief of Staff</li> <li>• Rukhaya Alikhan, General Counsel</li> <li>• Douglas Dorando, Deputy General Counsel</li> <li>• Judy Kauerauf, Section Chief Communicable Disease</li> <li>• Brad Colantino, External Audit Coordinator</li> <li>• Candice Long, Chief Internal Auditor</li> </ul>	
Illinois Office of the Auditor General	<ul style="list-style-type: none"> <li>• Scott Wahlbrink, Senior Audit Manager</li> <li>• Bill Helton, Audit Manager</li> <li>• Geoff Piehl, Audit Supervisor</li> <li>• Michael Haskins, Audit Staff</li> </ul>	
<b>DHS OIG Exit Conference</b>		<b>March 31, 2022</b>
<b>Agency</b>	<b>Name and Title</b>	
Illinois Department of Human Services' Office of the Inspector General	<ul style="list-style-type: none"> <li>• Peter Neumer, Inspector General</li> <li>• Amy Macklin, DHS Chief Internal Auditor</li> <li>• John Schomberg, General Counsel</li> <li>• Jesse Escarpita, Chief Administrative Officer</li> </ul>	
Illinois Office of the Auditor General	<ul style="list-style-type: none"> <li>• Scott Wahlbrink, Senior Audit Manager</li> <li>• Bill Helton, Audit Manager</li> <li>• Geoff Piehl, Audit Supervisor</li> <li>• Michael Haskins, Audit Staff</li> <li>• Ryan Rizner, Audit Staff</li> </ul>	

## Appendix C

### IDVA Homes Report Emails

Note: These emails from the former Chief of Staff were blind copied to numerous individuals. These individuals included: the Director of IDVA; the IDPH State Medical Officer; the IDPH Public Health Educator, the IDPH Communicable Disease Section Chief, and the First Assistant Deputy Governor for Health & Human Services. The highlighted sections below were part of the original emails and were not added by auditors.

**From:** [IDVA Chief of Staff]  
**Sent:** Monday, November 2, 2020 8:45 AM  
**To:** [IDVA Chief of Staff]  
**Subject:** IDVA Homes report

---

**Note: Outbreak at LaSalle**

LaSalle:

Phase 1

0 Tests pending; Testing all other residents today

10 positive resident; 1 Recovered plus 9; one tested at hospital; all others antigen tested;

8 positive employee; Plus 3 – 2 identified during testing; third tested outside the facility. All Direct care

1 hospitalizations; non symptomatic but positive upon admission for septic

0 deaths residents or staff

Quincy:

Phase 1

0 Test pending ; Resident tests and first batch of staff tests dropping today

15 Positive residents: All recovered

40 Positive employees: All recovered

0 hospitalizations:

1 resident death:

Manteno:

Phase 1

0 Tests pending: Next round of tests dropping today and Wed.

38 positive staff : 37 recovered; one on long term disability

60 positive residents; 59 recovered, one still considered positive

0 hospitalizations

17 resident deaths;

Prince: (homeless program in Manteno but not within the veterans home – no interaction between the two)

0 Test pending;

4 positive employees: All recovered.

3 positive residents; All recovered;

0 hospitalizations;

0 deaths residents or staff

Anna:

Phase 1

0 Tests pending; Next round of tests dropping today and Wed.

7 positive staff; All recovered

6 positive residents; All recovered

0 hospitalizations;

██████████  
Chief of Staff

IL Dept. of Veterans Affairs

**From:** [IDVA Chief of Staff]  
**Sent:** Tuesday, November 3, 2020 9:03 AM  
**To:** [IDVA Chief of Staff]  
**Subject:** IDVA Homes Report

---

**Note: LaSalle and Quincy**

LaSalle:

Phase 1

121 Tests pending; All residents pending; Testing staff today  
 13 Total- 12 current positive residents; 1 Recovered plus 3 from yesterday.  
 10 total – 5 current positive employee; Plus 2 from yesterday  
 3 hospitalizations; residents – Plus 2 from yesterday 1 non symptomatic but positive upon admission for septic, other 2 are current positive residents sent to the hospital after diagnosis.  
 0 deaths residents or staff

Quincy:

Phase 1

382 Tests pending ; 249 resident and 133 staff pending; 32 resident and 59 staff negative; 2 positive employees  
 15 Positive residents: All recovered  
 43 Total 3 current Positive employees: All work in different areas, 2 identified through facility testing; third is a previously positive staffer who was asymptomatic during the previous positive (60 days ago); became symptomatic so tested again outside the facility and is positive  
 0 hospitalizations:  
 1 resident death:

Manteno:

Phase 1

0 Tests pending: Next round of tests dropping today and Wed.  
 38 positive staff : 37 recovered; one on long term disability  
 60 positive residents; 59 recovered, one still considered positive  
 0 hospitalizations  
 17 resident deaths;

Prince: (homeless program in Manteno but not within the veterans home – no interaction between the two)

0 Test pending;  
 4 positive employees: All recovered.  
 3 positive residents; All recovered;  
 0 hospitalizations;  
 0 deaths residents or staff

Anna:

Phase 1

51 Tests pending; All pending are staff.  
 7 positive staff; All recovered  
 6 positive residents; All recovered  
 0 hospitalizations;

From: [IDVA Chief of Staff]  
 Sent: Wednesday, November 4, 2020 8:30 AM  
 To: [IDVA Chief of Staff]  
 Subject: IDVA Homes Report

---

## LaSalle:

## Phase 1

127 Tests pending; 6 employees tested outside the facility pending; 121 resident test pending; Staff tests dropping today.  
 23 Total- 22 current positive residents; 1 Recovered plus 10 from yesterday; these are all antigen tested; awaiting confirmation via normal testing  
 12 total 7 current positive employee; plus 2 from yesterday  
 3 hospitalizations; residents –1 non symptomatic but positive upon admission for septic, other 2 are current positive residents sent to the hospital after diagnosis.  
 0 deaths residents or staff

## Quincy:

## Phase 1

382 Tests pending ; 249 resident and 133 staff pending; 32 resident and 59 staff negative;  
 15 Positive residents: All recovered  
 43 Total 3 current Positive employees: All work in different areas, 2 identified through facility testing; third is a previously positive staffer who was asymptomatic during the previous positive (60 days ago); became symptomatic so tested again outside the facility and is positive  
 0 hospitalizations:  
 1 resident death:

## Manteno:

## Phase 1

269 Tests pending: 152 resident and 117 staff pending; additional staff dropping today.  
 38 positive staff : 37 recovered; one on long term disability  
 60 positive residents; 59 recovered, one still considered positive  
 0 hospitalizations  
 17 resident deaths;

Prince: (homeless program in Manteno but not within the veterans home – no interaction between the two)

0 Test pending;  
 4 positive employees: All recovered.  
 3 positive residents; All recovered;  
 0 hospitalizations;  
 0 deaths residents or staff

## Anna:

## Phase 1

51 Tests pending; All pending are staff.  
 7 positive staff; All recovered  
 6 positive residents; All recovered  
 0 hospitalizations;

██████████

From: [IDVA Chief of Staff]  
 Sent: Thursday, November 5, 2020 8:46 AM  
 To: [IDVA Chief of Staff]  
 Subject: IDVA Homes Report

---

LaSalle:

Phase 1

127 Tests pending; 6 employees tested outside the facility pending; 121 resident test pending; Staff tests dropping today.

45 Total- 44 current positive residents; 1 Recovered plus 22 from yesterday;

14 total 9 current positive employee; plus 2 from yesterday

3 hospitalizations; residents –1 non symptomatic but positive upon admission for septic, other 2 are current positive residents sent to the hospital after diagnosis.

0 deaths residents or staff

Quincy:

Phase 1

194 Tests pending ; 6 resident and 185 staff pending; 278 resident and 197 staff negative;

15 Positive residents: All recovered

47 Total 7 current Positive employees: Plus 4; additional are a mix of administrative; and maintenance staff.

0 hospitalizations:

1 resident death:

Manteno:

Phase 1

86 Tests pending: 4 resident and 82 staff pending; 148 residents 34 employees negative; additional staff dropping today.

40 positive staff : 2 current; 37 recovered; one on long term disability plus 2 from yesterday; staff do not work in the area of the positive resident.

61 positive residents; 59 recovered, one still considered positive; plus one previously positive (more than 90 days ago) resident tested positive again.

0 hospitalizations

17 resident deaths;

Prince: (homeless program in Manteno but not within the veterans home – no interaction between the two)

0 Test pending;

4 positive employees: All recovered.

3 positive residents; All recovered;

0 hospitalizations;

0 deaths residents or staff

Anna:

Phase 1

19 Tests pending; all pending are staff 32 staff negative.

7 positive staff; All recovered

6 positive residents; All recovered

0 hospitalizations;

██████████

From: [IDVA Chief of Staff]  
 Sent: Friday, November 6, 2020 9:02 AM  
 To: [IDVA Chief of Staff]  
 Subject: IDVA Homes report

Note: Report will be updated over the weekend but will be late morning on Saturday.

LaSalle:

Phase 1

282 Tests pending; 192 staff and 90 resident pending;

49 Total- 48 current positive residents; 1 Recovered plus 4 from yesterday;

17 total 12 current positive employee; plus 3 from yesterday

3 hospitalizations; residents –1 non symptomatic but positive upon admission for septic, other 2 are current positive residents sent to the hospital after diagnosis.

0 deaths residents or staff

Quincy:

Phase 1

181 Tests pending ; 6 resident and 181 staff pending; 284 (all) residents and 197 staff negative;

15 Positive residents: All recovered

47 Total 7 current Positive employees: Plus 4; additional are a mix of administrative; and maintenance staff.

0 hospitalizations:

1 resident death:

Manteno:

Phase 1

190 Tests pending: 4 resident and 186 staff pending; 148 residents 34 employees negative;

40 positive staff : 2 current; 37 recovered; one on long term disability

61 positive residents; 59 recovered, one still considered positive;

0 hospitalizations

17 resident deaths;

Prince: (homeless program in Manteno but not within the veterans home – no interaction between the two)

0 Test pending;

4 positive employees: All recovered.

3 positive residents; All recovered;

0 hospitalizations;

0 deaths residents or staff

Anna:

Phase 1

19 Tests pending; all pending are staff 32 staff negative.

7 positive staff; All recovered

6 positive residents; All recovered

0 hospitalizations;

Chief of Staff

IL Dept. of Veterans Affairs

**From:** [IDVA Chief of Staff]  
**Sent:** Monday, November 9, 2020 9:06 AM  
**To:** [IDVA Chief of Staff]  
**Subject:** IDVA Homes Report

---

LaSalle:

Phase 1

66 Tests pending; 1 resident and 65 staff pending (Staff are a re-test of those not positive last week) Retesting residents today

63 Total- 59 current positive residents; 1 Recovered plus 3 deaths ;

70 total 65 current positive employee; plus 53 over the weekend.

3 hospitalizations; residents –1 non symptomatic but positive upon admission for septic, other 2 are current positive residents sent to the hospital after diagnosis.

3 deaths residents; Two were on hospice prior to COVID diagnosis.

Quincy:

Phase 1

0 Tests pending ; All residents and 370 employees negative. Positives updated below

15 Positive residents: All recovered

55 Total 15 current Positive employees: Plus 8 over the weekend.

0 hospitalizations:

1 resident death:

Manteno:

Phase 1

0 Tests pending: 152 (cumulative) residents and 213 employees negative;

47 positive staff : 9 current; 37 recovered; one on long term disability plus 7 over the weekend

61 positive residents; 59 recovered, one still considered positive;

0 hospitalizations

17 resident deaths;

Prince: (homeless program in Manteno but not within the veterans home – no interaction between the two)

0 Test pending;

4 positive employees: All recovered.

3 positive residents; All recovered;

0 hospitalizations;

0 deaths residents or staff

Anna:

Phase 1

0 Tests pending; All staff negative.

7 positive staff; All recovered

6 positive residents; All recovered

0 hospitalizations;

██████████  
Chief of Staff

IL Dept. of Veterans Affairs



**From:** [IDVA Chief of Staff]  
**Sent:** Tuesday, November 10, 2020 9:26 AM  
**To:** [IDVA Chief of Staff]  
**Subject:** IDVA Homes Report

---

LaSalle:

Phase 1

2 Tests pending; 2 staff still pending from last week; additional employee tests dropping today  
 68 Total- 64 current positive residents; 1 Recovered plus 6 deaths ;  
 70 total 65 current positive employee; plus 53 over the weekend.  
 4 hospitalizations; residents –plus 1 from yesterday; this includes one released and two admitted.  
 1 hospitalization; Employee new  
 6 deaths residents; Plus 3 from yesterday.

Quincy:

Phase 1

361 Tests pending ; 201 residents and 116 employees negative 278 staff and 83 residents pending,  
 4 staff positive  
 15 Positive residents: All recovered  
 59 Total 19 current Positive employees: Plus 4  
 0 hospitalizations:  
 1 resident death:

Manteno:

Phase 1

377 Tests pending: 156 resident and 221 employees pending  
 47 positive staff : 9 current; 37 recovered; one on long term disability  
 61 positive residents; 59 recovered, one still considered positive;  
 0 hospitalizations  
 17 resident deaths;


Prince: (homeless program in Manteno but not within the veterans home – no interaction between the two)

0 Test pending;  
 4 positive employees: All recovered.  
 3 positive residents; All recovered;  
 0 hospitalizations;  
 0 deaths residents or staff

Anna:

Phase 1

0 Tests pending; All staff negative.  
 7 positive staff; All recovered  
 6 positive residents; All recovered  
 0 hospitalizations;

  
 Chief of Staff

IL Dept. of Veterans Affairs

**From:** [IDVA Chief of Staff]  
**Sent:** Thursday, November 12, 2020 9:24 AM  
**To:** [IDVA Chief of Staff]  
**Subject:** IDVA Homes Report

---

LaSalle:

Phase 1

0 Tests pending; All negative residents will be rapid tested today; UDVA and DPH onsite today

73 current positive residents; plus deaths listed below

88 current positive employee;

3 hospitalizations; residents

1 hospitalization; Employee

9 deaths residents;

Quincy:

Phase 1

61 Tests pending ; 285 (cumulative) residents and 316 employees negative 60 staff and 1 resident pending.

15 Positive residents: All recovered zero residents currently positive

14 current Positive employees: (this is reflective of additional positives and recoverys)

0 hospitalizations:

1 resident death:

Manteno:

Phase 1

2 Tests pending: 1 resident and 1 employee pending

12 current staff positive

61 positive residents; 59 recovered, one still considered positive;

0 hospitalizations

17 resident deaths;

Prince: (homeless program in Manteno but not within the veterans home – no interaction between the two)

0 Test pending;

4 positive employees: All recovered.

3 positive residents; All recovered;

0 hospitalizations;

0 deaths residents or staff

Anna:

Phase 1

0 Tests pending; All staff and residents being tested today

1 current positive staff;

6 positive residents; All recovered

0 hospitalizations;

██████████  
Chief of Staff

IL Dept. of Veterans Affairs

From: [IDVA Chief of Staff]  
 Sent: Friday, November 13, 2020 9:16 AM  
 To: [IDVA Chief of Staff]  
 Subject: IDVA Homes Report

Please note the new report style

Coronavirus Disease 2020 (COVID-19) Tracker  
 Illinois Department of Veterans Affairs  
 Affairs Homes

FACILITY INFORMATION				RESIDENT COVID-19 DATA					STAFF COVID-19 DATA					NOTES About Updates
Facility Name	County	Date Updated	Census	Cumulative # Tests Positive	Current # Tests Positive	# Current Hospitalizations	# Recovered	# Deaths	Cumulative # Tests Positive	Current # Tests Positive	# Current Hospitalizations	# Recovered	# Deaths	
Anna	Union	11/13/2020		6	0	0	5	0	7	1	0	2	0	
LaSalle	LaSalle	11/13/2020		83	82	3	1	11	93	88	1	5	0	plus 2 residents deaths
Martino	Kankakee	11/13/2020		61	0	0	59	17	49	5	0	37	0	plus 2 employees
Prince	Kankakee	11/13/2020		3	0	0	2	0	4	2	0	4	0	
Quincy	Adams	11/13/2020		15	0	0	11	1	72	15	0	40	0	plus 1 employee

Chief of Staff  
 IL Dept. of Veterans Affairs

**State of Illinois - CONFIDENTIALITY NOTICE:** The information contained in this communication is confidential, may be attorney-client privileged or attorney work product, may constitute inside information or internal deliberative staff communication, and is intended only for the use of the addressee. Unauthorized use, disclosure or copying of this communication or any part thereof is strictly prohibited and may be unlawful. If you have received this communication in error, please notify the sender immediately by return e-mail and destroy this communication and all copies thereof, including all attachments. Receipt by an unintended recipient does not waive attorney-client privilege, attorney work product privilege, or any other exemption from disclosure.

## Appendix D

### IDVA Chief of Staff Response

Titles for Redacted Names	
1	IDVA Chief of Staff (former)
2	Infection Control Consultant
3	Infection Control Consultant
4	IDPH Infection Control Coordinator
5	Contractual Medical Lead
6	Deputy Governor, Health & Human Services
7	First Assistant Deputy Governor, Health & Human Services
8	IDPH Public Health Educator
9	State Medical Officer
10	IDPH Communicable Disease Control Section Chief
11	Inspector General, Illinois Department of Human Services

The former IDVA Chief of Staff's complete unedited response related to the OIG investigation, COVID-related training at the LaSalle Home, the IDPH response to the outbreak, his duties as Chief of Staff, and other questions are shown in this Appendix. Auditors did not attempt to verify all of the statements made by the former Chief of Staff.

## LaSalle Veterans Home Response Audit

To: Scott Wahlbrink – Office of the Auditor General

From: [REDACTED]

Date: November 25, 2021

Mr. Wahlbrink,

Please find below my responses regarding the LaSalle Veterans' Home.

Please feel free to contact me with any additional questions you may have.

[REDACTED]

1. *Could you please describe anything within the OIG report that you believe to be incorrect or inaccurate? Could you also please explain why it is inaccurate and can you provide any documentation?*

Generally, the report appears to make a significant number of assumptions and bold declarations of opinion without the benefit of any substance to understand how the author formed the opinion. One area in particular the author completely failed to identify in the report is that each of the facilities initiated a Continuing Operations Plan (COOP) to address the pandemic. That document for each facility was circulated to the Illinois Emergency Management Agency (IEMA) as well as representatives of the Illinois Department of Public Health (IDPH). While IEMA provided feedback, IDPH did not. The documents were sent to [REDACTED] and [REDACTED] in March of 2020 via email. The report suggests there was no preparation in terms of policy, which is inaccurate. These documents were provided to the author, who chose not to include. If the COOP's were not sufficient, there was no indication from IDPH that they needed changed. Further, this document was in place at the Manteno facility when they experienced a significant outbreak. IDPH consulted with the facility leadership on the response and sent [REDACTED] to the facility to review response. At no time did anyone indicate the policy was insufficient. Further, this issue was not identified in any of IDPH's review of LaSalle until [REDACTED] identified a need to establish a much broader agency policy structure (13 initial policies) in January 2020. To re-iterate: At no time did anyone at IDPH identify that the COOP policy in place at all IDVA facilities was insufficient.

2. *During the first two weeks of November 2020, the beginning of the outbreak at LaSalle, can you describe the involvement from the Governor's office? You mentioned you*

believe that [REDACTED] was receiving your daily report figures. To your knowledge, did anyone else provide information about the outbreak to the Governor's office, and if so, who provided it and what information was provided? What involvement did they have in the outbreak? Specifically, were there meetings with [REDACTED] and [REDACTED] to discuss the outbreak and possible involvement of other agencies like IEMA or IDPH?

Governor's Office: For several months prior to the LaSalle outbreak, I provided a daily email outlining the testing as well as positive results for residents and staff at each facility. This testing was in accordance with IDPH and CDC recommendations and typically exceeded both agency's recommendations. The report author's staff indicated they found these emails to be confusing but didn't seem interested in understanding them when I explained. Further, none of the IDPH, USDVA, IDVA Staff or Governor's office indicated confusion when they were sent. I am unaware if [REDACTED] was specifically briefed daily on the report. The report was sent directly to [REDACTED] who is [REDACTED]'s deputy (her title is First Assistant Deputy Governor). Further, the report was sent to staff at IDPH ([REDACTED]) who plugged the numbers in for a daily briefing for the IDPH Director. It was my understanding this information was used by Director Ezike to brief [REDACTED] and the Governor, but I have no first-hand knowledge of this. I did send an e-mail that included [REDACTED] (I do not recall if [REDACTED] was on the email) indicating there was an outbreak at LaSalle when I was notified of the first two cases. At some point, [REDACTED] did call and asked if the facility had rapid tests. I indicated we were not provided these by the Federal Government as we were not (Federal CMS) certified but the local hospital had provided a small number for emergency use. She also asked if IDPH had provided antigen tests (BINAXNOW). I responded we had not received these. After our call [REDACTED] e-mailed the IDPH Chief of Staff directing BINAX Now tests be sent to the facility that day and to arrange for all IDVA facilities to receive them. There should be email traffic to support this. Discussion with [REDACTED] / [REDACTED] centered around IDPH having spoken to the facility, [REDACTED]'s response to that point, and I relaying that no additional guidance (or change in what we were doing) had been identified by IDPH.

3. *Are you specifically aware of any COVID related training that was conducted at the LaSalle Veterans' Home? Do you know the specific topics and the dates of these trainings?*

I am not aware of Covid specific training conducted at the facilities. The facility leadership (Administrator, Director of Nursing, Infection Control Nurse) would be responsible for ensuring the staff was aware of the protocol as it relates to infection control. Some of the items identified in both the IDPH/USDVA report and mentioned in the IG report are, as I understand it, basic infection control items that were not followed and not corrected by the leadership at the facility.

4. *From your perspective, should IDPH have realized the significance of the outbreak at LaSalle and should they have provided guidance and assistance earlier? The first*

*detailed discussion with officials from the Home regarding the outbreak appeared to occur on November 11, 2020.*

Upon notification of the outbreak, I sent an email to multiple people indicating this. IDPH had [redacted 2] or [redacted 3] (don't recall which) contact the facility a couple of times and reported to [redacted 9], the facilities response was appropriate (this is contained in at least one or more e-mails). I believe on Sunday, I spoke with [redacted 9] and we agreed to have a call on Monday November 9<sup>th</sup> to touch base with administrators and their leadership staff to review any issues/questions (this can be verified on my calendar and by speaking with the administrators). Specific to LaSalle, my recollection is the Administrator, Director of Nursing (DON) and Infection Control Nurse were in attendance. The other facilities likewise had their DON and Infection Control staff participate on the call. I recall in addition to [redacted 9], [redacted 3], [redacted 2] and [redacted 10] (last name starts with a [redacted]) participated. IDPH again stated they believed LaSalle was taking all the necessary steps to deal with the outbreak. All facilities were provided the opportunity to ask questions/seek guidance. Both the Director and Assistant Director participated in this call and this should be on their calendars as well. Later that day more positive results came back. While IDPH indicated they felt the facility was doing everything appropriate in response, IDPH had gone out to Manteno for an on-site visit when their outbreak expanded beyond the initial round of positives. I emailed [redacted 9] and explained [redacted 5] had suggested a IDPH staff ([redacted 4]) come to Manteno and requested the same for LaSalle. As has been previously identified, that email was not responded to until November 11<sup>th</sup>. Between the 9<sup>th</sup> and the 11<sup>th</sup>, I sent the daily reports which I can only assume were briefed to the Governor as the IDPH COS emailed [redacted 9] and indicated the Governor was concerned about the outbreak. I believe [redacted 9] responded that IDPH staff had been in contact with the facility, but someone would be sent. (it wasn't quite that direct but that was the result). I offer no opinion as to when IDPH should or should not respond. I feel as though they contacted the facility and received the same information the IDVA Director, and I were receiving. IDPH did not express any issue with the information they were receiving and therefore the Director nor I had any reason to believe the response was not appropriate.

5. *Can you describe all of the duties you were dealing with during the time of the outbreak that were in excess of the Chief of Staff position? The OIG report noted that you were performing the duties of the Director and of the Senior Home Administrator (position was vacant). Is this accurate?*

The author of the IG report indicates I was acting as the Director. I explained to the author that over the course of several Directors, some are more involved in the day-to-day operations than others. That does not mean they are totally detached from what is happening within the agency, it means they are not a micro manager or they are focused on other items. In the case of Director ChapaLaVia, she participated in every call and was consulted on major decisions. I, as the COS spoke on her behalf and with

her approval. She did allow me significant latitude and relied on me to make sound reasoned recommendations/decisions as is the expectation of the individual holding the COS position. However, those who felt she was not involved in the processes, were not informed of our communications. I expressed that to the author of the IG report. Prior to the creation of the Senior Home Administrator position, the Chief of Staff was directly responsible for all the homes. The position was my idea back in the 2008 -2009-time frame when issues arose at the homes and the COS would receive 2 -4 conflicting answers from the home administrators. The position was established to provide administrative oversight of the facilities by another licensed home administrator. The Department attempted to fill the position prior to the pandemic but the candidate was not acceptable to the Governor's office. The pandemic hit and filling the position was tabled for a couple of reasons. First, the process takes a significant amount of time (3-4 months from posting to final interviews). Second, most hiring was on hold at CMS. Third, we were informed we could not post the position in the manner in which we had previously posted. CMS informed us we must require the license at the time of application. (We had previously posted the position requiring the applicant obtain their license within a year of hire) As a result, it was our thought that finding someone would be incredibly difficult in the midst of the pandemic. During this period, I also spoke with the DPH COS and asked if there was anyone within DPH who would be a possibility for this position. He informed me that unfortunately the person he would have recommended, DPH had just terminated and said the reason would be public soon. (It was later reported the DPH Long Term Care unit had not been investigating abuse reports. This can be found in news reports in 2020.). The position was posted in November 2020. In late April or early May of 2021, the Director level interview was held for the one candidate that made it through the selection process. As was predicted, the process did not produce a suitable candidate for hire. At the time of my departure from the Department, the position remained vacant. The author of the IG report was fixated on a federal model that facility supervisors have a medical background. I pointed out to the author that the home administrators are not required to have a medical background and the Senior Home Administrator likewise does not necessarily have to possess a medical background. This fact was dismissed by the author. There also seemed to be a fixation on the federal model of the COS having a medical background. I would point out that of the five previous COS's did not have a medical background and nor does the current COS.

In addition to monitoring the homes during 2020, and my COS duties, the Human Resources Director was new and had several issues with his staff, the Chief Fiscal Officer and several staff within the fiscal division tuned over. There was an audit of the agency underway with a new CFO and significant deficiencies within that division which had to be addressed. (See agency audit) DUIT was extremely slow in filling the CIO position. Further over most of 2020, there were a total of five staff in the office. This included the Directors' assistant, my assistant (who was helping other areas of the department), the front desk staffer, a DOIT employee who kept the IDVA IT running and myself. In addition to operations at the homes, I also participated in all interactions with CMS and



the various bargaining units regarding the various divisions within the department. Almost everything ran through me during this time as I was the only management physically in the office. That isn't to say the Director was not consulted on major issues.

6. *From your perspective, was there a difference in IDPH's response to the Manteno home outbreak as opposed to the LaSalle outbreak? For example, did IDPH respond more quickly to Manteno? Did someone have to ask for assistance for IDPH to visit the home and provide guidance?*

During the Manteno outbreak, IDPH initially responded with a call to the facility. I do not recall how many days into the outbreak before [REDACTED] suggested IDPH physically go to Manteno. During the LaSalle outbreak, IDPH responded quickly with a phone call to the facility and follow up calls to the facility. After the previously mentioned Monday, the 9<sup>th</sup> call and additional positive cases (which had been reported to IDPH and Gov's office) I felt I needed to ask for IDPH to send someone to the facility (which I did the evening of the 9<sup>th</sup>). I cannot speak to the workload/other priorities IDPH had going on in November 2020 during the LaSalle outbreak vs the May 2020 Manteno outbreak. I have been told IDPH was stretched thin and other outbreaks in the state were more significant. I have no direct knowledge of this.

7. *Are you aware of any differences in practices at the LaSalle home that may have contributed to the LaSalle outbreak being more deadly than the outbreaks at the other homes?*

I do not believe that there were any differences in operational practices at the LaSalle home that would have contributed to a more deadly outbreak there than at the other IDVA facilities. The one item that I would note is the physical structure of LaSalle is different than Manteno. While the LaSalle home is one large building with wings, the Manteno facility is several stand-alone buildings connected by a large hallway between and through the buildings. During Manteno's outbreak, a small number of residents, the entire building and most of the staff in that building became infected. The only thing that stopped the spread was that the other staff and residents were in other buildings. This was observed at Quincy as well in November and December when that facility had outbreaks. LaSalle is one large building. I can only guess on the reason why the virus was more deadly at LaSalle than at the other facilities. I'm sure a medical review may show a different strand of the virus or that simply the residents had more significant co-morbidities. Also it should be noted that during both outbreaks, CDC and DPH were identifying that the virus was transmitted via close contact and on flat surfaces. Airborne transmission via HVAC systems really wasn't being identified as a possible transmission source. It is my opinion that there were regional differences in how the communities around the facilities viewed the virus, this likely contributed to how the virus entered the LaSalle facility. A simple google search for statements from public officials around the facility can validate this.

8. *What things did you learn from the Manteno outbreak that you were able to apply the outbreak at LaSalle?*

As previously noted, IDPH was on-site in Manteno during their outbreak. There were items which were identified as needing improvement. None were expressed as critical issues. Throughout the outbreak at Manteno, the Administrators and other facility staff were in contact (via daily meetings in addition to direct contact). Additionally, all briefings with IDPH regarding Manteno were attended by all Administrators as well as the Director and Assistant Director. One item that did stand out was the need to limit staff movement within the facility. Floating staff from one building/wing to another limited to only when absolutely necessary to maintain adequate staffing for the safety of the residents. There were multiple bargaining unit complaints regarding this as it limited where staff could pick up overtime at.

9. *What was your understanding of the flow of information from the LaSalle home to other outside agencies, like the US DVA and the local health Department? Were you aware of any other agencies that the home was providing information to, and do you know the ways the information was communicated?*

All homes have multiple entities in which they report to. Prior to and during the outbreak in Manteno, the facility was in contact with the Kankakee County Health Dept. and the US Dept. of Veterans Affairs Region 11 staff. Likewise, the LaSalle Administrator was in contact with the LaSalle County Health Department and the US Dept. of Veterans Affairs prior to and during the outbreak at that facility. I believe I may have been included in a small number of those communications. It is my understanding communication with the local health department was via phone and limited email. Communication with the USDVA was mainly via email but also phone in some instances. During the Manteno outbreak, the USDVA offered staffing assistance, however at that time it required a survey of the facility to determine (in their opinion) if all staffing mitigations had been pursued by the state prior to USDVA sending staff.

10. *Do you have any additional comments you would like to add? If so, please include below.*

From the beginning of the pandemic through my resignation and departure from the agency, I repeatedly stressed the need for IDVA to not only meet the requirements but exceed them. Every decision, every step the Dept took was the extreme most conservative approach. This can be confirmed by interviewing any of the Administrators at the other three facilities. The contract firm who authored the IG report was given six weeks to conduct the investigation. They did not start until they had three weeks to complete the work. It should be noted that a similar USDVA investigation took more than eleven months to complete. Mr. [REDACTED] seemed to be more concerned about ensuring the contract attorney was paid than anything else. When the LaSalle staff contacted a local official (Representative Yednock) about being interviewed for the

investigation, I had to call Mr. [REDACTED] and request he open up a call line or other mechanism for staff to provide information relevant to the investigation. The whole concept that myself and others in the IDVA leadership were derelict in our duties is not logical given the extent in which we (and I personally) tried to aid in the investigation. Further, during my interview, the law firm representing the IG specifically told me, Dir. Chapa LaVia declined to be interviewed and the Administrator was no longer employed by the state so I was "the last man standing, and someone has to answer for this." It is not surprising the author's opinions are neither substantiated by documentation or were challenged in any way. Clearly there were things that went wrong in the days following the first positive at LaSalle, but the simplistic and opinionated conclusions by the IG report author lack basic substance and read more like a personal injury attorney filing an unsubstantiated or challenged lawsuit.

## Appendix E

# Agency Responses



STATE OF ILLINOIS  
**DEPARTMENT OF VETERANS' AFFAIRS**

833 SOUTH SPRING STREET, P.O. BOX 19432, SPRINGFIELD, IL 62794-9432  
TELEPHONE: 217-782-6641 \* FAX: 217-524-0344

JB PRITZKER  
GOVERNOR

TERRY PRINCE  
DIRECTOR

April 19, 2022

Mr. Frank J. Mautino  
Illinois Auditor General  
Illinois Office of the Auditor General  
740 East Ash Street  
Springfield, Illinois 62703

Dear Auditor General Mautino:

The Illinois Department of Veterans' Affairs (IDVA) appreciates the work performed by Scott Wahlbrink and your office in conducting the performance audit of the LaSalle Veterans' Home pursuant to House Resolution 62.

Enclosed with this letter are detailed responses that address each of the recommendations for the Illinois Department of Veterans' Affairs.

If you have any questions or comments about our response to the recommendations, please contact my office at (217) 785-4114.

Sincerely,

  
Terry Prince  
Director

**Illinois Department of Veterans' Response to Performance Audit pursuant to House Resolution 62**

**Recommendation #1:**

*The Illinois Department of Veterans' Affairs should ensure each of its Veterans' Homes have policies and procedures in place that mandate timely testing of its residents and employees during COVID-19 outbreaks, and should ensure that residents and employees are tested according to the policy.*

**IDVA response:**

IDVA agrees with this recommendation. Even though IDVA is not a Centers for Medicare and Medicaid Services ("CMS") facility, IDVA followed the CMS guidance for testing and the Illinois Department of Public Health (IDPH) Guidance for Nursing Homes and Other Long-Term Care Facilities and Programs. Prior to the COVID-19 outbreak, in October 2020, IDVA staff were tested weekly, and the residents were tested every other week. The interim IDPH guidance from October 21, 2020, referenced that testing was based on the county positivity rate, and this rate was based on CMS data. IDVA was testing staff in accordance with the positivity rate the week before the outbreak. The residents were not tested that last week in October 2020, because the Illinois Veterans' Home at LaSalle (IVHL) was not in outbreak status, nor were there any staff positives, and the residents had been tested the week before (the week of October 20, 2021) with no positives.

Regarding the collection of tests, IVHL typically attempted to deliver tests every day or every other day to the IDPH laboratory. For the week of November 2, 2020, IVHL had already collected the first round of testing on the residents by Monday, November 2, 2020, and those tests were pending at the Chicago laboratory. On November 3<sup>rd</sup> and 4<sup>th</sup>, IVHL then did their round of testing on its staff. There is an e-mail from the IDVA Chief of Staff (COS), dated November 2, 2020, to IDPH that stated IVHL planned on delivering the tests to the laboratory on Wednesday (November 4, 2020). The COS also referenced the residents were swabbed, and those tests were pending at the IDPH Chicago laboratory. In the daily report from the COS dated November 3, 2020, he referenced that staff would be tested that day, and in his daily report from November 4, 2020, he stated, "Staff tests dropping today." On November 5, 2020, IVHL did a second round of testing on the residents and tested a small number of employees that were not caught on November 3<sup>rd</sup> and 4<sup>th</sup>.

Generally, with IVHL's testing schedule, the staff tests should have been ready to be delivered to the IDPH laboratory on November 4, 2020. However, it appears that the tests were not delivered on Wednesday (November 4, 2020). At that time, there were issues with the IDPH Chicago laboratory being overwhelmed since the Springfield lab was temporarily closed. During the beginning of the outbreak, the timing of collection and delivery of tests appears to be an isolated incident due to the circumstances with the laboratories.

After the outbreak began in November 2020, IDVA worked with the United States Department of Veterans' Affairs (USDVA) and IDPH and adjusted its PCR testing of staff

from weekly to twice a week (every 3-4 days) and on November 13, 2020, implemented daily pre-shift antigen testing for staff. IDVA continues to test in this manner when in outbreak status, regardless of vaccination status.

During the outbreak, there were residents that IVHL did not send to the hospital for further treatment due to the wishes of their Powers of Attorney(POA)/families. The Medical Director and his staff had specific conversations with the residents' POAs/families about whether they would allow IVHL to send the residents to the hospital for further care. These conversations were documented in the residents' records. Monoclonal antibody treatments were new, and the supply was limited during the outbreak at IVHL. These treatments were primarily administered at hospitals. Nonetheless, IVHL was able to obtain monoclonal antibody treatments through the Medical Director and his hospital, and under the Medical Director's medical supervision, residents, who met the treatment criteria and agreed to the use, were provided with this treatment beginning in November 2020.

Prior to the testing policy being signed on November 1, 2020, IDVA was waiting on the Illinois Department of Central Management Services (CMS) Labor Relations Bureau to provide guidance for employees that refused to test as IDVA needed to be able to enforce testing through the disciplinary process. CMS Labor issued a memorandum on October 28, 2020, outlining the guidelines for testing at the 24-hour facilities, and how to handle refusals to test through disciplinary measures. The IDVA policy was finalized and signed within days after receipt of this memorandum.

IDVA continued to follow the Centers for Medicare and Medicaid Services and IDPH guidance for testing up and until IDVA implemented a new written policy, HOM-25 COVID-19 Testing Plan, on April 23, 2021, with the assistance of Dr. Avery Hart from IDPH. This policy was again updated on November 22, 2021. Per the policy, IDVA collects staff and resident samples within a 24-hour period and designates an extra day to collect samples from staff who are not available for testing for reasons such as scheduled absences. Testing of staff and residents is done regardless of vaccination status. Due to COVID-19 guidance continuing to evolve, IDVA monitors changes with CDC, CMS, and IDPH guidance in order to update its policies.

**Recommendation #3:**

*The Illinois Department of Veterans' Affairs should ensure that:*

- *the IDVA Director work with the Department of Public Health and the Governor's office during COVID-19 outbreaks to advocate for the health, safety, and welfare of the veterans who reside in the Homes under IDVA's care; and*

- *the Senior Home Administrator position is filled and the duties of the position include monitoring and providing guidance to the Veterans' Homes during COVID-19 outbreaks.*

**IDVA response:**

IDVA agrees with these recommendations. For nearly all of 2021 and until recently, the Director participated in daily calls with the senior leaders and Home Administrators.

While recently adjusted to twice weekly, the morning calls with the Home Administrators and Senior Home Administrator still continue in which they discuss COVID updates at each respective home. The Director or his designee also communicates with the Governor's Office and IDPH when there are COVID updates at any of the homes involving topics such as significant outbreaks, changes in visitation, testing, and PPE. Additionally, there are bi-monthly calls with IDPH in which the Director, Senior Home Administrator, the Home Administrators and other senior leaders discuss COVID issues and new guidance. Since the outbreak in November of 2020, IDPH has made numerous site visits to the veterans' homes for consultation purposes related to COVID mitigation and infection prevention.

On November 16, 2021, the Senior Home Administrator (SHA) position was filled. As stated above, the SHA hosts twice weekly calls with the Home Administrators to discuss COVID issues/updates, and also hosts the bi-monthly phone calls with IDPH. The SHA also monitors and reviews the homes' policies for updates. In order to supplement assistance for the SHA, each home has an Infection Control Preventionist, and IDVA recently hired a Senior Home Infection Preventionist to oversee the infection prevention positions at all of the homes. The Senior Home Infection Preventionist starts employment on May 2, 2022.





525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • [www.dph.illinois.gov](http://www.dph.illinois.gov)

April 20, 2022

Honorable Frank J. Mautino  
Illinois Auditor General  
Office of the Auditor General  
Hes Park Plaza  
740 East Ash  
Springfield, IL 62703-3154

Dear Auditor General Mautino:

The Illinois Department of Public Health (IDPH) appreciates the work performed by your office in conducting the performance audit pursuant to House Resolution Number 62 – the COVID-19 outbreak at the LaSalle Veteran's Home. Enclosed with this letter is our detailed response that addresses the recommendation. IDPH thanks the Office of the Auditor General for the opportunity to meet and provide our written response.

If you require any additional information or have questions, please contact Candice Long, Chief Internal Auditor, at 217-782-2497.

Sincerely,

Amaal Tokars, Ed.D.  
Acting Director

Enclosure

cc: Justin DeWitt, Chief of Staff  
Laura Vaught, Chief of Staff  
Rukhaya Alikhan, General Counsel  
Scott Wahlbrink, Senior Audit Manager, OAG  
Candice Long, Chief Internal Auditor

PROTECTING HEALTH, IMPROVING LIVES  
*Nationally Accredited by PHAB*

**Attachment Response****Report: COVID-19 Outbreak at the LaSalle Veterans Home**

---

**Recommendation Number 2** – COVID-19 Monitoring and Policies

The Illinois Department of Public Health should:

- clearly define its role in relation to monitoring COVID-19 outbreaks at Illinois Veterans' Homes; and
- develop policies and procedures that clearly identify criteria which mandate IDPH intervention at Veterans' Homes during an outbreak of COVID-19

**IDPH Response:**

IDPH accepts this recommendation.

The Illinois Department of Public Health (IDPH) is evaluating its role in relation to the State of Illinois Veterans Homes, specifically how IDPH can strengthen its ability to provide guidance and support to these homes, as well as other congregate facilities, during a pandemic or other infectious disease outbreak.

This written response will address the Office of the Auditor General's (OAG) Audit Report (Report) on the Illinois Veteran's Home at LaSalle (IVH - LaSalle) fall 2020 COVID-19 outbreak, describing how IDPH has modified its operations to ensure effective communication and collaboration with the Illinois Department of Veteran's Affairs (IDVA) leadership.

**SARS COV 2 Infection for Residents and Individuals in Congregate Care Settings**

Since the beginning of the COVID-19 pandemic, individuals living in congregate settings, including long-term care facilities (LTCs), shelters, and corrections systems (including jails and prisons) were identified to be at significant risk for exposure to COVID-19 due to large numbers of people living in shared spaces. Older adults, especially those with immunocompromised systems and comorbidities, had an added risk associated with contracting COVID-19 and experiencing adverse health outcomes.

The first case of COVID-19 in the United States was identified in King County, Washington in February of 2020. It would not be long before COVID-19 began to spread throughout the rest of the United States.

IDPH recognized the potential for LTCs to be heavily impacted by COVID-19 and took swift action. On March 3, 2020, IDPH issued its first LTC COVID-19 guidance. Following that, IDPH provided weekly COVID-19 infection and prevention educational sessions for LTC administrators and staff, which began on March 9, 2020, in conjunction with Governor J.B. Pritzker's Disaster Proclamation. On March 11, 2020, the State directed that LTCs restrict visitors, cancel group activities, and implement screening of staff and residents for illness. The Centers for Medicare and Medicaid Services (CMS) also issued a memorandum from its Quality, Safety and Oversight Program, directing state agencies, including IDPH, as delegates of the federal government, to

refrain from entering long-term care facilities given the high transmission rate of COVID-19 and to perform on-site surveys for very limited reasons.

In the weeks that followed this initial wave, the number of COVID-19 cases and deaths quickly increased in Illinois, and at LTCs, peaking in May 2020. The IDPH LTC response focused on creating testing capacity for facilities, providing personal protective equipment to facilities, and working with facilities and Local Health Departments (LHDs) to recommend that the core principals of infection prevention were put into practice. As a temporary measure, IDPH contracted with healthcare organizations to perform limited on-site LTC infection prevention evaluations and COVID-19 testing. IDPH filed emergency rules requiring LTC facilities to perform testing during outbreaks at the end of May 2020, including, requiring routine testing of staff. IDPH also arranged for a testing company to facilitate testing supplies and training for LTCs.

By the Summer of 2020, the number of cases had decreased substantially. While case numbers went down, the State's ability to test for COVID-19 continued to expand. IDPH supported LTCs in maintaining adequate access to antigen tests, following CMS' lead. IDPH was the first public health laboratory system in the country to implement the Centers for Disease Control's SARS CoV-2 assay. With the launch of the new lab-based test, testing volumes quickly grew from 800 tests per week to approximately 6,000 to 8,000 specimens/day in the IDPH labs. New technologies for point of care (POC) tests were emerging and in September 2020, the U.S. Department of Health and Human Services announced that it had contracted with Abbott laboratories to deploy direct shipments of the BinaxNOW point-of-care antigen test to LTCs across the nation, as well as to state health departments. IDPH received its first batch of antigen or POC tests on October 6, 2020. IDPH received approximately 248,000 tests. In collaboration with local health departments, tests were distributed according to prioritization, with a focus on LTCs, correctional facilities, schools, and hospitals.

During this second wave, LTC staff testing helped to identify infected asymptomatic workers who could inadvertently spread the virus to residents and co-workers. The demand during this period for POC testing was very high and IDPH ensured that these tests were made available as soon as possible for congregate care settings. Understanding the high risk of COVID-19 transmission, IDPH delivered the first shipment of BinaxNOW tests to IVH-LaSalle on November 18, 2020. When IDVA expressed an urgent need for more tests around this time, an IEMA representative arranged to deliver tests to IDVA leadership to meet its needs. At the time antigen test first started being available, IDPH was providing the preferred COVID-19 test to IDVA, which was the laboratory-based PCR test, as the "gold standard" for diagnostic accuracy. IDPH continued to provide BinaxNOW tests to DVA homes on a weekly basis, providing the quantity of tests requested by IDVA.

**IDPH Infection Prevention and Medical Support for Congregate Settings at the time of the IVH-LaSalle COVID-19 Outbreak**

For perspective, between October 17, 2020, to November 14, 2020, there were approximately 260,000 people diagnosed with COVID-19 in Illinois. This included nearly 11,000 residents in LTCs.

At the time of the COVID-19 outbreak at IVH-LaSalle, the IDPH infection prevention and medical consulting staff consisted of a physician and four infection preventionists to cover congregate

settings throughout Illinois. Additionally, the IDPH infection preventionist assigned to work with IDVA passed away unexpectedly just two weeks prior to the IVH-LaSalle outbreak.<sup>1</sup>

This team provided remote consultation and guidance to 97 local health departments as they worked with more than 1,500 long-term care facilities, as well as: shelters; daycares; county jails; the sister state agencies operating 54 state-operated 24/7 facilities, including Illinois Department of Corrections, Illinois Department of Juvenile Justice, Illinois Department of Human Services, Illinois Department of Veteran's Affairs; and the Department of Child and Family Services facilities. During the relevant period, IDPH staff were inundated with communications, receiving thousands of emails, phone calls, and text messages, from every corner of the State, seeking advice and guidance in managing the pandemic. In short, this was a difficult and unprecedented time.

In addition to the prolific communications seeking consultations at the time of the outbreak at IVH-LaSalle, the IDPH congregate setting team was meeting with community stakeholders, including: nursing home associations; citizen groups; senior advocacy groups; and other partners, to develop infection prevention protocols and guidance for POC/antigen testing. There was also a great deal of planning for the upcoming rollout of COVID-19 mass vaccination clinics in Illinois.

At the time of the IVH-LaSalle outbreak, IDPH was not conducting in-person or on-site visits to investigate COVID-19 cases in LTCs due to the prevalence of disease, the sensitivity to disease being brought into the facilities, and the extraordinary demand for resources. Onsite visits to facilities were rarely performed, and only if requested by a local health department or a sister state agency.

#### **The Importance of Local Health Departments During Outbreaks**

The COVID-19 pandemic strained public health departments across the nation at the federal, state, and local level. This was true in Illinois during the Fall of 2020, prior to COVID-19 vaccinations being available.

For background, Illinois has a decentralized public health system based on the principle that local health departments have the best knowledge about the public health needs in their communities. There are 97 state-certified LHDs performing the "boots on the ground" frontline public health work, including infectious disease investigations, with the Illinois Department of Public Health providing general supervision and oversight. All reportable infectious disease reports are routed immediately to the LHD where the affected person lives for the necessary follow-up.

During the COVID-19 pandemic, LHDs received the reports of positive tests for people living in their jurisdiction and were required to perform contact tracing and report outbreaks to IDPH

---

<sup>1</sup> One of IDPH's long-standing infection preventionists (IP), passed away suddenly on October 17, 2020 (two weeks prior to the LaSalle Outbreak). This individual was a highly experienced IP and had been assigned to work as the IP point person with the VA homes in July 2020. This IP was also covering the Marion and Edwardsville Regions of the state and was the point person for all IDHS developmental disability facilities. Although duties were technically "divided" between the remaining IPs, it was a challenge for all the needed work to be accomplished by this small state-wide team as the second wave of COVID-19 cases swept across Illinois in late 2020.

through the outbreak reporting system (ORS). This would include responding to reports of cases of COVID-19 in long-term care facilities within their jurisdiction.

During the relevant period of the Report, the LaSalle County Health Department staff had been in regular communication with long-term care facilities within their jurisdiction, including the IVH-LaSalle, sharing IDPH guidance, information on the local level of disease, community testing sites, and recommendations for visitation. This communication included a notification on October 22, 2020, that there had been a dramatic increase in the level of COVID-19 in the community. In April 2020, the LaSalle County Health Department also provided personal protective equipment to LTCs within their jurisdiction including the IVH-LaSalle.

The IVH-LaSalle staff consulted with the LaSalle County Health Department about the few cases of COVID-19 that occurred prior to the Fall 2020 outbreak, and immediately notified the Health Department about the new cases identified by email on November 1, 2020. The LaSalle County Health Department staff responded promptly and continued to provide guidance to the IVH-LaSalle in the early days of the outbreak.

#### **Monoclonal Antibody Treatments Were Not Available During LaSalle Outbreak**

Although the Report references that monoclonal antibody treatments had been allocated or reserved for the State, the treatments were not yet available for use. Monoclonal antibody treatments require specific equipment and handling and were to be shipped directly from the manufacturer to hospitals initially for administration. At its earliest opportunity, in Fall 2020, IDPH began the process of determining how monoclonal antibodies would be distributed across the State with limited information from the federal government. Bamlanivimab was the first monoclonal antibody therapy treatment to be allocated and distributed to treatment sites in Illinois. The first distribution cycle was November 9-17, 2020, and the State was allocated 6,380 patient courses. This medication was to be administered according to the Emergency Use Authorization (EUA) provided to healthcare providers from the Food and Drug Administration (FDA). An additional resource was the Lilly Bamlanivimab Antibody Playbook to assist healthcare providers in operationalizing the administration of monoclonal antibodies.

Calculations for allocation were made based on a strategy that included: prioritization of Safety Net hospitals; Regional Hospital Coordinating Centers (RHCCs); considerations for the proportion of Medical/Surgical and ICU beds in use by COVID patients for the previous week; and those hospitals that indicated they have the capability to administer the medications according to the EUA via a survey. Monoclonal antibodies were initially not approved for use in institutional settings, like LTCs, for COVID-19 outbreaks.

On November 11, 2020, IDPH contacted CDC about the possibility of using monoclonal antibodies for treatment at the LaSalle VA Home. Although the CDC's initial response stated that there was no guidance yet on the use of monoclonal antibody treatments in institutional settings, on November 13, 2020, approval was given for use at IVH-LaSalle. As part of the first shipment of Bamlanivimab to Illinois, IDPH ensured that 20 doses were sent to St. Margaret's Hospital in Spring Valley, Illinois, to treat veterans at the LaSalle VA Home. IVH-LaSalle veterans were among the first to receive monoclonal antibody treatments in Illinois.

**COVID-19 Vaccinations in VA Homes**

The first doses of COVID-19 vaccinations were received in Illinois in mid-December 2020, and IDPH worked with county health departments in each of the IDVA homes' respective communities to deliver vaccines. All IDVA staff and residents had been offered COVID-19 vaccinations by December 31, 2020, with IDPH prioritizing LTCs as a top priority.

**IDPH Operational Changes to Support Infection Prevention in IDVA Homes**

IDPH infection prevention practitioners and medical staff continue to hold weekly COVID-19 meetings and consultations with IDVA leadership and the administrative and clinical staff from the five IDVA facilities. A protocol has been developed whereby each COVID-19 case at an IDVA home is evaluated by the facility's administration and clinical staff, IDVA leadership, and IDPH infection preventionists. On-site visits are conducted by IDPH infection prevention practitioners in response to cases or outbreaks. IDPH's Division of Laboratories now communicates with IDPH colleagues in the Medical Services Division, Communicable Disease Division, and Office of Health Care Regulation (OHCR) when there is a positive COVID-19 case at an IDVA home. This allows IDPH to respond and follow up timely with the IDVA facility to determine what mitigations are being implemented. IDPH continues to work in tandem with its sister state agencies through authoring joint guidance and communicating through weekly meetings and strategy sessions as it relates to IDVA facilities and other congregate settings across Illinois.

In March of 2022, IDPH filed administrative rules requiring LTCs to have an infection prevention program along with a required infection preventionist to serve on staff for facilities the size of IDVA homes. The rules also mandate written policies and procedures for the appropriate use of personal protective equipment and other precautions grounded in CDC guidance and protocols. Between December 1, 2020, and March 21, 2022, IDPH infection preventionists have visited IDVA homes 37 times.

While IDPH has historically had regulatory requirements for infection control planning, newer rules make documentation, training, and qualifications very specific to ensure that LTCs have the appropriate staff during an outbreak. IDPH will enforce these infection control requirements for all facilities under its jurisdiction. IDPH in the past 12 months has increased the number of infection prevention consultants and staff responding to COVID-19 cases in congregate settings to eight full-time staff overall. There are currently four infection control staff assigned to work with IDVA facilities for consultation and cooperation with IDVA administration. A new Medical Services Division has been created at IDPH which will substantially increase the number of physicians, and the infection control staff will increase from two to nine full-time employees. With the addition of new IDPH staff and implementation of infection prevention policies in IDVA homes, these facilities will be better equipped to control the spread of any future COVID-19 or other communicable disease threatening the health of its residents.



---

JB Pritzker, Governor

Illinois Department of Human Services

Grace B. Hou, Secretary

Office of the Inspector General  
401 S. Clinton, 3rd Floor • Chicago, Illinois 60607

April 20, 2022

**VIA EMAIL**

Scott Wahlbrink  
Senior Manager  
State of Illinois Office of the Auditor General  
Iles Park Plaza  
740 East Ash  
Springfield, IL 62703

RE: IDHS OIG Response to the Performance Audit Concerning the Fall 2020  
COVID-19 Outbreak at the LaSalle Veterans Home

Dear Mr. Wahlbrink:

The Office of the Inspector General for the Illinois Department of Human Services (IDHS OIG) thanks the Illinois Auditor General's Office for its performance audit concerning the fall 2020 outbreak of COVID-19 at the State of Illinois Department of Veterans' Affairs' (IDVA) LaSalle Veterans' Home. The Auditor General Office's report contains a discussion of IDHS OIG's investigation of the outbreak. As background, upon request by the Office of the Governor and pursuant to the scope set out in an intergovernmental agreement with the Office of the Governor, IDVA, and IDHS, in 2021, IDHS OIG conducted an investigation of "the conduct, policies, procedures, protocols, and safeguards employed by IDVA, its staff, and supervisors at the Home in addressing and mitigating COVID-19 and, in particular, staff compliance with the COVID-19 protocols in effect at the time of the outbreak."

IDHS OIG obtained outside counsel to assist with its investigation and, on April 26, 2021, produced a report containing nine recommendations for IDVA to prevent future outbreaks. To IDVA's credit, the Department took action regarding many of IDHS OIG's recommendations prior to the issuance of OIG's report.

Specific to the contents of the Auditor General Office's report, IDHS OIG notes that the former IDVA Chief of Staff's written response to the Auditor General Office's written questions, set forth in Appendix D of the Auditor General Office's report, contains multiple factual inaccuracies concerning the length and manner of OIG's investigation. Those inaccuracies call into question the reliability of the former IDVA Chief of Staff's response generally and caution against any reliance on that response.



---

**JB Pritzker, Governor**

**Illinois Department of Human Services**

**Grace B. Hou, Secretary**

**Office of the Inspector General**  
401 S. Clinton, 3rd Floor • Chicago, Illinois 60607

As to the rest of the report, IDHS OIG notes that the three recommendations contained in the Auditor General Office's report are generally consistent with IDHS OIG's recommendations. IDHS OIG is proud of the quality and timeliness of its investigative work and stands by its findings and recommendations.

Respectfully,

**SIGNED ORIGINAL ON FILE**

Peter Neumer  
Inspector General  
Illinois Department of Human Services





