OFFICE OF THE AUDITOR GENERAL

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Performance Audit
Report Highlights

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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 |
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| *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)* | • 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. 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) |
| *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.* | • 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) |
| *The nature of changes made by the Department in operating protocols and staff* | • IDVA provided auditors with new infection prevention policies on June 17, 2021, which were drafted with the |

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| *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

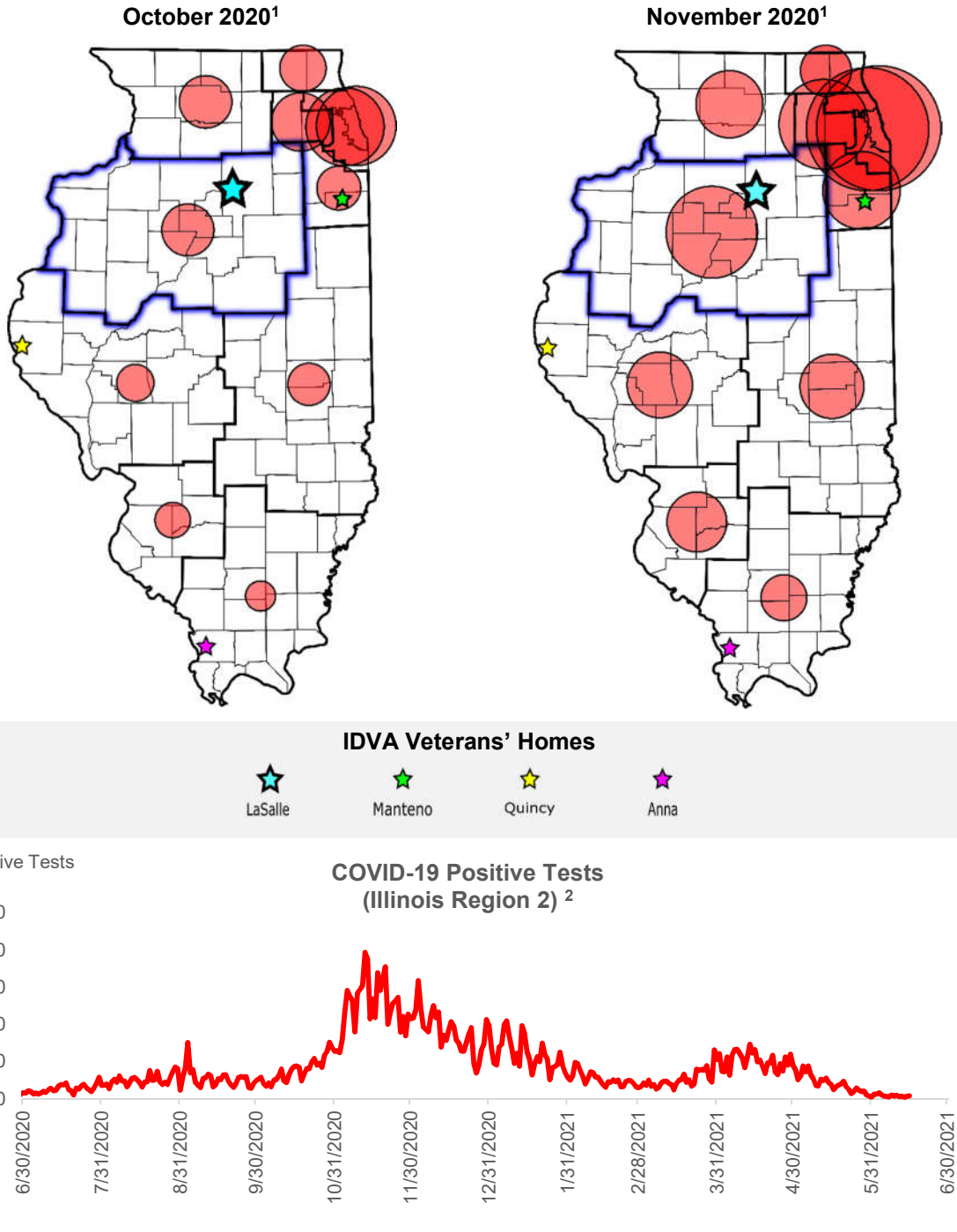
The Illinois Department of Public Health (IDPH) announced the first case of COVID-19 in Illinois on January 24, 2020, and the spouse of the individual was the second confirmed case on January 30, 2020. These were the first two known cases of Illinois residents to test positive. By March 5, 2020, Illinois 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




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.

## 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 (1st 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 **2 residents** and **2 staff** 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 "**We must stop this outbreak in its tracks!** 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 |

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| | 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. |
| | **Monday, November 2, 2020** |
| 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 **10 positive residents** (one recovered) and **8 positive staff**. 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. |

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| 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?" |
| Tuesday, November 3, 2020 | |
| 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 **13 residents (12 current)** and **10 staff (5 current)** 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:<br>• Are any of the 12 residents who tested positive experiencing symptoms?<br>• Were the 12 residents who tested positive on the same unit?<br>• Were the staff on the same unit?<br>• I'm guessing positive staff are quarantining for 14 days, can you confirm?<br>• How are you isolating the residents? |
| 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:<br>"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. |

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| 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. |
| Wednesday, November 4, 2020 | |
| 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 **23 total (22 current) residents** and **12 (7 current) staff** 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 **36 positive residents and 8 positive staff**. |
| Thursday, November 5, 2020 | |
| 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 **45 total (44 current) residents** and **14 (9 current) staff** 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:<br>"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 |

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| | 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 **48 positive residents and 12 positive staff**. 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. |
| Friday, November 6, 2020 | |
| 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 **49 total (48 current) residents** and **17 (12 current) staff** 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." |
| Saturday, November 7, 2020 | |
| 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 **60 residents and 43 employees positive.** 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 | |
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| 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 **she was sorry to hear about the deaths and thanked him for letting her know.** |
| 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:<br>"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." |
| **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 |

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| | were a total of **63 total (59 current) residents** and **70 (65 current) staff** with positive cases. He reported **3 deaths** 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:<br>• They are doing no more admitting, no visitors as of Friday.<br>• In addition to regular PCR testing to DPH labs, they are also going to ramp up the use of more antigen faster time tests.<br>• They have segregated staff and residents into the covid wing who are positive.<br>• Reinforced all of the safety measures to employees for their personal lives.<br>• They also have 3 residents currently hospitalized. |
| 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. |

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| 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: **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.** |
| Tuesday, November 10, 2020 | |
| 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 **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. |
| 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:<br>"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." |
| Wednesday, November 11, 2020 | |
| 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. |

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| 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." |

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| 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. |
| Thursday, November 12, 2020 | |
| 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 **73 positive residents** and **88 positive staff**. He reported **9 total deaths** 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:<br><br>**"October 27/28** – Regular employee testing was conducted and sent to the lab on October 29th<br><br>**October 31** – 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.<br><br>**Nov 1** – 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. |

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| | **Nov 2** – 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.<br>**Nov 3** – First positive resident PCR tests coming back – 22 residents, 7 staff<br>**Nov 4** – 14 additional resident antigen test positive<br>**Nov 5** – additional resident positives<br>**Nov 6** – another round of staff tests shipped 48 residents; 18 staff positive<br>**Nov 7** – Two residents pass; multiple staff positives received.<br>**Nov 8** – Resident passes Current count 59 residents, 64 staff<br>**Nov 9** – more results - 66 resident, 69 employees two residents pass; retesting (PCR) of residents<br>**Nov 10** – Two residents pass – USDVA conducts call with facility to review policies/protocols. Request made for DPH onsite visit.<br>**Nov 11** – 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<br>**Nov 12** – two residents pass (total 9)" |
| 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 | 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)<br><br>[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." |
| 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. |
| Friday, November 13, 2020 | |
| 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 | 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:<br>• delayed implementation of mitigation efforts with contact tracing, exclusion, and testing of residents and staff;<br>• delay in receiving test results; |

| | |
|---|---|
| | • delay in contact tracing to identify close contacts to be excluded, tested and quarantine when initial cases were identified;<br>• staff gatherings outside of facility- Halloween party off grounds hosted and attended by multiple staff;<br>• staff self reporting and ignoring minor symptoms;<br>• as observed staff congregating and not adhering to social distancing; and<br>• ineffective substance for hand hygiene.<br><br>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." |
| 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 **83 total (82 current) residents** and **93 (88 current) staff** with positive cases. He reported **11 total deaths** 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 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)[2] | Infrastructure Improvements | COVID-19 Testing[3] | Total Costs Outbreak and Pandemic |
|---|---|---|---|---|---|
| **FY20** | 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 |
| **FY21** | 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 |
| **Totals[1]** | | **$536,456** | **$1,162,719** | **$1,673,421** | **$3,372,596** |

Notes:

[1] Totals may not add due to rounding.

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

[3] 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

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