

**The COVID-19 Outbreak at the Department of Military and Veterans' Affairs
Southeastern Veterans' Center**

Report on the Special Investigation for the Office of the Governor

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October 15, 2020, as revised December 29, 2020

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I. Executive Summary

The Southeastern Veterans' Center ("SEVC") in Chester County is one of six State Veterans Homes ("SVH") in Pennsylvania. The Pennsylvania Bureau of Veterans Homes ("BVH") administers the SVHs. BVH is within the Commonwealth's Department of Military and Veterans Affairs ("DMVA").

SEVC has a 292 resident capacity, and over 400 clinical and professional staff. It consists of three buildings, the Community Living Center ("CLC"), Coates Hall, and Tilghman Hall. Seven skilled nursing units, one skilled memory care unit and two personal care units are housed across the CLC building and Coates Hall.

In late March 2020, when the COVID-19 outbreak began at SEVC, the facility was led by Commandant Rohan Blackwood. Under Blackwood was [REDACTED] [REDACTED] and Director of Nursing ("DON") Debbie Mullane. Reporting to Mullane were two Assistant Directors of Nursing ("ADONs"). Above Blackwood at DMVA was the Director of BVH, Andrew Ruscavage. DMVA's Chief Medical Officer, Dr. Darryl Jackson, reported to Mr. Ruscavage during the relevant time. Ruscavage, in turn, reported to the Deputy Adjutant General for Veterans Affairs ("DAG"), who reports directly to the Adjutant General of Pennsylvania ("TAG"). In 2019, SEVC was listed as sixth among Pennsylvania's 39 best nursing homes in Pennsylvania by *Newsweek*. The COVID-19 outbreak, however, told a very different story.

SEVC began its preparations for COVID-19 towards the end of February / early March. SEVC attempted to ensure the facility had sufficient personal protective equipment ("PPE") by working to procure PPE through DMVA, the Chester County Health Department ("CCHD"), and other sources. SEVC also implemented certain measures in an unsuccessful attempt to keep COVID-19 from entering the facility. SEVC began screening staff through the use of a symptom questionnaire on March 6. On March 9, it closed its doors to residents' friends and families. On March 16, the facility prohibited access to all outside service vendors and non-essential medical providers. By March 17, SEVC began screening all staff members for elevated temperatures.

In March, SEVC also began to consider implementing measures to try to curb the spread of COVID-19 within the facility. SEVC considered canceling communal dining as early as March 6. By mid-March, the federal Centers for Medicare and Medicaid Services ("CMS"), DMVA, and the Pennsylvania Department of Health ("DOH") instructed long-term care facilities to cancel communal dining. Nevertheless, SEVC did not do so at that time. It was not until April 1 that SEVC began even to impose some limitations on communal dining. This was the day after the first staff member tested positive for COVID-19. SEVC did not cancel communal dining until April 6, three days after it received notification of the first positive test for a resident. By then, it was too late.

SEVC's planning for the isolation of COVID-19 residents did not start until late March. It was similarly inadequate. At that time, SEVC began to develop plans for dedicated COVID-19 treatment teams and for isolating COVID-19 positive residents. SEVC also began to consider

the use of 3 West – a vacant 32-bed unit – as an isolation unit. However, SEVC did not use 3 West for resident isolation. Instead, SEVC decided to use six negative pressure rooms in CLC to isolate COVID-19 positive residents, but quickly abandoned even that limited measure. In connection with COVID-19 planning, DMVA provided SEVC and the other SVHs with tools and guidance – including an infection control self-assessment and a model pandemic plan – to assist in preparation. SEVC, however, largely ignored DMVA’s planning directives.

After its first staff member tested positive on March 31, and SEVC’s first resident tested positive on April 3, the virus swept through the facility like wildfire. Once the COVID-19 outbreak was underway in the facility, SEVC’s belated planning for limiting the spread of the virus within the facility quickly began to unravel. The vacant 32-bed unit was not used to isolate residents. Instead, it was reserved for staff overnights, even though DMVA could and did secure hotel rooms for SEVC for that purpose. After only eight days, SEVC abandoned the use of negative pressure rooms. This was based on SEVC’s mistaken interpretation of oral guidance it received from CCHD.

As a result, from April 10 until the first week of May, SEVC largely left COVID-19 positive residents on units with both symptomatic and asymptomatic residents. Furthermore, in an effort to conserve PPE, SEVC had staff on those units provide care to asymptomatic residents wearing the same PPE (except for gloves) used when attending to COVID-19 positive and symptomatic residents. Those decisions significantly contributed to the risk of the exposure of asymptomatic residents to the virus and the spread of the virus in the facility. In fact, SEVC ultimately suffered significant COVID-19 outbreaks on six of its ten units across CLC and Coates Hall.

SEVC also quickly abandoned its plan for dedicated COVID-19 staffing. The rate of COVID-19 spread within the facility, coupled with increasing staff absences, resulted in SEVC utilizing the same staff in both COVID-19 positive and negative units. As SEVC’s staffing problems intensified, DMVA decided to call National Guard service members and Veterans Administration (“VA”) nurses to SEVC. By the time the National Guard arrived at SEVC on April 15, and the VA nurses on April 28, COVID-19 already had spread throughout the facility, including to the units that were originally thought to be COVID-19 negative units. Furthermore, the National Guard service members were not well utilized or integrated into the facility, and were at times intentionally pushed aside.

On May 26, after news reports on the spread of COVID-19 in the facility, Commandant Blackwood and DON Mullane were placed on administrative leave. [REDACTED] took on the role of SEVC’s Acting Commandant. [REDACTED] took on the role of Acting DON until July 10. On May 28, BVH Director Ruscavage was recused from further oversight of SEVC. New management quickly instituted significant and impactful positive improvements to address the outbreak, which only illustrated how much could have been done earlier to help curb the outbreak.

SEVC fared far worse than any of the other SVHs in the Commonwealth in battling COVID-19. Between April 1 and May 26, 87 SEVC residents tested positive for COVID-19,

and 14 more were presumed COVID-19 positive. By that time, 40 SEVC residents who were either confirmed or presumed positive for COVID-19 had passed away. This represented 78% of the positive or presumed positive cases throughout all SVHs, and 80% of all deaths in the SVHs during that same time. Forty-one staff members also tested positive for COVID-19 by May 26. This represented 79% of all SVH staff who tested positive for COVID-19 during that time. The spread of COVID-19 within SEVC slowed under SEVC's interim administration. Between May 26 and July 29, 17 more SEVC residents tested positive for COVID-19 and two more residents who were COVID-19 positive passed away.

No single factor accounts for the devastation COVID-19 wreaked on the residents of SEVC and their loved ones, and SEVC's staff. SEVC is located in Chester County, which borders Montgomery, Delaware, Lancaster, and Berks Counties, all among the hardest hit counties in Pennsylvania.¹ COVID-19 is a disease about which much remains unknown to this day, let alone when it first entered SEVC's doors. Guidance at the county, state, and federal levels frequently changed, and was, at times, in conflict, with respect to issues such as cohorting and contact tracing. Premature, and even misleading information, was coming from certain quarters about the safety and efficacy of potential treatment. The country was facing critical shortages of PPE, testing, and other materials and services needed to combat the virus and treat ailing patients.

Thus, even the most well-planned, coordinated, and effectively executed approach could not have kept COVID-19 from the facility, or eliminated entirely its impact. However, the response at SEVC was not well-planned, coordinated, or effective. On the contrary, SEVC mishandled its response to COVID-19 in many significant ways, which contributed tragically to the heartrending events that occurred there.

At the core of SEVC's failures were its misjudgments and lost opportunities in controlling and limiting the spread of the virus. These were aggravated by failures in leadership at a number of levels: an overly rigid chain of command within and above SEVC; an SEVC management culture concerned more with managing perception than getting things done; a woeful lack of accountability; poor communication both internally and with resident families; a history of poor morale among the staff at SEVC; and failures in advance preparation. While the toll of COVID-19 could not have been avoided in its entirety, there is little doubt that this horrible tragedy could have meaningfully been ameliorated and mitigated if not for these failures.

Despite these shortcomings, it is important to recognize those at SEVC, and in particular the frontline healthcare providers and staff, who worked grueling hours, fought tirelessly for the facility's residents with empathy and diligence, and felt deeply the terrible tragedies they witnessed. They did so despite significant personal risk, and often for very low pay. Their courage should be recognized and lauded. This report commends their efforts.

¹ Pa. Dep't of Health, *COVID-19 Data for Pennsylvania*, [health.pa.gov](https://www.health.pa.gov/topics/disease/coronavirus/Pages/Cases.aspx) (updated Sept. 19, 2020), <https://www.health.pa.gov/topics/disease/coronavirus/Pages/Cases.aspx>.

Nevertheless, their leadership failed them, and much went wrong at SEVC that could have been avoided. In particular, our investigation found the following key deficiencies:

1. Poor Infection Control Planning. Despite directives from DMVA to begin COVID-19 related infection control planning in mid-March, SEVC largely failed to do so. As part of a DMVA directed self-assessment, SEVC identified infection control weaknesses that were not remedied or brought to DMVA's attention. DMVA also provided a pandemic plan to SEVC for it to adapt to its own facility. SEVC never completed the plan. This lack of planning left SEVC ill-prepared to respond to the COVID-19 outbreak, resulting in ad hoc and seemingly arbitrary infection control decisions.

2. Failure to Stop Communal Dining. SEVC did not stop communal dining until early April. This was well after DMVA issued its mid-March guidance and directives calling for the cessation of group activities, including communal dining. In the time between mid-March and early April, communal dining continued and symptomatic residents, including those who later tested positive for COVID-19, regularly dined with asymptomatic residents, creating a significant risk of spreading the virus throughout SEVC.

3. Failure to Use a Vacant Unit for Isolation and Cohorting Purposes. SEVC had a significant asset to fight the spread of COVID-19. This was its vacant 32-bed unit, 3 West, in Coates Hall. The unit could have been used in any number of ways to isolate or cohort residents. However, SEVC did not take advantage of that asset. Instead, it reserved the unit for use by staff to stay overnight. DMVA, however, had secured hotel rooms for SEVC staff for that purpose. In fact, few SEVC staff ever stayed in 3 West. As a result, the unit was not used for cohorting purposes until the week of July 20, when SEVC's new interim administration set up 3 West for exposed but asymptomatic residents.

4. Failure Adequately to Isolate Residents. Guidance from DOH and other public health agencies instructed facilities to prioritize, to the extent possible, isolating COVID-19 positive residents from residents whose COVID-19 status was unknown. SEVC initially implemented a plan to separate COVID-19 positive residents from residents with unknown COVID-19 status through the use of negative pressure rooms. On April 6, however, SEVC received guidance from CCHD that symptomatic residents on units with more than one COVID-19 positive resident were to be presumed COVID-19 positive. SEVC misinterpreted this guidance to mean that once a unit had more than one COVID-19 positive resident, they were to presume the entire unit to be COVID-19 positive, and refrain from moving any residents off the unit. As a result, SEVC stopped separating COVID-19 positive residents (and exposed symptomatic residents) from asymptomatic residents. This left numerous asymptomatic residents exposed to confirmed and presumed COVID-19 positive residents, greatly increasing the risk of the virus's spread throughout entire units.

5. Improper Implementation of Extended PPE Use. Although SEVC engaged in considerable efforts to procure sufficient PPE to protect its staff and residents, it was unable to procure sufficient supplies. SEVC therefore implemented procedures for extending the use of the PPE it had. SEVC's extended use of isolation gowns was not in accordance with Centers for Disease Control and Prevention ("CDC") guidance, which allows for the extended use of

isolation gowns only when providing care to residents known to have the same respiratory infection. SEVC, however, used the same isolation gowns for all residents on COVID-19 impacted units, again increasing the risk of spreading COVID-19 to asymptomatic patients.

6. Inadequate Infection Prevention and Control Training. SEVC's COVID-19 related infection prevention and control training was limited, reactive, and generally inadequate. Indeed, the only infection prevention and control training SEVC provided to prepare staff for COVID-19 did not include information specific to COVID-19, and consisted of "read-and-sign" handouts. Given the inadequacies of SEVC's training, SEVC staff members largely did not retain early trainings related to COVID-19 at SEVC and, in many cases, did not even recall that they had occurred. Instead, most SEVC staff members recalled only the more robust trainings administered under SEVC's new interim leadership that replaced Commandant Blackwood and DON Mullane.

7. Inappropriate Use of Hydroxychloroquine. Beginning in early April, SEVC, in consultation with DMVA Chief Medical Officer Dr. Darryl Jackson, decided to administer hydroxychloroquine to treat COVID-19 positive and presumed positive residents. This was after the U.S. Food & Drug Administration's ("FDA") Emergency Use Authorization ("EUA"). The EUA, however, authorized the use of hydroxychloroquine in only limited circumstances, and only after disclosure of the risks, benefits, and alternatives to the use of hydroxychloroquine. SEVC administered the drug to a large majority of all residents with confirmed or presumed COVID-19 at SEVC. It was administered without regard to underlying conditions or potential reactions with other medications. This was despite the fact that many residents were on medications that interacted poorly with hydroxychloroquine. The residents' ages were also a significant factor counselling against the use of hydroxychloroquine. Further, the drug was administered without explaining the potential risks, benefits, or available alternative treatments to the residents (or their designated powers of attorney). Such disclosure was required under the EUA, and the failure to do so is inconsistent with best practices when administering such medication for off-label use. Aggravating the risk of use of the drug, SEVC did not appropriately monitor residents treated with hydroxychloroquine, for example, by electrocardiogram, as provided for in the EUA.

8. Poor Internal Communication. Virtually from inception there were failures of communication at SEVC about the extent and seriousness of the COVID-19 outbreak. SEVC staff members were largely kept in the dark by SEVC's leadership. Thus, these critical personnel were not apprised of significant information such as the number of residents and staff who had tested positive, where positive residents were located, or how many residents had died. SEVC staff also reported being largely unaware of the units where there were residents suspected of having COVID-19. Additionally, at the instruction of TAG, SEVC did not share information regarding the location of COVID-19 positive residents or residents under investigation for COVID-19 with National Guard leadership deployed to SEVC. The rationale for this directive was that this information should only be shared with "need to know" personnel because it was deemed sensitive. This overall lack of transparency exacerbated the risk of unwitting exposure to infected persons, thereby risking further spread to both staff and other residents.

9. Poor Communication with Resident Families. SEVC did not communicate with resident family members in a transparent or timely manner. SEVC provided information to families through both mass communications to all families and individualized communications regarding residents' conditions. The information SEVC provided to families in mass communications was unnecessarily vague and did not accurately convey the seriousness or extent of the COVID-19 outbreak at the facility. For instance, when SEVC advised families that "several" residents had tested positive for COVID-19, there were 16 residents who had tested positive and 13 additional residents who were presumed COVID-19 positive. Moreover, resident specific information SEVC provided to family members often was untimely, sporadic, and inconsistent. For instance, a family member reported learning of a resident's passing only after contacting SEVC to speak with the resident. Another family member reported learning of a resident's COVID-19 symptoms not from SEVC, but from the resident's roommate. Family members are entitled to empathetic, open, and timely communication about the condition and care of their loved ones. SEVC, however, fell far short of meeting this goal, contributing unnecessarily to the fear and anxiety experienced by family members.

10. Failures of Leadership. Employees described a toxic working environment at SEVC, one driven primarily by Commandant Blackwood and DON Mullane. Blackwood and Mullane managed by intimidation and dictate, leaving employees afraid to provide feedback, offer suggestions, or question decisions. DMVA, for its part, also suffered from a contentious work environment in which key leadership kept information from each other. Others, like DMVA's Chief Medical Officer and his team, were overruled in favor of SVH leadership. Some DMVA employees described a work environment in which competing egos engendered disagreement among staff. Due in part to this contentious work environment, DMVA failed to exercise sufficient authority over SEVC, giving in to resistance rather than insisting on compliance with DMVA directives.

There was also a culture of lack of accountability and unwillingness to accept responsibility evident at both SEVC and DMVA. SEVC leadership necessarily delegated responsibility for some aspects of SEVC's COVID-19 response to staff. However, they did not provide adequate direction or oversight in doing so. Instead, they later used that delegation to disclaim responsibility for how or why certain decisions were made. At the same time, staff was often left to flounder, being provided neither the guidance nor training needed to make well-informed judgments.

This lack accountability also manifested itself in an unwillingness to engage in any self-reflection or criticism. For example, when asked about what DMVA or SEVC could have done better in its COVID-19 response efforts, the BVH Director explained that the COVID-19 outbreak was a difficult situation and thus stated that he would refuse to "Monday morning quarterback" the decisions made. Ultimately, the buck seems to have stopped nowhere.

11. Weaknesses in the Organization Structure. Structurally, there were three core deficiencies. First, DMVA – through BVH – did not exercise sufficient oversight of the operations of the six SVHs, or ensure compliance with its directives. Second, a rigid military chain of command impeded the flow of information necessary to ensure flexible, nimble, and informed decision-making above SEVC at DMVA. Third, at DMVA, there is no requirement

that the official with ultimate policy and decision-making authority for the SVHs – currently the DAG – have any medical expertise or experience administering long-term care facilities. As currently structured, the DAG does not have a medical officer as a direct report.

At the end of this report are a series of recommendations designed to address these findings.

II. Investigation Background

Beginning in mid-April, various news outlets started reporting on SEVC's rapidly increasing COVID-19 numbers and the measures the facility was taking, and not taking, in response.² The Pennsylvania Senate Democratic Caucus began investigating SEVC's and DMVA's response, conducting a live web hearing on May 6. On May 26, SEVC leadership – Blackwood and Mullane – were suspended and new interim leadership was installed. On May 28, BVH Director Andrew Ruscavage was recused from overseeing SEVC. This investigation followed.

The Governor's Office of General Counsel of the Commonwealth of Pennsylvania retained this firm to conduct an independent investigation into SEVC's and DMVA's COVID-19 response. Our mandate was to find out what happened and why. In the course of that investigation we conducted interviews of 78 individuals from DMVA, BVH, SEVC, the Pennsylvania National Guard, the VA, [REDACTED], CCHD, and family members of SEVC residents. Of those we sought to interview, all but one agreed to be interviewed without limitation. The sole exception was [REDACTED], [REDACTED]

[REDACTED]. [REDACTED] participated in one telephonic interview, but declined to participate in a scheduled continuation. We also reviewed approximately 55,000 documents, and engaged an expert – Dr. Sharon Brangman, a professor of Geriatric Medicine at SUNY Upstate Medical University – to review records related to, among other things, SEVC's use of hydroxychloroquine to treat COVID-19 positive and presumed positive residents. A complete list of individuals interviewed and categories of records reviewed is included in Appendix I.

² E.g., William Bender, Allison Steele & Vinny Vella, *Coronavirus has killed at least 10 at a state-run veterans home in Chester County. The National Guard is on site*, Phila. Inquirer (Apr. 17, 2020), <https://www.inquirer.com/news/coronavirus-southeastern-veterans-center-chester-county-pennsylvania-20200417.html>; William Bender, Allison Steele & Vinny Vella, “*It’s a sinking ship*”: *COVID-19 deaths triple at state-run vets nursing home in Chester County as families clamor for information*, Phila. Inquirer (Apr. 25, 2020), <https://www.inquirer.com/news/southeastern-veterans-center-coronavirus-chester-county-covid-20200425.html>.

III. Factual Background

A. The Department of Military and Veterans Affairs

1. Mission and Structure

Pennsylvania is home to more than 800,000 veterans and their families – the fourth largest veteran population in the nation.³ The DMVA is dedicated to serving Pennsylvania’s veterans. It “has a dual mission: to provide quality service to the commonwealth’s veterans and their families, and to oversee and support the members of the Pennsylvania National Guard” The DMVA and the Pennsylvania National Guard are headquartered at Fort Indiantown Gap in Lebanon County. As part of its mission, the DMVA provides resources and assistance to Pennsylvania’s aging and disabled veterans and their families.⁴

The DMVA is one of Pennsylvania’s largest employers, with approximately 22,000 military and civilian personnel in some 90 communities statewide. The DMVA falls under TAG. TAG is a governor appointed cabinet-level position. Governor Wolf appointed, and the Pennsylvania Senate confirmed, the current TAG, Major General Anthony Carrelli, on January 14, 2016. Major General Carrelli was re-confirmed on January 15, 2019. TAG essentially is the Secretary of the DMVA, responsible for oversight of all of the Commonwealth’s programs for Pennsylvania’s veterans. In addition, TAG commands the Pennsylvania National Guard – Army and Air Force.⁵

BVH sits within the DMVA. BVH is responsible for overseeing and administering Pennsylvania’s six SVHs, in which over 1,300 veterans and veterans’ spouses reside and for which over 2,000 clinical and professional staff work.⁶ BVH is led by the DAG, whom TAG appoints. Major General Carrelli appointed Major General (Retired) Eric Weller, with Governor Wolf’s approval, as DAG on November 21, 2016.⁷ The DAG manages the Bureau of Veterans’

³ Press Release, Pa. Dep’t of Military & Veterans Affairs, DMVA Encourages Everyone to Light a Candle on World Suicide Prevention Day (Sept. 9, 2020),

<https://www.media.pa.gov/pages/Military-and-Veteran-Affairs-details.aspx?newsid=459>.

⁴ Pa. Dep’t of Military & Veterans Affairs, *Mission*, dmva.pa.gov, <https://www.dmvpa.gov/Pages/Mission.aspx> (last visited Sept. 20, 2020).

⁵ Pa. Dep’t of Military & Veterans Affairs, *The Adjutant General*, <https://www.dmvpa.gov/Pages/TAG-Biography.aspx> (last visited Sept. 20, 2020).

⁶ Pa. Dep’t of Military & Veterans Affairs, *Veterans Homes*, dmva.pa.gov, <https://www.dmvpa.gov/paveteranshomes/Pages/default.aspx> (last visited Sept. 20, 2020).

⁷ Pa Dep’t of Military & Veterans Affairs, *Deputy Adjutant General for Veterans Affairs*, dmva.pa.gov, <https://www.dmvpa.gov/dmvaoffices/Public-Affairs/Pages/Deputy-Adjutant-General-of-Veterans-Affairs.aspx> (last visited Sept. 20, 2020).

Programs (“BVP”) and the BVH.⁸ Neither the current DAG nor TAG have clinical or nursing home administration experience.⁹

Pennsylvania’s SVHs are SEVC, Hollidaysburg Veterans’ Home (“HVH”), Delaware Valley Veterans’ Home (“DVH”), Pennsylvania Soldiers’ and Sailors’ Home (“PSSH”), Gino J. Merli Veterans’ Center (“GJMVC”), and Southwestern Veterans’ Center (“SWVC”). SEVC is the second largest of the homes, with 292 beds and approximately 430 clinical and professional staff.¹⁰

Andrew Ruscavage has been the BVH Director since 2013. In that position, he oversees the operations of the six SVHs and reports to the DAG. Ruscavage, a retired First Sergeant in the Army,¹¹ holds both an active Registered Nurse license and an active Nursing Home Administrator license. Before joining BVH, Ruscavage served as the Executive Director of the Golden Living Center of Lansdale.¹²

Each SVH is led by a Commandant. The Commandants report directly to the BVH Director. Also reporting to the BVH Director are the Chief Medical Officer (“CMO”), Dr. Darryl Jackson, and the Chief Operating Officer, [REDACTED].¹³ The Chief Compliance and Ethics Officer [REDACTED] also previously reported to the BVH Director. [REDACTED]

[REDACTED] As a result, Adjutant General Carrelli recently reorganized the position so that the Chief Compliance and Ethics Officer now reports to DMVA’s Deputy for Administration [REDACTED] who heads DMVA’s Office of Administration.¹⁵

Dr. Jackson has served as the CMO at DMVA since January 2017. He previously served for one year as the Chief of Clinical Services at DMVA. Before that, Dr. Jackson served for three years as the Medical Director of DVH, and was a clinician for many years.¹⁶ The CMO position initially reported to the DAG, but, in mid-2018, at DAG Weller’s urging, the position

⁸ Interview of E. Weller (Aug. 18, 2020).

⁹ Interview of A. Carrelli (Aug. 14 & 17, 2020); Interview of E. Weller (Aug. 18, 2020).

¹⁰ Pa. Dep’t of Military & Veterans Affairs, *Southeastern Veterans’ Center*, dmva.pa.gov, <https://www.dmvpa.gov/paveteranshomes/SouthEasternVeteransCenter/Pages/default.aspx> (last visited Sept. 20, 2020).

¹¹ Brian Bingaman, *Military Service from Different Eras Recalled*, The Reporter (Aug. 17, 2018), https://www.thereporteronline.com/news/military-service-from-different-eras-recalled/article_555f1b4e-e64a-548a-81ac-1f40477d9615.html.

¹² Brian Bingaman, *Military Service from Different Eras Recalled*, The Reporter (Aug. 17, 2018), https://www.thereporteronline.com/news/military-service-from-different-eras-recalled/article_555f1b4e-e64a-548a-81ac-1f40477d9615.html.

¹³ Interview of A. Ruscavage (June 9, 2020).

¹⁴ Email from [REDACTED] to E. Weller re [REDACTED] (Mar. 7, 2020) [REDACTED].

¹⁵ Interview of [REDACTED] (Aug. 6, 2020); Interview of [REDACTED] (Aug. 13 & 25, 2020).

¹⁶ Darryl Jackson, LinkedIn.com, <https://www.linkedin.com/in/darryl-jackson-5a019694/> (last visited Sept. 20, 2020).

was restructured to report to the BVH Director.¹⁷ Reporting to Dr. Jackson are the Chief Nursing Officer, [REDACTED], and two Nursing Administrators, [REDACTED] [REDACTED].¹⁸

2. *Work Environment*

DMVA has suffered from a contentious work environment. DAG Weller explained that everyone within BVH – except for him – has an “outsized ego” and that those egos often led to a contentious atmosphere within DMVA.¹⁹ DAG Weller maintained, however, that it did not impede DMVA’s work.

Other DMVA personnel felt differently.

[REDACTED] stated that there was tension up the DMVA ranks through BVH Director Ruscavage and DAG Weller. She noted that there was poor communication both top-down and across DMVA. She observed that the department operated with an “information is power” ethos, and, as result, information tended to be siloed. For example, [REDACTED] noted that CMO Jackson shared information only with staff members he considered to be in “need to know” positions. There were times that Dr. Jackson did not consider DMVA leadership as “need to know” with respect to certain information. As a result, in some instances Dr. Jackson left even DAG Weller in the dark as to certain matters. [REDACTED] recalled DAG Weller complaining on occasion that he was not being kept adequately informed.²⁰

DMVA [REDACTED] related a similar dynamic on Dr. Jackson’s clinical team in that Dr. Jackson viewed the clinical team as “his people” and Ruscavage as having his own people. Indeed, although BVH Director Ruscavage was the final authority on many BVH matters, Dr. Jackson often would instruct [REDACTED] not to share information with Ruscavage.²¹

Dr. Jackson and his staff reported that they were undermined by Ruscavage.²² For example, Ruscavage would undo decisions made by Dr. Jackson’s team without consultation.²³ [REDACTED] explained that Ruscavage could be dismissive, and, as a result, she tended to be reserved about her concerns.²⁴ Both [REDACTED] and [REDACTED] noted that Dr. Jackson

¹⁷ Interview of E. Weller (Aug. 18, 2020).

¹⁸ Interview of D. Jackson (June 9, 2020).

¹⁹ Interview of E. Weller (Aug. 18, 2020).

²⁰ Interview of [REDACTED] (July 17, 2020).

²¹ Interview of [REDACTED] (June 25, 2020).

²² Interview of D. Jackson (June 9, 2020); Interview of [REDACTED] (July 17, 2020); Interview of [REDACTED] (June 25, 2020).

²³ Interview of [REDACTED] (June 25, 2020).

²⁴ Interview of [REDACTED] (June 11, 2020).

and DMVA [REDACTED] did not get along.²⁵ Dr. Jackson similarly recalled a disagreement that he had with [REDACTED] during which, in a fit of anger, [REDACTED] threw a chair and phone.²⁶

B. Southeastern Veterans Center

1. *History*

DMVA established SEVC in December 1986 with the transfer of the property that was formerly the Pennsylvania Department of Welfare's Pennhurst State School and Hospital ("Pennhurst"). Pennhurst's New Horizons Building (now Coates Hall) became SEVC's first home.²⁷ In 2012, SEVC built the CLC building, which has a 120-bed capacity designed "to de-institutionalize long-term care by creating a more home-like setting."²⁸ CLC residents each have their own bedroom and bathroom.

2. *Care and Physical Layout*

SEVC provides both skilled nursing care and personal care. Personal care is akin to an assisted living environment, in which residents largely are able to live independently, and may come and go from the facility as they please. Skilled nursing, on the other hand, is for those unable to live independently and require more significant care. SEVC has seven skilled care nursing units, one skilled care dementia unit, and two personal care units. SEVC's 292 beds are distributed between the older Coates Hall and the newer CLC building. Tilghman Hall connects Coates Hall and CLC, and includes SEVC largest communal dining area.²⁹

CLC has four floors. The first houses SEVC's post office, dentist's office, a chapel, a library, and a beauty/barber shop, as well as SEVC's memory care unit. Each remaining floor has two hallways of resident bedrooms. Each resident hallway has a living room, activities room, dining room, and nursing station. SEVC's bariatric isolation rooms, which have negative pressure capabilities, are also located in the CLC building, two on each floor.³⁰

Coates Hall has five floors. The ground floor is used for storage, various offices and utility rooms, and an activities/game room. The first floor of Coates Hall is largely comprised of administrative offices, but also includes the canteen store, a library, a multipurpose room, and physical therapy facilities.

The remaining floors of Coates Hall are residential. Each residential floor is divided into two units, an East and a West unit. Coates Hall bedrooms range from one- to four-person rooms. The second and third floors are skilled nursing units with separate nursing stations and resident

²⁵ Interview of [REDACTED] (June 25, 2020); Interview of [REDACTED] (July 17, 2020).

²⁶ Interview of D. Jackson (June 9, 2020).

²⁷ [REDACTED], Southeastern Veteran's Center New Employee Orientation, at 15-16 (May 31, 2016).

²⁸ *Id.* at 16.

²⁹ *Id.* at 11, 16-17.

³⁰ CLC Floor Plans [REDACTED].

common areas for each unit. The fourth floor, home to SEVC's personal care units, has separate resident common areas for each unit, but no nursing stations. In Coates Hall, there is only one dining room per floor. As a result, the two units on each floor of Coates Hall share a dining room with each other.³¹

3. SEVC Organizational Structure

a. Commandant and Director of Nursing

During the period relevant to this report, SEVC was led by Commandant Rohan Blackwood. Reporting to Blackwood were Deputy Commandant [REDACTED], and DON Debbie Mullane. Also under Blackwood, among other departments, were Social Services, [REDACTED], Medical Records, [REDACTED], Quality Assurance, [REDACTED] and [REDACTED], and Adult Daycare Administration, [REDACTED].

[REDACTED] direct reports were the two [REDACTED] and [REDACTED], Chief Pharmacist [REDACTED], Activities Coordinator [REDACTED], Registered Nurse Instructors ("RNI") [REDACTED] and [REDACTED],³² and the nursing schedulers, [REDACTED] and [REDACTED].³³

b. Assistant Directors of Nursing

ADON [REDACTED] retired from SEVC on June 26. During her tenure, she was responsible for overseeing Coates Hall. ADON [REDACTED] was responsible for CLC. The ADONs are responsible for managing nurse supervisors, ensuring that nurses are providing the appropriate level of care on the floor, scheduling staff, reviewing documentation to make sure any changes in resident condition are managed correctly and that supervisors follow up appropriately, and reviewing policies and procedures to make sure that they comply with applicable guidance. The ADONs also rotate on-call duties so that one ADON is available at SEVC at all times.

[REDACTED] had three unit managers in Coates Hall – [REDACTED], [REDACTED], and [REDACTED], three nurse supervisors, [REDACTED]. The Restorative Program Nurse, [REDACTED], reported to [REDACTED] as did the three Unit Clerks on Coates Hall. The Nursing Scheduler for Resident Appointments, [REDACTED] and Registered Nurse Assessment Coordinator ("RNAC"), [REDACTED], also reported directly to [REDACTED].

In addition, SEVC's Infection Preventionist [REDACTED], referred to at SEVC as an Infection Control Nurse ("ICN"), reported to [REDACTED] "on paper." In practice, however, [REDACTED] reported directly to DON Mullane. As a result, [REDACTED] felt that she was "at a loss" in

³¹ Coates Hall Floor Plans [REDACTED].

³² [REDACTED], Southeastern Veteran's Center New Employee Orientation, at 12 (May 31, 2016) [REDACTED].

³³ Interview of D. Mullane (Aug. 20, 2020).

terms of the Infection Preventionist position and “did not have a grasp of what was going on” with regard to infection control at SEVC.³⁴

Because CLC does not employ the unit manager model, ADON [REDACTED] had fewer direct reports.³⁵ The CLC Unit Clerks, RNACs, and nurse supervisors reported to her. [REDACTED] was responsible for working with CLC’s interdisciplinary team to coordinate the day-to-day activities of the residents.³⁶ Wound Care Nurse, [REDACTED], also reported to [REDACTED].³⁷

4. *Staffing Issues at SEVC*

Staffing perennially has been an issue for SEVC. Both SEVC and DVVH rely on a large hiring pool from Philadelphia. Many staff use SEVC as a “stepping stone” to get hired at DVVH, a home that is an easier commute for Philadelphia residents.³⁸ In addition, SEVC has had difficulty recruiting and retaining staff because of the low salaries it offered.³⁹ As a result, staffing levels at SEVC traditionally have been a concern for DMVA.⁴⁰ Nevertheless, in advance of the COVID-19 outbreak at SEVC, SEVC had sufficient staff to meet per patient day (“PPD”) requirements, but “it was tight.”⁴¹

5. [REDACTED] – SEVC’s Medical Providers

[REDACTED] is a private medical practice that offers a network of physicians and other healthcare providers to assist institutions with geriatric care.⁴² [REDACTED] [REDACTED]. The team consists of two physicians, [REDACTED] and two nurse practitioners, [REDACTED] and [REDACTED]⁴³. [REDACTED] began working at SEVC approximately two-and-a-half years ago,⁴⁴ and [REDACTED] became [REDACTED]

³⁴ Interview of [REDACTED] (Jun. 25, 2020).

³⁵ Interview of [REDACTED] (Jul. 13, 2020).

³⁶ Interview of [REDACTED] (Aug. 12, 2020).

³⁷ Interview of [REDACTED] (Jun. 25, 2020). Although [REDACTED] reported that the ICN and Wound Care Nurse both reported to both ADONs, [REDACTED] explained that the ICN reported to her and the Wound Care Nurse reported to [REDACTED]. *Id.*; Interview of [REDACTED] (Aug. 12, 2020).

³⁸ Interview of A. Carrelli (Aug. 14 & 17, 2020).

³⁹ Interview of A. Ruscavage (Aug. 13, 2020); Interview of [REDACTED] (June 9, 2020).

⁴⁰ Interview of A. Ruscavage (Aug. 13, 2020).

⁴¹ Interview of A. Carrelli (Aug. 14 & 17, 2020). PPD is a methodology of calculating the required number of staff based on the number of residents being cared for. Interview of [REDACTED] (June 9, 2020).

⁴² [REDACTED]

⁴³ Interview of [REDACTED] (Jun. 17, 2020).

⁴⁴ Interview of [REDACTED] (June 17, 2020).

[REDACTED] when she started at [REDACTED] in February of 2020. [REDACTED] and [REDACTED] both work at SEVC full time.⁴⁵

C. SEVC Leadership under Rohan Blackwood's Administration

On February 2, 2015, DMVA appointed Rohan Blackwood as the Commandant of SEVC. Blackwood joined SEVC after 15 years of experience in long-term care, as an administrator at various privately run facilities.⁴⁶ Blackwood is licensed by the State Board of Examiners of Nursing Home Administrators in both Pennsylvania and Connecticut.

When Blackwood joined SEVC, the facility was on a provisional license, and was the worst financially performing facility within BVH. It was rated a two-star facility by CMS.⁴⁷ Within six months, the facility had its provisional designation removed.⁴⁸ Within five years, CMS upgraded SEVC to a five-star facility, and, in 2019, SEVC was ranked as one of the best nursing homes in Pennsylvania by *Newsweek*.⁴⁹ It also became the best financially performing facility within BVH.⁵⁰

While Blackwood turned around SEVC's performance, his relationship with SEVC's staff soured. He was described by many different staff members as difficult and autocratic, and creating an authoritarian work environment at SEVC. This bred significant resentment, distrust of leadership, and an unwillingness to speak up. The prevailing sentiment was that SEVC was militaristic in nature, and staff members were required to follow the chain of command and not ask questions.

SEVC staff expressed concerns during this investigation about Blackwood and DON Mullane's leadership style, with individuals indicating that the tension between the staff and the

⁴⁵ Interview of [REDACTED] (June 17, 2020).

⁴⁶ Dep't of Military & Veterans Affairs, Press Release, New Commandant of Southeastern Veterans' Center Appointed, (Feb. 2, 2015), <https://www.media.pa.gov/Pages/Military-and-Veteran-Affairs-Details.aspx?newsid=138>.

⁴⁷ Interview of A. Ruscavage (Aug. 13, 2020). CMS uses a five-star rating system to assess nursing home quality. Nursing homes with five stars are considered "much above average quality," and homes with one star "are considered to have quality much below average." Ctrs. for Medicare & Medicaid Servs., *Five-Star Quality Rating System*, cms.gov (Oct. 7, 2019), <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/FSQRS>.

⁴⁸ Interview of A. Ruscavage (Aug. 13, 2020).

⁴⁹ Interview of A. Ruscavage (June 9, 2020); Interview of [REDACTED] (Aug. 12, 2020); Linda Hasco, *These Are the 10 Best Nursing Homes in Pennsylvania*, PennLive.com (Oct. 22, 2019), <https://www.pennlive.com/news/g661-2019/10/062c4fb2da533/these-are-the-10-best-nursing-homes-in-pennsylvania-.html>; Southeastern Veterans' Center: Nursing Home Profile, <https://www.medicare.gov/nursinghomecompare/profile.html#profTab=0&ID=39A435&Distn=0.0&loc=19475&lat=40.1767757&lng=-75.5477029> (last visited Sept. 20, 2020).

⁵⁰ Interview of A. Ruscavage (Aug. 13, 2020).

administration was palpable. While these concerns were not uniform, they were sufficiently widespread that they cannot be written off simply as complaints of disgruntled employees unhappy with demanding bosses. For example, staff commented: “[Blackwood is] disrespectful and rude” and similar descriptions;⁵¹ “Blackwood plays mind games;”⁵² Blackwood and Mullane “did not treat people very nicely;”⁵³ and Blackwood and Mullane were not “the nicest” nor “the most welcoming people.”⁵⁴

Blackwood’s and Mullane’s authoritative style of leadership had a damaging and chilling effect on the staff’s willingness to ask questions or raise concerns.⁵⁵ As [REDACTED] explained, she “did not feel free to express [her] opinion” under Blackwood’s administration, because she had “learned [her] place at SEVC and tended to keep [her] mouth shut to avoid controversy.”⁵⁶ Staff reported that some of the friction between leadership and staff was because Blackwood was a micromanager, wanting to have his hand in everything occurring at the facility.⁵⁷

Blackwood’s leadership style engendered formal complaints to DMVA. Adjutant General Carrelli recalled that DMVA received numerous complaints about Blackwood that were investigated by the DMVA Office of Administration. No action was taken, however, notwithstanding the substantial volume of similar complaints. Adjutant General Carrelli took no action against Blackwood because, in Adjutant General Carrelli’s view, all the complaints were found to be “unsubstantiated.” This was the case even though the volume of complaints was high enough that Blackwood himself once remarked to Adjutant General Carrelli: “You’re probably tired of hearing about me.”⁵⁸ BVH Director Andrew Ruscavage similarly recognized that SEVC had one of the highest number of complaints among the SVHs. He likewise took no action, also claiming that the complaints were “unsubstantiated.”⁵⁹

DMVA leadership also reported significant challenges in communicating with Blackwood and Mullane. For instance, CMO Dr. Jackson noted that he and his team consistently received pushback from Blackwood and Mullane. [REDACTED] similarly explained that Mullane has a “her way or no way” leadership style, and that information [REDACTED] provided Mullane would go in one ear and out of the other. [REDACTED] also noted

⁵¹ Interview of [REDACTED] (July 7, 2020); Interview of [REDACTED] (July 6, 2020).

⁵² Interview of [REDACTED] (July 7, 2020).

⁵³ Interview of [REDACTED] (July 15, 2020).

⁵⁴ Interview of [REDACTED] (July 21, 2020); Interview of [REDACTED] (July 6, 2020).

⁵⁵ Interview of [REDACTED] (July 20, 2020).

⁵⁶ Interview of [REDACTED] (June 25, 2020).

⁵⁷ Interview of [REDACTED] (July 7, 2020) (“[S]ome of the rigidity of roles was definitely coming from [] Blackwood’s desire to have his hand in everything.”); Interview of [REDACTED] (June 26, 2020) (“Blackwood [was] very controlling and insisted that [REDACTED] copy [Blackwood] on all communications with [REDACTED] and [REDACTED].”).

⁵⁸ Interview of A. Carrelli (Aug. 14 & 17, 2020).

⁵⁹ Interview of A. Ruscavage (Aug. 13, 2020).

similar concerns with Blackwood.⁶⁰ [REDACTED] advised that Blackwood and Mullane often would ignore emails. [REDACTED] also expressed concern that BVH Director Ruscavage had a close relationship with Blackwood and Mullane that made it difficult for Ruscavage to discipline and control SEVC.⁶¹

[REDACTED] reported that Blackwood always seemed annoyed when she contacted him, and that SEVC staff seemed nervous about whether she was in the building when she visited SEVC. [REDACTED] explained further that she got the sense that SEVC was trying to keep information in-house, stating that Blackwood would try to shut down any visits or inspections with which he did not agree. [REDACTED] also reported receiving an inordinate volume of complaints from SEVC staff [REDACTED] during the COVID-19 outbreak. The constant theme of these complaints was about Blackwood's administration's leadership style, and the resulting fear of retaliation.⁶²

Unlike many others, BVH Director Ruscavage denied encountering similar difficulties with Blackwood or Mullane. He claimed that Blackwood and his administration were receptive to DMVA guidance, and did not push back against any particular DMVA initiatives. Ruscavage claimed that he viewed SEVC's response to COVID-19 as a model to inform DMVA's guidance to other SVHs.⁶³ This investigation found these claims by Ruscavage to be inconsistent with the weight of the evidence.

This investigation also revealed that DMVA leadership – and, in particular, CMO Dr. Jackson and BVH Director Ruscavage – failed to respond sufficiently to SEVC's pushback. Dr. Jackson explained that because SEVC ignored his suggestions so often, he stopped pushing. He stated that he was "shell shocked" by their resistance. Dr. Jackson reported raising his concerns about SEVC leadership to Ruscavage, but that his concerns were not addressed.⁶⁴

D. SEVC's Handling of Recent Norovirus Outbreak

Just prior to the COVID-19 outbreak in the United States, SEVC dealt with an outbreak of norovirus, a highly contagious viral infection that can cause the sudden onset of severe vomiting and diarrhea.⁶⁵ The outbreak began on December 28, 2019, with SEVC notifying CCHD that multiple residents on 2 East were experiencing norovirus symptoms.⁶⁶ Ultimately, over 170 residents and employees experienced symptoms of norovirus. SEVC discovered that

⁶⁰ Interview of [REDACTED] (June 11, 2020).

⁶¹ Interview of [REDACTED] (July 17, 2020).

⁶² Interview of [REDACTED] (Aug. 6, 2020).

⁶³ Interview of A. Ruscavage (Aug. 13, 2020).

⁶⁴ Interview of D. Jackson (June 9, 2020).

⁶⁵ *Id.*; Mayo Clinic, Norovirus Infection, MayoClinic.org (Feb. 5, 2020), <https://www.mayoclinic.org/diseases-conditions/norovirus/symptoms-causes/syc-20355296>.

⁶⁶ Email to [REDACTED] re PROD SIR #20-54 SEVC Final Submitted to DAG – to HQ (Mar. 3, 2020) [REDACTED]; Dep't of Military & Veterans Affairs Serious Incident Report #20-54 (Feb. 28, 2020) [REDACTED].

one of primary causes of the outbreak was the fact that it had recently started using a disinfectant that did not kill norovirus.⁶⁷

Throughout the norovirus outbreak, SEVC implemented certain infection control measures, such as closing units, sanitizing and cleaning all resident and common areas throughout the building, and instructing staff to utilize contact precautions for all residents. SEVC implemented social distancing measures to reduce community spread, including serving meals to all residents using disposable products, limiting activities to each unit, limiting therapy services to resident rooms where feasible with equipment sanitization after each use, and attempting to maintain continuity of staff on units whenever possible. The institution engaged in floor-by-floor monitoring of the spread of the virus.

In response to the norovirus outbreak, within days, SEVC limited communal dining until a unit had been symptom free for longer than 72 hours.⁶⁸ [REDACTED] [REDACTED], provided instruction to leadership at SEVC regarding in-room dining, indicating that dietary staff “will deliver the food carts outside the closed door of each unit for distribution and ask that Nursing staff return the carts to the outside of each door the moment all trays have been collected so the carts can be picked up, and cleaned and sanitized for the next round.”⁶⁹ This was conducted for a significant portion of the facility, including 2 East, 2 West, 3 East, 2CLC, 3CLC, 4CLC, and later 1CLC.

SEVC’s Quality Assurance assessment of the norovirus outbreak recommended the implementation of certain performance improvements. Among those recommended improvements was that SEVC should cancel communal dining earlier when there is an infection in the facility to help prevent its spread.⁷⁰

E. The COVID-19 Outbreak at SEVC

1. *The Emergence of COVID-19 in Long-Term Care Facilities*

In late February 2020, one of the first major outbreaks of COVID-19 in the United States occurred at the Life Care Center nursing home in Kirkland, Washington. This revealed that nursing homes are particularly vulnerable to the spread of COVID-19. The CDC considers nursing home populations at high risk for COVID-19 “[g]iven their congregate nature and resident population served (e.g., older adults often with underlying chronic medical

⁶⁷ Interview of [REDACTED] (July 17, 2020).

⁶⁸ Email to [REDACTED] re PROD SIR #19-493 SEVC Follow-On Submitted to Admin – From Server MVFIGSQLPROD01 (Jan. 14, 2020) ([REDACTED]); see also Dep’t of Military & Veterans Affairs Serious Incident Report #19-493 (Jan. 9, 2020) [REDACTED].

⁶⁹ Email from [REDACTED] re GI outbreak (Jan. 6, 2020) [REDACTED].

⁷⁰ Interview of [REDACTED] (July 28, 2020 & Aug. 11, 2020).

conditions).⁷¹ The fact that nursing homes rely on staff that might live in areas with a high prevalence of COVID-19 also presents a unique risk to nursing home residents.⁷²

The CDC reported the first case of COVID-19 in the United States on January 22, 2020. By April 3, when SEVC's first resident had tested positive for COVID-19, the United States had 274,143 cases of COVID-19.⁷³ Pennsylvania reported its first presumed case of COVID-19 on March 6.⁷⁴ By April 3, Pennsylvania had 8,420 COVID-19 cases and 102 deaths.⁷⁵ Chester County reported its first case of COVID-19 on March 13.⁷⁶ On April 1, Chester County had 183 cases of COVID-19, and one county resident had died of the disease. By April 3, Chester County had 226 cases of COVID-19, and two county residents had died of the disease.⁷⁷

The CDC's National Healthcare Safety Network ("NHSN") collects data from nursing homes on the number of COVID-19 cases, suspected COVID-19 cases, and deaths from COVID-19 weekly. As of May 24 (the end of the first week of complete data), U.S. nursing homes had had 83,772 confirmed resident cases of COVID-19, 50,495 suspected resident cases of COVID-19, and 26,287 resident deaths from COVID-19.⁷⁸ By August 30, 216,219 nursing home residents had tested positive for COVID-19, 129,338 residents were suspected to have had

⁷¹ Ctrs. for Disease Control & Prevention, Infection Control for Nursing Homes (updated June 25, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>.

⁷² Sandra M. Shi, et al., *Risk Factors, Presentation, and Course of COVID-19 in a Large, Academic Long-Term Care Facility*, J. Am. Med. Dir. Ass'n (forthcoming 2020) (manuscript at 10), available at [https://www.jamda.com/article/S1525-8610\(20\)30733-7/pdf](https://www.jamda.com/article/S1525-8610(20)30733-7/pdf).

⁷³ Ctrs. for Disease Control & Prevention, Trends in Number of COVID-19 Cases in the US Reported to CDC, by State/Territory (updated Sept. 19, 2020), https://covid.cdc.gov/covid-data-tracker/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-updates%2Fcases-in-us.html#trends.

⁷⁴ Pa. Dep't of Health, Pennsylvania Coronavirus (COVID-19) Update Archive: March 2020 (Mar. 31, 2020), <https://www.health.pa.gov/topics/disease/coronavirus/Pages/March-Archive.aspx>.

⁷⁵ Pa. Dep't of Health, Pennsylvania Coronavirus (COVID-19) Update Archive: April 2020 (Apr. 30, 2020), <https://www.health.pa.gov/topics/disease/coronavirus/Pages/April-Archive.aspx>.

⁷⁶ Pa. Dep't of Health, Pennsylvania Coronavirus (COVID-19) Update Archive: March 2020 (Mar. 31, 2020), <https://www.health.pa.gov/topics/disease/coronavirus/Pages/March-Archive.aspx>.

⁷⁷ Pa. Dep't of Health, Pennsylvania Coronavirus (COVID-19) Update Archive: April 2020 (Apr. 30, 2020), <https://www.health.pa.gov/topics/disease/coronavirus/Pages/April-Archive.aspx>.

⁷⁸ Ctrs. for Medicare and Medicaid Servs., COVID-19 Nursing Home Dataset – Archived Data – Week Ending 5/31/2020 (updated June 25, 2020), <https://data.cms.gov/Special-Programs-Initiatives-COVID-19-Nursing-Home/COVID-19-Nursing-Home-Dataset-Archived-Data-Week-E/im64-swdq>.

COVID-19, and 53,196 residents died as a result of COVID-19.⁷⁹ DOH began publishing data on COVID-19 cases in nursing homes on April 15. At that time, Pennsylvania had COVID-19 cases in 297 nursing home facilities, with 3,316 positive cases and 324 COVID-19 deaths. Chester County had 14 long-term care facilities with COVID-19 cases, 105 nursing home residents that were COVID-19 positive, and 16 nursing home residents that had died of COVID-19.⁸⁰

2. COVID-19 Preparedness Planning

DMVA instructed SVHs to begin planning for COVID-19 in early March. DMVA convened regular mandatory conference calls with the SVH leadership teams to discuss the COVID-19 pandemic and preparedness planning.⁸¹ DMVA also sent a regular “Commandant Communication” to SVH leadership, in which it provided preparedness instruction.⁸² Through these channels, DMVA disseminated preparedness directives to SVHs, on topics such as prevention measures, PPE, infection control, and staff training.

As explained below, while SEVC complied with some of DMVA’s directives, SEVC leadership was either non-responsive or resistant to others.

a. Measures to Prevent COVID-19 from Entering SEVC

SEVC began implementing measures to keep COVID-19 out of the facility in early March. The measures consisted of closing SEVC to visitors and outside vendors, and screening visitors and staff when entering the facility. SEVC’s implementation of the measures was timely. However, as detailed below, it was not always in accord with DMVA direction.

(i) SEVC’s Restriction of Visitation

SEVC closed its doors to residents’ friends and families on March 9.⁸³ SEVC did so in advance of DMVA’s instruction to SVHs “to limit visitation in line with the VA recommendations for CLC’s and the SVH program.”⁸⁴ On March 16, in accordance with DMVA guidance issued on the same date, SEVC prohibited outside service vendors and non-

⁷⁹ Ctrs. for Medicare & Medicaid Servs., COVID-19 Nursing Home Data (Aug. 30, 2020), <https://data.cms.gov/stories/s/bkwz-xpvg>.

⁸⁰ Pa. Dept. of Health, Pennsylvania Coronavirus (COVID-19) Update Archive: April 2020 (Apr. 30, 2020), <https://www.health.pa.gov/topics/disease/coronavirus/Pages/April-Archive.aspx>.

⁸¹ Calendar Invite re MANDATORY Corona Virus Conference Call (Mar. 9, 2020) [REDACTED].

⁸² E.g., COVID19 Commandant Communication (Mar. 16, 2020) [REDACTED].

⁸³ Email from [REDACTED] re Infection Control Precautions at SEVC (Mar. 9, 2020)

[REDACTED] (announcing that SEVC was “cancelling all events and opportunities for visitors to come into [the] building until further notice” as part of “an on-going effort to prevent the spread of illness to [SEVC] and the vulnerable population that [it] care[s] for”).

⁸⁴ SITREP (Mar. 10, 2020) [REDACTED].

essential medical providers from entering the facility.⁸⁵ On April 1, SEVC moved hospice services to telemedicine.⁸⁶

(ii) SEVC's Screening of Visitors and Staff

On March 6, DMVA instructed SVHs to screen all visitors for COVID-19 symptoms, using a provided questionnaire. In addition, DMVA instructed that SVHs have all staff complete “an initial screening” questionnaire before beginning their next shift and to report any changes in status from their initial responses.⁸⁷ In response, SEVC first began screening visitors to the facility for “possible symptoms of COVID-19 and/or exposure to the virus.”⁸⁸ By March 10, SEVC was screening all non-SEVC employees in the lobby before permitting the non-SEVC employees to enter SEVC units.⁸⁹

On March 16, DMVA instructed all SVHs to screen all staff members for elevated temperatures on a daily basis.⁹⁰ The day before, BVH Director Ruscavage had provided SVH Commandants instruction regarding implementation of the new screening process. First, Ruscavage advised that SVHs were expected to begin taking daily temperatures of staff as soon as DMVA was able to provide the thermometers necessary “to ensure a prompt process.” Second, DMVA instructed SVHs that “[s]creenings must take place outside” the SVHs, explaining that whether a facility had “a guard shed or not [SVH] staff must encounter the individual and screen outside.”⁹¹

Commandant Blackwood advised Ruscavage that, as of March 17, SEVC was “following similar process of DVVH in setting up outside stations to temp all employee as part of screening process before entering facility.”⁹² Some SEVC employees recalled screenings – at least initially – being conducted in a tent outside the facility, as Blackwood had represented.⁹³ However, SEVC ultimately brought screenings inside because it was too cold to take accurate temperatures outside.⁹⁴ ██████████ explained that SEVC made the decision to move screening indoors

⁸⁵ SITREP (Mar. 16, 2020) ██████████; BVH Combined Team Timeline ██████████.

⁸⁶ BVH Combined Team Timeline ██████████.

⁸⁷ Email from ██████████ to SVH Leadership re Coronavirus Screening (Mar. 6, 2020) ██████████.

⁸⁸ SEVC Stand-Down Meeting Minutes (Mar. 6, 2020 entry) ██████████.

⁸⁹ Email from R. Blackwood re Lobby Protocols (Mar. 10, 2020) ██████████.

⁹⁰ Email from A. Ruscavage to SVH Leadership re Updated screening tool (Mar. 16, 2020) ██████████.

⁹¹ Email from A. Ruscavage to SVH Leadership re review (Mar. 15, 2020) ██████████.

⁹² Email from R. Blackwood to A. Ruscavage re SITREP (Mar. 18, 2020) ██████████.

⁹³ Interview of A. Ruscavage (Aug. 13, 2020); Interview of R. Blackwood (Aug. 19 & 21, 2020); Interview of ██████████ (July 13, 2020); Interview of ██████████ (June 10, 2020).

⁹⁴ Interview of A. Ruscavage (Aug. 13, 2020); Interview of R. Blackwood (Aug. 19 & 21, 2020); Interview of ██████████ (July 13, 2020).

unilaterally, and that Ruscavage was upset to learn about the decision.⁹⁵ On April 23, CMO Dr. Jackson identified the fact that SEVC was conducting screening “in the lobby of the building” as a “concerning issue[.]”⁹⁶

b. Measures to Respond to COVID-19 Within SEVC

SEVC took some steps in the middle of March to identify and respond to COVID-19 within the facility. However, it largely was unresponsive to DMVA’s instructions to formalize plans outlining how SEVC would respond to COVID-19.

SEVC’s first action for responding to COVID-19 within the facility came on March 13, when SEVC began to screen residents for elevated temperatures every 11-7 shift. Under this screening protocol, if any resident registered a temperature “over 100.0,” SEVC nurses were to assess the resident for respiratory and cold symptoms. If the nurse observed such symptoms, the resident was to be swabbed for influenza. If the influenza test was negative, nurses were to notify the ADON on duty to determine next steps.⁹⁷

SEVC also started to establish COVID-19 testing capacity in mid-March. By March 19, SEVC reported that it had a contract with Pottstown Memorial Hospital to conduct COVID-19 testing, as well as a “secondary contract” with Quest.⁹⁸ By March 23, SEVC had procured 30 COVID-19 swab tests from CCHD.⁹⁹

In a number of other ways, however, SEVC was largely non-responsive to DMVA COVID-19 preparedness planning instructions. For instance, on March 4, Dr. Jackson requested that all SVHs have their infection prevention teams provide DMVA “a comprehensive plan” regarding how the SVH was preparing to address COVID-19.¹⁰⁰ We have not identified any SEVC response to Dr. Jackson’s request for such a comprehensive plan. Nor, however, have we identified any action by Dr. Jackson to follow up on this request. On March 20, DMVA requested that the SVHs provide the “[p]andemic section of [their] Emergency Preparedness Plans.”¹⁰¹ During the course of our investigation, we uncovered no evidence that SEVC ever provided that section to DMVA or that DMVA ever followed up with SEVC.

⁹⁵ Interview of [REDACTED] (Aug. 6, 2020). Ruscavage did not recall whether he found out before or after SEVC already had moved screening indoors. Interview of A. Ruscavage (Aug. 13, 2020).

⁹⁶ Email from D. Jackson to A. Ruscavage and [REDACTED] re SEVC COVID (Apr. 23, 2020) [REDACTED].

⁹⁷ Email from [REDACTED] to Nursing Supervisors re Resident Precautions update – Coronavirus Information (Mar. 13, 2020) [REDACTED].

⁹⁸ COVID19 Commandant Communication (Mar. 19, 2020) [REDACTED].

⁹⁹ Email from R. Blackwood to [REDACTED] re 032320 Commandant Communication (Mar. 23, 2020) [REDACTED].

¹⁰⁰ Email from D. Jackson to SVH DONs re COVID 19 (Mar. 4, 2020) [REDACTED].

¹⁰¹ Email from [REDACTED] to SVH IFSS re Emergency Preparedness Plans Pandemic (Mar. 20, 2020) [REDACTED].

On March 24, DMVA instructed the SVHs to utilize a “COVID-19 Nursing Home Preparedness Checklist,” created by the CDC, to assess their “COVID Infection Control Program.”¹⁰² The Preparedness Checklist set out “key areas that long-term care facilities should consider in their COVID-19 planning,” and was distributed as a “tool to self-assess the strengths and weaknesses of current preparedness efforts.” Among the categories included on the checklist were the identification of a planning committee, the individuals with responsibility for monitoring public health guidance and training, and the development of a comprehensive written COVID-19 infection control plan.¹⁰³ DMVA communicated a clear expectation that the SVHs would utilize the checklist to identify any deficiencies in the facilities’ infection control programs. DMVA further directed that SVHs would provide updates to DMVA – specifically BVH Director Ruscavage – regarding their progress in reviewing and fixing any identified deficiencies.¹⁰⁴ SEVC completed the CDC Preparedness Checklist on April 8. In doing so, SEVC identified several deficiencies in its COVID-19 Infection Control Program. For example, SEVC listed that it had not started the development of “infection control policies that outline the recommended Transmission-Based Precautions” for caring “for residents with suspected or confirmed COVID-19.”¹⁰⁵ The investigation uncovered no evidence that SEVC followed up with DMVA regarding those findings. Nor did the investigation uncover any evidence that Ruscavage followed-up with SEVC about its progress.

Finally, on March 26, Dr. Jackson provided the SVH leadership teams a “COVID Pandemic Plan” that the teams were to implement and tailor to their facilities.¹⁰⁶ The plan was a 15-page template that included sections for, among other things: (1) the identification of a pandemic response team and its responsibilities; (2) individual responsibilities for infection control nurses, the pandemic response coordinator, the medical director, the nurse instructors, and the DON and ADONs, among others; and (3) procedures for various phases of a pandemic.¹⁰⁷ SEVC, however, did not adapt the COVID-19 Pandemic Plan to its facility until mid-June under the new administration. Dr. Jackson, however, never followed up with SEVC about its failure to do so.

c. COVID-19 Training

SEVC began providing COVID-19 related training in March. For example, on March 9, SEVC represented to DMVA that it had begun “staff education relating to CDC guidelines for

¹⁰² COVID19 Commandant Communication (Mar. 24, 2020) [REDACTED]

¹⁰³ SEVC CDC Nursing Home Preparedness Checklist (last modified Apr. 8, 2020)
[REDACTED]

¹⁰⁴ COVID19 Commandant Communication (Mar. 24, 2020) [REDACTED].

¹⁰⁵ SEVC CDC Nursing Home Preparedness Checklist, at 2-3 (last modified Apr. 8, 2020)
[REDACTED].

¹⁰⁶ Email from D. Jackson to SVH Leadership Teams re COVID 19 Pandemic Plan (Mar. 26, 2020)
[REDACTED].

¹⁰⁷ BVH Pandemic Emergency Response Plan (Mar. 26, 2020) [REDACTED].

COVID-19, with focus on handwashing, not touching face, nose, mouth, etc.”¹⁰⁸ However, while this training covered general principles of “respiratory hygiene,” “cough etiquette,” and “hand hygiene,” like much of the other COVID-19 related training at SEVC, it was nothing more than “read and sign.”¹⁰⁹ “Read-and-sign” training consists of reading a sheet of paper to staff (or having staff read it) and then signing to acknowledge having done so. This type of training stands in contrast to demonstrative forms of training, for example, an instructor demonstrating the subject matter of the training, or competencies, where a staff member is required in a one-on-one setting to demonstrate his or her understanding of the subject matter.¹¹⁰

SEVC later conducted targeted training to educate certain staff on its infection control procedures, such as the protocols for using negative pressure rooms to treat COVID-19 positive residents.¹¹¹ As COVID-19 spread to units throughout the facility, SEVC conducted training directed to staff on those units.¹¹² This continued training was a mix of “read and sign” and demonstrative, depending in part on who conducted the training.¹¹³

d. Building PPE Supply

(i) Efforts to Procure and Optimize PPE

At the beginning of March, DMVA began checking in on the SVHs’ PPE supply. At that time, SEVC reported approximately 1.5 months’ supply of PPE.¹¹⁴ The N95 masks SEVC had on hand at that time, however, were expired and in poor condition.¹¹⁵

Through March, DMVA continued working with the SVHs in an effort to ensure that the SVHs had adequate PPE supplies and that SVH staff were fit tested for N95 masks in the event they were needed.¹¹⁶ DMVA’s instruction to SVHs was to “have enough PPE equipment” – surgical masks, gloves, face shields/goggles, and gowns – “to cover residents, staff and permitted visitors, etc.”¹¹⁷ As of March 19, DMVA was “working to determine . . . the . . . most

¹⁰⁸ Email from R. Blackwood to DMVA and SVH Leadership re Coronavirus SITREP (Mar. 9, 2020) ([REDACTED]).

¹⁰⁹ Email from [REDACTED] to [REDACTED] re Infection Prevention (Mar. 6, 2020) ([REDACTED]).

¹¹⁰ E.g., Interview of [REDACTED] (June 11, 2020).

¹¹¹ Employee Training Records (July 7, 2020); Interview of [REDACTED] (July 29, 2020).

¹¹² E.g., Employee Training Records (July 7, 2020); Interview of [REDACTED] (July 29, 2020); Interview of [REDACTED] (June 30, 2020).

¹¹³ E.g., Interview of [REDACTED] (July 15, 2020); Interview of [REDACTED] (Aug. 17, 2020); Interview of [REDACTED] (Aug. 17, 2020); Interview of [REDACTED] (July 10, 2020); Interview of [REDACTED] (July 17, 2020).

¹¹⁴ Email chain from [REDACTED] to SVH and DMVA Leadership re Coronavirus (Mar. 6, 2020) [REDACTED].

¹¹⁵ Interview of [REDACTED] (July 28, 2020); Interview of [REDACTED] (July 6, 2020).

¹¹⁶ COVID19 Commandant Communication (Mar. 16, 2020) [REDACTED].

¹¹⁷ COVID19 Commandant Communication (Mar. 17, 2020) [REDACTED].

expeditious way to purchase (i.e. through local EOC, PEMA, etc.)” PPE. By that time, SEVC had confirmed that it had sufficient PPE for “normal ops,” but had only 300 N95 masks “on hand.”¹¹⁸ Therefore, SEVC – like all other SVHs – “expressed concerns” about whether it had sufficient PPE “if/when things start[ed] escalating.”¹¹⁹ Moreover, as of March 19, SEVC still needed to fit test its staff. At that time, DMVA was attempting to locate fit-testing kits for the SVHs.¹²⁰

Initially, [REDACTED] assisted in overseeing the procurement process for the SVHs during COVID-19 preparedness planning, before turning responsibility over to [REDACTED].¹²¹ [REDACTED] explained that procurement was like the “wild west.” DMVA instructed SVHs not to rely only on procurement through DMVA and PEMA. While DMVA was working on procurement for all SVHs, DMVA instructed SVHs to explore procurement at a local level and to buy whatever they could buy.¹²² DMVA would then assess what all the SVHs had been able to procure and coordinate the PPE supply by cross-leveling PPE supply among the SVHs. DMVA thus encouraged SVHs to obtain sufficient PPE “to provide the appropriate protections to [their] staff and residents,” but not to hoard supplies they did not need. DMVA requested that SVHs report their inventories to DMVA so that the SVHs could share any excess PPE with other SVHs that were in need.¹²³ For example, as of April 6, SEVC had over 20 days’ supply of N95 masks. At that time, HVH had over 300 days’ supply of N95 masks.¹²⁴ As a result, DMVA redistributed masks from HVH to SEVC.¹²⁵

At SEVC, [REDACTED] was responsible for procurement of supplies, including PPE, as part of SEVC’s COVID-19 preparedness planning.¹²⁶ In the beginning of March, SEVC started ordering N95 masks to build up its supply.¹²⁷ In addition to relying on DMVA supply lines, SEVC sought supplies from other sources, such as Chester County. For instance, on March 30, SEVC secured a shipment of 600 N95 masks and 500 surgical masks from Chester County.¹²⁸ As of March 31, SEVC had 1,000 N95 masks on hand.¹²⁹ On April 2, SEVC received shipment of 1,000 additional N95 masks. SEVC

¹¹⁸ COVID19 Commandant Communication (Mar. 19, 2020) [REDACTED].

¹¹⁹ COVID19 Commandant Communication (Mar. 20, 2020) [REDACTED].

¹²⁰ COVID19 Commandant Communication (Mar. 19, 2020) [REDACTED].

¹²¹ Interview of [REDACTED] (June 29, 2020); Interview of [REDACTED] (June 9, 2020).

¹²² Interview of [REDACTED] (June 29, 2020).

¹²³ COVID19 Commandant Communication (Apr. 2, 2020) [REDACTED].

¹²⁴ COVID19 Commandant Communication (Apr. 6, 2020) [REDACTED].

¹²⁵ COVID19 Commandant Communication (Apr. 9, 2020) [REDACTED].

¹²⁶ Interview of [REDACTED] (July 29, 2020).

¹²⁷ SEVC COVID-19 Stand-Down Meeting Minutes (Mar. 6, 2020 entry) [REDACTED].

¹²⁸ SEVC COVID-19 Stand-Down Meeting Minutes (Mar. 30, 2020 entry) [REDACTED].

¹²⁹ SEVC COVID-19 Stand-Down Meeting Minutes (Apr. 1, 2020 entry) [REDACTED].

leadership, however, determined the facility had sufficient supply of N95s to send those masks to another SVH “that needed them more than [SEVC did].”¹³⁰

Notwithstanding that SEVC turned away a shipment of N95 masks, SEVC implemented optimization strategies to extend the supply of N95s. For example, SEVC initially required staff to wear an N95 mask for seven straight days.¹³¹ That policy was later changed to a three-mask rotation, with each mask lasting for three weeks.¹³² Applicable CDC guidance, however, recommended a five-mask rotation to allow for “a minimum of five days between each [N95 mask] use.”¹³³

(ii) Availability of Fit-Testing Equipment

In order for N95s to be used properly, they have to be fit tested to ensure a tight seal.¹³⁴ Before the COVID-19 pandemic, the SVHs did not have their own fit-testing kits. DMVA had only a few fit-testing kits that were to be shared among the SVHs.¹³⁵

On March 18, Blackwood requested a fit-testing kit from DMVA.¹³⁶ Beginning on March 23, [REDACTED], who was certified to conduct fit testing, began testing approximately 50 staff members who had been designated as the COVID-19 treatment team.¹³⁷ SEVC conducted fit testing through March 31, but on April 1 had to send the fit-testing kit to PSSH.¹³⁸ On April 7, SEVC requested another fit-testing kit. However, SEVC did not receive a fit-testing kit in April and, therefore, did not conduct any

¹³⁰ SEVC COVID-19 Stand-Down Meeting Minutes (Apr. 2, 2020 entry)
[REDACTED].

¹³¹ SEVC COVID-19 Stand-Down Meeting Minutes (Apr. 1, 2020 entry)
[REDACTED].

¹³² Interview of [REDACTED] (July 7, 2020).

¹³³ Ctrs. for Disease Control & Prevention, COVID-19 Decontamination and Reuse of Filtering Facepiece Respirators (Apr. 1, 2020), *available at* <https://web.archive.org/web/20200401222020/https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html>.

¹³⁴ Ctrs. for Disease Control & Prevention, NIOSH Science Blog, *Proper N95 Respirator Use for Respiratory Protection Preparedness*, CDC.gov (Mar. 16, 2020), <https://blogs.cdc.gov/niosh-science-blog/2020/03/16/n95-preparedness/>.

¹³⁵ Email from [REDACTED] to [REDACTED] re Fit Test (Apr. 1, 2020) (“We have a few kits we are shuffling around between the Homes.”) [REDACTED]; *see also* Interview of [REDACTED] (July 6, 2020).

¹³⁶ Email from R. Blackwood to [REDACTED] re Commandant AM Communication (Mar. 18, 2020) [REDACTED].

¹³⁷ Email from R. Blackwood to [REDACTED] D. Mullane, and [REDACTED] re N95 (Mar. 23, 2020).

¹³⁸ Interview of [REDACTED] (July 6, 2020); Email from [REDACTED] to [REDACTED] re Fit Test Equipment (Apr. 1, 2020) [REDACTED].

further fit testing in April. As a result, staff were on COVID-19 positive floors, and were treating COVID-19 residents, wearing N95 masks that had not been fit tested.¹³⁹

In early June, DMVA was able to procure a fit-testing kit for SEVC.¹⁴⁰ During the second week of June, under the new administration and with the assistance of the National Guard, SEVC completed fit testing of all staff.¹⁴¹

3. Social Distancing Measures at SEVC

SEVC discussed restricting group activities as early as March 6,¹⁴² and DMVA provided directives to cancel communal dining as early as March 14.¹⁴³ SEVC, however, did not cancel all communal activities, including communal dining, until April 6. SEVC's cancellation of all communal activities came 12 days after SEVC began monitoring a cluster of residents with respiratory illness, five days after SEVC suspected that several residents had contracted COVID-19, and three days after SEVC had confirmation of its first positive residents.¹⁴⁴ SEVC leadership acknowledged that they did not take the first concrete steps toward cancelling communal dining until April 1, when SEVC split dining for the second floor of Coates Hall into two seatings to accommodate social distancing and requested that all other floors "spread out in the dining room."¹⁴⁵ CMO Dr. Jackson stated, however, that SEVC represented on COVID-19 conference calls that the facility had stopped communal dining in March.¹⁴⁶ BVH Director Ruscavage also said that he believed that SEVC had stopped communal dining in March,

¹³⁹ E.g., Interview of [REDACTED] (July 8, 2020); Interview of [REDACTED] (June 25, 2020); Interview of [REDACTED] (July 23, 2020).

¹⁴⁰ Interview of [REDACTED] (July 6, 2020).

¹⁴¹ SEVC COVID-19 Timeline – 2020; *see also* Email from [REDACTED] re National Guard Fit Testing (June 5, 2020) [REDACTED].

¹⁴² SEVC COVID-19 Stand-Down Meeting Minutes (Apr. 6, 2020 entry)

([REDACTED] ("All residents are isolated on their units. They will eat on their units, no dining in Tilghman Hall, no activities. Suspended opening of canteens and AHOD participation until further notice.").

¹⁴³ Email from [REDACTED] re COVID-19 Nursing Home Guidance (Mar. 14, 2020)

[REDACTED].

¹⁴⁴ SEVC Timeline Document (Mar. 25, 2020 entry) [REDACTED] ("Spoke with [REDACTED] [REDACTED] notified of 2 West Respiratory illness. Protocol reviewed regarding increase resident Temp & resp assessment from once a shift to every shift. In agreement with increase no new recommendation."); SITREP (Apr. 1, 2020) [REDACTED] ("Several residents on 4CLC with fevers, monitoring very closely. Resident of 3 East transferred to negative pressure room, after consultation with Chester County. . . . Resident had three previous roommates now *all on airborne precautions* isolation per Chester County." (emphasis in original)); SITREP (Apr. 4, 2020) (reporting positive COVID-19 test results).

¹⁴⁵ Interview of R. Blackwood (Aug. 19 & 21, 2020); COVID 19 SEVC Dietary Department Doc [REDACTED].

¹⁴⁶ Interview of D. Jackson (Aug. 19 & 26, 2020).

consistent with the guidance BVH had provided.¹⁴⁷ However, SEVC, in fact, had not stopped communal dining as of that time.

4. *Limited Testing Capacity*

At the beginning of the COVID-19 outbreak at SEVC, testing capacity was extremely limited, and turnaround times for test results could be over a week. SEVC tested its first resident on April 2. Between April 2 and April 5, SEVC administered COVID-19 tests to eight residents. By April 5, however, SEVC was down to 22 remaining swabs for COVID-19 tests and was working on procuring additional swabs through CCHD.¹⁴⁸ Although, in March, SEVC had secured a contract for testing with [REDACTED],¹⁴⁹ as of the first week of April, [REDACTED] lacked the equipment necessary to process COVID-19 tests.¹⁵⁰ CMO Dr. Jackson noted, that, by the time of the outbreak at SEVC, testing was exclusively run through DOH, because there were not enough facilities or supplies for private testing.¹⁵¹ In order to obtain a test through DOH, however, SEVC first had to obtain a PUI (person under investigation) number.¹⁵² DOH and CCHD would issue PUI numbers only if certain criteria were met. In mid-March, those criteria required, at a minimum, that the resident be symptomatic.¹⁵³

On April 6, CCHD informed SEVC of additional restrictions on obtaining a PUI number. As a means to conserve scarce testing capacity, CCHD stated that it would no longer issue PUI numbers for symptomatic residents on a unit with one or more confirmed positive residents.¹⁵⁴ From that point through the end of April, SEVC administered only two more COVID-19 tests.

¹⁴⁷ Interview of A. Ruscavage (Aug. 13, 2020). DAG Weller recalled understanding from Commandant Blackwood that SEVC would “ease” into in-room dining over a two-week period. Interview of E. Weller (Aug. 13, 2020).

¹⁴⁸ Email from R. Blackwood to A. Ruscavage, D. Mullane, and D. Jackson re SITREP update (Apr. 5, 2020) [REDACTED].

¹⁴⁹ SITREP (Mar. 20, 2020) [REDACTED].

¹⁵⁰ Email from [REDACTED] to D. Mullane re COVID-19 testing (Apr. 1, 2020) [REDACTED] (“Once kits get released, [REDACTED] does not have the equipment to do testing.”).

¹⁵¹ Interview of D. Jackson (June 9, 2020).

¹⁵² Email from CCHD Health Operations Center re Updated Health Information: Specimen Collection and COVID-19 Testing Guidance (Mar. 13, 2020) [REDACTED].

¹⁵³ See PA HAN 487 (Mar. 14, 2020), available at <https://www.health.pa.gov/topics/Documents/HAN/2020-PAHAN-487-03-14-ALT%20-%20Interim%20C.pdf> (approving of testing for “symptomatic contacts of a confirmed case, symptomatic residents of a congregate care setting, symptomatic healthcare workers, and hospitalized patients with relevant symptoms and no alternative diagnosis”).

¹⁵⁴ CCHD Communications [REDACTED]; Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

At the end of April, DMVA took several measures to obtain additional testing for SEVC. First, Dr. Jackson sought to procure SEVC a contract to process its tests directly through Quest Diagnostics.¹⁵⁵ Second, on April 24, BVH Director Ruscavage requested assistance from the VA Medical Center (“VAMC”) in Philadelphia to process SEVC’s COVID-19 tests.¹⁵⁶ As a result of DMVA’s efforts, on April 25, the Philadelphia VAMC agreed to accept and process SEVC’s COVID-19 tests beginning April 28.¹⁵⁷ By April 27, DMVA secured SEVC an account with Quest to process further SEVC COVID-19 tests.¹⁵⁸

SEVC and DMVA leadership uniformly stated that the very limited availability of testing in early April severely hampered SEVC’s efforts to contain the virus. CMO Dr. Jackson explained that, without universal testing, it was difficult to control the outbreak.¹⁵⁹ BVH Director Ruscavage noted that the lack of testing was one of the biggest obstacles SEVC faced.¹⁶⁰ DAG Weller noted that the unavailability of testing and the long turn-around times for test results made it extremely difficult to contain the outbreak.¹⁶¹ Commandant Blackwood noted that the only thing he thinks he should have done differently in responding to the outbreak was that he wishes he had “begged” for additional testing.¹⁶²

5. *Resident Isolation and Cohorting Plans at SEVC*

a. *SEVC’s Isolation and Cohorting Plans*

In preparing for a potential COVID-19 outbreak, SEVC considered two primary isolation strategies: the conversion to and use of six negative pressure isolation rooms with the capacity to hold 18 beds (three per room),¹⁶³ and the use of 3 West in Coates Hall, a 32-bed vacant unit.¹⁶⁴

¹⁵⁵ Email from D. Jackson to [REDACTED] re Contract for SEVC for COVID testing (Apr. 23, 2020) [REDACTED].

¹⁵⁶ Email from [REDACTED] to A. Ruscavage re SEVC Information (Apr. 24, 2020) [REDACTED].

¹⁵⁷ Email from [REDACTED] to A. Ruscavage re SEVC Information (Apr. 25, 2020) [REDACTED].

¹⁵⁸ Email from D. Jackson to A. Ruscavage re Quest Diagnostics-New Account: 19475000 (Apr. 27, 2020) [REDACTED].

¹⁵⁹ Interview of D. Jackson (Aug. 19 & 26, 2020).

¹⁶⁰ Interview of A. Ruscavage (June 9, 2020).

¹⁶¹ Interview of E. Weller (Aug. 18, 2020).

¹⁶² Interview of R. Blackwood (Aug. 19 & 21, 2020).

¹⁶³ E.g., Interview of [REDACTED] (June 25, 2020).

¹⁶⁴ E.g., Interview of [REDACTED] (July 28 & Aug. 11, 2020); see Southeastern Veterans’ Center Advisory Council Meeting Minutes (Feb. 19, 2020) [REDACTED] (reporting “the temporary closure of one unit – Coates Hall 3W, with 32 beds”).

On March 24, SEVC began clearing out its negative pressure rooms, which are located on the top three floors of the CLC building with two negative pressure rooms per floor.¹⁶⁵ At the same time SEVC was preparing negative pressure rooms to house COVID-19 positive residents, SEVC also considered using 3 West as an isolation unit. SEVC had closed 3 West in the beginning of February “due to staffing needs in order to keep up with PPD [per patient day] levels,”¹⁶⁶ but as of March 6, SEVC was planning on re-opening 3 West by the end of March.¹⁶⁷ As late as March 24, SEVC was considering using 3 West as an isolation unit for COVID-19 positive residents.¹⁶⁸ By April 6, however, SEVC had abandoned plans for using 3 West as a COVID-19 unit in favor of opening 3 West “for staff who may need to self-isolate.”¹⁶⁹

Ultimately, the vacant floor was not used as an isolation unit or as part of a resident cohorting plan until Blackwood and Mullane were suspended and new leadership was appointed.

b. SEVC’s Initial Execution of Its Isolation and Cohorting Plans

On April 1, “after consultation with Chester County [Health Department],” SEVC moved its first resident to a negative pressure room after the resident had developed signs and symptoms of COVID-19 and was awaiting results of a COVID-19 test.¹⁷⁰ As of April 5, SEVC had only eight beds remaining in its negative pressure rooms. At that time, SEVC was closely monitoring all residents on both 4CLC and 3 East Coates Hall.¹⁷¹

c. Chester County Health Department’s Epi-linking Guidance

On April 6, SEVC received guidance from CCHD that “[w]hen 2 resident tests [sic] positive on a Unit refrain from additional COVID-19 Testing” and “[s]ymptomatic residents” on that unit “are considered Probable/Epi-linked” – or epidemiologically linked – “and should be

¹⁶⁵ SEVC COVID-19 Stand-Down Meeting Minutes (Mar. 24, 2020 entry)

[REDACTED] (“[C]learing out negative pressure (bariatric) rooms in CLC.”).

¹⁶⁶ SEVC Quality Improvement Monthly Meeting (Feb. 12, 2020) (reporting that the facility had “completed moves off” 3 West and that 3 West closed “at beginning of the month”)

[REDACTED]; SEVC Resident Council Meeting Minutes (Mar. 6, 2020) (reporting that SEVC had closed 3 West “due to staffing needs in order to keep up with PPD levels”)

[REDACTED].
¹⁶⁷ SEVC Resident Council Meeting Minutes (Mar. 6, 2020) (“Re-opening of the 3West Unit is anticipated for the end of the month.”) [REDACTED].

¹⁶⁸ SEVC COVID-19 Stand-Down Meeting Minutes (Mar. 24, 2020 entry)

[REDACTED] (“Considering 3W CH for COVID-19 resident treatment area[.]”).

¹⁶⁹ SEVC COVID-19 Stand-Down Meeting Minutes (Apr. 6, 2020 entry)

[REDACTED] (“3W was opened for staff who may need to self-isolate, particularly if they have an older loved one at home, or other individuals they live with who may have underlying conditions.”).

¹⁷⁰ SITREP (Apr. 1, 2020) [REDACTED].

¹⁷¹ SITREP (Apr. 5, 2020) [REDACTED].

treated based on symptoms.”¹⁷² The next day, according to SEVC’s communication log, CCHD advised SEVC that it could use the same PPE for all residents on 3 East.¹⁷³ CCHD, however, denies providing that guidance to SEVC.¹⁷⁴

On April 21, according to SEVC’s log of its communications between its ICNs and CCHD, SEVC had a lengthy conversation with CCHD “regarding consolidating residents linked or positive to one unit.” According to the same log, CCHD “concluded that residents would likely have been already exposed, and moving them around may simply cause more exposure to others.” CCHD therefore “[r]ecommended” that SEVC “stay the course,” leave residents on the unit, and monitor residents for signs and symptoms of COVID-19.¹⁷⁵ CCHD likewise denies providing that guidance to SEVC.¹⁷⁶

d. SEVC’s Subsequent Isolation Policy

As of April 7, SEVC had 21 residents with signs and symptoms of COVID-19, eight confirmed COVID-19 positive residents, and one resident awaiting test results. While SEVC had only five residents in negative pressure rooms, 12 of the 28 residents on 3 East were exhibiting signs and symptoms of COVID-19 and three additional residents on 3 East had tested positive for COVID-19. SEVC, noting the April 6 guidance from CCHD described above, reported to DMVA that 3 East was a “presumptive positive” unit.¹⁷⁷ SEVC moved immediately to a policy of not transferring any confirmed COVID-19 positive residents from 3 East to negative pressure rooms. Thus, as outlined in detail in Appendix III, SEVC moved none of the three 3 East residents who tested positive on April 7 to negative pressure rooms. SEVC continued to follow this policy of not moving COVID-19 positive, or epi-linked/presumed positive residents, to negative pressure rooms after there had been two confirmed positive COVID-19 cases on 2 East and 4CLC.

¹⁷² SEVC Timeline (Apr. 6, 2020 entry) [REDACTED]. [REDACTED] at CCHD, denied that he instructed SEVC to “refrain” from testing, but confirmed that – because of the shortage of available tests – he advised SEVC that, where there already were two or more positive cases, SEVC did not need to test additional symptomatic residents, and, in fact, CCHD would not issue a PUI for those symptomatic residents. He explained that, at the time, a PUI number was required in order to obtain a test through the Pennsylvania Bureau of Laboratories. Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

¹⁷³ CCHD Communications [REDACTED]. Although the April 7 communication log entry refers to “2 East Unit,” other documents make clear that this was in reference to 3 East. See SITREP (Apr. 7, 2020) [REDACTED] (“[T]his unit whole unit [3 East] is now presumptive positive and has dedicated staff who will don PPE and do not have to change this for each resident except for glove usage.”).

¹⁷⁴ Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

¹⁷⁵ CCHD Communications [REDACTED].

¹⁷⁶ Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

¹⁷⁷ SITREP (Apr. 7, 2020) [REDACTED].

[REDACTED] explained that once SEVC declared 3 East a COVID-19 unit, SEVC moved away from its plan to move COVID-19 residents into negative pressure rooms.¹⁷⁸ [REDACTED] confirmed that SEVC stopped moving COVID-19 positive residents to negative pressure rooms after consulting with CCHD. [REDACTED] explained that SEVC utilized negative pressure rooms for the first “week or two” of the COVID-19 outbreak, but that the numbers of suspected COVID-19 positive residents started to outpace the negative pressure room beds SEVC had available.¹⁷⁹ Similarly, DON Mullane explained that SEVC, per CCHD guidance, stopped using the negative pressure rooms for residents on units where more than two residents had already tested positive for COVID-19.¹⁸⁰

Notwithstanding SEVC’s decision to stop moving COVID-19 residents off of 3 East, SEVC subsequently continued moving COVID-19 positive residents off other units upon diagnosis. SEVC, however, did not move those residents to negative pressure rooms, and instead began emptying those rooms. On April 17, SEVC moved the last two residents out of its negative pressure rooms. On that same day, the first two residents on 4 West tested positive for COVID-19.¹⁸¹ Instead of transferring these newly diagnosed COVID-19 residents to the now-vacant negative pressure rooms, SEVC transferred these residents to rooms on 4CLC, which SEVC had designated an isolation unit.¹⁸²

e. SEVC Begins Cohorting

With the increased availability of testing in late April, SEVC was able to begin surveillance testing – i.e., universal testing – with the testing of residents on 4CLC on April 24.¹⁸³ By May 4, SEVC had completed its surveillance testing of all residents.¹⁸⁴ By May 5, SEVC was planning on making “[r]oom changes based on swab results.”¹⁸⁵

By May 8, SEVC had implemented a cohorting plan based on test results that contained three categories of units: positive, negative and comingled. Those “comingled units” (3 East and 4CLC) housed COVID-19 positive and COVID-19 negative residents on the same floor.¹⁸⁶ This was the cohorting plan that was in place until Blackwood and Mullane were suspended on May 26.

¹⁷⁸ Interview of [REDACTED] (June 25, 2020).

¹⁷⁹ Interview of [REDACTED] (Aug. 12, 2020).

¹⁸⁰ Interview of D. Mullane (Aug. 20, 2020).

¹⁸¹ SITREP (Apr. 17, 2020) [REDACTED]; SEVC SVH COVID-19 Tracking All Units [REDACTED].

¹⁸² SITREP (Apr. 17, 2020) [REDACTED].

¹⁸³ SITREP (Apr. 25, 2020) [REDACTED].

¹⁸⁴ SITREP (May 4, 2020) [REDACTED].

¹⁸⁵ SITREP (May 5, 2020) [REDACTED].

¹⁸⁶ Email D. Mullane to R. Blackwood re SEVC Information Requested (May 9, 2020)

6. Lack of Contact Tracing Protocol

SEVC did not develop or implement a contact tracing policy or procedure at any time before June. On March 31, SEVC learned of its first staff member – [REDACTED] – testing positive for COVID-19.¹⁸⁷ SEVC observed a resident exhibiting signs and symptoms of COVID-19 on 3 East, which SEVC “identified as a location where the [REDACTED] with positive results had worked.”¹⁸⁸ However, the facility, did not engage in any formal contact tracing to identify the scope of potential contacts with the first positive staff member within the facility at that time. As reflected in SEVC’s stand-down meeting minutes, SEVC did not conduct formal contact tracing, purportedly “per state instruction not to try to trace cases, and to maintain employee’s privacy.”¹⁸⁹

Our investigation, however, did not identify any state instruction to healthcare facilities not to trace cases. Rather, as of March 31, both CDC and DOH guidance advised that contact tracing was the “recommended strategy for identifying and reducing the risk of transmission of COVID-19” within healthcare facilities.¹⁹⁰ It was not until April 15 – over two weeks after SEVC claimed to have received state instruction not to trace cases – that the CDC explained that the extent of community transmission, “and the role that asymptomatic and pre-symptomatic individuals with COVID-19 play in transmission,” limited the likely benefits of “formal contact tracing.”¹⁹¹ The next day, DOH advised healthcare facilities that they could “consider foregoing contact tracing” in communities where community transmission had intensified.¹⁹² DOH, however, did not instruct facilities to stop contact tracing.

Nevertheless, several SEVC staff members claimed that SEVC did not conduct contact tracing because of “health department” guidance. For instance, [REDACTED]

¹⁸⁷ SITREP (Mar. 31, 2020) [REDACTED].

¹⁸⁸ Email from A. Ruscavage to E. Weller, D. Jackson, and [REDACTED] re Update (Apr. 1, 2020) [REDACTED].

¹⁸⁹ SEVC COVID-19 Stand-Down Meeting Minutes (Mar. 31, 2020 entry) [REDACTED].

¹⁹⁰ Ctrs. for Disease Control & Prevention, Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (updated Mar. 7, 2020); PA HAN 484 (Mar. 9, 2020) (recognizing that “a sustainable plan for healthcare personnel caring for patients with COVID-19” at a facility in an area with “sustained community transmission . . . may include risk assessment”).

¹⁹¹ Ctrs. for Disease Control & Prevention, Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (Apr. 15, 2020), *available at* <https://web.archive.org/web/20200430210344/https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>.

¹⁹² PA HAN 497 (Apr. 16, 2020), *available at* https://www.health.pa.gov/topics/Documents/HAN/2020-PAHAN-497-04-16-UPD-UPDATE_Univ.pdf.

explained that DON Mullane instructed that contact tracing was “not recommended” by the time the first SEVC staff member tested positive for COVID-19 given the extent of community spread outside the facility.¹⁹³ Mullane explained that SEVC did not conduct contact tracing, because they were not aware of any guidance requiring contact tracing.¹⁹⁴ [REDACTED] stated that SEVC did not conduct contact tracing because Commandant Blackwood advised that the “health department” did not recommend contact tracing at the time SEVC had its first positive cases, because COVID-19 was so widespread.¹⁹⁵

7. *COVID-19 Spread Through SEVC*

The [REDACTED] who tested positive on March 31 had been sent home after failing screening on March 24.¹⁹⁶ [REDACTED] had worked on 3 East.¹⁹⁷ The spread of COVID-19 among residents at SEVC ultimately started on 3 East, where SEVC’s first COVID-19 positive resident tested positive on April 3. Several additional residents on that unit tested positive during the first week of April. Thereafter, also in the first week of April, both 4CLC and 2 East had residents who tested positive for COVID-19. Later in April, positive test results revealed that COVID-19 had continued to spread through 3 East, 4CLC, and 2 East, and appeared for the first time on 4 West, 2 West, and 4 East. A detailed description of the spread of COVID-19 by patient and unit is included in Appendix III.

8. *National Guard and Veterans Administration Assistance at SEVC*

After the COVID-19 outbreak started at SEVC, staffing became an issue of increasing concern to SEVC. Any staff members with signs or symptoms of COVID-19 were required to stay home and get tested. Given the time it took to obtain test results early in the COVID-19 outbreak, this resulted in the number of staff members out awaiting test results “stacking up.” Thus, in mid-to-late April, DMVA requested that the National Guard and the VA provide support to SEVC’s staff.¹⁹⁸

a. *The National Guard*

On April 15, at the request of Adjutant General Carrelli, 30 members of Pennsylvania National Guard, Task Force South (“PTF South”) arrived at SEVC.¹⁹⁹ The first PTF South

¹⁹³ Interview of [REDACTED] (June 25, 2020).

¹⁹⁴ Interview of D. Mullane (Aug. 20, 2020).

¹⁹⁵ Interview of [REDACTED] (June 11, 2020).

¹⁹⁶ SITREP (Mar. 31, 2020) [REDACTED].

¹⁹⁷ Email from A. Ruscavage to E. Weller, D. Jackson, and [REDACTED] re Update (Apr. 2, 2020) [REDACTED] (reporting that “Coates Hall 3 East” had been “identified as a location where the [REDACTED] with positive results had worked”).

¹⁹⁸ Interview of A. Carrelli (Aug. 14 & 17, 2020).

¹⁹⁹ SITREP (Apr. 17, 2020) [REDACTED] (reporting that “National Guard arrived Wednesday [April 15] at 1pm”); Interview of [REDACTED] (July 23, 2020). Interview of A. Carrelli (Aug. 14 & 17, 2020).

taskforce deployed to SEVC – [REDACTED] – consisted of 18 medics to handle responsibilities similar to CNAs and 12 general purpose forces to support SEVC’s dietary, housekeeping, and activities departments.²⁰⁰

Initially, DON Mullane and [REDACTED] were identified as key points of contacts between the National Guard and SEVC.²⁰¹ [REDACTED], [REDACTED], stated that Mullane initially was “very receptive” to receiving the National Guard’s assistance.²⁰² Soon after [REDACTED]’s mission at SEVC began, however, Mullane directed [REDACTED] that [REDACTED] would be the National Guard’s point of contact while at SEVC.²⁰³ From that point on, despite the National Guard’s repeated requests to meet with Blackwood and Mullane, National Guard leadership was denied access to SEVC’s leadership.²⁰⁴

b. The VA Nurses

Starting in late April, 20 nurses with the VA began working at SEVC.²⁰⁵ Although they were originally scheduled to stay for only two weeks, they ultimately stayed through the week of July 13.²⁰⁶ In total, approximately 40 VA RNs and LPNs worked at SEVC.²⁰⁷

9. Treatment of SEVC Residents with Hydroxychloroquine

On March 28, the FDA issued an EUA authorizing the emergency use of both chloroquine and hydroxychloroquine (brand name, Plaquenil) from the Strategic National Stockpile (“SNS”) to treat COVID-19.²⁰⁸ The EUA was accompanied by a “Fact Sheet” that

²⁰⁰ [REDACTED] SEVC Timeline Notes; [REDACTED] CONOP: Southeastern Veterans Center (Apr. 14, 2020); SEVC COVID-19 Stand-Down Meeting Minutes (Apr. 14, 2020 entry)

[REDACTED].
²⁰¹ [REDACTED] CONOP: Southeastern Veterans Center (Apr. 14, 2020).

²⁰² Interview of [REDACTED] (July 28, 2020).

²⁰³ Interview of [REDACTED] (July 28, 2020); Email from D. Mullane to [REDACTED] re MOA: SEVC (Apr. 17, 2020) (“If you have any questions or concerns please don’t hesitate to contact [REDACTED”]).

²⁰⁴Email from [REDACTED] to A. Carrelli re FW: Talking points SEVC (May 3, 2020) [REDACTED] (“Requests have been made to meet with the Commandant, which were reportedly denied.”). [REDACTED] recalled Blackwood and Mullane refusing to meet with National Guard leadership. Interview of [REDACTED] (July 9, 2020). Blackwood and Mullane, however, did not recall refusing to meet. Interview of D. Mullane (Aug. 20, 2020); Interview of R. Blackwood (Aug. 19 & 21, 2020).

²⁰⁵ Interview of [REDACTED] (July 1, 2020); Email from [REDACTED] re Respiratory illness update (July 7, 2020) [REDACTED] (“VA Nurses – they are with us through next week.”); SITREP (Apr. 28, 2020) [REDACTED].

²⁰⁶ Interview of [REDACTED] (July 1, 2020); SITREP (Apr. 28, 2020) [REDACTED].

²⁰⁷ Interview of [REDACTED] (July 1, 2020).

²⁰⁸ Food & Drug Admin, Hydroxychloroquine Emergency Use Authorization, at 1-4 (Mar. 28, 2020), available at <https://www.fda.gov/media/136534/download>.

provided guidance regarding the appropriate use of hydroxychloroquine, including identifying contraindications, warnings regarding potential cardiac effects, and recommended monitoring procedures.²⁰⁹

On April 2, CMO Dr. Jackson held a call with SVH medical providers. The SEVC [REDACTED], however, did not participate.²¹⁰ According to minutes of the call, Dr. Jackson explained that he was “NEITHER mandating NOR recommending any particular course of treatment,” but instead was providing information to enable the medical providers to exercise their medical judgment in individual cases.²¹¹ Dr. Jackson explained that, while DMVA was not making specific recommendations regarding the use of hydroxychloroquine, he did provide SVH providers information on which residents would be good candidates for treatment with hydroxychloroquine and which residents would not be good candidates.²¹² There also was discussion of whether it was appropriate to treat residents with hydroxychloroquine in a nursing home setting, as opposed to in a hospital setting.²¹³ Specifically, the [REDACTED] expressed that he was not comfortable administering hydroxychloroquine outside of a hospital setting.²¹⁴

On April 6, Dr. Jackson held a meeting with the SVH Chief Pharmacists during which they discussed an American Medical Directors Association report of “strong anecdotal evidence of . . . the efficacy” of a combined therapy of hydroxychloroquine and azithromycin.²¹⁵ Although concerns had been raised about that combined therapy,²¹⁶ Dr. Jackson’s view based on his research was that, as long as a resident did not have a history of heart arrhythmias, the risk of sudden cardiac arrest from the combined therapy would be low.²¹⁷

Dr. Jackson also provided guidance regarding the need for electrocardiogram (“EKG”) monitoring of residents receiving hydroxychloroquine. Specifically, he noted, that even “for residents with no known arrhythmias,” the “consensus” was that an EKG should be performed

²⁰⁹ Food & Drug Admin, Fact Sheet for Healthcare Providers: Emergency Use Authorization (EUA) of Hydroxychloroquine Sulfate Supplied from the Strategic National Stockpile for Treatment of COVID-19 in Certain Hospitalized Patients (“FDA EUA Fact Sheet”), at 2 (Mar. 28, 2020), available at <https://web.archive.org/web/20200402222957/https://www.fda.gov/media/136537/download>.

²¹⁰ See Interview of D. Jackson (Aug. 19 & 26, 2020) (reporting that Dr. Jackson did not speak to [REDACTED] from SEVC until mid-June).

²¹¹ DMVA Meeting Minutes Veterans Homes Providers – COVID Practices (Apr. 2, 2020) [REDACTED].

²¹² Interview of D. Jackson (Aug. 19 & 26, 2020).

²¹³ DMVA Meeting Minutes Veterans Homes Providers – COVID Practices (Apr. 2, 2020) [REDACTED].

²¹⁴ Interview of D. Jackson (Aug. 19 & 26, 2020).

²¹⁵ DMVA Meeting Minutes: COVID Pharmacy Follow Up (Apr. 6, 2020) [REDACTED].

²¹⁶ Email from [REDACTED] to D. Jackson re Treatment with Plaquenil for COVID 19 (Apr. 6, 2020) [REDACTED].

²¹⁷ Interview of D. Jackson (Aug. 19 & 26, 2020).

before initiating hydroxychloroquine “ONLY if EKG machine is available in house.” Otherwise, SVHs should order EKGs to be performed “the next day” after initiating hydroxychloroquine.²¹⁸

Between April 6 and 21, SEVC [REDACTED] prescribed hydroxychloroquine to 38 residents who were either positive, presumed positive, or awaiting test results for COVID-19.²¹⁹ This total represents the vast majority of positive or suspected positive residents at SEVC during that time period, reflecting no effort to screen residents who were poor candidates for the treatment. Contrary to Dr. Jackson’s guidance, no EKG monitoring was done for residents administered the medication. Furthermore, [REDACTED] typically prescribed the medication along with azithromycin, despite cautions that the combined therapy “increased risk of arrhythmia / cardiogenic complications.”²²⁰ Indeed, [REDACTED] colloquially referred to the combination therapy of hydroxychloroquine, azithromycin, flonastor, albuterol MDI, combivent respimate, and robafen as the “COVID-19 Cocktail.”²²¹

On April 21, in consultation with Dr. Jackson, and after a VA study demonstrating limited benefit from the use of hydroxychloroquine, SEVC stopped prescribing the medication.²²²

10. Early May Inspections of SEVC

In response to the negative press and inquiries by members of the Pennsylvania state legislature regarding SEVC’s COVID-19 response, Adjutant General Carrelli requested that DOH send an evaluation team to review compliance and COVID-19 infection control protocols at SEVC. Adjutant General Carrelli requested an evaluation of issues raised by the ongoing “allegations,” including but not limited to: employee screening/sick employee management, infection control/quarantine protocols, PPE usage, COVID-19 management testing/treatment, reporting requirements Positive/EPI/deaths, communications/coordination with the coroner,

²¹⁸ Providers COVID MINUTES 09APR20 (Apr. 9, 2020) [REDACTED].

²¹⁹ See Resident Surveillance residents [REDACTED]. A May 21 analysis done by DAG Weller identified 33 residents who were administered hydroxychloroquine. See Request for Information Regarding COVID-19 Interventions and Response at the Southeastern Veterans’ Center (SEVC) (May 21, 2020) [REDACTED] (the “Hydroxychloroquine Memo”). A review of medical charts, however, revealed 38 residents to whom hydroxychloroquine was administered for COVID-19 related reasons. There was at least one additional resident for whom the medication was prescribed but passed away before it was administered. Resident 6 File, at 175-76 [REDACTED].

²²⁰ Providers COVID MINUTES 09APR20 (Apr. 9, 2020) [REDACTED]; COVID Pharmacy Follow Up Minutes (Apr. 20, 2020) [REDACTED].

²²¹ See, e.g., Resident 31 File, at 454 [REDACTED].

²²² Email from D. Mullane to [REDACTED] and others re Plaquenil (Apr. 22, 2020) [REDACTED].

communications with families/adherence to HIPAA, and adherence to DNR/DNI restrictions and staff management.²²³

On May 1, DOH conducted a one-day on-site inspection of SEVC. In a letter dated May 6, DOH concluded that “[a]s a result of this survey, no evidence of deficient practice was identified.”²²⁴ Additionally, on May 4, CCHD completed a desk review of SEVC’s practices and found no deficient areas of concern.²²⁵

Notwithstanding DOH’s finding of no deficiencies, BVH Director Ruscavage and Commandant Blackwood requested that the VA Infection Control Team conduct an additional inspection to assess SEVC’s infection control practices.²²⁶ As a result, on May 5, two VA nurses conducted an inspection of SEVC. Their written comments were prepared the same day and shared with SEVC and DMVA leadership up through Adjutant General Carrelli. The VA nurses found, among other things, proper cleaning of high-touch areas, patient care, medicine delivery, food preparation, and PPE usage.

Among the VA nurses’ recommendations were increased social distancing among residents on negative units, and changes to seating arrangements for residents continuing to eat in common areas. They noted that they talked with SEVC “about the possibility of moving patients to [3 West] – move the non-positive patients over there to minimize further exposure.” SEVC informed the VA nurses, however, that “they [were] following the Chester County Department of Health in cohorting patients that are positive or exposed / presumed positive.”²²⁷ On May 9, DOH conducted a second survey at SEVC in response to a complaint from an unspecified person related to COVID-19 and the proper use of PPE. Although there is no written report from this inspection, in an oral report to Adjutant General Carrelli, DOH stated that the complaint that prompted the second survey was unsubstantiated.²²⁸

11. *SEVC Commandant and Director of Nursing Are Suspended and an Interim Leadership Team Arrives*

On May 26, Adjutant General Carrelli, ██████████ placed both Commandant Blackwood and DON Mullane on administrative leave, pending the outcome of this investigation. ██████████ on May 28, Adjutant General Carrelli recused BVH Director Ruscavage from overseeing SEVC.²²⁹ To replace Blackwood and Mullane,

²²³ See Email from ██████████ to A. Carrelli (Apr. 30, 2020) ██████████.

²²⁴ Letter from ██████████ to R. Blackwood (May 6, 2020) ██████████.

²²⁵ SEVC COVID-19 Stand-down Meeting Minutes (May 5, 2020 entry)

██████████; Interview of ██████████ (Aug. 13 & Sept. 11, 2020).

²²⁶ Email from ██████████ to A. Ruscavage (Apr. 30, 2020) ██████████.

²²⁷ Email from ██████████ to ██████████, ██████████, ██████████ re PA State VA Home (May 5, 2020) ██████████.

²²⁸ Email from A. Carrelli to ██████████ (May 9, 2020) ██████████.

²²⁹ Interview of A. Ruscavage (Aug. 13, 2020).

DMVA brought in [REDACTED] and [REDACTED] to serve as SEVC's Acting Commandant and DON respectively.

a. The New Team

[REDACTED] is a Registered Nurse and a licensed Nursing Home Administrator.²³⁰ She has worked in long-term care for the past 20 years and has served as [REDACTED] for the past 10 years. [REDACTED] had no COVID-19 cases under [REDACTED] leadership and had only one case of influenza during the 2019-2020 influenza season. She began serving as Acting Commandant for SEVC on May 28.²³¹

[REDACTED] is a Registered Nurse and has worked in long-term care for her entire career. [REDACTED] became a [REDACTED] for BVH in November of 2019. Before working at BVH, [REDACTED] had worked as a Nurse Supervisor, an ADON, and a DON at a long-term care facility. [REDACTED], arrived at SEVC on May 28.²³²

b. The CMS/DOH Inspection and the Immediate Jeopardy Designation

On June 1, shortly after the interim leadership team started, DOH and CMS arrived at SEVC to conduct an inspection of the facility.²³³ DOH and CMS conducted the inspection in response to complaints related to resident care and services, facility staffing, COVID-19 infection control and training, and issues identified in newspaper articles.

On June 1, the CMS and DOH surveyors identified several concerns, including that SEVC was not conducting screening properly and SEVC staff was working on COVID-19 positive units without being fit tested. Given the recent change in leadership, some of the issues that were raised were in process of being remediated. Similarly, [REDACTED] attempted to remediate identified issues in real time by requesting a fit-test kit as soon as possible.²³⁴

Ultimately, SEVC was placed in Immediate Jeopardy ("IJ") effective on June 2.²³⁵ The basis of the IJ finding was that SEVC "failed to follow CDC guidelines for COVID 19 case

²³⁰ Email re Southeastern Veterans' Center family update (May 31, 2020) [REDACTED]

²³¹ Interview of [REDACTED] (Aug. 6, 2020).

²³² Interview of [REDACTED] (July 20, 2020).

²³³ Email from [REDACTED] to D. Jackson and [REDACTED] re CMS & DOH here (June 1, 2020)

²³⁴ Email from [REDACTED] to D. Jackson re CMS & DOH here (June 1, 2020)

²³⁵ Email from [REDACTED] to D. Jackson re CMS & DOH here (June 2, 2020)

[REDACTED]. An "immediate jeopardy" designation "represents a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death." Ctrs. for Medicare & Medicaid Servs., State Operations Manual Appx. Q Core Guidelines for Determining Immediate Jeopardy (Mar. 6,

investigation and contact tracing after a known employee and resident were tested as confirmed positive,” that “this failure potentially infected additional residents and other staff members,” and that the failure to implement a “tracing plan” resulted “in 66 deaths and 52 current positive COVID 19 cases.”²³⁶

In response to the IJ Notification, Acting Commandant [REDACTED] compiled and submitted a proposed Corrective Action Plan, including a contact tracing policy, to the DOH and CMS surveyors on June 2.²³⁷ Following [REDACTED] submission of a Corrective Action Plan, the surveyors remained at SEVC until June 5. Before leaving SEVC on June 5, the surveyors also identified additional areas of concern. Specifically, in addition to SEVC’s lack of contact tracing, the surveyors identified “improper PPE use, improper hand hygiene, [and] incorrect swab techniques” as “widespread” infection control issues.²³⁸

The surveyors returned to SEVC on June 7 and lifted SEVC’s IJ status subject to SEVC’s satisfactory correction of the infection control deficiencies the surveyors had identified by June 24.²³⁹ As of August 18, DOH found that SEVC “is presumed to be in substantial compliance” with applicable regulations.²⁴⁰

F. Comparative COVID-19 Experiences at the SVHs

By April 2, both SEVC and SWVC had reported their first cases of COVID-19 – each home had one staff member test positive for COVID-19.²⁴¹ By June 1, SEVC and DVVH had the highest number of COVID-19 cases among their residents and staff. DVVH had 31 residents and nine staff test positive for COVID-19. SEVC had 95 residents confirmed or presumed COVID-19 positive and 42 staff confirmed COVID-19 positive.²⁴² Twelve DVVH residents passed away from COVID-19. Forty-two SEVC residents passed away who were either confirmed or presumed COVID-19 positive.²⁴³ By contrast, GJMVC, HVH, PSSH, and SWVC had no COVID-19 cases among their residents. Neither HVH nor PSSH had any staff test positive for COVID-19, and GJMVC and SWVC each had only two staff members test positive

2019), available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf.

²³⁶ CMS IJ Template (June 2, 2020) [REDACTED]. The 66 deaths appears to be the total number of deaths at the facility. *See id.* (“There have been 66 deaths since April 2020, at the facility.”).

²³⁷ Email from [REDACTED] to D. Jackson re CMS & DOH here (June 2, 2020)

[REDACTED].
²³⁸ See Email from [REDACTED] to D. Jackson re CMS & DOH here (June 5, 2020)

[REDACTED].
²³⁹ Email from [REDACTED] to D. Jackson re CMS & DOH here (June 7, 2020)

[REDACTED].
²⁴⁰ Ltr. from [REDACTED] to [REDACTED] (Sept. 14, 2020).

²⁴¹ SITREP (Apr. 1, 2020)

²⁴² SITREP (June 1, 2020)

²⁴³ SITREP (June 15, 2020)

for COVID-19.²⁴⁴ Two of the other SVHs – GJMVC and DVVH – are located in counties that, at the time, had significantly higher cases per 100,000 residents than Chester County.²⁴⁵

IV. Legal and Regulatory Public Health Guidance

A. CMS Infection Prevention Requirements

CMS regulations require that all nursing homes establish an “infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, and to help prevent the development and transmission of communicable diseases and infections.”²⁴⁶ Nursing home “infection prevention and control programs” are required to include, among other elements: (1) a system for identifying and reporting infections within the facility; and (2) written policies and procedures regarding “[s]tandard and transmission-based precautions to be followed to prevent spread of infections” and specifying “[w]hen and how isolation should be used for . . . resident[s].”²⁴⁷

CMS regulations require that nursing homes designate one or more Infection Preventionists, who are responsible for administering the facilities’ infection prevention and control programs.²⁴⁸ Infection Preventionists must “[h]ave primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field,” must “[b]e qualified by education, training, experience or certification,” and must “[h]ave completed specialized training in infection prevention and control.”²⁴⁹ CMS regulations require that nursing home Infection Preventionists work “at least part-time.”²⁵⁰

B. Communal Dining and Group Activities

On March 13, CMS announced new guidance instructing all nursing home facilities nationwide to “[c]ancel communal dining and all group activities.”²⁵¹ On March 18, DOH issued guidance in response to “questions from nursing care facilities . . . regarding best practices in nursing homes” for responding to COVID-19. DOH advised nursing home facilities that it was “supporting guidance on critical measures issued by CMS for all nursing facilities,” and, with

²⁴⁴ SITREP (June 1, 2020) [REDACTED].

²⁴⁵ Pa. Dep’t of Health, COVID-19 Data for Pennsylvania, <https://www.health.pa.gov/topics/disease/coronavirus/Pages/Cases.aspx> (last visited Sept. 26, 2020).

²⁴⁶ 42 C.F.R. § 483.80.

²⁴⁷ *Id.* § 483.80(a).

²⁴⁸ *Id.* § 483.80(b).

²⁴⁹ *Id.*

²⁵⁰ *Id.* § 483.80(b)(3).

²⁵¹ Memorandum from Director, Quality, Safety & Oversight Group, Ctrs. for Medicare & Medicaid Servs. re Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (*REVISED*) (Mar. 13, 2020), available at <https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf>.

reference to that guidance, instructed nursing home facilities to “[p]rovide in-room meal service for those that are assessed to be capable feeding themselves without supervision or assistance.” DOH instructed nursing facilities to feed residents who were deemed “high-risk” for choking and “at-risk for aspiration” in their rooms and, if not possible to feed those residents in their rooms, to feed those residents “in a common area . . . with as few residents in the common area as feasible.”

In the event some form of communal dining was necessary, the guidance laid out social distancing measures to be taken, including staggering arrival times, offering multiple meal services, distancing tables, and distancing residents at tables. DOH noted that “communal activities” generally should be cancelled, “unless doing so is necessary to maintain the health and welfare of the residents.” However, the DOH specifically instructed that “facilities should cancel all group activities and communal dining” where there was “evidence of community spread of COVID-19 *within* your county or adjacent counties.”²⁵²

By March 21, the CDC issued its own guidance specific to long-term care facilities and nursing homes. This guidance explained that “[g]iven their congregate nature and residents served . . . , nursing home populations are at the highest risk of being affected by COVID-19.” The CDC therefore identified several measures for nursing facilities to implement, including “[c]ancel[ling] communal dining and all group activities, such as internal and external activities.”²⁵³

C. Resident Isolation and Cohorting

Guidance regarding resident isolation and cohorting procedures for COVID-19 in healthcare settings, including nursing home facilities, evolved rapidly over time. The CDC’s initial guidance instructed that healthcare facilities place individuals “with known or suspected COVID-19 (i.e., PUI [person under investigation]) in an [Airborne Infection Isolation Room],” defined as a “single patient room[] at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour.” In fact, the CDC initially recommended facilities with no available negative pressure rooms transfer individuals with known or suspected COVID-19 to facilities with negative pressure rooms available.²⁵⁴ By March 10, however, the CDC had revised its guidance. The CDC’s updated guidance advised healthcare facilities to reserve negative pressure rooms “for patients who will be undergoing aerosol-generating procedures”

²⁵² Pa. Dep’t of Health, Interim Guidance for Nursing Facilities During COVID-19 (Mar. 18, 2020) [REDACTED] (emphasis in original).

²⁵³ Ctrs. for Disease Control & Prevention, Preparing for COVID-19: Long-Term Care Facilities and Nursing Homes (last rev’d Mar. 21, 2020) [REDACTED].

²⁵⁴ Ctrs. for Disease Control & Prevention, Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings (updated Feb. 21, 2020), *available at* <https://web.archive.org/web/20200310002117/https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>.

and to place patients “with known or suspected COVID-19 in a single-person room with the door closed” and a “dedicated bathroom.” In addition, the CDC’s updated guidance instructed healthcare facilities to “consider designating entire units within the facility, with dedicated HCP [healthcare professionals], to care for known or suspected COVID-19 patients.”²⁵⁵

On March 14, DOH adopted the CDC’s March 10 guidance, making clear that healthcare facilities were to reserve negative pressure rooms “for patients who will be undergoing aerosol-generating procedures” – e.g., “sputum induction, open suctioning of airways” – and to place patients “with known or suspected COVID-19 in a single-person room with the door closed” and a “dedicated bathroom.” Like the CDC, DOH instructed healthcare facilities to “consider designating entire units within the facility, with dedicated [healthcare professionals], to care for known or suspected COVID-19 patients.”²⁵⁶

By March 21, CDC had issued guidance specific to long-term care facilities and nursing homes. This guidance instructed facilities to “[a]ctively monitor all residents . . . at least daily for fever and respiratory symptoms” and to “implement recommended [Infection Prevention and Control] practices” for any resident that is “positive for fever or symptoms,” including “Standard, Contact, and Droplet Precautions.”²⁵⁷ “Precautions” are a set of “[e]ssential steps to prevent the spread of infections.”²⁵⁸ Precautions have two levels: (1) Standard Precautions for all patient care and (2) transmission-based precautions, which are precautions “for patients with known or suspected infections.”²⁵⁹ There are three types of transmission-based precautions: (1) contact precautions, used “for patients with known or suspected infections that represent an increased risk for contact transmission”; (2) droplet precautions, used “for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking”; and (3) airborne precautions, used for “patients known or suspected to be infected with pathogens transmitted by the airborne route (e.g., tuberculosis, measles, chickenpox, disseminated herpes zoster).” Droplet precautions include – at a basic level – source control (i.e., putting a mask on the patient with the known or suspected infection), placing the patient with the known or suspected infection in a single-person room, staff use of PPE (e.g., donning a mask upon entry into the patient’s room), and limiting the

²⁵⁵ Ctrs. for Disease Control & Prevention, Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings (updated Mar. 10, 2020), *available at*

<https://web.archive.org/web/20200313224827/https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html>.

²⁵⁶ PAHAN 496 (Mar. 11, 2020), <https://www.health.pa.gov/topics/Documents/HAN/2020-PAHAN-486-03-11-ALT%20-%20Infect%20Pr.pdf>.

²⁵⁷ Ctrs. for Disease Control & Prevention, Preparing for COVID-19: Long-Term Care Facilities, Nursing Homes (last rev’d Mar. 21, 2020) [REDACTED]

²⁵⁸ Ctrs. for Disease Control & Prevention, Infection Control (rev’d Apr. 29, 2020), <https://www.cdc.gov/infectioncontrol/index.html>.

²⁵⁹ Ctrs. for Disease Control & Prevention, Infection Control Basics (rev’d Jan. 5, 2016), <https://www.cdc.gov/infectioncontrol/basics/index.html>.

transport and movement of patients with the known or suspected infection outside of their room “to medically-necessary purposes.”²⁶⁰

The CDC guidance stated that “[r]esidents with known or suspected COVID-19 do not need to be placed into an [AIIR]” and that residents with known or suspected COVID-19 “should ideally be placed in a private room with their own bathroom.” The CDC also instructed facilities to “[c]reate a plan for cohorting residents with symptoms of respiratory infection, including dedicating [healthcare professionals] to work only on affected units.”²⁶¹

There still existed conflicting guidance on this point, however. On March 22, DOH, Division of Nursing Care Facilities, distributed a *Post Acute and Long Term Care COVID-19 Toolkit*.²⁶² Included in this toolkit was a document titled *Ten Initial Steps for Long-Term Care Facilities with a Confirmed Case of COVID-19*, instructing long-term care facilities to place a “positive resident in an airborne isolation room with a private bathroom if available” and, only if a negative pressure room was not available, to place a positive resident in “a private room” with “the door closed.”²⁶³ On March 25, CCHD provided the *Post Acute and Long Term Care COVID-19 Toolkit*, including the *Ten Initial Steps for Long-Term Care Facilities with a Confirmed Case of COVID-19* document, explaining that the toolkit was meant to “assist . . . nursing homes with COVID response.”²⁶⁴ The CDC also published a flyer providing information for “[w]hat healthcare personnel should know about caring for patients with confirmed or possible coronavirus disease 2019 (COVID-19),” including to “[a]ssess and triage” patients “with confirmed or possible COVID-19 . . . in an examination room with the door closed in an Airborne Infection Isolation Room (AIIR), if available.”²⁶⁵

Such guidance evidently engendered some confusion among Pennsylvania’s healthcare facilities, resulting in DOH receiving “many questions regarding the CDC guidance for infection prevention and control in healthcare facilities updated March 10, and issued by DOH on March 11.” On March 24, DOH therefore issued additional “guidance to reiterate and clarify” previously released guidance. In this guidance, DOH made clear that long-term care facility

²⁶⁰ Ctrs. for Disease Control & Prevention, Infection Control: Transmission-Based Precautions (rev’d Jan. 7, 2016), <https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html>.

²⁶¹ Ctrs. for Disease Control & Prevention, Preparing for COVID-19: Long-Term Care Facilities, Nursing Homes (last rev’d Mar. 21, 2020) [REDACTED].

²⁶² Email from [REDACTED] re Post Acute and Long Term Care COVID-19 Toolkit (Mar. 22, 2020) [REDACTED].

²⁶³ *TEN INITIAL STEPS for Long-term Care Facilities with a confirmed Case of COVID-19* [REDACTED] (emphasis in original).

²⁶⁴ Email from [REDACTED] to [REDACTED] re LTCF recommendations (Mar. 25, 2020) [REDACTED].

²⁶⁵ Ctrs. for Disease Control & Prevention, What Healthcare Personnel Should Know About Caring for Patients with Confirmed or Possible Coronavirus Disease 2019 (COVID-19) (Mar. 21, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/caring-for-patients-H.pdf>.

residents with known or suspected COVID-19 “do *not* need to be cared for in an Airborne Infection Isolation Room (AIIR)” and that such residents should be placed “in a single-person room with the door closed” and “a dedicated bathroom.” DOH went on to explain that aerosol-generating procedures on residents with known or suspected COVID-19 “should be performed cautiously and avoided if possible.” If such procedures were necessary, DOH instructed that they “[i]deally” be conducted in negative pressure rooms, but also instructed healthcare facilities to reserve negative pressure rooms for residents “with conditions that require AIIR rooms, such as patients with Tuberculosis (TB) or measles.”²⁶⁶

On April 2, CMS, in conjunction with CDC, issued guidance setting forth “immediate actions” long-term care facilities should take “to keep patients and residents safe.” This guidance was consistent with CDC and DOH guidance that long-term care facilities should plan to isolate COVID-19 residents in designated units, instructing long-term care facilities to “separate . . . residents who have COVID-19 from . . . residents who do not, or have an unknown status” and to “work with State and local community leaders to designate separate . . . units within a facility” to facilitate this separation of residents.²⁶⁷

The next day, DOH issued guidance to congregate care facilities, including long-term care facilities, regarding how to implement resident separation strategies. This guidance directed facilities to “consider all residents on the same wing/unit/floor . . . with a COVID-19 positive resident as infectious.” The guidance also instructed facilities to create “a separate area of the building or a designated unit with the plan to move COVID-19 positive residents there upon diagnosis,” if feasible. Facilities were to move COVID-19 positive residents to the designated COVID-19 unit and to maintain the residents’ “original unit under all precautions” for monitoring as “many residents of that unit might already be COVID-positive.”²⁶⁸

On April 14, DOH expanded this guidance on cohorting. DOH reiterated that “[c]ohorting of residents with COVID-19 in dedicated units within skilled nursing facilities can be an effective transmission prevention strategy” and that facilities must implement the strategy “deliberately to be effective.” “Once COVID-19 is identified in a nursing care facility, there are three types of residents to consider” – cases, exposed, and unexposed. Cases are those residents “with confirmed or probable COVID-19,” including “residents who were exposed to COVID-19 and are exhibiting symptoms consistent with COVID-19 but have not yet been tested or will not be tested.” Exposed residents are “[t]hose who have been exposed to COVID-19 but are not yet

²⁶⁶ PAHAN 490 (Mar. 24, 2020), available at https://www.health.pa.gov/topics/Documents/HAN/2020-PAHAN-UPDATE-Infection%20Control_.pdf (emphasis in original).

²⁶⁷ Ctrs. for Medicare & Medicaid Servs., COVID-19 Long-Term Care Facility Guidance (Apr. 2, 2020), <https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf>.

²⁶⁸ PAHAN 492 (Apr. 3, 2020), available at <https://www.health.pa.gov/topics/Documents/HAN/2020-PAHAN-492-04-03-ALT-Universal%20Masking.pdf> (emphasis in original).

exhibiting symptoms.” Unexposed residents are “[t]hose who are not known to have been exposed to COVID-19.”

Under the guidance, “[t]he primary goal of cohorting is to restrict mixing of residents who are cases or are exposed with those who are thought to be unexposed” and “[s]eparating cases from exposed residents is a secondary goal of cohorting.” DOH reiterated that facilities should “[c]onsider all residents in units with COVID-19 cases as exposed and potentially infectious” and that facilities should, if possible, create “a designated area of the building or a designated unit for COVID-19 positive residents.” The guidance instructed that facilities able to designate such a unit should move COVID-19 positive residents to that unit and maintain the residents’ original units under all recommended infection control precautions because “many residents of that unit might already be COVID-19 positive (even without symptoms).”

The guidance does note, however, certain limitations to this cohorting strategy. For instance, while moving COVID-19 positive residents to a designated unit upon diagnosis and maintaining the residents’ original units under precautions “is a reasonable approach” for cases “identified early,” the risks of moving positive residents may eventually outweigh the benefits of moving those residents “[a]s more residents become symptomatic or are confirmed positive for COVID-19.” This is because where there is a positive resident on a unit “where there are also other residents with possible symptoms or several positive residents . . . identified . . . within a few days . . . transmission has likely occurred to many others in the unit.” In these circumstances, “newly identified symptomatic residents [usually] present over the following week, and moving residents becomes no longer feasible.” DOH advised that, in those circumstances, “[u]rgent room changes may negatively impact the health and well-being of the residents and should occur when benefits outweigh the risk.”²⁶⁹

As COVID-19 testing became more widely available, DOH recommended that nursing facilities employ a point prevalence survey (“PPS”) to drive cohorting decisions. DOH instructed that “facilities with suspected or confirmed cases of COVID-19” should consider conducting “[f]acility-wide PPS of all residents” to “identify infected residents who can be cohorted on a pre-specified unit or transferred to a COVID-specific facility.” In the event the facility lacked sufficient capacity to test all residents, DOH instructed that facilities prioritize “performing PPS on units with symptomatic residents.”

Under this DOH guidance, facilities were to cohort “[r]esidents to . . . separate units in three zones, based on test results.” Residents with confirmed COVID-19 were to be cohorted in “Red Zone” units on which transmission-based precautions were to be maintained. Residents who tested negative for COVID-19 and were asymptomatic “but are within 14 days of possible exposure to COVID-19” were to be cohorted in “Yellow Zone” units. All residents who either

²⁶⁹ PAHAN 496 (Apr. 14, 2020), available at <https://www.health.pa.gov/topics/Documents/HAN/2020-PAHAN-496-04-14-ADV-Cohorting%20R.pdf>.

tested negative for COVID-19 or were not tested “and [were] thought to be unexposed to COVID-19” were to be cohorted in “Green Zone” units.²⁷⁰

D. Contact Tracing

By early February, the CDC had issued guidance recommending that healthcare facilities conduct contact tracing in order to assist “with assessment of risk, monitoring, and work restriction decisions for [healthcare providers] with potential exposure to 2019-nCoV.” The CDC explained that, given healthcare professionals’ “often extensive and close contact with vulnerable individuals in healthcare settings,” its initial guidance took “a conservative approach to [healthcare professional] monitoring and restriction from work . . . to quickly identify early symptoms and prevent transmission from potentially contagious [healthcare professionals] to patients, [other healthcare professionals], and others visiting or working in a healthcare setting.”²⁷¹

The CDC updated its recommendation on March 4, explaining that because “[c]ommunity transmission of COVID-19 . . . ha[d] been reported in multiple areas” in the United States, previously recommended “contact tracing and risk assessment of all potentially exposed [healthcare professionals]” had become “impractical for implementation by healthcare facilities.” Therefore, the CDC advised that healthcare facilities in areas experiencing “community transmission” of COVID-19 “shift emphasis” from contact tracing “to more routine practices, which include asking [healthcare providers] to report recognized exposures, regularly monitor themselves for fever and symptoms of respiratory infection and not report to work when ill.” To further these “routine practices,” the CDC instructed healthcare facilities to “develop a plan for how they [would] screen for symptoms and evaluate ill [healthcare professionals].”²⁷² On March 7, the CDC clarified that “contact tracing and risk assessment . . . of potentially exposed [healthcare professionals] remain[ed] the recommended strategy for identifying and reducing the risk of transmission of COVID-19 to [healthcare professionals], patients, and others” and that healthcare facilities should implement such measures unless “not practical or

²⁷⁰ PAHAN 508 (May 12, 2020), *available at* <https://www.health.pa.gov/topics/Documents/HAN/2020%20%80%93PAHAN%20%80%93508%20%80%9305-12-ADV-Test-based%20Strategies.pdf>.

²⁷¹ Ctrs. for Disease Control & Prevention, Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with 2019 Novel Coronavirus (2019-nCoV) (rev’d Feb. 8, 2020), *available at* <https://web.archive.org/web/20200211035415/https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>.

²⁷² Ctrs. for Disease Control & Prevention, Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (updated Mar. 4, 2020), *available at* <https://web.archive.org/web/20200305134337/https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>.

achievable,” such as when the healthcare facility was in an area experiencing “[c]ommunity transmission of COVID-19.”²⁷³

In line with the CDC’s updated contact tracing guidance, DOH issued guidance on March 9 instructing that “contact tracing and risk assessment . . . of potentially exposed [healthcare professionals] remains the recommended strategy for identifying the risk of transmission of COVID-19 to [healthcare professionals], patients, and others.” Like the CDC, DOH also noted that, for healthcare facilities in “areas . . . that are demonstrating sustained community transmission, . . . devoting resources to contact tracing and retrospective risk assessment could divert resources from other important infection prevention and control activities,” and that those facilities may “shift their emphasis to more routine practices.” DOH, however, recognized that healthcare facilities in areas with community spread may include contact tracing as part of “a sustainable management plan for healthcare personnel caring for patients with COVID-19.”²⁷⁴

On March 18, according to notes of a Hospital and Healthsystem Association of Pennsylvania (“HAP”) / DOH call, DOH advised that “it will be the responsibility of the facility if you get a COVID + resident or staff to track them.” DOH stated further that “[a] ‘tracing sheet’ is being created at DOH and will be posted at the DOH website by the end of this week.”²⁷⁵

On April 13, the CDC reiterated that “[a]s community transmission intensifies within a region, healthcare facilities could consider foregoing contact tracing for exposures in a healthcare setting in favor of universal source control for [healthcare professionals] and screening for fever and symptoms before every shift.”²⁷⁶ By April 15, the CDC had archived its

²⁷³ Ctrs. for Disease Control & Prevention, Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (updated Mar. 7, 2020), *available at*

<https://web.archive.org/web/20200309230138/https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>.

²⁷⁴ PA HAN 484 (Mar. 9, 2020), *available at*

<https://web.archive.org/web/20200309230138/https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html> (recognizing that “a sustainable plan for healthcare personnel caring for patients with COVID-19” at a facility in an area with “sustained community transmission . . . may include risk assessment . . .”).

²⁷⁵ Email from ██████ to A. Ruscavage, D. Jackson and others re SUMMARY NOTES: HAP/DOH Conference Call 3/18/20 1 pm (Mar. 18, 2020) ██████.

²⁷⁶ Ctrs. for Disease Control & Prevention, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings (updated Apr. 13, 2020), *available at*

https://web.archive.org/web/20200415050349/https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-recommendations.html.

guidance regarding contact tracing in healthcare facilities. The CDC explained, “[g]iven the ongoing transmission of COVID-19 in communities across the United States and the role that asymptomatic and pre-symptomatic individuals with COVID-19 play in transmission, the feasibility and benefits of formal contact tracing for exposures in healthcare settings [were] likely limited” at that time.²⁷⁷

On April 16, DOH issued guidance advising healthcare facilities that, “[a]s community transmission intensifies within a region, [they could] consider foregoing contact tracing for exposures . . . in favor of universal source control for [healthcare providers] and screening for fever and symptoms before every shift.”²⁷⁸ The following day, CCHD forwarded the updated DOH guidance to Chester County healthcare facilities, including SEVC, advising those facilities that they could “consider foregoing contact tracing.”²⁷⁹ On June 1, DOH instructed healthcare facilities that had stopped contact tracing due to community spread to “[r]esume contact tracing and application of work restrictions” if the “spread of COVID-19 in the community ha[d] decreased.”²⁸⁰

E. Hydroxychloroquine

The FDA approved label for hydroxychloroquine does not include the treatment of COVID-19 as an approved use. Thus, any use of the drug to treat COVID-19 is off-label. On March 28, however, the FDA issued an EUA, authorizing emergency use of hydroxychloroquine from the SNS to treat COVID-19 “[b]ased on the totality of scientific evidence available to FDA . . . that chloroquine phosphate and hydroxychloroquine sulfate may be effective in treating COVID-19.” The EUA authorized healthcare providers to use hydroxychloroquine from the SNS to treat patients who were “hospitalized with COVID-19,” and “for whom clinical trial is not available, or participation is not feasible.” The EUA also required that “the product information contained in” the hydroxychloroquine “approved package insert” (FDA approved

²⁷⁷ Ctrs. for Disease Control & Prevention, Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (Apr. 15, 2020), *available at* <https://web.archive.org/web/20200430210344/https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>.

²⁷⁸ PA HAN 497 (Apr. 16, 2020), *available at* https://www.health.pa.gov/topics/Documents/HAN/2020-PAHAN-497-04-16-UPD-UPDATE_Univ.pdf.

²⁷⁹ Email from Chester County Health Department re Health Update: Interim Infection Prevention and Control Recommendations for Patients with Known or Patients Under Investigation for 2019 Novel Coronavirus (COVID-19) in a Healthcare Setting (Apr. 17, 2020) [REDACTED].

²⁸⁰ PA HAN 510 (June 1, 2020), *available at* <https://www.health.pa.gov/topics/Documents/HAN/2020-PAHAN-510-06-01-UPD-UPDATE%20Expo.pdf>.

label), and the fact sheets explaining the EUA parameters and risks of using hydroxychloroquine be provided to both healthcare providers and patients and/or caregivers.²⁸¹

The fact sheet for healthcare providers specifically warns healthcare providers to “[u]se [hydroxychloroquine] with caution in patients with cardiac disease, QT prolongation, a history of ventricular arrhythmias, bradycardia, uncorrected potassium or magnesium imbalance, and during concomitant administration with QT interval prolonging drugs such as azithromycin and some other antibacterial drugs.”²⁸² This fact sheet also warned healthcare providers that use of azithromycin in concert with hydroxychloroquine may increase the “risk of inducing ventricular arrhythmias.” In all events, the fact sheet recommended obtaining “[a] baseline electrocardiogram” before initiating treatment and instructed healthcare providers to “[m]onitor the electrocardiogram during treatment.” Like the EUA, the fact sheet for healthcare providers instructed healthcare providers to communicate to patients, among other things, “[t]he significant known and potential risks and benefits of hydroxychloroquine sulfate, as supplied under th[e] EUA” and “[t]he alternative products that are available and their benefits and risks, including clinical trials.”²⁸³

On June 15, the FDA revoked the EUA because “[b]ased on its ongoing analysis of the EUA and emerging scientific data, the FDA determined that chloroquine and hydroxychloroquine are unlikely to be effective in treating COVID-19 for the authorized uses in the EUA.”²⁸⁴ Furthermore, the FDA acknowledged that “in light of ongoing serious cardiac adverse events and other potential serious side effects, the known and potential benefits of chloroquine and hydroxychloroquine no longer outweigh the known and potential risks for the authorized use.”²⁸⁵

²⁸¹ Food & Drug Admin, Hydroxychloroquine Emergency Use Authorization, at 1-4 (Mar. 28, 2020), available at <https://www.fda.gov/media/136534/download>.

²⁸² FDA EUA Fact Sheet, at 2 (Mar. 28, 2020). The Mayo Clinic explains that a QT interval measures the amount of time it takes the heart’s electrical system (which triggers the heart to contract and beat) to recharge between each heartbeat. If it takes normal than longer for your heart to recharge between beats, which can be seen on an electrocardiogram, the delay is called a prolonged QT interval. Prolonged QT intervals can cause, among other things, Torsades de pointes, a potentially lethal ventricular arrhythmia, or ventricular fibrillation (where the ventricles beat so fast that the heart quivers and stops pumping blood), which can lead to brain damage and death without proper intervention (defibrillation). Mayo Clinic, *Long QT Syndrome*, MayoClinic.org (June 16, 2020), <https://www.mayoclinic.org/diseases-conditions/long-qt-syndrome/symptoms-causes/syc-20352518>.

²⁸³ FDA EUA Fact Sheet, at 2, 4-5 (Mar. 28, 2020).

²⁸⁴ FDA News Release, *Coronavirus (COVID-19) Update: FDA Revokes Emergency Use Authorization for Chloroquine and Hydroxychloroquine* (June 15, 2020), <https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-revokes-emergency-use-authorization-chloroquine-and>.

²⁸⁵ FDA News Release, *Coronavirus (COVID-19) Update: FDA Revokes Emergency Use Authorization for Chloroquine and Hydroxychloroquine* (June 15, 2020),

While the EUA applied only to hydroxychloroquine from the SNS – and, thus, not applicable to hydroxychloroquine prescribed at SEVC – the EUA and its accompanying fact sheet provided the FDA’s views on the appropriate use and accompanying risks of hydroxychloroquine.

V. Analysis

The COVID-19 global pandemic presents unprecedented challenges for all tasked with trying to curb its spread. Guidance from the federal, state, and local levels has changed frequently over time. Healthcare providers have had to deal with the limited, ever changing, and often conflicting information available to them. In this environment, long-term care facilities are particularly vulnerable and have been hard hit. They are congregate facilities housing elderly, often infirm residents, many of whom often need focused attention and assistance with everyday tasks of daily life. As Dr. Sharon Brangman – the consulting expert retained in connection with this investigation – observed, nursing homes are “sitting ducks.”²⁸⁶ Even in that already susceptible universe, SEVC’s demographics – predominately male and particularly frail in a location with community spread – made the challenge even more daunting.

Even at the inception of the pandemic, however, there were measures that could and should have been taken to reduce the severity of a COVID-19 outbreak in long-term care facilities. Further, lessons have been learned that cannot be ignored should a second wave emerge. In the early example of the Life Care Center nursing home in Kirkland, Washington, CMS attributed the scale of the COVID-19 outbreak to “the facility’s failure to rapidly identify and manage ill residents, notify the Washington Department of Health about the increasing rate of respiratory infection among residents, and failure to possess a sufficient backup plan following the absence of the facility’s primary clinician, who fell ill.”²⁸⁷ We similarly find that there were a number of crucial deficiencies and obvious errors that SEVC leadership made in its COVID-19 response. We also find that the organizational culture and structure at both SEVC and DMVA contributed directly to those failings.

A. SEVC Failed to Follow DMVA Preparation Directives

Throughout March, DMVA issued directions to the SVHs to facilitate the homes’ COVID-19 preparations. SEVC, however, did little in response to these directions. This contributed to leaving the facility ill-prepared for various aspects of its infection control

<https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-fda-revokes-emergency-use-authorization-chloroquine-and>.

²⁸⁶ Interview of S. Brangman (Sept. 4, 2020).

²⁸⁷ Press Release, Ctrs. for Medicare & Medicaid Servs., CMS Announces Findings at Kirkland Nursing Home and New Targeted Plan for Healthcare Facility Inspections in light of COVID-19 (Mar. 23, 2020), <https://www.cms.gov/newsroom/press-releases/cms-announces-findings-kirkland-nursing-home-and-new-targeted-plan-healthcare-facility-inspections>.

response. DMVA, purporting to be worn down by SEVC’s consistent pushback, failed to exercise necessary oversight over SEVC or insist on compliance with its directives.

For example, on March 24, DMVA directed the SVHs to utilize the CDC Preparedness Checklist to assess their infection control program. Although SEVC completed the CDC Preparedness Checklist on April 8,²⁸⁸ as of April 13, SEVC was the only SVH that had not provided DMVA an update regarding its findings from its use of the checklist.²⁸⁹ Those findings included the absence of “infection control policies that outline the recommended Transmission-Based Precautions” for caring “for residents with suspected or confirmed COVID-19.”²⁹⁰

Blackwood could not recall whether SEVC ever provided DMVA an update on its progress working through the CDC Preparedness Checklist. Nor could Blackwood confirm that SEVC alerted DMVA to the deficiencies in its infection control program that it had identified when completing the checklist. Blackwood’s understanding, however, was that SEVC had completed the necessary planning even if the checklist had not been properly completed.²⁹¹ However, as demonstrated by SEVC’s failure to implement coherent policies for placing residents on infection control precautions or for isolation and cohorting – identified deficiencies below – SEVC had *not* conducted the necessary planning. Had SEVC used the checklist to identify and remedy infection control weaknesses, it would have been better positioned to respond to the subsequent COVID-19 outbreak.

SEVC also failed to complete the COVID-19 Pandemic Plan that DMVA circulated on March 26 for the SVHs to adapt to their individual facilities. That plan too was designed to help the facilities formalize infection control procedures and responsibilities.²⁹² [REDACTED]

[REDACTED] explained that SVHs should have been able to complete adaptation of the COVID-19 Pandemic Plan in 48 hours.²⁹³ As of April 7, however, SEVC was the only SVH not to have even begun working on its home-specific updates to the COVID-19 Pandemic Plan.²⁹⁴ The next day SEVC represented to DMVA that it had completed its plan.²⁹⁵

Blackwood stated that he believed [REDACTED] and [REDACTED] had completed SEVC’s COVID-19 Pandemic Plan. Blackwood claimed that SEVC was delayed in completing its COVID-19 Pandemic Plan because applicable guidance was changing frequently and SEVC leadership was engaged in conversations regarding

²⁸⁸ SEVC CDC Nursing Home Preparedness Checklist (last modified Apr. 8, 2020) [REDACTED].

²⁸⁹ COVID19 Commandant Communication (Apr. 13, 2020) [REDACTED].

²⁹⁰ SEVC CDC Nursing Home Preparedness Checklist, at 2-3 (last modified Apr. 8, 2020) [REDACTED].

²⁹¹ Interview of R. Blackwood (Aug. 19 & 21, 2020).

²⁹² BVH Pandemic Emergency Response Plan (Mar. 26, 2020) [REDACTED].

²⁹³ Interview of [REDACTED] (July 17, 2020).

²⁹⁴ COVID19 Commandant Communication (Apr. 7, 2020) [REDACTED].

²⁹⁵ COVID19 Commandant Communication (Apr. 8, 2020) [REDACTED].

“tweaking” the plan to account for the changing guidance.²⁹⁶ [REDACTED], however, stated that he provided Blackwood a draft of the COVID-19 Pandemic Plan and never heard back from him.²⁹⁷

Acting Commandant [REDACTED] explained that, when she started at SEVC at the end of May, the facility’s COVID-19 Pandemic Plan was just two pages long and not complete.²⁹⁸ The new administration tasked [REDACTED] with creating an SEVC-specific plan, to which she responded by attaching an existing plan and noting that it “was revised in March,” and that “[i]t look[ed] like a version existed that we were not aware of.”²⁹⁹ She added that the plan was recently redone, approved by the Safety Committee in May, and was still awaiting Blackwood’s approval.³⁰⁰ Even that plan, however, was not in accordance with DMVA’s expectation. SEVC had removed “many items” from DMVA’s template COVID-19 Pandemic Plan and, as a result, the SEVC COVID-19 Pandemic Plan was substantially shorter than DMVA expected.³⁰¹ [REDACTED] explained that SEVC’s modifications to DMVA’s COVID-19 Pandemic Plan created material weaknesses in the plan.³⁰²

Despite SEVC’s failure to comply with DMVA’s planning directives, DMVA did not take sufficient action to ensure compliance. CMO Dr. Jackson claimed that he and his team were worn down by SEVC’s constant pushback, and that they therefore relented. He noted, for example, that Mullane was “very argumentative,” and he did not have time to argue.³⁰³ BVH Director Ruscavage made excuses for SEVC when asked about the facility’s non-compliance with DMVA directives, noting that things were “very chaotic.” He said he “imagined” that DMVA must have discussed SEVC’s COVID-19 Pandemic Plan with SEVC leadership and that SEVC “may” have sent it to him.³⁰⁴ Ruscavage agreed to send any such plan he located to the investigation team. He never did.

We find that SEVC’s failure to follow DMVA’s directives was a result of and contributed to SEVC’s lack of planning. This left SEVC unprepared for crucial aspects of its COVID-19

²⁹⁶ Interview of R. Blackwood (Aug. 19 & 21, 2020).

²⁹⁷ Interview of [REDACTED] (July 6, 2020).

²⁹⁸ Interview of [REDACTED] (Aug. 6, 2020).

²⁹⁹ Email from [REDACTED] to [REDACTED] and others re SEVC Pandemic Plan needs revised asap please (June 15, 2020) [REDACTED]; *see also* Email from [REDACTED] to [REDACTED] and others re Pandemic Plan (June 15, 2020) [REDACTED].

³⁰⁰ Email from [REDACTED] to [REDACTED] and others re SEVC Pandemic Plan needs revised asap please (June 15, 2020) [REDACTED]; *see also* Email from [REDACTED] to [REDACTED] and others re Pandemic Plan (June 15, 2020) [REDACTED].

³⁰¹ Email from [REDACTED] to [REDACTED] re SEVC Pandemic Plan needs revised asap please (June 16, 2020) [REDACTED]; *see also* Interview of [REDACTED] (July 20, 2020) (reporting that SEVC had removed sections of DMVA’s Pandemic Plan template and trimmed the template from 15 pages down to 9 pages).

³⁰² Interview of [REDACTED] (July 17, 2020).

³⁰³ Interview of D. Jackson (Aug. 19 & 26, 2020).

³⁰⁴ Interview of A. Ruscavage (Aug. 13, 2020).

response. This is a failure of both SEVC leadership in not following DMVA directives and DMVA leadership in not doing enough to insist on compliance.

B. SEVC Leadership Made Poor Infection Control Decisions

We have identified a number of deficiencies in SEVC's infection control policies. The deficiencies are all significant, and each may have contributed to COVID-19's spread within the facility. The three most serious deficiencies were: (1) SEVC's failure to stop communal dining in March; (2) SEVC's misinterpretation of and unquestioning adherence to isolation and cohorting guidance from CCHD; and (3) SEVC's failure to use 3 West – a vacant unit – for isolation.

1. *SEVC Should Have Stopped Communal Dining in March*

On March 13, CMS issued its guidance directing nursing homes to cancel communal dining. DMVA timely circulated that guidance to the SVH Commandants the next day.³⁰⁵ On March 15, BVH Director Ruscavage wrote the Commandants of the SVHs "to ensure that [they were] taking every precaution to keep our residents safe." In doing so, Ruscavage listed several preparedness items for the Commandants to address, including cancelling communal dining.³⁰⁶ On March 16, BVH's direction to the SVHs was: "No communal dining if possible due to staffing patterns."³⁰⁷

SEVC, however, did not begin even to *modify* communal dining until April 1. It did not cease communal dining until April 6, at which point SEVC already had three residents who tested positive for COVID-19, six residents with tests pending, 11 staff members with tests pending, and many more residents with signs and symptoms of COVID-19.³⁰⁸

The most common reason cited for the delay in cancelling communal dining was that it was difficult and time-consuming to implement in-room dining, and that SEVC had implemented socially distanced communal dining. Blackwood stated that shutting down communal dining and serving all residents in their room was a significant undertaking for a facility of SEVC's size. He observed that, in most instances where there is an outbreak of infectious disease within SEVC, they would shut down dining on a unit-by-unit basis, not facility-wide. The primary logistical obstacle he observed was the need to screen and identify residents who could safely eat in their rooms. Furthermore, Blackwood contended that all staff participated in meal service through an "All Hands on Deck" program, and that, with cancellation of that program due to COVID-19, staffing for in-room meal service was a challenge.³⁰⁹

³⁰⁵ Email from [REDACTED] re COVID-19 Nursing Home Guidance (Mar. 14, 2020)

[REDACTED].
³⁰⁶ Email from A. Ruscavage re checking in (Mar. 15, 2020) [REDACTED].

³⁰⁷ COVID19 Commandant Communication (Mar. 16, 2020) [REDACTED].

³⁰⁸ SEVC COVID-19 Stand-Down Meeting Minutes (Apr. 6, 2020 entry)

[REDACTED]; SITREP (Apr. 28, 2020) [REDACTED].

³⁰⁹ Interview of R. Blackwood (Aug. 19 & 21, 2020).

Mullane claimed that, given the logistical difficulties, SEVC stopped communal dining as soon as it was logically feasible to do so.³¹⁰ [REDACTED] also noted the logistical obstacles to transitioning to in-room dining, including procuring trays, containers, and changing the food service set up to ensure the delivery of hot food.³¹¹

In light of these difficulties, Blackwood explained that implementing social distancing was appropriate, because he believed that the applicable guidance required cancellation of communal dining only where there had been community spread and there was no community spread in SEVC's vicinity at the time the guidance came down to cancel communal dining.³¹² In the interim, both Blackwood and Mullane pointed to DOH guidance issued on March 18 as permitting socially distanced dining.³¹³

Every aspect of these explanations is flawed. First, it is true that DOH allowed, "at a minimum," the implementation of "social distancing in dining practices and activities," where there was "no community spread of COVID-19 *within*" a facility's "county or adjacent counties."³¹⁴ SEVC, however, first implemented social distancing measures for communal dining on April 1.³¹⁵ Thus, even accepting that the DOH guidance permitted modified dining in lieu of in-room dining, SEVC took no measures to comply with that guidance for two weeks.

Second, by March 15, there was already evidence of community spread of COVID-19 in Montgomery County, which is a county adjacent to Chester County where SEVC is located.³¹⁶ As reported internally at SEVC's daily "Stand-down meeting," by March 27, there were 84 positive cases in Chester County.³¹⁷ Within the facility, as of March 25 – a week before SEVC first implemented social distancing measures for communal dining – SEVC was monitoring a cluster of residents on 2 West "with cold like symptoms."³¹⁸ Thus, even assuming SEVC was

³¹⁰ Interview of D. Mullane (Aug. 20, 2020); Interview of R. Blackwood (Aug. 19 & 21, 2020).

³¹¹ Interview of [REDACTED] (July 29, 2020).

³¹² Interview of R. Blackwood (Aug. 19 & 21, 2020); *see also* Interview of [REDACTED] (July 6, 2020).

³¹³ Interview of D. Mullane (Aug. 20, 2020); Interview of R. Blackwood (Aug. 19 & 21, 2020).

³¹⁴ Pa. Dep't of Health, Interim Guidance for Nursing Facilities During COVID-19 (Mar. 18, 2020) [REDACTED].

³¹⁵ Interview of R. Blackwood (Aug. 19 & 21, 2020); COVID 19 SEVC Dietary Department Doc [REDACTED].

³¹⁶ Press Release, Montgomery Cnty. Bd. of Comm'rs, Four More Presumptive Positive COVID-19 Cases Reported in Montgomery County: Total Number of Montgomery County Cases is 24 (Mar. 15, 2020), available at <https://www.montcopa.org/ArchiveCenter/ViewFile/Item/5093> (reporting cases of COVID-19 in individuals with "direct contact with . . . previously identified presumptive positive individual[s] in Montgomery County").

³¹⁷ SEVC COVID-19 Stand-Down Meeting Minutes [REDACTED].

³¹⁸ SEVC Timeline Document (Mar. 25, 2020 entry) [REDACTED] ("Spoke with [REDACTED] [REDACTED] notified of 2 West Respiratory illness. Protocol reviewed regarding increase resident Temp & resp assessment from once a shift to every shift. In agreement with increase no new

relying on the March 18 DOH guidance, on its own terms, the guidance did not permit socially distanced dining throughout March.

Furthermore, there is no evidence that SEVC was actually engaged in the time-consuming resident assessment it now says was a primary reason for the delay. Blackwood claimed that he believed the nursing staff was in the process of evaluating residents from mid-March to April. He was not sure, however, what the process was for evaluating residents and could not recall ever receiving any updates regarding the progress of evaluating residents during this timeframe. Moreover, Blackwood acknowledged that SEVC nursing staff would have needed to have known which residents were choking risks as a general matter, even during communal dining. Dr. Jackson similarly confirmed that staff would have known that information.³¹⁹

Even if there was some need to evaluate residents, we do not credit that it took from March 13 to April 6 – over three full weeks – to conduct that assessment. Indeed, SEVC *had just implemented in-room dining* for a large portion of the facility in connection with the late December/early January norovirus outbreak. That was accomplished in a matter of days. At a minimum, those residents who had been assessed as capable of eating in-room then (assuming any assessment even was needed), could have transitioned to in-room dining in March.

Moreover, despite SEVC leadership’s claim that logistical difficulties prevented the facility from cancelling communal dining, SEVC was able to cancel communal dining immediately after staff and residents first tested positive for COVID-19. SEVC began the transition on April 1, the day after the first staff member tested positive. On Friday, April 4, the day after the first resident was confirmed positive for COVID-19, SEVC transitioned two floors – including the floor on which the positive resident was located – to in-room dining. By Monday, April 6, the entire building had moved to in-room dining.³²⁰ Both Mullane and Blackwood stated, however, that this timing was simply the natural progression of the efforts to transition to in-room dining that started in mid-March.³²¹ We do not find this suggestion of mere coincidence credible.

We note that SEVC was not alone among the SVHs in expressing concerns regarding the logistics of shutting down communal dining. For instance, as of March 14, HVH had not yet closed its dining rooms, because it did not “have the staff to do it safely, keep temps, and serve

recommendation.”); Memorandum to All Staff re COVID-19 Information & Update (Mar. 26, 2020) [REDACTED].

³¹⁹ Interview of D. Jackson (Aug. 19 & 26, 2020).

³²⁰ COVID 19 SEVC Dietary Department Doc [REDACTED]; CCHD Communications [REDACTED].

³²¹ Interview of D. Mullane (Aug. 20, 2020); Interview of R. Blackwood (Aug. 19 & 21, 2020).

[meals] in a timely manner.”³²² Similarly, neither SWVC nor PSSH had been able to close their dining rooms as of March 14.³²³

By March 15, however, SWVC – a facility comparable in size to SEVC³²⁴ – had cancelled communal dining for all but one unit,³²⁵ and had cancelled “all communal dining and group activities” by March 16.³²⁶ HVH – a larger facility than SEVC with “9 dining rooms in three different buildings with the kitchen in the center of campus,” making cancelling communal dining a “[b]ig logistical drill to say the least”³²⁷ – cancelled communal dining by mid-March.³²⁸ PSSH cancelled communal dining by the third week in March.³²⁹ Dr. Jackson confirmed that there was nothing about the size or layout of SEVC that should have prevented it from stopping communal dining earlier, as other facilities were able to do.³³⁰ Thus, while stopping communal dining may have been logistically difficult, it could and should have been done well before the first week of April.

SEVC leadership also gave other reasons for the delay, none of which are any more persuasive. One reason cited was resident morale. For instance, both Blackwood and Mullane explained that initial moves to limit communal dining were met with resistance from residents who felt as if SEVC was becoming a “prison.”³³¹ [REDACTED], also explained that there was hesitation to cancel communal dining at SEVC due to concerns over resident morale. Specifically, [REDACTED] explained that the decision-making process with respect to

³²² Email from [REDACTED] to [REDACTED] re COVID-19 Nursing Home Visitor Guidance (Mar. 14, 2020) [REDACTED].

³²³ Email from [REDACTED] to [REDACTED] re COVID-19 Nursing Home Visitor Guidance (Mar. 14, 2020) [REDACTED].

³²⁴ Interview of [REDACTED] (Aug. 19 & 21, 2020).

³²⁵ SITREP (Mar. 15, 2020) [REDACTED] (“SWVC . . . Group dining was stopped for all units except for 4N at 1200 on 3/15/19 [sic] – additional needs to improve the process to be addressed by DC.”).

³²⁶ Ltr. from [REDACTED] Southwestern Veterans Center (Mar. 16, 2020)

[REDACTED].

³²⁷ Email from [REDACTED] to [REDACTED] re COVID-19 Nursing Home Visitor Guidance (Mar. 14, 2020) [REDACTED]. Compare Hollidaysburg Veterans’ Home, dmva.pa.gov, <https://www.dmvpa.gov/paveteranshomes/HollidaysburgVeteransHome/Pages/default.aspx> (last visited Sept. 20, 2020) (reporting that Hollidaysburg Veterans’ Homes has 424 beds and over 550 dedicated clinical and professional staff), with Southeastern Veterans Center, dmva.pa.gov,

<https://www.dmvpa.gov/paveteranshomes/SoutheasternVeteransCenter/Pages/default.aspx> (last visited Sept. 20, 2020) (reporting that SEVC has 292 beds and 430 dedicated clinical and professional staff).

³²⁸ Interview of [REDACTED] (July 20, 2020).

³²⁹ Interview of [REDACTED] (Aug. 6, 2020).

³³⁰ Interview of D. Jackson (Aug. 19 & 26, 2020).

³³¹ Interview of D. Mullane (Aug. 20, 2020); Interview of R. Blackwood (Aug. 19 & 21, 2020).

cancelling communal dining was sensitive to the importance of resident “socialization,” as mealtime was a time for residents to mingle and speak to each other.³³²

This is a patently insufficient reason to disregard such important and explicit infection control guidance. While we have no doubt that maintaining resident morale was a challenge, ensuring the health and safety of the residents in the midst of a pandemic was paramount. It was incumbent on SEVC leadership to address resident concerns while ensuring proper infection control measures were in place.

Ultimately, because communal dining was not stopped until after residents began testing positive, residents who eventually did test positive, including the first positive resident, ate at communal dining while symptomatic and contagious. Residents who ate with the symptomatic (and subsequently positive) residents continued to eat at communal dining, several of whom also ultimately tested positive.³³³ For instance, the first resident to test positive at SEVC first presented with symptoms consistent with COVID-19 on March 31 when he “complained of ‘having the chills’ before and during supper.”³³⁴ The second resident to test positive at SEVC ate in the dining room on April 2, even after developing respiratory symptoms consistent with COVID-19.³³⁵ Another resident who ultimately tested positive continued to eat in “the common room” on 4CLC as late as April 11, after developing signs and symptoms consistent with COVID-19.³³⁶

Thus, while it is impossible to say with certainty that any one decision resulted in the virus’s spread, continued communal dining certainly materially increased that risk.

2. *SEVC’s Isolation and Cohorting Decisions Were Plainly Insufficient*

From early April through the end of May, SEVC implemented a series of isolation and cohorting strategies that reflected no coherent infection control strategy and, we find, substantially increased the risk of COVID-19’s spread through the facility.

a. *SEVC Misunderstood and Failed to Question CCHD’s “Epi-linking” Guidance*

Pursuant to CCHD guidance, if there were two or more COVID-19 positive residents on a single unit, then residents on that unit who exhibit signs or symptoms of COVID-19 were considered epidemiologically linked, or “epi-linked.” The concept was used during the early COVID-19 outbreak to identify presumptively positive residents given the lack of testing capacity.³³⁷

³³² Interview of [REDACTED] (July 28, 2020 & Aug. 11, 2020).

³³³ Interview of [REDACTED] (July 29, 2020).

³³⁴ Resident 1 File,

³³⁵ Resident 2 File,

³³⁶ Resident 46 File,

³³⁷ Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

According to SEVC's internal records, SEVC received "epi-linking" guidance from CCHD on two occasions. First, on April 6, SEVC's records indicate that CCHD advised the facility that "[w]hen 2 resident tests positive on a Unit refrain from additional COVID-19 Testing" and "[s]ymptomatic residents" on that unit "are considered Probable/Epi-linked and should be treated based on symptoms."³³⁸ Then, on April 21, according to SEVC's log of its communications with CCHD, [REDACTED] – [REDACTED] at CCHD – advised SEVC that it did not need to "consolidat[e] residents linked or positive to one unit," because [REDACTED] "concluded that residents would likely have been already exposed, and moving them around may simply cause more exposure to others."³³⁹

SEVC implemented this "epi-linking" guidance, starting on April 7, by leaving confirmed COVID-19 positive residents on "epi-linked" units rather than moving them to negative pressure rooms.

(i) SEVC Misunderstood the Guidance

We find that SEVC both misinterpreted and misapplied CCHD's "epi-linking" guidance. A resident is considered "epi-linked" or presumptively positive only if two conditions are met: (1) the resident is on a unit where two or more other residents have tested positive; and (2) the resident exhibits signs or symptoms of COVID-19.³⁴⁰ Thus, on an "epi-linked" unit, there are three categories of residents: positive, presumed positive ("epi-linked"), and exposed but asymptomatic. SEVC's internal communication log appears to reflect the correct understanding that a resident must be symptomatic to be "epi-linked," and both Commandant Blackwood and DON Mullane understood that premise.³⁴¹ Nevertheless, SEVC implemented an isolation and cohorting strategy based on a different, incorrect understanding of "epi-linked" – namely, that once there are two more COVID-19 positive residents, the entire unit is deemed presumptively positive.

From an isolation and cohorting perspective, the distinction is important. If the whole floor is presumed positive, there is no need to move anyone off the floor. If only those who are symptomatic are presumed positive, those who are asymptomatic can be isolated from the positive residents and cohorted together as exposed residents. As [REDACTED] explained, in facilities with sufficient space, positive and presumed positive residents should be cohorted

³³⁸ SEVC Timeline (Apr. 6, 2020 entry) [REDACTED]. [REDACTED] denied that he instructed SEVC to "refrain" from testing, but confirmed that he advised SEVC that where there already were two or more positive cases, CCHD would not issue a PUI number for symptomatic residents. Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

³³⁹ CCHD Communications [REDACTED].

³⁴⁰ Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

³⁴¹ CCHD Communications [REDACTED]; Interview of R. Blackwood (Aug. 19 & 21, 2020); Interview of D. Mullane (Aug. 20, 2020).

together, negative residents should be cohorted together, and exposed but asymptomatic residents should also be cohorted together.³⁴²

SEVC's misunderstanding of the "epi-linking" concept and its consequences are evident as early as April 7, the day after its first "epi-linking" conversation with CCHD. In a report to DMVA, SEVC noted that, because of additional COVID-19 positive residents on 3 East, "per CCHD recommendations, this unit whole unit is now presumptive positive."³⁴³ After April 7, consistent with its incorrect understanding of "epi-linking," SEVC stopped moving positive residents off of 3 East and into negative pressure rooms (even though the guidance only purported to relate to testing). [REDACTED], however, denied having any conversations with SEVC in which he provided guidance or recommendations to stop moving residents to negative pressure rooms as an isolation strategy. We find [REDACTED]'s account to be credible, because such advice would only make sense – if at all – if it was referring to a unit that was wholly positive or presumptively positive.

Similarly, the April 21 conversation – which [REDACTED]'s notes indicate was with [REDACTED]³⁴⁴ – was nominally about cohorting "linked or positive" residents together.³⁴⁵ However, SEVC's notes further indicate that the guidance was to leave the residents on the unit and monitor for signs and symptoms. That again suggests an understanding of "linked" to include asymptomatic residents who need to be monitored for the development of COVID-19 symptoms. [REDACTED] stated that, although he had conversations with SEVC about cohorting, he never would have recommended that they leave exposed, asymptomatic residents in place on a floor with COVID-19 positive residents. [REDACTED] was unequivocal: "I would never say keep an asymptomatic resident in a unit with positive residents. That would never happen." Instead, [REDACTED] explained that his guidance would have been that, if SEVC had the capability to do so, it should move residents such that exposed but asymptomatic residents were not cohorted with COVID-19 positive residents.³⁴⁶

This misunderstanding of "epi-linking" also had important repercussions for SEVC's related PPE protocols. On April 7, SEVC explained that once a "whole unit" is deemed presumptively positive, staff on the unit "do not have to change [PPE] for each resident except for glove usage."³⁴⁷ [REDACTED], however, stated that he would "never have instructed [SEVC] to use the same PPE over and over." Rather, [REDACTED] stated that he would have referred SEVC to guidance from DOH and the CDC regarding strategies to optimize PPE supplies.³⁴⁸ Applicable CDC guidance does not allow for the reuse of isolation gowns for all residents on a unit without regard to the residents' COVID-19 status. Instead, that guidance permits the use of the same

³⁴² Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

³⁴³ SITREP (Apr. 7, 2020) [REDACTED].

³⁴⁴ Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

³⁴⁵ CCHD Communications [REDACTED].

³⁴⁶ Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

³⁴⁷ SITREP (Apr. 7, 2020) [REDACTED]; see also CCHD Communications [REDACTED].

³⁴⁸ Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

isolation gowns as an optimization strategy only when providing care for residents “*known to be* infected with the same infectious disease.”³⁴⁹ Thus, CDC guidance did not – and does not – permit using the same PPE for known, presumed, and exposed residents.

SEVC employees reported that, under this PPE protocol, staff would provide care to asymptomatic residents wearing the same PPE worn to provide care to positive and symptomatic residents.³⁵⁰ This increased the risk that asymptomatic residents on those units who had not already contracted COVID-19 would be exposed to COVID-19 through contaminated PPE. As [REDACTED] recognized, this practice “obviously would be a concern.”³⁵¹

The upshot of these combined policies – leaving asymptomatic residents in place and using the same PPE for the entire unit – greatly increased the risk of exposure to the virus for COVID-19 negative residents on the unit.

(ii) DMVA Misunderstood the Guidance As Communicated by SEVC

DMVA, in overseeing SEVC’s isolation and cohorting practices, also labored under SEVC’s misunderstanding of the CCHD “epi-linking” guidance. SEVC’s misinterpretation of “epi-linking” was evident in its reporting to DMVA. This resulted in DMVA itself inconsistently using the concept of “epi-linking” in daily situation reports prepared and distributed by BVH. For example, an April 9 report correctly noted that “per Chester County Health Department Guidance: When two or more residents on a unit have tested COV19 [sic] positive no further testing is indicated. When additional residents on that Unit become symptomatic, they are considered Probable/Epilinked.”³⁵² An April 7 report, on the other hand, noted that “SEVC has 28 residents on the 3 East Nursing Unit of Coates Hall that are now considered presumptively positive for COVID-19 according to Chester County DOH.”³⁵³ In other words, the entire unit was considered presumptively positive, regardless of signs and symptoms.

While the documentation was inconsistent, DMVA leadership’s understanding of “epi-linking” was not. Virtually everyone with decision-making authority at DMVA – including the Adjutant General, the BVH Director, and the CMO – incorrectly understood that everyone on a floor with two or more positive residents was considered “epi-linked” irrespective of

³⁴⁹ Ctrs. for Disease Control & Prevention, Strategies for Optimizing the Supply of Isolation Gowns (updated Mar. 17, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html> (emphasis added).

³⁵⁰ Interview of [REDACTED] (Aug. 17, 2020).

³⁵¹ Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

³⁵² SITREP (Apr. 9, 2020)

³⁵³ SITREP (Apr. 7, 2020) [REDACTED].

symptoms.³⁵⁴ We find that this misunderstanding contributed to DMVA’s incorrect belief that SEVC’s subsequent isolation and cohorting strategies were consistent with CCHD guidance.

(iii) Objections to the Guidance Were Disregarded

CCHD’s purported guidance to leave positive and presumed positive residents on their units with asymptomatic residents was controversial at the time. For example, SEVC Nurse [REDACTED] had concerns about leaving asymptomatic residents on floors that had been designated COVID-19 positive and wondered why SEVC would not “give those residents a chance not to catch the virus.” He explained that the response to his concerns was that SEVC was doing what CCHD told it to do and that SEVC had to follow CCHD’s guidance to minimize the risk of lawsuits.³⁵⁵ [REDACTED] also reported that she and other nurses were concerned about this practice and that she had heard that nurses who raised concerns were given vague answers like there was not enough room to move residents around the facility.³⁵⁶

Those in positions of authority, however, seemed unwilling even to question the practice of leaving asymptomatic residents on “epi-linked” units. [REDACTED], for example, did not have concerns about the policy and did not recall anyone else raising concerns.³⁵⁷ DON Mullane similarly explained that she understood the guidance and was not aware of any concerns.³⁵⁸ She believed that moving exposed residents to other areas of the building could cause more exposure to other residents. Commandant Blackwood did not express any disagreement with the policy either.³⁵⁹ BVH Director Ruscavage too could not recall whether anyone at DMVA disagreed with the guidance.³⁶⁰

Dr. Jackson, however, believed the “epi-linking” guidance was “puzzling,” because it would inevitably result in the other residents being further exposed to the virus.³⁶¹ Although he raised his concerns with Blackwood and Mullane, they told him that they were going to follow CCHD’s guidance.³⁶² Dr. Jackson tried to follow-up with CCHD directly, but was told by Blackwood that CCHD only wanted to communicate with its points of contact at SEVC.³⁶³

³⁵⁴ Interview of A. Ruscavage (Aug. 13, 2020) (noting that “epi-linked” applied to everyone on a floor where there were two or more positives, even if asymptomatic); Interview of A. Carrelli (Aug. 14 & 17, 2020) (same); Interview of D. Jackson (Aug. 19 & 26, 2020) (same).

³⁵⁵ Interview of [REDACTED] (July 7, 2020).

³⁵⁶ Interview of [REDACTED] (Aug. 14, 2020).

³⁵⁷ Interview of [REDACTED] (Aug. 12, 2020).

³⁵⁸ Interview of D. Mullane (Aug. 20, 2020).

³⁵⁹ Interview of R. Blackwood (Aug. 19 & 21, 2020).

³⁶⁰ Interview of A. Ruscavage (Aug. 13, 2020).

³⁶¹ Interview of D. Jackson (Aug. 19 & 26, 2020).

³⁶² Interview of [REDACTED] (Aug. 6, 2020).

³⁶³ Interview of D. Jackson (Aug. 19 & 26, 2020); Interview of [REDACTED] (Aug. 6, 2020) (noting that Dr. Jackson had concerns about the policy but was instructed by Blackwood that CCHD did not want him to call directly); Interview of A. Carrelli (Aug. 14 & 17, 2020) (noting that he learned from Andrew Ruscavage and General Weller that Dr. Jackson was “absolutely against”

[REDACTED], SEVC's point of contact at CCHD, reported that he never provided such an instruction to Blackwood.³⁶⁴ As discussed below, as CMO, Dr. Jackson should have insisted on direct access to CCHD, either separately, or together with SEVC's points of contact.

[REDACTED] recalled rooms with multiple patients, and when one patient tested positive for COVID-19, the other residents were not removed or separated. [REDACTED] was informed that was because the patients were already exposed. [REDACTED] expressed her disagreement with the practice to DON Mullane and [REDACTED]. They told her that they had discussed this practice with CCHD, and were told there was no point in moving the resident.³⁶⁵ As [REDACTED] for the facility, however, it was incumbent on [REDACTED] to understand precisely what the guidance was, how it was being implemented, and whether the guidance and/or implementation was appropriate.

On this point, we note that [REDACTED] was not heavily involved in SEVC's COVID-19 planning or decision-making. When she raised her concerns about her lack of involvement with Blackwood and Mullane, they invited her to participate on one call.³⁶⁶ CMO Dr. Jackson was aware that [REDACTED] was not participating on the calls for all of the SVH [REDACTED], but did nothing about it. He noted, however, that he believed it was important for the [REDACTED] to be involved in COVID-19 planning.³⁶⁷ Thus, this failure to involve [REDACTED] in all aspects of the facility's infection control planning is a failure of Blackwood and Mullane for not including her, as well as Dr. Jackson and [REDACTED] for not insisting that, as [REDACTED], she be heavily involved.

Ultimately, despite the concerns raised by Dr. Jackson and others, SEVC followed the "epi-linking" guidance from CCHD as they understood it. In explaining why SEVC chose to follow CCHD's guidance over any objections from DMVA – including from the CMO – DMVA leadership uniformly stated that they believed that CCHD's guidance was mandatory and that SEVC was therefore required to follow CCHD's direction.³⁶⁸ CCHD, on the other hand, disclaimed any authority to direct or authorize SEVC's actions, noting that its role was limited to providing guidance and recommendations.³⁶⁹

SEVC leadership bears significant responsibility for the misunderstood guidance and the resulting infection control errors, but it does not rest with them alone. SEVC leadership were

CCHD's "epi-linking" guidance); Email from R. Blackwood to D. Mullane and D. Jackson re Coroner Call (Apr. 8, 2020) ("I don't want too many people calling Chester county. It can't be managed.").

³⁶⁴ Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

³⁶⁵ Interview of [REDACTED] (June 17, 2020).

³⁶⁶ Interview of [REDACTED] (June 17, 2020).

³⁶⁷ Interview of D. Jackson (Aug. 19 & 26, 2020).

³⁶⁸ Interview of A. Ruscavage (Aug. 13, 2020); Interview of D. Jackson (Aug. 19 & 26, 2020); Interview of A. Carrelli (Aug. 14 & 17, 2020).

³⁶⁹ Interview of [REDACTED] (Aug. 13, 2020); Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

certainly on the ground, and obviously more familiar with the facility, its residents, and the nature of the conversations with CCHD. However, DMVA leadership – and in particular, Dr. Jackson and Ruscavage – should not have ceded so easily to SEVC leadership or CCHD. A recurring theme in conversations with Dr. Jackson was that he was intimidated by Commandant Blackwood and DON Mullane and did not push for what he believed was in the best interest of SEVC’s residents. For example, he cut short a mid-outbreak review of SEVC’s infection control procedures, because Mullane pushed back on his suggestions. In his words, “I had to leave. I was done.”³⁷⁰ When SEVC did not follow through on COVID-19 preparation plans, Dr. Jackson did not follow up, because he was “shell shocked.”³⁷¹ He said that he had been shot down so many times, he stopped pushing.

When it came to a decision as important and controversial as not isolating COVID-19 positive residents, however, it was incumbent upon Dr. Jackson as the Chief Medical Officer, and Ruscavage as BVH Director, to be fully engaged. It was a decision with which Dr. Jackson (and, as it turned out, CCHD) strongly disagreed.³⁷² Others, including VA nurses working at the facility, VA nurses who inspected the facility,³⁷³ the facility’s [REDACTED]³⁷⁴, [REDACTED]³⁷⁵, and at least one Nurse Supervisor,³⁷⁶ also had concerns. Yet for unexplained reasons, those concerns were dismissed in favor of ill-informed guidance translated through SEVC’s infection control nurses, who, as discussed below, were both overwhelmed and, in [REDACTED]’s case, under qualified.

Furthermore, Dr. Jackson and Ruscavage were not only in a position of authority to insist on compliance, they were also in a position of perspective. With responsibility for six homes in different parts of the state, each interfacing with different local health departments, Dr. Jackson and Ruscavage were well suited to question the guidance with both SEVC and CCHD. It was their responsibility to ensure they understood the guidance (which they did not), the reasons behind it, and the alternatives – if any – considered. A controversial decision of this magnitude, with the gravest of potential consequences at stake, should not be made with such little deliberation and with such great deference to unwritten “guidance.” The consequences of doing

³⁷⁰ Interview of D. Jackson (Aug. 19 & 26, 2020); *see also* Email from D. Mullane to [REDACTED] re Plaquenil (Apr. 22, 2020) [REDACTED] (noting that Dr. Jackson was at SEVC “[f]or a hot minute”).

³⁷¹ Interview of D. Jackson (June 9, 2020); Interview of D. Jackson (Aug. 19 & 26, 2020).

³⁷² Interview of D. Jackson (Aug. 19 & 26 2020).

³⁷³ Email from [REDACTED] to R. Blackwood re FW: PA State VA Home (May 8, 2020) [REDACTED]. The inspectors noted that they were told at SEVC that “they are following [CCHD] in cohorting patients that are positive or exposed / presumed positive.” The inspectors continued that they found DOH guidance on CCHD’s website that stated nursing facilities should “[c]onsider all residents in units with COVID-19 cases as exposed and potentially infectious.” *Id.* That guidance, however, does not support the decision to leave positive and exposed residents on the same floor together.

³⁷⁴ Interview of [REDACTED] (June 17, 2020).

³⁷⁵ Interview of [REDACTED] (June 25, 2020).

³⁷⁶ Interview of [REDACTED] (July 10, 2020).

so are only underscored by CCHD's representation that it would never have given the guidance as SEVC understood it.³⁷⁷

This failure, therefore, rests, not only with SEVC, but with certain members of DMVA's leadership, specifically Dr. Jackson and BVH Director Ruscavage.

b. SEVC Should Have Used 3 West for Isolation and Cohorting

SEVC had a vacant, 32-bed unit – 3 West in Coates Hall. It considered using that unit for isolation purposes during its initial COVID-19 planning. Instead, SEVC elected to utilize negative pressure rooms – 18 beds in six rooms across three floors in CLC. That decision was reasonable had the number of beds been sufficient. What was unreasonable was that, when COVID-19 began spreading through the building and overwhelming negative pressure room capacity, SEVC never seriously considered how it could use 3 West, even after abandoning the use of negative pressure rooms.

To the limited extent SEVC leadership and staff offered any reasons for their decision not to use 3 West, their explanations were flawed. First, SEVC noted that it reserved 3 West for staff so they would not risk exposing their families at home. However, by the time SEVC abandoned 3 West as an option to isolate COVID-19 positive residents, DMVA had communicated to the SVHs that it was procuring hotel rooms for staff to "quarantine . . . after they cared for residents with COVID-19" and for staff to use as a place to stay as needed.³⁷⁸ By April 7 – the day after SEVC had decided to use 3 West for staff, rather than as a COVID-19 unit – DMVA had notified SEVC that it had procured hotel rooms for its staff to use as needed.³⁷⁹ Commandant Blackwood acknowledged that staff largely did not utilize 3 West. Regardless, once DMVA procured hotel rooms for SEVC staff, it no longer was necessary to reserve 3 West for staff use, as even Blackwood acknowledged during this investigation. At that point, Blackwood stated that 3 West was available to use for resident cohorting, but that SEVC was never "directed to use it."

Another explanation commonly given for the decision not to use 3 West was a lack of staff. Blackwood claimed that he was uncertain that 3 West could be adequately staffed because the facility was already short staffed.³⁸⁰ DON Mullane stated that staffing was an issue in deciding not to use 3 West as an isolation unit. She and [REDACTED] acknowledged, however, that it would take less staff to operate a positive unit than to have dedicated staffing for each of six isolation rooms.³⁸¹ Indeed, Nurse Supervisor [REDACTED] explained that 3 West could have been a more effective isolation strategy than using the negative pressure rooms, because it would have required fewer staff than covering six negative pressure rooms required.³⁸²

³⁷⁷ Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

³⁷⁸ COVID19 Commandant Communication (Apr. 3, 2020) [REDACTED].

³⁷⁹ COVID19 Commandant Communication (Apr. 7, 2020) [REDACTED].

³⁸⁰ Interview of R. Blackwood (Aug. 19 & 21, 2020).

³⁸¹ Interview of D. Mullane (Aug. 20, 2020); Interview of [REDACTED] (Aug. 12, 2020).

³⁸² Interview of [REDACTED] (July 10, 2020).

Another explanation proffered by nursing leadership was that SEVC did not use 3 West because it was contrary to CCHD guidance.³⁸³ This just reinforces SEVC's misjudgments regarding "epi-linking." As CCHD's [REDACTED] explained, the guidance was never that it did not need to separate positive residents from asymptomatic residents, or that it should not use a vacant unit for cohorting purposes.³⁸⁴ There was no reason SEVC could not have moved positive residents from other units, or exposed residents from "epi-linked" units, to the vacant unit. Indeed, leaving COVID-19 positive residents on the same unit as the exposed residents – and treating them all using the same PPE – was against operative DOH guidance, which instructed facilities to separate, if possible, "COVID-19 positive residents" from potentially exposed residents.³⁸⁵ In any event, SEVC *was* moving residents, just not to negative pressure rooms or 3 West.³⁸⁶

Moreover, there is no evidence that, in connection with any discussion with CCHD regarding its "epi-linking" guidance, SEVC mentioned the existence of a vacant unit, much less one located on the same floor as the first "epi-linked" unit.³⁸⁷ As CCHD explained, the existence of such a unit, and its location, would be relevant to the recommendations it gave.³⁸⁸

Indeed, the lack of any meaningful discussion about 3 West is evident from SEVC's own notes of CCHD's purported guidance. The concern motivating the April 21 guidance, according to SEVC's records, was that "residents would likely have been already exposed, and moving them around may simply cause more exposure to others."³⁸⁹ However, moving exposed but asymptomatic residents on 3 East to a vacant unit across the hall – from the east side of the floor to the west side – could not possibly have "caused more exposure to others." There were no other residents on the floor to expose. On the other hand, SEVC's resulting plan was *guaranteed* to expose every resident on the unit. The plan essentially became a self-fulfilling prophecy: treat the whole unit as positive, and the whole unit will become positive. Those asymptomatic residents were doomed to be exposed on 3 East. Moving them to 3 West at least would have given them a chance.

³⁸³ Interview of [REDACTED] (Aug. 12, 2020).

³⁸⁴ Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

³⁸⁵ PAHAN 492 (Apr. 3, 2020), *available at* <https://www.health.pa.gov/topics/Documents/HAN/2020-PAHAN-492-04-03-ALT-Universal%20Masking.pdf>.

³⁸⁶ SITREP (Apr. 17, 2020) [REDACTED].

³⁸⁷ Interview of [REDACTED] (July 28, 2020) (noting that she did not recall having conversations with CCHD regarding 3 West, and if she did, they would be reflected in the communication log); CCHD Communications [REDACTED] (reflecting no discussion of 3 West); Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020). *But see* Interview of D. Mullane (Aug. 20, 2020) (noting that she recalled talking to [REDACTED] at some point about 3 West).

³⁸⁸ Interview of [REDACTED] (Aug. 13, 2020); Interview of [REDACTED] (Aug. 13, 2020 & Sept. 11, 2020).

³⁸⁹ CCHD Communications [REDACTED].

Commandant Blackwood and BVH Director Ruscavage could offer no viable reason why SEVC did not consider 3 West once the outbreak worsened. Blackwood explained that while 3 West was available at that time for COVID-19 positive residents or the isolation of exposed residents, SEVC did not consider moving residents there because CCHD did not direct SEVC to do so.³⁹⁰ This is a complete abdication of SEVC's responsibility to develop and implement its own infection control plans.

Ruscavage stated that he believed that SEVC would have considered 3 West as an option once SEVC started seeing more positive cases, but did not know why it was not used. He declined to "speculate" as to whether 3 West should have been used, because he does not believe in "Monday morning quarterbacking."³⁹¹

SEVC staff also did not understand why 3 West was not used. Nurse [REDACTED] advised that she and other staff wondered why 3 West was not being used for isolation and that, when they asked supervisors, they responded simply that the unit was not being reopened.³⁹² Unit Manager [REDACTED] did not know why SEVC did not use 3 West, but believes it should have been used for isolation purposes, rather than reserving it for staff.³⁹³ Another Nurse Supervisor, [REDACTED], also did not know why 3 West was never used as an isolation unit, but opined that using 3 West might have helped stem the tide of SEVC's COVID-19 outbreak.³⁹⁴

Outside inspectors similarly questioned why 3 West was not used for isolation purposes. On May 5, ICNs from the VA completed an assessment of SEVC. During that assessment, the VA nurses suggested using 3 West for cohorting residents "to minimize further exposure" to COVID-19 within the facility.³⁹⁵ The email went on to explain that SEVC "stated they are following the Chester County Department of Health in cohorting patients that are positive or exposed / presumed positive." This explanation, however, is only further evidence of SEVC's misunderstanding of CCHD's guidance. By conflating "presumed positive" (or "epi-linked") with "exposed," it drove the misguided non-isolation policy SEVC pursued.

Dr. Brangman agreed that it made no sense for SEVC not to use the vacant floor to isolate exposed but asymptomatic residents off of 3 East. In her opinion, the failure to use 3 West is the natural consequence of relying on generalized guidance that is not based on an understanding of the facts on the ground.³⁹⁶

This failure to consider 3 West for any isolation or cohorting purpose rests squarely with SEVC leadership. DMVA leadership – including BVH Director Ruscavage and CMO Jackson – also bear responsibility for this failure. In their positions of oversight and authority, they should

³⁹⁰ Interview of R. Blackwood (Aug. 19 & 21, 2020).

³⁹¹ Interview of A. Ruscavage (Aug. 13, 2020).

³⁹² Interview of [REDACTED] (Aug. 17, 2020).

³⁹³ Interview of [REDACTED] (July 13, 2020).

³⁹⁴ Interview of [REDACTED] (July 10, 2020).

³⁹⁵ Email chain re PA State VA Home Confidential (May 9, 2020) [REDACTED].

³⁹⁶ Interview of S. Brangman (Sept. 4, 2020).

have insisted on compelling, informed reasons for the decision not to use a vacant unit for isolation purposes.

c. SEVC's Cessation of the Use of Negative Pressure Rooms

After receiving “epi-linking” guidance from CCHD, SEVC changed its initial isolation plan and stopped using negative pressure rooms for isolation purposes. By April 17, SEVC had moved the last residents out of its negative pressure rooms. Thus, at that point, SEVC was using neither the 18 negative pressure room beds nor 3 West for isolation purposes, although they continued to move COVID-19 positive and presumed positive residents around the building as necessary, for example, to move personal care residents to skilled nursing units.³⁹⁷

No one at SEVC was able to articulate the facility’s isolation plan that was in place during this period. Mullane could not recall why they decided to stop using the negative pressure rooms altogether, instead noting that they were trying to do their best.³⁹⁸ Commandant Blackwood – by his own account a hands-on manager – could only describe the isolation plan at that point in time as “whatever Chester County Health Department told us to do.”³⁹⁹

This inability to articulate SEVC’s isolation plan – or to provide any explanation for why the facility stopped using the negative pressure rooms for any purpose – is a clear infection control and leadership failure. Furthermore, Blackwood’s refusal even to acknowledge SEVC’s obligation to have its own infection control plan is demonstrative of a cultural unwillingness to accept responsibility, which we discuss below.

d. SEVC Unnecessarily Used Commingled Units

With access to additional testing capacity in late April, SEVC conducted universal testing of all residents to facilitate cohorting. On May 7, CMO Dr. Jackson emailed Commandant Blackwood and DON Mullane to confirm that they were “creating a plan to move the COVID negative residents to clean units” and “off isolation units.”⁴⁰⁰ Notwithstanding the availability of 3 West, Blackwood represented to DMVA leadership that SEVC was unable to “move [its] negative residents to clean units” as DMVA instructed.⁴⁰¹ As a result, although SEVC was able to cohort residents based on their test results by May 8, SEVC still had “commingled units” (3 East and 4CLC) where COVID-19 positive and COVID-19 negative residents were on the same floor.⁴⁰²

³⁹⁷ SITREP (Apr. 17, 2020) [REDACTED]; Interview of R. Blackwood (Aug. 19 & 21, 2020).

³⁹⁸ Interview of D. Mullane (Aug. 20, 2020).

³⁹⁹ Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁴⁰⁰ Email chain re Relocating COVID Negative Residents (May 7, 2020) [REDACTED].

⁴⁰¹ Email from A. Ruscavage to R. Blackwood re Cohort (May 7, 2020) [REDACTED].

⁴⁰² Email D. Mullane to R. Blackwood re SEVC Information Requested (May 9, 2020)

The decision to create commingled units – particularly given the availability of a vacant 32-bed unit – is one that needlessly created risk of cross-contamination between COVID-19 positive and negative residents. It was also controversial at the time. [REDACTED] expressed concerns about the decision to create commingled units, but Mullane explained that the policy was an effort to limit the movement of residents off of the previously positive units.⁴⁰³

SEVC's cohorting strategy suffered from two additional weaknesses that undermined its effectiveness. First, SEVC did not clearly mark the status of the units. Acting Commandant [REDACTED] reported that when she arrived at SEVC at the end of May, the entrances to all but three units were covered in black tarps, with no indication of whether the units were COVID-19 positive or COVID-19 exposed units.⁴⁰⁴ Acting DON [REDACTED] similarly reported that there was no indication outside the units in Coates Hall as to whether the units were COVID-19 positive or COVID-19 exposed, and there was no indication of what PPE should be used when on the units.⁴⁰⁵

Moreover, SEVC's positive units – including its “commingled” units – were set up with a single place to enter and exit the unit. Outside of the unit was an anteroom in which staff donned PPE when entering the unit and doffed PPE when exiting. This created the potential for cross-contamination between staff within the anteroom, where staff who had not yet donned PPE were exposed to PPE that already had been worn on the unit.⁴⁰⁶ On commingled units, the potential for cross-examination was even more evident. [REDACTED] explained, for example, that one side of 3 East had COVID-19 positive residents and the other had COVID-19 negative residents, without any physical barrier between the sides.⁴⁰⁷ The point of entry and exit was on the COVID-19 negative side of the unit. As a result, staff from the COVID-19 positive side of the unit had to walk through the COVID-19 negative side of the unit wearing their contaminated PPE and doff that PPE in the anteroom on the COVID-19 negative side of the unit before exiting.⁴⁰⁸

When the new SEVC administration came in, they took immediate steps to address these deficiencies. First, the administration, in conformity with DOH guidance, created “Green” (negative or unexposed), “Yellow” (exposed), and “Red” (positive) units.⁴⁰⁹ They created large, clear signage designating the status of the unit and the type of PPE to be worn on it. The new administration also created separate entrances and exits for the units to prevent cross-

⁴⁰³ Interview of [REDACTED] (June 25, 2020).

⁴⁰⁴ Interview of [REDACTED] (Aug. 6, 2020).

⁴⁰⁵ Interview of [REDACTED] (July 20, 2020).

⁴⁰⁶ E.g., Interview of [REDACTED] (Aug. 6, 2020).

⁴⁰⁷ Interview of [REDACTED] (June 25, 2020).

⁴⁰⁸ *Id.*; see also Interview of [REDACTED] (July 20, 2020); Interview of [REDACTED] (Aug. 17, 2020).

⁴⁰⁹ Interview of [REDACTED] (June 11 & 15, 2020); Interview of [REDACTED] (July 17, 2020); Interview of [REDACTED] (Aug. 6, 2020); PAHAN 508 (May 12, 2020), available at <https://www.health.pa.gov/topics/Documents/HAN/2020%20%80%93PAHAN%20%80%93508%20%80%9305-12-ADV-Test-based%20Strategies.pdf>.

contamination within the donning and doffing anterooms.⁴¹⁰ They also began using 3 West as a “Yellow” isolation unit.⁴¹¹ According to DMVA [REDACTED], SEVC had the capacity to implement these changes as early as April, but obviously did not.⁴¹²

3. SEVC Should Have Conducted Contact Tracing

On March 25, CCHD provided [REDACTED] a COVID-19 “toolkit,” compiled by DOH, that included guidance setting forth the “steps to conduct contact tracing for a COVID-19-positive case.”⁴¹³ As of April 10, CCHD was instructing long-term and congregate care facilities within Chester and Delaware Counties to conduct contact tracing, starting two days “prior to the symptom onset date.”⁴¹⁴ Nevertheless, SEVC engaged in no meaningful contact tracing for the staff and residents who tested positive in early April.

SEVC’s decision not to conduct formal contact tracing was based on purported “state instruction not to try to trace cases” and “to maintain employee’s privacy.”⁴¹⁵ Several SEVC staff members confirmed that their understanding was that SEVC was not conducting contact tracing based on health department guidance. For instance, DON Mullane instructed that contact tracing was “not recommended” by the time the first SEVC staff member tested positive for COVID-19 given the extent of community spread outside the facility.⁴¹⁶ [REDACTED] stated that SEVC did not conduct contact tracing because Commandant Blackwood advised that the health department did not recommend contact tracing at the time SEVC had its first positive cases because COVID-19 was so widespread.⁴¹⁷

Blackwood, while acknowledging that there was no formal contract tracing policy, stated that he believed that ICN [REDACTED] was doing a “version” of contact tracing and thought that she was on the floors to identify “clusters.” However, he did not know whom or how many staff members she spoke with regarding the “contact tracing” he believed she was conducting.⁴¹⁸ ICN [REDACTED] stated that she could not recall any conversations with CCHD regarding contact tracing and did not recall SEVC leadership discussing contact tracing.⁴¹⁹ Blackwood also suggested that, because there was no formal contact tracing policy, he did not believe he could take any

⁴¹⁰ Interview of [REDACTED] (Aug. 6, 2020); Interview of [REDACTED] (July 17, 2020).

⁴¹¹ Interview of [REDACTED] (Aug. 6, 2020); Interview of [REDACTED] (July 17, 2020).

⁴¹² Interview of [REDACTED] (July 17, 2020).

⁴¹³ Steps to Conduct Contact Tracing for a COVID-19-Positive Case (Mar. 21, 2020)

[REDACTED]; Email from [REDACTED] to D. Mullane, [REDACTED], [REDACTED], [REDACTED], and R. Blackwood re LTCF (Mar. 25, 2020) [REDACTED].

⁴¹⁴ Email from [REDACTED] to R. Blackwood re AGENDA for 10 April Chester & Delaware Counties Weekly Long Term and Congregate Care Facilities COVID-19 Call (Apr. 10, 2020) [REDACTED].

⁴¹⁵ SEVC COVID-19 Stand-Down Minutes (Mar. 31, 2020 entry) [REDACTED].

⁴¹⁶ Interview of [REDACTED] (June 25, 2020); Interview of D. Mullane (Aug. 20, 2020).

⁴¹⁷ Interview of [REDACTED] (June 11, 2020).

⁴¹⁸ Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁴¹⁹ Interview of [REDACTED] (July 28, 2020).

steps – such as quarantining an exposed but asymptomatic staff member – had they done more rigorous contact tracing.⁴²⁰

With respect to the applicable guidance at the time of the first positive cases at SEVC, as of March 31, there was no state instruction *not* to conduct contact tracing. Rather, under both DOH and CDC guidance, contact tracing was “the recommended strategy for identifying the risk of transmission of COVID-19” within healthcare facilities.⁴²¹ While the guidance recognized that contact tracing might not be practicable for healthcare facilities in areas with sustained community spread, it appears that SEVC determined that once there was a COVID-19 positive case in the building, that was “community spread” and no contact tracing was necessary.⁴²² There is no indication – either from interviews or documents – that SEVC considered whether contact tracing at any point would be impractical. Furthermore, there is no indication that CCHD – the entity on which SEVC claims principally to have relied for COVID-19 related guidance – had determined that community spread within Chester County had risen to the level that contact tracing was impractical for SEVC.

To the contrary, the week before SEVC had its first positive case, CCHD provided SEVC and other long-term care facilities a “toolkit” containing guidance on how to conduct contact tracing in long-term care facilities.⁴²³ As of April 10, CCHD still was instructing long-term care facilities within Chester and Delaware Counties to conduct contract tracing.⁴²⁴ In fact, on April 4, the day after SEVC received confirmation of its first positive resident, SEVC discussed with CCHD, “at great lengths,” the resident’s “symptoms, tracing and roommates.”⁴²⁵ Moreover, as noted, SEVC engaged in at least some form of contact tracing with respect to the first staff

⁴²⁰ Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁴²¹ PA HAN 484 (Mar. 9, 2020), *available at* <https://web.archive.org/web/20200309230138/https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>; Ctrs. for Disease Control & Prevention, Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19) (updated Mar. 7, 2020), *available at* <https://web.archive.org/web/20200309230138/https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>.

⁴²² Interview of [REDACTED] (July 7 & 9, 2020) (explaining that [REDACTED] advised that contact tracing was unnecessary because SEVC already had a COVID-19 case in the building “which mean[t] it was community spread”).

⁴²³ Email from [REDACTED] to D. Mullane, [REDACTED], [REDACTED], [REDACTED], and R. Blackwood re LTCF (Mar. 25, 2020) [REDACTED].

⁴²⁴ Email from [REDACTED] to R. Blackwood re AGENDA for 10 April Chester & Delaware Counties Weekly Long Term and Congregate Care Facilities COVID-19 Call (Apr. 10, 2020) [REDACTED].

⁴²⁵ CCHD Communications [REDACTED].

member who tested positive.⁴²⁶ Nevertheless, SEVC took no infection control measures based on the tracing it had done.

It should be recognized that, on this point, SEVC was not alone among the SVHs.

[REDACTED], stated that none of the SVHs were conducting contact tracing. [REDACTED] explained that, early in April, Dr. Jackson consulted with DOH and was told that there were too many cases already, that contact tracing therefore was not necessary, and DOH did not have the time to issue further contact tracing guidance at that time.⁴²⁷ Dr. Jackson explained that DMVA did not implement contact tracing procedures applicable to all SVHs, because there was not enough time at the outset of the COVID-19 outbreak to draft and implement the procedures.⁴²⁸ At the end of April, Dr. Jackson circulated a request to all SVHs for their “COVID Pandemic Documentation,” including each home’s “contact tracing” policy.⁴²⁹ It does not appear that any SVH provided a formal contact tracing policy in response to Dr. Jackson’s inquiry. [REDACTED] – who was the [REDACTED] until her transfer to SEVC – explained that her administration [REDACTED] did not develop and implement a formal contact tracing policy. Rather, [REDACTED] engaged in only informal contact tracing in the same manner the home did for influenza.⁴³⁰

Even if the eventual extent of the COVID-19 outbreak both within and around SEVC explains the absence of a full contact tracing protocol, it does not justify SEVC’s decision not to engage in any meaningful tracing at the outset of the outbreak. Nor does it explain why, when SEVC engaged in the limited contact tracing it did do – for example, with the first positive resident and staff – it took no infection control precautions based on that information.

4. SEVC Failed to Implement Any Consistent Policy for Infection Control

SEVC did not execute – nor were staff or the administration able to articulate – a standard infection prevention protocol. In particular, there appeared to be no policy for the timing of infection control precautions, such as “droplet precautions,” which are the measures implemented to prevent the spread of infections by residents known or suspected to be infected with certain pathogens. Sometimes precautions were implemented at the onset of signs or symptoms of COVID-19, at other times only after a test was done, and still other times only after a positive test result was received. For example, one nurse who worked on 4CLC – an early hot bed of SEVC’s COVID-19 outbreak – explained that one of the first residents who tested positive for COVID-19 on the floor had a fever and was very weak before testing positive for COVID-19. The resident, however, was not placed on infection prevention and control precautions in the time between developing a fever and testing positive for COVID-19. Even

⁴²⁶ Email from A. Ruscavage to E. Weller, D. Jackson, and [REDACTED] re Update (Apr. 1, 2020) [REDACTED].

⁴²⁷ Interview of [REDACTED] (Aug. 6, 2020).

⁴²⁸ Interview of D. Jackson (Aug. 19, 2020).

⁴²⁹ E.g., Email from D. Jackson to [REDACTED], [REDACTED], and [REDACTED] re COVID Pandemic Documentation (Apr. 30, 2020) [REDACTED].

⁴³⁰ Interview of [REDACTED] (Aug. 6, 2020).

after several 4CLC residents had tested positive for COVID-19, SEVC did not universally implement infection prevention and control precautions for 4CLC residents exhibiting signs and symptoms of COVID-19 until on or around April 15.⁴³¹

Another SEVC nurse who worked on 4 West in Coates Hall reported that, early on, residents exhibiting signs and symptoms were not placed on infection prevention and control precautions or isolated as a matter of course. Instead, residents exhibiting signs or symptoms of respiratory illness were treated as SEVC treated any other respiratory illness before COVID-19. SEVC would notify SEVC's providers of the signs and symptoms and await further instruction.⁴³²

A National Guard medic working on 2 West in Coates Hall – where a COVID-19 outbreak began in late April into May – reported a similar experience. He recalled a resident on the unit who was exhibiting signs and symptoms of respiratory illness for three to four days before the resident was placed on infection prevention and control precautions.⁴³³ According to this medic, it was not until the resident was diagnosed with pneumonia that SEVC placed the resident on precautions, as confirmed in the resident's medical record.⁴³⁴ This practice exposed both residents and staff to the risk of contracting COVID-19. As a result, the National Guard was forced to pull nine service members from SEVC after those service members provided direct care to a symptomatic resident in inadequate PPE.⁴³⁵

SEVC leadership was similarly unable to explain any consistent policy for the timing of the facility's infection control interventions. Commandant Blackwood explained that decisions to place residents on infection prevention and control precautions were left up to SEVC's ICNs and were made on a "resident specific" basis.⁴³⁶ Thus, Blackwood could only state that "in many cases," SEVC placed residents under infection prevention and control precautions before they were tested for COVID-19.⁴³⁷ SEVC's ICNs, however, denied that they were responsible for those decisions and could not say for certain whether residents suspected of having COVID-19 were placed on droplet precautions before receiving test results.⁴³⁸

DON Mullane explained that it was up to the facility's [REDACTED] to determine whether and when a resident should be placed on droplet precautions and that the nursing staff had no involvement in that decision.⁴³⁹ CMO Dr. Jackson noted, however, that any resident exhibiting signs and symptoms of COVID-19 – and certainly any resident with symptoms

⁴³¹ Interview of [REDACTED] (Aug. 17, 2020).

⁴³² Interview of [REDACTED] (July 15, 2020).

⁴³³ Interview of [REDACTED] (July 22, 2020).

⁴³⁴ Interview of [REDACTED] (July 22, 2020); Resident 64 File, [REDACTED]

⁴³⁵ May 1, 2020 Email from [REDACTED] to [REDACTED] re SEVC Concerns / Update / Recommendation.

⁴³⁶ Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁴³⁷ Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁴³⁸ Interview of [REDACTED] (July 28, 2020).

⁴³⁹ Interview of D. Mullane (Aug. 20, 2020).

significant enough to warrant a test – should have been placed on precautions without exception.⁴⁴⁰

This lack of a standardized policy regarding infection control precautions resulted in wildly different practices for different residents. For example, the first resident to test positive for COVID-19, first exhibited symptoms on April 1. The next day he was swabbed, moved to an isolation room, and placed on isolation precautions (he received a positive test result on April 3).⁴⁴¹ On the other hand, SEVC did not place the second resident to test positive for COVID-19 under droplet precautions until several days after he began exhibiting symptoms and was tested for COVID-19. This resident developed a cough on March 20 and by, April 3, SEVC was treating him for pneumonia. On April 4, SEVC tested the resident for COVID-19. SEVC did not place the resident under droplet precautions until April 6, when SEVC received notice of the resident's positive COVID-19 test and moved him to a negative pressure room.⁴⁴² Similarly, another resident developed symptoms consistent with COVID-19 and was tested for influenza on March 30. It does not appear that SEVC placed the resident under droplet precautions until April 7, upon receipt of the resident's positive COVID-19 test result.⁴⁴³ Another resident to test positive for COVID-19 was swabbed on April 5 after developing a low-grade fever, but was not placed under droplet precautions until April 7, when SEVC received notification of the resident's positive COVID-19 test result.⁴⁴⁴

This failure to have any discernable infection control protocol resulted in seemingly arbitrary decisions and risked further spread of the virus. We find that it is directly attributable to SEVC's preparedness failures we have already identified. Ultimately, the responsibility for those failures lies with SEVC leadership for failing to develop adequate infection control plans and ceding all responsibility for infection control to SEVC's ICNs.

5. SEVC Failed to Use Dedicated Staff for COVID-19 Positive Units

SEVC did not consistently use dedicated staff to provide care for COVID-19 positive residents. This was despite directions from DMVA to do so. Some of SEVC's leadership team claimed that it was rare for staff to move between COVID-19 positive and COVID-19 negative units from shift to shift. However, that is inconsistent with the weight of the evidence uncovered during this investigation. This failure to utilize dedicated staffing created significant risks of cross-contamination throughout the facility.

⁴⁴⁰ Interview of D. Jackson (Aug. 19 & 26, 2020).

⁴⁴¹ Resident 1 File [REDACTED].

⁴⁴² Resident 2 File, [REDACTED].

⁴⁴³ Resident 5 File,

[REDACTED]. But see Resident 5 File, [REDACTED].

⁴⁴⁴ Resident 4 File, [REDACTED].

Initially, SEVC planned to have a team of approximately 50 staff who would be dedicated to providing care for residents with COVID-19.⁴⁴⁵ Once the COVID-19 outbreak at the facility started, however, staff were calling off or being sent home due to COVID-19 screening. Maintaining dedicated staffing at that point became difficult.⁴⁴⁶ In addition, the number of infections among residents within SEVC outpaced the number of dedicated staff SEVC had to provide care to those residents. SEVC's plan for having a dedicated staff for the few residents it expected to be infected with COVID-19 was therefore "overtaken."⁴⁴⁷

Despite these difficulties, and over pushback from Commandant Blackwood and DON Mullane, BVH Director Ruscavage and CMO Dr. Jackson insisted that, unless truly impossible, SEVC was required to maintain dedicated staffing for COVID-19 positive residents.⁴⁴⁸ As of April 10, however, SEVC supervisors were still pulling staff from COVID-19 units to clean units.⁴⁴⁹

Despite contending that they had insufficient staffing resources, Mullane claimed during this investigation that staff being pulled from COVID-19 units to clean units was the exception, not the norm, at SEVC. She stated that SEVC tried "desperately" to ensure that staff working on COVID-19 units stayed on those units and that "95 percent of the time" SEVC was successful in maintaining dedicated staff.⁴⁵⁰ [REDACTED], however, expressed concerns to Mullane that nurses and CNAs were moving from COVID-19 positive to COVID-19 negative units. Mullane responded to her that this was necessary to "balance" staffing and it could not be done any other way.⁴⁵¹

The majority of SEVC employees interviewed reported that it was not uncommon for staff to be pulled from COVID-19 positive floors to work on clean floors and vice versa. Nurse Supervisor [REDACTED], for example, explained that while supervisors would try their best not to pull staff from a COVID-19 positive floor to a clean floor, the practice was not prohibited.⁴⁵² Nurse Supervisor [REDACTED] similarly explained that staff could be pulled from exposed units to "clean" units. When [REDACTED] raised the issue with Mullane, she explained the "no pulling" policy as a "soft rule," and that the units needed to be staffed appropriately.⁴⁵³ Social Worker [REDACTED] reported that it was common for staff to switch between COVID-19 negative units and COVID-19 positive units. For instance, [REDACTED] recalled that CNAs would work on a COVID-19 positive

⁴⁴⁵ SEVC COVID-19 Stand-Down Meeting Minutes (Mar. 24, 2020 & April 6, 2020 entries) [REDACTED]; Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁴⁴⁶ Interview of [REDACTED] (June 25, 2020); Interview of [REDACTED] (June 11, 2020).

⁴⁴⁷ Interview of A. Carrelli (Aug. 14 & 17, 2020).

⁴⁴⁸ Interview of [REDACTED] (Aug. 6, 2020); Interview of D. Jackson (Aug. 19 & 26, 2020); Interview of A. Ruscavage (Aug. 13, 2020).

⁴⁴⁹ Email from A. Ruscavage to R. Blackwood and D. Mullane re SEVC LM Meeting Follow Up (Apr. 10, 2020) [REDACTED].

⁴⁵⁰ Interview of D. Mullane (Aug. 20, 2020).

⁴⁵¹ Interview of [REDACTED] (June 17, 2020).

⁴⁵² Interview of [REDACTED] (July 8, 2020).

⁴⁵³ Interview of [REDACTED] (July 7 & 9, 2020).

floor on one shift and then work on a COVID-19 negative floor the next day. [REDACTED] also reported that CNAs would work on COVID-19 positive floors one shift and then stay on for the following shift and work overtime on a COVID-19 negative floor.⁴⁵⁴ Nurse [REDACTED] similarly explained that CNAs were pulled from COVID-19 negative units to work on COVID-19 positive units and that CNAs, at times, would work on COVID-19 positive units one day and COVID-19 negative units the next day.⁴⁵⁵ [REDACTED] similarly reported that, at times, there were staff members who worked on both COVID-19 positive units and COVID-19 negative units.⁴⁵⁶

National Guard service members also reported that SEVC staff moving between COVID-19 positive and negative units was common. For instance, [REDACTED] received reports from National Guard service members at SEVC that staff was moving from COVID-19 negative to positive floors more than once a day.⁴⁵⁷ [REDACTED] explained that staff members appeared to be moving constantly between COVID-19 positive and negative units.⁴⁵⁸ [REDACTED] explained that there were staff members who would work a shift on a floor with suspected or confirmed COVID-19 cases and then move to a clean floor for a second shift. [REDACTED] recalled observing a CNA come to work on 2 West – which, at the time, was a clean floor – after working on a COVID-19 positive floor on their previous shift. [REDACTED] believed SEVC shifted staff between COVID-19 positive units and COVID-19 negative units on a daily basis.⁴⁵⁹ Yet another National Guard service member, [REDACTED], reported that SEVC nurses commonly moved between COVID-19 positive and negative floors.⁴⁶⁰

One of the significant factors contributing to this issue was a lack of clear communication regarding which units were COVID-19 positive units. SEVC did not identify the COVID-19 status of units on staffing schedules due to perceived HIPAA concerns.⁴⁶¹ While [REDACTED] explained that she did her best to avoid moving staff from COVID-19 positive floors to COVID-19 negative floors, [REDACTED] reported that when she arrived on May 28, [REDACTED] was not even sure which units were COVID-19 positive units.⁴⁶² In any event,

⁴⁵⁴ Interview of [REDACTED] (July 6, 2020).

⁴⁵⁵ Interview of [REDACTED] (July 29, 2020).

⁴⁵⁶ Interview of [REDACTED] (July 7, 2020).

⁴⁵⁷ Interview of [REDACTED] (June 29, 2020).

⁴⁵⁸ Interview of [REDACTED] (July 8, 2020).

⁴⁵⁹ Interview of [REDACTED] (July 22, 2020).

⁴⁶⁰ Interview of [REDACTED] (July 21, 2020).

⁴⁶¹ Interview of [REDACTED] (June 11, 2020); Interview of [REDACTED] (July 7 & 9, 2020). Any claim that HIPAA prevented supervisors and staffing personnel from listing the COVID-19 status of units – not residents – is unfounded, and demonstrates an utter lack of training. The presence of unidentified individuals on a unit with COVID-19 is not personally identifiable information of anyone. Indeed, as discussed, current leadership has clearly identified the status of units and the staff who have worked on those units.

⁴⁶² Interview of [REDACTED] (July 20, 2020).

[REDACTED] responsibility was to create the initial schedule; it was the supervisors who would pull from other units when staff called out.⁴⁶³

In short, there does not appear to have been any serious effort under Blackwood and Mullane to manage staffing in such a way as to limit cross-contamination.

In contrast, new leadership has taken concrete steps to ensure dedicated staffing. In particular, Acting DON [REDACTED] created schedules listing each staff member organized by whether the staff member worked with COVID-19 positive residents or COVID-19 negative residents. Any necessary staffing decisions then could be based on up-to-date information on whether staff had worked on red, yellow, or green units. Where unit continuity could not be maintained, [REDACTED] implemented policies to ensure color continuity. In other words, if a red unit needed staffing, staff from another unit could be assigned, so long as the unit the staff member previously worked on was a red unit. Where a staff member had to move from a green unit to a red or yellow unit, that staff member was then maintained on that color unit.⁴⁶⁴

These are all steps the prior administration could have implemented to ensure dedicated staffing to the greatest degree possible.

6. SEVC's Infection Control Training Was Inadequate

SEVC failed to ensure that staff received meaningful, comprehensive COVID-19 related infection control training. As a threshold matter, there appeared to be a lack of understanding as to who was responsible for infection control training. The ICNs, [REDACTED] and [REDACTED], denied responsibility for infection control training, stating that it was the responsibility of the nurse instructors.⁴⁶⁵ One of SEVC's [REDACTED] stated that infection control training was the ICNs' responsibility, and the other viewed it as a mixed responsibility among the Nursing Instructors, ICNs and supervisors.⁴⁶⁶ From DMVA's perspective, infection control training was primarily the responsibility of the ICNs.⁴⁶⁷ SEVC's COVID-19 preparedness checklist assigned training responsibility to the nurse instructors.⁴⁶⁸ Any confusion on this issue rests with SEVC's leadership and, we believe, is due to SEVC's preparedness failures discussed above.

What training was done did not prepare SEVC staff for the infection control procedures that were necessary to prevent the spread of COVID-19 throughout the facility. After initial hand and respiratory hygiene training starting on March 9,⁴⁶⁹ SEVC conducted no further

⁴⁶³ Interview of [REDACTED] (July 15, 2020).

⁴⁶⁴ Interview of [REDACTED] (July 20, 2020).

⁴⁶⁵ Interview of [REDACTED] (June 10, 2020); Interview of [REDACTED] (July 28, 2020).

⁴⁶⁶ Interview of [REDACTED] (June 11, 2020); Interview of [REDACTED] (June 12, 2020).

⁴⁶⁷ Interview of [REDACTED] (July 17, 2020).

⁴⁶⁸ COVID-19 Preparedness Checklist [REDACTED]; Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁴⁶⁹ Email from [REDACTED] to [REDACTED] re Infection Prevention (Mar. 6, 2020)

COVID-19 infection prevention trainings in March.⁴⁷⁰ Instead, the only COVID-19-related trainings SEVC conducted in March related to conducting screenings. In addition, SEVC conducted a training entitled “COVID-19 Information and Update.”⁴⁷¹ That training, however, provided no infection control guidance or other substantive COVID-19 guidance. Instead, it directed staff to “refrain from passing rumors” and advised that “[s]hould SEVC have a case of COVID-19 among the residents, there is a strong system in place to address them, and a back up system already developed.” The training did not provide any education on what SEVC’s plans were for handling a COVID-19 case among its residents. Rather, the training advised that SEVC would “educate” staff if it “need[ed] to implement those plans.”⁴⁷²

The trainings SEVC did conduct were virtually all “read and sign.” Staff members were provided a sheet of paper and acknowledged in writing that it had been read by or to them.⁴⁷³ Unit Manager [REDACTED] confirmed that Nurse Supervisors and Unit Managers were responsible for conducting “read-and-sign” trainings on infection control, which consisted of simply handing out information on infection control.⁴⁷⁴ As BVH Director Ruscavage noted, however, that “is not a way to do training.”⁴⁷⁵ There were few demonstrative trainings and no competencies. As DON Mullane explained to DMVA in May, SEVC was too busy to perform competencies.⁴⁷⁶ Mullane also explained to DMVA that SEVC was conducting “read-and-sign” trainings to avoid having instructors unnecessarily visit units where there were COVID-19 positive residents.⁴⁷⁷ Other facilities, however, did competencies on hand hygiene and donning and doffing PPE, and demonstrations on swabbing for COVID-19 testing.⁴⁷⁸

After reviewing the “trainings” SEVC had conducted, [REDACTED] observed that many of the “trainings” were “just ‘handouts’” of information with no effort made to put the material “in a ‘training’ format.”⁴⁷⁹ Thus, both in substance and format, the training was wholly inadequate.⁴⁸⁰ However, when BVH sent COVID-19 training materials

⁴⁷⁰ See Email from [REDACTED] to [REDACTED] re COVID-19 Staff Education (Attached) for Licensed Nurses (Mar. 20, 2020) [REDACTED] (providing sign-in sheets for the Infection Prevention training and explaining that “[t]his is the education we provided to all staff in our building a few weeks ago” and that it “was [SEVC’s] focus until we were tasked with screening all employees”); Employee Training Records (July 7, 2020).

⁴⁷¹ Employee Training Records (July 7, 2020).

⁴⁷² COVID-19 Information and Update (Mar. 26, 2020) [REDACTED]; *see also* Interview of [REDACTED] (July 8, 2020).

⁴⁷³ E.g., Interview of [REDACTED] (July 17, 2020).

⁴⁷⁴ Interview of [REDACTED] (July 13, 2020).

⁴⁷⁵ Interview of A. Ruscavage (Aug. 13. 2020).

⁴⁷⁶ Email from D. Mullane to [REDACTED], [REDACTED], [REDACTED], [REDACTED] re Training Materials needed - Jan/May Covid (May 22, 2020) [REDACTED].

⁴⁷⁷ Interview of [REDACTED] (July 17, 2020).

⁴⁷⁸ Interview of [REDACTED] (Aug. 6, 2020).

⁴⁷⁹ Email from [REDACTED] to [REDACTED] re SEVC Training Material for COVID (Jan-May) (May 22, 2020) [REDACTED].

⁴⁸⁰ Interview of [REDACTED] (July 17, 2020); Interview of [REDACTED] (July 20, 2020).

to the facilities, SEVC, rather than implementing the training, pushed back. On March 20, DMVA provided SVHs “a professionally prepared training *Coronavirus (COVID-19) 101 for Nursing Professionals*.⁴⁸¹ [REDACTED] forwarded the training to Commandant Blackwood and DON Mullane, explaining that she was “not keen on putting staff in a 2 hour training” even though DMVA directed that “[a]ll nursing” take the training. [REDACTED] also expressed concern over being able to conduct the training when SEVC was “to be social distancing” and advised that she had “advised the RNIs to halt on this until they receive direction from” SEVC leadership.⁴⁸² Mullane agreed with [REDACTED] that SEVC should not conduct the training DMVA had provided to help prepare their nurses for COVID-19.⁴⁸³

Further demonstrating the inadequacy of the training SEVC did provide, many staff did not even recall having received it.⁴⁸⁴ Even those who remembered receiving training from SEVC, recalled it as generic and unrelated in any way to COVID-19.⁴⁸⁵

SEVC eventually conducted targeted trainings to educate certain staff on its infection control procedures, such as the protocols for using negative pressure rooms to house COVID-19 positive residents.⁴⁸⁶ Many staff reported, however, that they did not receive training on SEVC’s COVID-19 infection control plans until there already were COVID-19 positive residents, and others said they never received such training. For example, [REDACTED] could not recall any trainings on how to handle a COVID-19 positive resident before SEVC had its first case of COVID-19.⁴⁸⁷ [REDACTED] also stated that training on proper PPE usage occurred only after there were COVID-19 positive residents on a unit.⁴⁸⁸ Nurse Supervisor, [REDACTED], explained that SEVC provided no formal training for handling COVID-19 within the facility.⁴⁸⁹ Nurse [REDACTED] reported that, although she was responsible for providing care to COVID-19 residents, she never received training on how to handle those residents from an infection control standpoint.⁴⁹⁰ VA Nurse [REDACTED] confirmed SEVC’s lack of COVID-19 specific training. She explained that, while SEVC’s orientation for VA nurses did cover some infection

⁴⁸¹ Email from [REDACTED] to [REDACTED], D. Mullane and others re COVID-19 STAFF EDUCATION (ATTACHED) for Licensed Nurses (Mar. 20, 2020) [REDACTED].

⁴⁸² Email from [REDACTED] to R. Blackwood and D. Mullane re COVID-19 STAFF EDUCATION (ATTACHED) for Licensed Nurses (Mar. 20, 2020) [REDACTED].

⁴⁸³ Email from D. Mullane to [REDACTED] and R. Blackwood re COVID-19 STAFF EDUCATION (ATTACHED) for Licensed Nurses (Mar. 20, 2020) [REDACTED].

⁴⁸⁴ E.g., Interview of [REDACTED] (July 15, 2020); Interview of [REDACTED] (Aug. 11, 2020); Interview of [REDACTED] (July 7, 2020).

⁴⁸⁵ Interview of [REDACTED] (July 1, 2020).

⁴⁸⁶ Employee Training Records (July 7, 2020); Interview of [REDACTED] (July 29, 2020).

⁴⁸⁷ Interview of [REDACTED] (July 13, 2020).

⁴⁸⁸ Interview of [REDACTED] (June 30, 2020).

⁴⁸⁹ Interview of [REDACTED] (July 10, 2020).

⁴⁹⁰ Interview of [REDACTED] (July 15, 2020).

control principles, it did not cover the CDC or DOH COVID-19 specific guidelines, or cover any other information specific to COVID-19.⁴⁹¹

Some staff reported that they only received COVID-19 related training after there was a positive resident on their unit.⁴⁹² Others stated that they did not even receive training at that point. For example, [REDACTED] explained that she was not at work when the first resident on her unit tested positive for COVID-19. When she returned, there were PPE carts in front of a number of resident rooms on the unit, which indicated that the rooms were under droplet precautions. [REDACTED], however, was not provided any training or education on the procedures for those rooms and she was forced to “hit the ground running.”⁴⁹³

Training under the new administration has improved dramatically. After CMS placed SEVC in IJ, one of [REDACTED]’s first initiatives was to put the SEVC staff through mandatory trainings in PPE protocols and infection control.⁴⁹⁴ [REDACTED] personally administered contact tracing training for the SEVC staff on June 3.⁴⁹⁵ As CMS and DOH surveyors observed “continued improper usage of PPE” during their inspection, [REDACTED] requested that DMVA have [REDACTED] and [REDACTED] “create a proper PPE policy” and come to SEVC “to physically conduct the training & physically conduct the PPE usage audits.”⁴⁹⁶ [REDACTED] also requested that DMVA assist in developing and completing a training in “infection control needs.”⁴⁹⁷ In addition, [REDACTED] brought the U.S. Public Health Services in to SEVC to assist in a mandatory, all staff training, covering topics including PPE donning and doffing, handwashing, and cleaning environmental surfaces.⁴⁹⁸

These initial trainings have been markedly different from – and more memorable than – the trainings administered under the Blackwood and Mullane administration. Indeed, most staff believed that the first true COVID-19 training they received was in June, under the new administration.⁴⁹⁹ Nurse [REDACTED] reported that the trainings administered under [REDACTED] acting administration were more demonstrative than the largely read-and-sign format of trainings under Blackwood’s administration.⁵⁰⁰ [REDACTED] explained that she could not

⁴⁹¹ Interview of [REDACTED] (July 1, 2020).

⁴⁹² Interview of [REDACTED] (July 10, 2020).

⁴⁹³ Interview of [REDACTED] (July 13, 2020).

⁴⁹⁴ Interview of [REDACTED] (Aug. 8, 2020).

⁴⁹⁵ Email from [REDACTED] to [REDACTED], [REDACTED], [REDACTED], and [REDACTED] re Contact Tracing Training (June 5, 2020) [REDACTED].

⁴⁹⁶ Email from [REDACTED] to D. Jackson re policy, training & audits (June 5, 2020) [REDACTED] (emphasis in original).

⁴⁹⁷ Email from [REDACTED] to [REDACTED] re other needs (June 5, 2020) [REDACTED]

⁴⁹⁸ Email from [REDACTED] to [REDACTED] re Mandatory Education for All (June 8, 2020) [REDACTED].

⁴⁹⁹ Interview of [REDACTED] Interview (July 7, 2020); Interview of [REDACTED] (July 15, 2020); Interview [REDACTED] (Aug. 11, 2020); Interview [REDACTED] (Aug. 20, 2020).

⁵⁰⁰ Interview of [REDACTED] (July 23, 2020).

recall mandatory, staff-wide formal trainings occurring under Blackwood's administration.⁵⁰¹ SEVC's [REDACTED] also have seen a difference in training and instruction under [REDACTED] acting administration.⁵⁰²

7. *PPE Deficiencies*

As COVID-19 spread through the United States, there were shortages of PPE throughout the country. Pennsylvania was no exception. SEVC, through [REDACTED], [REDACTED], and DMVA, through [REDACTED] and [REDACTED], acted aggressively to procure as much necessary PPE as possible. SEVC sought and received PPE from, among other sources, other SVHs, PEMA, CCHD, and local suppliers. SEVC and DMVA tracked supply on a daily basis, calculated and updated PPE burn rates, and coordinated on obtaining additional PPE for SVHs in need.⁵⁰³ Notably, at the outset, long-term care facilities were considered Tier 3 in terms of priority for PPE by DOH, whereas hospitals were Tier 1, meaning it was even more difficult for nursing homes to obtain PPE.⁵⁰⁴

a. *Certain Optimization Strategies Conflicted with Guidance*

Because of these PPE supply challenges, SEVC attempted to maintain and build up its PPE supply at least in part through measures to optimize PPE supply and extend its use. For example, on COVID-19 positive floors, SEVC had staff wear gowns for their entire shift, instead of doffing and donning gowns between residents.⁵⁰⁵ Some of the optimization strategies, however, were inconsistent with applicable guidance.

The first, discussed above, was the use of the same PPE on "epi-linked" floors regardless of the status of the individual resident. As discussed above, this policy was based on a misunderstanding of CCHD guidance and was inconsistent with applicable CDC guidance.

SEVC also implemented policies to preserve their supply of N95 masks. SEVC initially sought to maintain supply by providing N95 masks only to staff on COVID-19 positive floors.⁵⁰⁶ However, SEVC did distribute N95 masks to certain SEVC staff that did not provide direct resident care. [REDACTED] – whom, along with [REDACTED]

[REDACTED], Blackwood tasked with distributing masks – explained that Blackwood instructed distribution of N95s initially to limited staff, including management, in part, as a

⁵⁰¹ Interview of [REDACTED] (June 30, 2020).

⁵⁰² Interview of [REDACTED] (June 17, 2020).

⁵⁰³ Interview of [REDACTED] (July 6, 2020); Interview of [REDACTED] (July 29, 2020).

⁵⁰⁴ Email from [REDACTED] to [REDACTED], [REDACTED], R. Blackwood and others re FW: Department of Military and Veterans Affairs- (Apr. 3, 2020) [REDACTED]; Interview of A. Ruscavage (Aug. 13, 2020); Interview of [REDACTED] (June 9, 2020).

⁵⁰⁵ SITREP (Apr. 7, 2020) ("[T]his . . . whole unit is now presumptive positive and has dedicated staff who will don PPE and do not have to change this for each resident except for glove usage.").

⁵⁰⁶ SEVC COVID-19 Stand-Down Meeting Minutes (Mar. 24, 2020 entry)

means to conserve PPE supply. Blackwood provided [REDACTED] the illogical explanation that wearing N95s would be uncomfortable, and thus that they should be distributed to management staff who could easily remove the N95s while in their offices without risking exposure.⁵⁰⁷

[REDACTED] confirmed that, at Blackwood's instruction, N95s were distributed to SEVC's management team, including members of the business office staff, before nurses.

[REDACTED] explained that most of the management team did not go on floors with COVID-19 positive residents, and could not explain why those members of management would need N95s.⁵⁰⁸ In addition, [REDACTED] advised that she and her staff were offered N95s even though the activities staff were not conducting activities with COVID-19 positive residents.⁵⁰⁹ [REDACTED] explained that she was aware of complaints about management receiving N95s. She stated that it did not materially affect supply, however, because it was limited to a handful of masks that did not need to be replaced.

In that regard, we also investigated allegations that Commandant Blackwood hoarded N95 masks in his office, but found this allegation to be unsubstantiated. [REDACTED]

[REDACTED] noted that, for a time, N95 and other PPE deliveries were stored in Blackwood's office before being moved to the nursing suite.⁵¹⁰ [REDACTED] confirmed that account.⁵¹¹ [REDACTED] noted further that she would have known whether N95s were missing, because she carefully counted N95 supply. She was unaware, however, of any missing N95s.⁵¹²

Blackwood did, however, implement measures to extend the life of distributed N95s that did not adhere to CDC's guidance on best practices for reuse.⁵¹³ At the outset, SEVC instructed staff receiving N95s to wear the "masks for seven days, then exchange for a new mask."⁵¹⁴ Subsequently, SEVC implemented a three-mask rotation, by which employees on COVID-19 positive floors would receive three masks, use one per day, and rotate through the three masks for three weeks.⁵¹⁵ Applicable CDC guidance, however, recommended issuing five masks for rotation such that there was "a minimum of five days between each [N95 mask] use." In the event a healthcare facility did not have sufficient supply to issue five masks to each healthcare worker, the CDC guidance recommended decontaminating the masks between uses.⁵¹⁶

⁵⁰⁷ Interview of [REDACTED] (July 7, 2020).

⁵⁰⁸ Interview of [REDACTED] (June 25, 2020).

⁵⁰⁹ Interview of [REDACTED] (July 6, 2020).

⁵¹⁰ Interview of [REDACTED] (July 29, 2020).

⁵¹¹ Interview of [REDACTED] (July 28, 2020).

⁵¹² Interview of [REDACTED] (July 29, 2020).

⁵¹³ Interview of [REDACTED] (July 7, 2020); SEVC COVID-19 Stand-Down Meeting Minutes (Apr. 1, 2020 entry) [REDACTED].

⁵¹⁴ SEVC COVID-19 Stand-Down Meeting Minutes (Apr. 1, 2020 entry) [REDACTED].

⁵¹⁵ Interview of [REDACTED] (July 7, 2020).

⁵¹⁶ Ctrs. for Disease Control & Prevention, COVID-19 Decontamination and Reuse of Filtering Facepiece Respirators (Apr. 1, 2020), available at

The three-mask policy was implemented, at least in part, to maximize supply.⁵¹⁷ That explanation, however, does not bear scrutiny. In May, at the urging of the National Guard and CMO Dr. Jackson, SEVC switched to a five-mask rotation, which was the protocol recommended by the CDC.⁵¹⁸ As ██████████ observed when changing to the five-mask policy in mid-May, the change had a “minimal” impact on SEVC’s burn rate.⁵¹⁹

b. SEVC Lacked Adequate Fit Testing

While SEVC was able to distribute N95s to staff on COVID-19 positive floors, staff were routinely using those masks without fit testing.⁵²⁰ This is mostly attributable to a lack of fit-testing equipment supply. The lack of fit-testing kits became a bigger problem due to the fact that, as SEVC was accumulating N95 supply, it – like other SVHs – was obtaining whatever masks it could find. Different types of masks, however, require separate fit testing.⁵²¹ Thus, even if a staff member was fit tested on one type of N95, he or she would have to be re-fit tested on a different type of mask.⁵²² Ultimately, fit testing was not completed until June, shortly after Acting Commandant ██████████ demanded a fit-testing kit from DMVA “ASAP.”⁵²³

c. PPE Compliance Was Poor

Virtually everyone we interviewed reported that they observed or heard of consistent violations of PPE protocols by SEVC staff: wrong PPE worn in COVID-19 positive units; masks

<https://web.archive.org/web/20200401222020/https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html>.

⁵¹⁷ SEVC COVID-19 Stand-Down Meeting Minutes (Apr. 1, 2020 entry) ██████████.

⁵¹⁸ Ctrs. for Disease Control & Prevention, COVID-19 Decontamination and Reuse of Filtering Facepiece Respirators (Apr. 1, 2020), available at <https://web.archive.org/web/20200401222020/https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html>.

⁵¹⁹ Email from ██████████ to ██████████ re N95 Mask Usage Question (May 11, 2020) ██████████.

⁵²⁰ Interview of ██████████ (July 6, 2020); Interview of ██████████ (July 23, 2020); Interview of ██████████ (July 7, 2020); Interview of ██████████ (July 31, 2020); Interview of ██████████ (July 8, 2020); Interview of D. Mullane (Aug. 20, 2020).

⁵²¹ Interview of ██████████ (June 9, 2020).

⁵²² Email from ██████████ to ██████████ and ██████████ re Homes’ Questions; Requesting your help (Apr. 8, 2020) ██████████ (“The Homes questions about fit testing and types of masks that I am not able to answer. The main issue seems to be that they are fit tested for one type of N95 mask, then the home receives a supply of masks that are different from the ones they were fit tested.”).

⁵²³ Email from ██████████ to D. Jackson re CMS & DOH here (June 1, 2020) ██████████; Interview of ██████████ (July 17, 2020); Interview of ██████████ (July 20, 2020).

worn around necks; PPE worn off of units; and neglecting to wear PPE when entering resident rooms that were under droplet precautions. Acting DON [REDACTED], for example, advised that she was aware of staff noncompliance with PPE protocols at SEVC.⁵²⁴ Nurse Supervisor [REDACTED] noted that she had heard of nurse aides going from unit to unit in contaminated PPE and going outside for smoke breaks wearing contaminated PPE.⁵²⁵ National Guard [REDACTED]

[REDACTED], [REDACTED], recalled receiving frequent reports of PPE compliance lapses. This included staff wearing masks under their chins while providing resident care, staff not donning appropriate PPE when entering rooms that were under infection prevention and control precautions, and a general lack of compliance with donning, doffing, and hand washing protocols.⁵²⁶

Those breaches were attributable to the combination of (1) inadequate training; (2) inadequate enforcement; and (3) willful disregard of known policies. First, as discussed above, SEVC's infection control training was poor. Even when it was provided, it was ineffectual and not memorable. Acting DON [REDACTED] reported that, when she conducted PPE training in June, the staff exhibited a lack of understanding of what the PPE donning and doffing process was and how to follow it.⁵²⁷

Without proper training, enforcement of PPE protocols took on an even more important role. This too was lacking. VA Nurse [REDACTED] reported that, in addition to inadequate training, she and her staff observed that where there was a consistent presence of a nurse supervisor on a unit, PPE compliance was better. However, not every unit had dedicated supervision on every shift.⁵²⁸ In fact, one unit supervisor did not go on COVID-19 positive floors, because [REDACTED] had failed fit testing.⁵²⁹ [REDACTED] therefore, was not in a position to monitor PPE compliance on those floors. [REDACTED] stated that there was not a uniform system of monitoring compliance with PPE protocols on a regular basis at SEVC – such as having SEVC's Quality Assurance team auditing the facility – making it impossible to ensure that staff members were wearing PPE appropriately.⁵³⁰ Furthermore, it does not appear that PPE enforcement was regularly undertaken by nursing leadership. For example, in April, CMO Dr. Jackson toured SEVC's COVID-19 positive units with DON Mullane. Dr. Jackson observed a nurse wearing only a surgical mask on a COVID-19 positive floor. When Dr. Jackson pointed out the breach, rather than enforcing the PPE requirements, Mullane stated that it did not matter because the nurse was a supervisor who "knew what she could touch."⁵³¹ This type of messaging from nursing leadership – that PPE compliance was not important – undoubtedly affected the PPE compliance culture of supervisors and staff.

⁵²⁴ Interview of [REDACTED] (July 20, 2020).

⁵²⁵ Interview of [REDACTED] (July 8, 2020); *see also* Interview of [REDACTED] (June 25, 2020).

⁵²⁶ Interview of [REDACTED] (June 26, 2020).

⁵²⁷ Interview of [REDACTED] (July 20, 2020).

⁵²⁸ Interview of [REDACTED] (July 1, 2020).

⁵²⁹ Interview of [REDACTED] (July 7 & 9, 2020).

⁵³⁰ Interview of [REDACTED] (June 26, 2020).

⁵³¹ Interview of D. Jackson (Aug. 19 & 26, 2020).

In contrast, the new administration has made a concerted effort to be on the floors educating and correcting staff on the spot.⁵³² Acting DON [REDACTED] instituted a formal system for spot checking and auditing SEVC staff compliance with PPE protocols.⁵³³ They also enlisted the National Guard, who is already on the ground at SEVC, to audit PPE compliance.⁵³⁴

Finally, we note that certain of the breaches appear to be staff intentionally disregarding known protocols, for example, wearing PPE on smoking breaks.⁵³⁵ National Guard [REDACTED] [REDACTED] recounted an instance in which a staff member responded to a service member pointing out that the staff member had left a COVID-19 unit wearing contaminated PPE by stating, “I don’t care. They can write me up.”⁵³⁶ Several staff reported that the breaches were due to the fact that units were too hot, which made the PPE – and particularly the masks – uncomfortable to wear for full eight-hour shifts.⁵³⁷ Unlike the prior administration, the new administration both addressed these intentional breaches with better enforcement, and installed air conditioning units on the floor so staff could wear PPE more comfortably.⁵³⁸

In sum, there were numerous and regular breaches of PPE protocols, many of which could have been addressed by better training and more consistent enforcement. These failings rest with SEVC leadership who did not insist on proper training, instill a culture of compliance, or use available resources to monitor PPE compliance.

8. *The Investigation Did Not Find Evidence Substantiating Allegations that SEVC Staff Were Improperly Pressured to Return to Work*

We also investigated allegations that SEVC staff who contracted COVID-19 were pressured to return to work, thereby risking the spread of COVID-19 among residents and staff. This investigation was unable to substantiate those claims.

SEVC and DMVA leadership undoubtedly expressed frustration about staff absences. For example, Commandant Blackwood noted that there were concerns about staff calling out without failing a test.⁵³⁹ BVH Director Ruscavage complained that he believed DMVA was hamstrung in certain ways [REDACTED] in its COVID-19 response. As an example, he noted that staff members were taking off 14 or 21 days based on their doctors’ advice, even if they did not have symptoms or a positive test.⁵⁴⁰ [REDACTED]

⁵³² Interview of [REDACTED] (Aug. 6, 2020).

⁵³³ Interview of [REDACTED] (July 20, 2020).

⁵³⁴ Interview of [REDACTED] (Aug. 6, 2020).

⁵³⁵ Interview of [REDACTED] (July 8, 2020); *see also* Interview of [REDACTED] (June 25, 2020).

⁵³⁶ Interview of [REDACTED] (June 29, 2020).

⁵³⁷ E.g., Interview of [REDACTED] (July 20, 2020); Interview of [REDACTED] (July 7, 2020).

⁵³⁸ Interview of [REDACTED] (July 17, 2020).

⁵³⁹ Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁵⁴⁰ Interview of A. Ruscavage (Aug. 13, 2020).

[REDACTED]

Accordingly, on March 26, CMO Dr. Jackson circulated to the SVHs a “draft letter and policy for returning workers,” which was to be used for staff returning to work.⁵⁴² The policy, based on CDC and DOH guidance, set forth different strategies – including a test-based strategy and a symptom-based strategy – to determine when a staff member could return to work.⁵⁴³ DMVA circulated an updated policy on April 20, which was similarly based on applicable guidance.⁵⁴⁴

Staff also reported that there were criteria that staff had to meet before returning to work. [REDACTED] reported, for example, that, while initial return to work policies were not clear, her understanding was that a physician’s clearance was necessary before staff could return to work.⁵⁴⁵ Other staff reported that staff were required to stay out of work for a specified period of time or until a negative test.⁵⁴⁶ None of the staff we spoke with reported being pressured to come back.

Accordingly, we were unable to substantiate this allegation.

C. SEVC Leadership Relied on an Unqualified and Overwhelmed Infection Control Team

1. *The Infection Control Team*

The ICN position at SEVC does not require any prior infection control experience. Rather, the position typically goes to the most senior registered nurse on staff who wants the position.⁵⁴⁷ [REDACTED] has been SEVC’s ICN since 2019.⁵⁴⁸ Commandant Blackwood recognized that [REDACTED] lacked the necessary experience and training to handle infection control responsibilities in the event of a COVID-19 outbreak.⁵⁴⁹ Accordingly, in mid-March, Blackwood assigned [REDACTED], who had been SEVC’s ICN from 2009 through 2017, to assist [REDACTED] with COVID-19 infection control responsibilities, effectively creating two ICNs.⁵⁵⁰

⁵⁴¹ Interview of [REDACTED] (Aug. 13 & 25, 2020).

⁵⁴² Email from D. Jackson to [REDACTED] and others re Return to Work letter and policy (Mar. 26, 2020) [REDACTED].

⁵⁴³ BVH Return to Work Criteria for HCW 3-26-20 [REDACTED].

⁵⁴⁴ Email from [REDACTED] to [REDACTED] and others re Updated Return to Work Criteria for the HCW, Screening Questionnaire & Guidance 4-20-2020 (Apr. 20, 2020) [REDACTED].

⁵⁴⁵ Interview of [REDACTED] (June 25, 2020).

⁵⁴⁶ Interview of [REDACTED] (July 31, 2020); Interview of [REDACTED] (June 10, 2020).

⁵⁴⁷ E.g., Interview of D. Mullane (Aug. 20, 2020).

⁵⁴⁸ Interview of [REDACTED] (June 25, 2020).

⁵⁴⁹ Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁵⁵⁰ Interview of [REDACTED] (July 28, 2020); Interview of R. Blackwood (Aug. 19 & 21, 2020).

2. SEVC Leadership Failed to Define Clearly the Infection Control Nurses' Responsibilities

[REDACTED] had a narrow view of their responsibilities as ICNs. [REDACTED] said that she viewed her responsibilities in COVID-19 response as limited to reviewing resident progress notes for symptoms in order to identify where infections were occurring within SEVC and to make reports. She denied any responsibility for SEVC's isolation processes, and was not aware of when or how SEVC implemented infection prevention and control precautions for COVID-19. [REDACTED] likewise disclaimed responsibility for understanding public health guidance relating to COVID-19.⁵⁵¹

[REDACTED] similarly viewed her role as limited to monitoring SEVC's residents for signs and symptoms of infection. She denied any responsibility for establishing infection control policies for SEVC or training staff on those policies. [REDACTED] also denied responsibility for tracking changes in public health guidance relating to COVID-19, claiming that the DON or the ADONs were responsible for tracking that guidance.⁵⁵²

We find the ICNs' view of their responsibilities to be deficient. First, it is inconsistent with the regulatory requirement that the Infection Preventionist be the person "responsible for the facility's [infection prevention and control program]."⁵⁵³ That program is required to include, among other things, a "system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases," and "[w]ritten standards, policies, and procedures for the program," including policies for "[s]tandard and transmission-based precautions to be followed to prevent spread of infections," and "[w]hen and how isolation should be used for a resident."⁵⁵⁴ Furthermore, it is inconsistent with SEVC's and DMVA's understanding of the ICNs' responsibilities. Both Commandant Blackwood and DON Mullane stated that [REDACTED] were responsible for monitoring public health guidance and keeping SEVC updated on the most recent developments.⁵⁵⁵ [REDACTED]

[REDACTED] also viewed infection control training to be partially if not entirely the ICNs' responsibility.⁵⁵⁶

We find that this disconnect between the ICNs' understanding of their roles and leadership's expectation is ultimately a failure of SEVC leadership. It is related to a significant degree to leadership's COVID-19 planning failures discussed above.

⁵⁵¹ Interview of [REDACTED] (July 28, 2020).

⁵⁵² Interview of [REDACTED] (June 10, 2020).

⁵⁵³ 42 C.F.R. § 483.80(b).

⁵⁵⁴ *Id.* § 483.80(a).

⁵⁵⁵ Interview of R. Blackwood (Aug. 19 & 21, 2020); Interview of D. Mullane (Aug. 20, 2020); *see also* SEVC CDC Nursing Home Preparedness Checklist, at 3 (last modified Apr. 8, 2020) [REDACTED]

⁵⁵⁶ Interview of [REDACTED] (July 17, 2020); Interview of [REDACTED] (June 12, 2020); Interview of [REDACTED] (June 11, 2020); Interview of [REDACTED] (July 20, 2020).

3. The Infection Control Nurses' Performance Was Inadequate

Blackwood and Mullane claimed to rely on the ICNs, with minimal oversight, for crucial aspects of SEVC's COVID-19 response. Nevertheless, SEVC and DMVA employees alike described [REDACTED] as not qualified for the job of ICN or to implement SEVC's infection prevention and control program.⁵⁵⁷ SEVC [REDACTED] explained that [REDACTED] did not have the experience or depth of knowledge required to handle SEVC's COVID-19 response efforts, and was simply overwhelmed.⁵⁵⁸ VA nurse [REDACTED] likewise found [REDACTED] to be overwhelmed.⁵⁵⁹ Others felt that [REDACTED] did not know what she was doing,⁵⁶⁰ and was a "mess" who was not a suitable ICN.⁵⁶¹ Indeed, it was because of concerns about [REDACTED]'s capabilities that Blackwood assigned [REDACTED] to assist [REDACTED] in the first instance.⁵⁶²

Still, even with [REDACTED]'s assistance, SEVC's Infection Control team performed poorly. After working closely with SEVC under the new administration, [REDACTED] stated that she believed that [REDACTED] had no idea what she was doing and, instead, continuously blamed the staff for infection control issues.⁵⁶³ Similarly, [REDACTED] stated that she found [REDACTED] to be "totally disorganized."⁵⁶⁴

DMVA staff pointed to the ICNs' inadequate COVID-19 tracking as a concrete example of their shortcomings. SEVC utilized two methods for tracking the spread of COVID-19, a line list and a separate excel spreadsheet.⁵⁶⁵ SEVC was required to use the line list, a tool developed by CCHD, to monitor residents with signs or symptoms consistent with COVID-19. ICNs [REDACTED] and [REDACTED] used the line list to complete daily infection control surveillance and provided daily updates to CCHD.⁵⁶⁶ The ICNs also reported information to DMVA using an excel spreadsheet developed by DMVA. This spreadsheet tracked information including but not limited to: resident name, date of birth, symptoms, comorbidities, date symptoms began, whether

⁵⁵⁷ E.g., Interview of [REDACTED] (July 17, 2020); Interview of [REDACTED] (July 15, 2020); Interview of [REDACTED] (July 28, 2020); Interview of [REDACTED] (July 8, 2020); Interview of [REDACTED] (June 11, 2020); Interview of [REDACTED] (July 7 & 9, 2020); Interview of [REDACTED] (July 31, 2020). *But see* Interview of [REDACTED] (Aug. 24, 2020) (explaining that [REDACTED] had extensive infection control experience before coming to SEVC); Interview of [REDACTED] (July 10, 2020) (explaining that he believes that [REDACTED] must have been qualified because she was hired for the job and did what she was asked to do).

⁵⁵⁸ Interview of [REDACTED] (July 28, 2020).

⁵⁵⁹ Interview of [REDACTED] (July 1, 2020).

⁵⁶⁰ Interview of [REDACTED] (July 8, 2020).

⁵⁶¹ Interview of [REDACTED] (July 17, 2020).

⁵⁶² Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁵⁶³ Interview of [REDACTED] (June 11, 2020).

⁵⁶⁴ Interview of [REDACTED] (July 17, 2020).

⁵⁶⁵ Interview of [REDACTED] (Jul. 28, 2020).

⁵⁶⁶ Interview of D. Mullane (Aug. 20, 2020).

the patient was hospitalized, and whether they expired and resolution date (if the patient recovered).

DMVA described these tracking records as, at best, “hit or miss.”⁵⁶⁷ Although SEVC clinical leadership did not identify systemic problems with the surveillance information,⁵⁶⁸ DMVA leadership had concerns about the completeness of the ICNs’ COVID-19 tracking. The surveillance lists, for example, did not reliably include test dates, dates of symptom onset, or location of residents.⁵⁶⁹ While [REDACTED] spoke with [REDACTED] [REDACTED] about the inadequacy of the information, the problems were not remedied.⁵⁷⁰ It does not appear, however, that [REDACTED] or anyone else at DMVA escalated these concerns further. The spreadsheets also included information that DMVA staff subsequently discovered was inaccurate. The spreadsheets sometimes mistakenly stated, for example, that a resident had not been hospitalized or otherwise moved, when, in fact, the resident had been hospitalized one or more times and/or transferred between rooms.⁵⁷¹ Following Blackwood’s and Mullane’s suspension, the new administration had concerns that [REDACTED] did not have a grasp for the number of COVID-19 positive residents at SEVC. When asked for that information, [REDACTED] responded by indicating “I don’t know. I’m not a doctor.”⁵⁷² Upon further questioning, [REDACTED] noted that she would have to go through and look at her tracking and that this would take her awhile. Acting DON [REDACTED] thereafter observed that the tracking mechanisms were not clear, concise, or easy to read. As a result, she personally revamped the tracking mechanism.⁵⁷³

A clear example of the insufficiency of SEVC’s tracking data occurred in late April. On April 30, a family member reported an “upsetting call” with [REDACTED], during which [REDACTED] asked for permission to test the family member’s spouse for COVID-19. The spouse, however, was hospitalized and no longer at SEVC. [REDACTED] “did not believe her,” but after checking further told the spouse to “disregard the phone call.”⁵⁷⁴ Not only was the spouse not at the facility, it had already been determined that the spouse was COVID-19 positive. Responding to this and other documented inconsistencies,⁵⁷⁵ DON Mullane explained that “it is not unrealistic for there to be an error.”⁵⁷⁶

⁵⁶⁷ Interview of [REDACTED] (Jul. 17, 2020).

⁵⁶⁸ Interview of D. Mullane (Aug. 20, 2020).

⁵⁶⁹ Interview of [REDACTED] (Jul. 17, 2020); Interview of [REDACTED] (June 11, 2020).

⁵⁷⁰ Interview of [REDACTED] (Jul. 17, 2020).

⁵⁷¹ *Id.*; Email from [REDACTED] re follow-up (Aug. 23, 2020).

⁵⁷² Interview of [REDACTED] (July 20, 2020); *see also* Interview of [REDACTED] (June 11, 2020) (noting that [REDACTED] was unaware that, at one point, her data indicated incorrectly that approximately 80 residents and staff were out of the building with COVID-19).

⁵⁷³ Interview of [REDACTED] (July 20, 2020).

⁵⁷⁴ Email from [REDACTED] to [REDACTED], [REDACTED], D. Mullane and [REDACTED] re [Resident 34] (Apr. 30, 2020) [REDACTED].

⁵⁷⁵ E.g., Email from D. Mullane to A. Ruscavage, R. Blackwood, D. Jackson re SIT REP 4-24-20 (Apr. 24, 2020) [REDACTED].

⁵⁷⁶ Interview of D. Mullane (Aug. 20, 2020).

The infection control team plays an integral role in a facility's infection control efforts. We believe that the inadequacies of SEVC's infection control team significantly hampered SEVC's COVID-19 response. Ultimately, however, this is the team that SEVC leadership put in place. It was their responsibility to recognize the team's shortcomings, maintain clear oversight over their work, and, if necessary, seek additional assistance. Instead, SEVC leadership purported to rely to a great degree on the ICNs for virtually all aspects of the facility's infection control response. We believe this resulted in several of our observed deficiencies, none more important than the misunderstood CCHD guidance discussed above.

D. SEVC Leadership Did Not Cooperate or Coordinate Sufficiently with the National Guard

On April 15, 30 members of the Pennsylvania National Guard arrived at SEVC to assist with SEVC's COVID-19 response. Rather than take full advantage of these additional resources, however, SEVC viewed the National Guard as outsiders and with skepticism. The relationship was described within SEVC as "contentious."⁵⁷⁷

A dysfunctional relationship began almost immediately, starting with Commandant Blackwood's and DON Mullane's insistence that the National Guard have only one point of contact at SEVC, [REDACTED]. This can only be seen as an effort essentially to push the National Guard off to someone with no meaningful authority or responsibility related to SEVC's COVID-19 response efforts. [REDACTED] was hired in [REDACTED] 2019 [REDACTED]. She was not on SEVC's clinical staff, and had no formal medical education or training. The Monday before the National Guard arrived at SEVC, Commandant Blackwood advised [REDACTED] that she was going to be "in charge of them," but provided no further details on what her responsibilities would be.⁵⁷⁸ Remarkably, from that point on, Blackwood and Mullane denied repeated requests by National Guard leadership to meet or consult for any purpose.⁵⁷⁹

[REDACTED] acknowledged that there was an opportunity to partner with the National Guard that was squandered.⁵⁸⁰ National Guard service members similarly expressed frustration, feeling that there were missed opportunities for SEVC to leverage the National Guard's resources and experience.⁵⁸¹ For example, National Guard service members were regularly on the floor and

⁵⁷⁷ Interview of [REDACTED] (Aug. 6, 2020).

⁵⁷⁸ Interview of [REDACTED] (July 9, 2020).

⁵⁷⁹ Email from [REDACTED] to A. Carrelli re FW: Talking points SEVC (May 3, 2020) [REDACTED] ("Requests have been made to meet with the Commandant, which were reportedly denied."). [REDACTED] recalled Blackwood and Mullane refusing to meet with National Guard leadership. Interview of [REDACTED] (July 9, 2020).

⁵⁸⁰ Interview of [REDACTED] (July 9, 2020).

⁵⁸¹ See Interview of [REDACTED] (July 2, 2020); Interview of [REDACTED] (July 23, 2020).

well positioned to identify incorrect PPE usage.⁵⁸² Rather than viewing the National Guard as true partners who could help prevent the spread of infection, they were viewed as “spies.”⁵⁸³ ██████ reported that Commandant Blackwood and DON Mullane were not open to receiving reports from the National Guard regarding PPE protocol breaches by SEVC staff.⁵⁸⁴ As ██████ ██████ explained, when the National Guard arrived at SEVC their aim was to “help in any way [they] could.” However, “from the get-go,” the National Guard’s efforts to assist were frustrated.⁵⁸⁵

One of the earliest points of concern by the National Guard was the lack of information SEVC provided regarding the COVID-19 status of residents and staff.⁵⁸⁶ As ██████ explained in an email to ██████, his “biggest concern[]” when the National Guard mission started at SEVC was the “community spread throughout . . . SEVC” and “the lack of transparency of what the true COVID picture” was at the facility that was causing “discomfort” among the National Guard medics.⁵⁸⁷

The National Guard’s requests for COVID-19 information was forwarded up the DMVA chain of command to Adjutant General Carrelli.⁵⁸⁸ In response, Adjutant General Carrelli wrote that “any info NG needs they can get from us” and advised that DMVA “did the right thing not to release” the information because it was “[s]ensitive info.”⁵⁸⁹ Based on this response, Ruscavage instructed ██████ not to release “any information to the National Guard on site” and that “[i]f they need updates they will get them from the chain of command.”⁵⁹⁰

Adjutant General Carrelli explained that he did not recall his direction to SEVC as specifically prohibiting SEVC from providing the National Guard information on the COVID-19 status of the facility. Rather, he explained his direction was informed by his understanding that DOH at that time was not sharing information regarding the number of COVID-19 infections at any particular facility. Thus, his instruction to SEVC was to share information regarding COVID-19 infections at the facility only on a “need to know” basis. At the time, however, Adjutant General Carrelli believed that there were no National Guard service members working

⁵⁸² E.g., Email from ██████ to ██████ and ██████ re Talking points SEVC (May 2, 2020) ██████ (noting that “SEVC staff witnessed by SM going into PUI rooms without proper PPE and then returning to nursing station”).

⁵⁸³ Interview of ██████ (Aug. 6, 2020).

⁵⁸⁴ Interview of ██████ (July 9, 2020).

⁵⁸⁵ Interview of ██████ (July 23, 2020).

⁵⁸⁶ Email from ██████ to A. Ruscavage re ██████ (SEVC COVID tracking) (Apr. 20, 2020) ██████.

⁵⁸⁷ Email from ██████ to ██████ re (SITREP): SEVC (Apr. 21, 2020) ██████.

⁵⁸⁸ Email from E. Weller to A. Carrelli re ██████ (SEVC COVID tracking) (Apr. 21, 2020) ██████.

⁵⁸⁹ Email from A. Carrelli to E. Weller and A. Ruscavage re ██████ (SEVC COVID tracking) (Apr. 21, 2020) ██████.

⁵⁹⁰ Email from A. Ruscavage to ██████, D. Mullane, and R. Blackwood re ██████ (SEVC COVID tracking) (Apr. 21, 2020) ██████.

on COVID-19 positive units. This was because he had ordered that the National Guard work only in “green zones” on which there were no COVID-19 positive or suspected positive residents unless a National Guard member specifically requested to be staffed on a COVID-19 unit. Therefore, his view was that the National Guard did not “need to know” the COVID-19 status of the facility.⁵⁹¹

We do not agree that persons working at SEVC did not have a “need to know” where COVID-19 was located within the facility. Irrespective, Adjutant General Carrelli’s position was based on an incorrect factual premise. The National Guard *was* working on units with residents suspected of being COVID-19 positive; they just did not know that, because of the lack of information provided to them. On May 1, [REDACTED] advised [REDACTED] that six service members working on 2 West – a unit that the National Guard believed was a non-COVID-19 unit – had “been exposed to a COVID-19 positive” resident.⁵⁹² The resident to whom the service members were exposed developed symptoms consistent with COVID-19 starting on April 22, was tested for COVID-19 on April 23, and SEVC received notice of the resident’s positive COVID-19 test result on April 27.⁵⁹³ Ultimately, as a result of this exposure to a COVID-19 positive resident, [REDACTED] was forced to pull nine service members out of SEVC to quarantine.⁵⁹⁴

In comparison, the new SEVC administration has taken a constructive and collaborative approach to working with the National Guard. [REDACTED] observed that the relationship changed “like night to day.”⁵⁹⁵ [REDACTED], likewise described a “night-and-day shift” under the new administration, explaining that there was a more positive, frequent two-way communication between SEVC and the National Guard.⁵⁹⁶ [REDACTED], noticed that [REDACTED] was more able to embrace her role as liaison, actively reaching out to ask how she can keep “her” service members safe at SEVC.⁵⁹⁷

E. Poor Communication by SEVC and DMVA

Another common theme that we observed during the course of our investigation was pervasive communications failures at both SEVC and DMVA. SEVC did not adequately communicate the COVID-19 status of the facility or the facility’s COVID-19 response efforts

⁵⁹¹ Interview of A. Carrelli (Aug. 14 & 17, 2020).

⁵⁹² Email from [REDACTED] re SEVC/Impact to Force Health Protection (May 1, 2020).

⁵⁹³ Resident 64 File, at 227-42 [REDACTED].

⁵⁹⁴ Email from [REDACTED] to [REDACTED] re SEVC Member Quarantine and PPE Changes (May 2, 2020); Email from [REDACTED] to [REDACTED] re SEVC Concerns / Update / Recommendation (May 2, 2020) (reporting that [REDACTED] and [REDACTED] had “significant concerns about the risk and exposure of the team” and had “assess[ed] at least (9) members as high risk and should not re-enter the facility”).

⁵⁹⁵ Interview of [REDACTED] (July 9, 2020).

⁵⁹⁶ Interview of [REDACTED] (July 2, 2020).

⁵⁹⁷ Interview of [REDACTED] (June 28, 2020).

with staff members or others onsite. SEVC also did not provide residents' families the clear, candid information regarding the COVID-19 outbreak and their loved ones' condition to which they were entitled. Finally, DMVA did not accurately and transparently communicate the COVID-19 status of SEVC to the public.

1. *SEVC Leadership Did Not Communicate Adequately with Its Staff Regarding Important COVID-19 Developments at the Facility*

SEVC staff interviewed in connection with this investigation almost uniformly reported that SEVC leadership failed to provide meaningful information regarding the COVID-19 status of the facility or the facility's infection control efforts. Commandant Blackwood explained that communication relating to COVID-19 came principally through daily meetings among SEVC leadership. Blackwood's expectation was that the supervisors in attendance at the meetings would then filter the information to their staff.⁵⁹⁸ From the outset of SEVC's planning efforts, however, SEVC staff reported not being provided with information about those COVID-19 response plans. For instance, on March 20, SEVC announced that there would be three teams of 20 staff members dedicated to providing care for COVID-19 positive residents.⁵⁹⁹ However, SEVC staff members who were designated as members of those teams reported to investigators that they were not informed that they were selected to work on a COVID-19 unit or as part of the COVID-19 team. Instead, they were left to assume that they had been selected, because they were fit tested for N95 masks.⁶⁰⁰

Communication failures continued throughout the outbreak with respect to fundamental information, such as the number and location of COVID-19 residents within the facility and infection control procedures. For example, staff on COVID-19 positive units were not provided information on what to do with symptomatic residents.⁶⁰¹ Staff members – including supervisors – indicated that they were not provided details of PPE use, such as where to don PPE, where to doff PPE, or how to enter and exit units. Similarly, staff reported that leadership did not discuss or explain physical changes that were being made to the units, including the creation of anterooms, or what PPE was required for certain units.⁶⁰² Staff reported being unaware of, among other things, the number of residents who were positive,⁶⁰³ where positive residents were located,⁶⁰⁴ what the facility's infection control plans were,⁶⁰⁵ or which units were positive units

⁵⁹⁸ Interview of R. Blackwood (Aug. 19 & 21, 2020); Interview of D. Mullane (Aug. 20, 2020); Interview of A. Ruscavage (Aug. 13, 2020).

⁵⁹⁹ SEVC COVID-19 Stand-Down Meeting Minutes (Mar. 20, 2020 entry) [REDACTED]

⁶⁰⁰ Interview of [REDACTED] (Jul. 29, 2020); Interview of [REDACTED] (July 8, 2020); *see also* Interview of [REDACTED] (July 7, 2020).

⁶⁰¹ Interview of [REDACTED] (Jul. 29, 2020).

⁶⁰² Interview of [REDACTED] (July 13, 2020).

⁶⁰³ Interview of [REDACTED] (July 29, 2020); Interview of [REDACTED] (July 29, 2020).

⁶⁰⁴ Interview of [REDACTED] (Aug. 17, 2020); Interview of [REDACTED] (July 13, 2020).

⁶⁰⁵ Interview of [REDACTED] (Aug. 14 & 18, 2020).

and which were negative.⁶⁰⁶ In short, staff complained – in real time – that “[u]nits [were] not receiving communication at all.”⁶⁰⁷

Commandant Blackwood and DON Mullane both were aware of staff concerns that information from the daily meetings was not being communicated throughout the facility.⁶⁰⁸ Rather than seek to improve upon communication within the facility, however, Blackwood and Mullane implemented a system to have staff sign a sheet to confirm that they received a particular communication.⁶⁰⁹ In other words, leadership was more focused on “proof” that there had been communication than addressing the underlying problems – namely, that information was being communicated poorly and whatever was being communicated was perceived to be insufficient.

Blackwood and Mullane both reported during this investigation that they believed that SEVC’s communications to staff were adequate.⁶¹⁰ Mullane stated that, while she was aware that staff expressed concerns about a lack of communication, she did not believe that those complaints were always true.⁶¹¹ Blackwood similarly did not credit complaints that staff was unaware of the status of various units. He stated that the COVID-19 positive units were closed off, identified with signage, with plastic anterooms at the entrance. He therefore believed that it was obvious where COVID-19 positive residents were located, noting “there was not a single person who did not know which units were affected or not affected.”⁶¹² DAG Weller echoed that sentiment, noting that staff would have to be “dumb” not to notice which units were COVID-19 positive and which were not.⁶¹³

Staff disagreed that those visual cues were so clear and reliable. Nursing Assistant [REDACTED], for example, explained that while there were plastic anterooms outside of COVID-19 positive units, not every unit that had COVID-19 residents had those plastic demarcations.⁶¹⁴ Nurse Supervisor [REDACTED] reported that she did not recall COVID-19 units being marked with clear signage.⁶¹⁵ Acting Commandant [REDACTED] stated that when she arrived at SEVC, the signage was confusing because it referenced only required PPE and was on

⁶⁰⁶ Interview of [REDACTED] (Aug. 17, 2020).

⁶⁰⁷ Email from [REDACTED] to [REDACTED] re Follow-up (Apr. 17, 2020) [REDACTED]; see also Email from [REDACTED] to [REDACTED], [REDACTED], [REDACTED] re SEVC – urgent (Apr. 17, 2020) [REDACTED].

⁶⁰⁸ Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁶⁰⁹ Interview of D. Mullane (Aug. 20, 2020); Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁶¹⁰ Interview of D. Mullane (Aug. 20, 2020); Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁶¹¹ Interview of D. Mullane (Aug. 20, 2020).

⁶¹² Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁶¹³ Interview of E. Weller (Aug. 18, 2020).

⁶¹⁴ Interview of [REDACTED] (Aug. 17, 2020).

⁶¹⁵ Interview of [REDACTED] (July 23, 2020).

every unit. Both she and Acting DON [REDACTED] explained that, in Coates Hall, both sides of each floor were covered with black plastic regardless of the COVID-19 status of the unit.⁶¹⁶

We find that this failure of communication rests with Blackwood and Mullane. They did not take seriously the importance of communication to *all staff* to the effectiveness of SEVC's infection control response. We also find that this unwillingness to communicate openly with staff is reflective of SEVC's cultural insularity discussed below.

In comparison, following the change in leadership, staff has almost uniformly described a marked difference in the transparency of COVID-19 information provided. Most notably, rather than relying exclusively on a trickle-down communication model, Acting Commandant [REDACTED] communicates to staff directly by email. From May 30 through July 7, while acclimating to a new facility and responding to a CMS/DOH inspection, Acting Commandant [REDACTED] sent no fewer than 18 all-staff emails. Those emails addressed, among numerous other topics, infection control procedures and changes – including contact tracing information, screening information, and cohorting procedures – testing and COVID-19 status statistics, the status of the inspection, and staff recruiting efforts.⁶¹⁷

Staff, who previously were unaware of applicable infection control policies in effect at any given time, noted the easy accessibility of facility policies under the new administration.⁶¹⁸ In response to one of [REDACTED]'s updates to staff, one staff member wrote: "This is the most information, I, personally, have received since the Coronavirus has been in this building, besides what I've read in the newspapers & on the news."⁶¹⁹ Others noted that the "new leadership seems to be on the ball, seems to know what they are doing," and that they communicate well.⁶²⁰

2. *SEVC Failed to Communicate in a Meaningful or Compassionate Manner with Families about the Conditions of Their Loved Ones and at the Facility*

As should be self-evident, family members were justifiably concerned about their loved ones' well-being as COVID-19 spread throughout the facility. During the COVID-19 outbreak at the facility, SEVC communicated with resident families primarily in two ways. One mode of communication was by letters and emails providing facility-wide COVID-19 information sent to all family members. The other mode of communication was individualized calls or emails

⁶¹⁶ Interview of [REDACTED] (Aug. 6, 2020); Interview of C. Hansel (July 20, 2020).

⁶¹⁷ Email from [REDACTED] to MV-SEVC and others re Respiratory illness update (July 7, 2020)

⁶¹⁸ Interview of [REDACTED] (July 7, 2020).

⁶¹⁹ Email from [REDACTED] to [REDACTED] re Respiratory Illness Update (June 10, 2020)

⁶²⁰ Interview of [REDACTED] (June 17, 2020); *see also* Interview of [REDACTED] (July 9, 2020),

Interview of [REDACTED] (Aug. 8, 2020), Interview of [REDACTED] (Aug. 14, 2020),

Interview of [REDACTED] (July 6, 2020).

relating to a particular resident's condition. We do not find that either form reliably provided timely, transparent information.

On April 4, after the first resident tested positive, Blackwood sent out a vaguely worded letter to resident families stating that "on April 3, 2020, we learned that one or more of our residents developed COVID-19."⁶²¹ According to Blackwood, he borrowed this language from a template letter he found online.⁶²² He did not modify the template, however, to reflect SEVC's actual circumstances. While unnecessarily generic, the language at least had the benefit of being technically correct. On April 18, however, SEVC sent out another communication informing families that "[t]o date the home has had *several* positive cases of COVID-19 in our building."⁶²³ By that point, however, there were 16 positive residents, 13 "epi-linked" residents, and nine COVID-19 positive deaths at SEVC.⁶²⁴ Yet, both Blackwood and Mullane maintained that they believed "several positive cases" accurately expressed the scale of the outbreak at SEVC.⁶²⁵ We disagree. We further find that their unwillingness to recognize the inadequacy of the communication demonstrates their continued lack of commitment to transparency.

SEVC also provided inconsistent information to families in response to direct requests. For example, staff reported being discouraged by SEVC leadership from disclosing to concerned family members whether residents were on COVID-19 positive floors. Social Worker [REDACTED], however, provided that information to families, because she believed it was important to be transparent. Thus, the types of information conveyed to family members ultimately depended on who was providing it.⁶²⁶

Family members of SEVC residents reported to investigators their frustrations with SEVC's communications. The son of an SEVC resident, for example, explained that he was only informed of his father's passing when he called to speak with him.⁶²⁷ Another family member reached out to ask about the number of deaths at the facility following reporting by the Philadelphia Inquirer. DON Mullane responded that she was unaware to what the family member was referring.⁶²⁸ Mullane, of course, was well aware of the number of deaths at the facility. Another family was informed of their loved one's COVID-19 symptoms from another

⁶²¹ Family Letter from R. Blackwood (Apr. 4, 2020) [REDACTED]. By the time the letter went out, there were two residents who had tested positive. See Email from R. Blackwood to A. Ruscavage (Apr. 4, 2020) [REDACTED].

⁶²² Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁶²³ Email from [REDACTED] to R. Blackwood (Apr. 18, 2020) [REDACTED] (emphasis added).

⁶²⁴ SITREP (Apr. 17, 2020) [REDACTED].

⁶²⁵ Interview of R. Blackwood (Aug. 19 & 21, 2020); Interview of D. Mullane (Aug. 20, 2020).

⁶²⁶ Interview of [REDACTED] (July 6, 2020).

⁶²⁷ Interview of Family Members of Resident 79 (Aug. 21, 2020). The family was informed that the death was not COVID-19 related. *Id.* The resident's medical file did not identify COVID-19 as a cause of death. Resident 79 File, [REDACTED] Dr. Brangman reviewed Resident 79's file and concluded that his death did not appear to be COVID-19 related.

Interview of S. Brangman (Sept. 4, 2020).

⁶²⁸ Interview of Family Member of Resident 39 (Aug. 24, 2020).

resident and his family, rather than being provided this information from SEVC. The family thought their relative had COVID-19 based on his symptoms. The family was also informed that a co-resident was caring for the resident, until he was taken to the hospital. At the hospital, the resident was found to be COVID-19 positive.⁶²⁹ Still another family member expressed frustrations regarding inconsistent information he received regarding his father's symptoms and condition, explaining that he was told his father was doing well the morning of the day he ultimately had to be sent to the hospital due to his deteriorating condition.⁶³⁰ According to the resident's medical records, he had a fever that morning.⁶³¹

Not only did SEVC fail to provide sufficient information to residents' families, but they also expressed derision for family concerns. For example, when [REDACTED] wrote DON Mullane an email describing a family member's concern over her mother's exposure to COVID-19, Mullane forwarded the email to Commandant Blackwood, [REDACTED] and [REDACTED], stating only: "She's still complaining."⁶³²

[REDACTED] did not limit herself to internal criticism and instead engaged directly with family members on an SEVC Facebook group. A family member specifically recalled that when news reports related to SEVC were published, an SEVC staff member and another group member took to the group to defend SEVC. The posters asserted that the news articles were false and none of what was described was taking place in the facility.⁶³³ Family members later discovered that the authors of these comments were [REDACTED] and [REDACTED]; the posts have since been deleted.⁶³⁴ On another occasion, [REDACTED] lashed out at a family member who expressed frustration about the lack of information SEVC was providing related to her father's care.⁶³⁵ [REDACTED] replied, in part, "[i]f I felt this horrible about a facility I could NEVER leave my loved one there. Please let us know where you want him transferred to? We can [get] right on that. [Family Member] please.. same old song, same old dance yet he is still there."⁶³⁶ [REDACTED] continued to engage with the family member and further ridiculed the concerns with a dismissive colloquialism: "Bye Felicia."⁶³⁷ When asked about the incident, Mullane simply noted that the [REDACTED] comments "[were not] good" and "[REDACTED] got disciplined."⁶³⁸ In her own Due Process Conference

⁶²⁹ Interview of Family Member of Resident 48 (Aug. 21, 2020).

⁶³⁰ Interview of Family Member of Resident 53 (Sept. 9, 2020).

⁶³¹ Resident 53 File, at 90 [REDACTED].

⁶³² Email from D. Mullane to R. Blackwood, [REDACTED], [REDACTED] re Fwd: [Resident 39's] daughter (May 11, 2020) [REDACTED].

⁶³³ Interview of Family Member of Resident 39 (Aug. 24, 2020). At least after the first article, Blackwood noted that "overall the article was fairly accurate." SEVC COVID-19 Stand-Down Meeting Minutes (Apr. 20, 2020 entry) [REDACTED].

⁶³⁴ Interview of Family Member of Resident 39 (Aug. 24, 2020).

⁶³⁵ [REDACTED], Due Process Conference Statement (May 13, 2020) [REDACTED]; see also Interview of [REDACTED] (July 15, 2020).

⁶³⁶ [REDACTED], Due Process Conference Statement (May 13, 2020) [REDACTED] (emphasis in original); MAIL 12May2020 [REDACTED].

⁶³⁷ [REDACTED], Due Process Conference Statement (May 13, 2020) [REDACTED].

⁶³⁸ Interview of D. Mullane (Aug. 20, 2020).

statement, [REDACTED] defended her conduct by stating that the family member “is nasty to staff members, sends emails demanding things, and so much more.”⁶³⁹ [REDACTED]’s dismissive Facebook posts – and her defensive explanations for them – are appalling expressions of an utter lack of empathy or concern.

The new administration has taken an opposite approach to family communications and transparency, regularly providing information about the COVID-19 status of residents, units and staff, the facility’s infection control plans, and the various inspections the facility was undergoing.⁶⁴⁰ None of this information – positive or negative – was provided to family members under the prior administration. Rather than treating family’s concerns as a burden to be dealt with, the new administration has proactively worked to provide transparency and a degree of certainty.

Family members reported appreciating the nearly daily updates, noting that “things have gotten a lot better since the new Commandant took over.”⁶⁴¹ In response to one of [REDACTED]’s updates to families, one family member wrote: “Thank you so much for the update. Very comforting to know the residents are in your care.”⁶⁴²

3. DMVA Was More Concerned with Controlling the Message than Transparency with the Public about the Extent of the COVID-19 Outbreak

DMVA leadership demonstrated a similar lack of commitment to transparency in its responses to press and other inquiries. These responses therefore resulted in inaccurate representations regarding the scope of the COVID-19 outbreak at SEVC. For example, a draft of an April 6 update to Pennsylvania legislatures noted that there had been two positive COVID-19 cases within the SVHs. Adjutant General Carrelli provided comments on the draft, noting: “let’s delete the line about 2 positive residents. We will confirm if asked but not going to broadcast stats.”⁶⁴³ Adjutant General Carrelli explained during this investigation that he was concerned about putting the information in a broadly circulated email.⁶⁴⁴

DMVA also provided incomplete and ultimately misleading information in response to press inquiries regarding the spread of COVID-19 at SEVC. For example, an April 22 press request sought “the number of COVID infections and fatalities” in the SVHs. In a response

⁶³⁹ [REDACTED], Due Process Conference Statement (May 13, 2020) [REDACTED].

⁶⁴⁰ SEVC 1st resident letter (June 1, 2020) [REDACTED]; *see also* Email re Southeastern Veterans’ Center family update (May 31, 2020) [REDACTED]; Email from MV, SEVC-Contact re Southeastern Veterans’ Center family update (July 7, 2020) [REDACTED].

⁶⁴¹ Interview of Family Member of Resident 39 (Aug. 24, 2020).

⁶⁴² Email from [REDACTED] to [REDACTED] re Southeastern Veterans’ Center family update (June 18, 2020) [REDACTED].

⁶⁴³ Email from A. Carrelli to [REDACTED] and others re Department of Military and Veterans Affairs COVID-19 Response Update (Apr. 6, 2020) [REDACTED].

⁶⁴⁴ Interview of A. Carrelli (Aug. 14 & 17, 2020).

reviewed by DAG Weller and BVH Director Ruscavage, DMVA provided only the number of confirmed positive cases.⁶⁴⁵ While this may have been “technically” accurate, it excluded all of the presumed positive cases, even though SEVC was no longer testing most of the residents with signs and symptoms of COVID-19. In other words, the numbers necessarily understated the incidence of COVID-19 at the facility.

Another press request specifically asked for the numbers of COVID-19 “positive or presumed positive” residents. Nevertheless, DMVA responded again with only confirmed positive numbers, approximately 63% of the total.⁶⁴⁶ DAG Weller explained the answers only by referencing DOH’s policy of reporting confirmed, not presumptive, numbers until May 22.⁶⁴⁷ We are unaware, however, of any DOH guidance *prohibiting* homes from providing that information (particularly where the home was not able to obtain tests to confirm positive status), and DMVA has not pointed us to any. [REDACTED]

[REDACTED] Furthermore, DMVA did not explain this policy in their responses at the time, thereby creating the misimpression that the responses were complete.

We find that this unwillingness to provide factual information, or at a minimum explain the limitations of the information provided, is indicative of the general lack of transparency with which SEVC and DMVA approached COVID-19 related communication. Further, there was no valid reason to withhold this information. Rather than keeping the public informed, DMVA appeared more concerned about spin and avoiding negative publicity.

F. SEVC Failed to Prescribe Hydroxychloroquine Appropriately or Provide Sufficient Information Regarding Its Use

The investigation engaged Dr. Sharon Brangman to review medical records and provide her opinion regarding SEVC’s administration of hydroxychloroquine. Dr. Brangman is a professor of Geriatric Medicine at SUNY Upstate Medical University. In addition to her academic role, Dr. Brangman is the Attending Physician at the Veteran’s Administration Hospital in Syracuse, New York, and the Medical Director at various long-term care facilities, including Greenpoint / The Hearth Senior Living Communities in Syracuse, New York, the Transitional Care Unit at Upstate Medical University Community Campus, and Onondaga

⁶⁴⁵ Email from [REDACTED] to A. Carrelli and others re REPORTER: The American Legion magazine re: COVID and state veterans homes (Apr. 22, 2020) [REDACTED]; SITREP (Apr. 21, 2020) [REDACTED].

⁶⁴⁶ Email from [REDACTED] to A. Ruscavage, E. Weller, [REDACTED] re Inquirer follow-up (Apr. 29, 2020) [REDACTED]; SITREP (Apr. 28, 2020) [REDACTED].

⁶⁴⁷ Interview of E. Weller (Aug. 18, 2020).

⁶⁴⁸ Interview of [REDACTED] (Aug. 13 & 25, 2020); *see also* Email from [REDACTED] to E. Weller, [REDACTED] re REPORTER: PHILA INQUIRER on SEVC (May 29, 2020) [REDACTED]
[REDACTED].

County Department of Social Services, Long Term Care Resource Center, Department of Aging and Youth. Dr. Brangman reviewed the medical charts of 33 SEVC residents to whom hydroxychloroquine was administered, and nine COVID-19 positive or presumed positive residents to whom hydroxychloroquine was not administered.

Based on her review, Dr. Brangman identified the following deficiencies in SEVC's use of hydroxychloroquine.

1. Resident Selection and Related Safety Concerns

Hydroxychloroquine was being used off-label, and thus its safety and efficacy in the treatment of COVID-19 had not been established. As such, [REDACTED] should have proceeded with particular vigilance in prescribing hydroxychloroquine cautiously, and after assessing the appropriateness of the individual patient for whom the treatment was being considered. SEVC's practices in using hydroxychloroquine for COVID-19 patients fell short in several important ways. It appears that, in some ways, SEVC fell victim to the early and misleading hype surrounding hydroxychloroquine emanating from some circles, and the need to "do something" in the face of an outbreak rapidly careening out of control.

a. SEVC Did Not Screen Residents to Identify Appropriate Candidates for Treatment with Hydroxychloroquine

Based on Dr. Brangman's review of the SEVC resident medical files, she did not observe any effort to screen residents with underlying medical conditions for which hydroxychloroquine is contraindicated.⁶⁴⁹ The FDA EUA Fact Sheet, for example, specifically provides that "Hydroxychloroquine sulfate should not be used in patients with a prolonged QT interval at baseline or at increased risk for arrhythmia."⁶⁵⁰ Yet SEVC treated residents with histories of cardiac issues with hydroxychloroquine. For example, SEVC [REDACTED] treated a resident with QT elongation despite the patient's medical record noting that the resident had "long QT syndrome" and that medicines "which prolong QT interval" were to be avoided "when possible." The notes state that hydroxychloroquine is "discouraged with prolonged Q-T syndrome."⁶⁵¹

SEVC [REDACTED] also regularly prescribed hydroxychloroquine to treat residents on hospice, or were otherwise coded as "Do Not Resuscitate" ("DNR"), "Do Not Intubate" ("DNI"), and/or "Do Not Hospitalize" ("DNH"). When a resident is on hospice care, however, they necessarily are on end-of-life treatment. The entire premise of hospice care is that a patient is suffering from a terminal illness with death expected within six months; hospice treatment is meant to focus on patient comfort, not medical intervention, and especially not experimental intervention. In Dr. Brangman's estimation, no patient on hospice should have been prescribed

⁶⁴⁹ Interview of S. Brangman (Aug. 28, 2020).

⁶⁵⁰ FDA EUA Fact Sheet, at 2; *see also* Interview of S. Brangman (Aug. 28, 2020).

⁶⁵¹ Resident 7 File, at 309 [REDACTED].

hydroxychloroquine. In total, Dr. Brangman identified four residents who were prescribed hydroxychloroquine despite being on hospice.

Dr. Brangman also opined that residents coded DNR, DNI, and/or DNH should not be prescribed hydroxychloroquine because the medication could affect a resident's heart rhythm and residents coded DNR, DNI, and/or DNH could not be resuscitated and/or hospitalized if they suffered an adverse reaction to hydroxychloroquine. Dr. Brangman identified 16 residents who were coded as DNR/DNI, three of which were also DNH, who were prescribed hydroxychloroquine.

Dr. Brangman also explained that a resident's age was relevant to whether prescribing hydroxychloroquine was appropriate. In the field of geriatrics "old" is typically viewed in three categories: "young old," for patients between 67 and 74, "middle old" for residents between 75 and 84, and "old old" for residents 85 and older. In this latter category, the goals of care have to be clearly delineated since any effort to treat a new condition may very well negatively affect an existing condition. For this category of resident, in Dr. Brangman's opinion, the risks of treating residents with hydroxychloroquine – particularly, as discussed below, without the necessary monitoring – far outweighed any potential benefit.⁶⁵² Yet, 14 of those for whom hydroxychloroquine was prescribed were older than 85 years old, with several residents 95 years or older, and some as old as 98.⁶⁵³

Dr. Brangman also reviewed medical files for nine residents who were COVID-19 positive or symptomatic during the period April 6 to April 21, but who were not administered hydroxychloroquine, to see if she could identify any effort to screen those residents. The medical records themselves do not explain why hydroxychloroquine was not prescribed to these residents, and, other than identifying certain residents who started becoming symptomatic towards the end of the period during which the medication was administered at SEVC, Dr. Brangman could discern no underlying principle distinguishing those who were prescribed hydroxychloroquine from those who were not.⁶⁵⁴ Thus, Dr. Brangman could not identify any evidence that SEVC [REDACTED] screened residents to determine those most likely to benefit from hydroxychloroquine treatment.

Accounts from SEVC staff corroborate Dr. Brangman's analysis. Although [REDACTED] claimed that [REDACTED] decided which patients would be prescribed hydroxychloroquine based on cardiac history and history of arrhythmia,⁶⁵⁵ no one else agreed. To the contrary, nursing staff confirmed that, during the period it was used, the medication was provided indiscriminately to many COVID-19

⁶⁵² Interview of S. Brangman (Sept. 4, 2020).

⁶⁵³ Resident 18 File [REDACTED]; Resident 19 File [REDACTED]; Resident 84 File [REDACTED]; Resident 16 File [REDACTED].

⁶⁵⁴ Interview of S. Brangman (Sept. 4, 2020).

⁶⁵⁵ Interview of [REDACTED] (June 17, 2020).

residents.⁶⁵⁶ Indeed, ██████████, one the ██████████, was of the opinion that no special screening of residents was necessary for hydroxychloroquine. His view was that concerns regarding hydroxychloroquine were overstated as it had been used safely and effectively for the vast majority of people who have taken it to treat a variety of diseases.⁶⁵⁷

b. SEVC Did Not Adequately Consider Potential Adverse Medication Interactions When Prescribing Hydroxychloroquine

In prescribing any medication, a necessary consideration is whether a patient's existing medication regime has potentially adverse interactions with the proposed medication. Dr. Brangman observed that there appeared to be little, if any, consideration by SEVC ██████████ of how hydroxychloroquine might react with residents' existing medications. For example, Dr. Brangman observed that many nursing home residents are on one of a class of medicines referred to as atypical anti-psychotics.⁶⁵⁸ This is used to manage behaviors in individuals with dementia, but has a high potential for an adverse reaction with hydroxychloroquine. Dr. Brangman found no indication in resident medical files, however, that SEVC ██████████ considered such risk of adverse interactions before prescribing hydroxychloroquine to residents treated with atypical anti-psychotics.⁶⁵⁹

Additionally, azithromycin – a component of SEVC's "COVID-19 cocktail" – has QT elongating properties and, therefore, presents an inherent risk of adverse interaction with hydroxychloroquine. Notwithstanding guidance regarding the risk associated with prescribing azithromycin together with hydroxychloroquine, there is no indication in resident files that SEVC ██████████ considered that risk before prescribing hydroxychloroquine and azithromycin to residents with confirmed or presumed COVID-19 as a matter of course.⁶⁶⁰

c. SEVC Did Not Appropriately Monitor Residents Prescribed Hydroxychloroquine

The FDA EUA for hydroxychloroquine instructed medical providers to monitor the EKG of patients prescribed hydroxychloroquine to treat COVID-19. Dr. Jackson – and ██████████ – similarly recognized the need to engage in at least some EKG monitoring of

⁶⁵⁶ Interview of D. Mullane (Aug. 20, 2020); Interview of ██████████ (July 13, 2020); Interview of ██████████ (July 10, 2020); Interview of ██████████ (July 29, 2020); *see also* Interview of ██████████ (July 17, 2020).

⁶⁵⁷ Interview of ██████████ (June 17, 2020).

⁶⁵⁸ Interview of S. Brangman (Aug. 28, 2020).

⁶⁵⁹ E.g., Resident 85 File ██████████.

⁶⁶⁰ Dr. Brangman observed that the only time it appeared that existing medication was considered at all, it related to patients with adrenal insufficiency. These patients suffer from insufficient hormones, including cortisol, a hormone that is especially needed when a patient is sick or stressed. ██████████ however, discontinued the use of cortisol inducing steroids out of concern that it could worsen COVID-19. E.g., Resident 23 File, at 181

residents prescribed hydroxychloroquine to treat COVID-19.⁶⁶¹ Dr. Jackson discussed this requirement with SVH medical providers, noting that hydroxychloroquine was “likely to exacerbate or create arrhythmias [sic]” in “all residents.” Dr. Jackson’s direction, therefore, was to perform EKGs on residents before prescribing hydroxychloroquine if the SVH had an “EKG machine . . . available in house” or to “order one for the next day” if the SVH did not have an EKG machine in house.⁶⁶² Dr. Brangman, however, found no indication that SEVC engaged in any EKG monitoring of those residents.⁶⁶³

In addition to heart arrhythmias, hydroxychloroquine can have other effects that require special monitoring. For instance, hydroxychloroquine can cause a diabetic’s blood sugar to dip very low.⁶⁶⁴ Dr. Brangman, however, found no indication that SEVC performed any special, blood sugar monitoring for diabetic residents who were prescribed hydroxychloroquine.

SEVC and DMVA staff confirmed the absence of any additional monitoring. Dr. Jackson, for example, was not aware of any EKG monitoring at SEVC and explained that a machine or a monitoring service could have been ordered.⁶⁶⁵ Our investigation revealed no indication that Dr. Jackson followed up with SVH providers to ensure that they were implementing the direction to perform EKG on residents either before or soon after administering hydroxychloroquine. ██████████ recalled ██████████ explaining that “technically” they should be getting EKGs on residents who were prescribed hydroxychloroquine, but they would not be able to find anyone willing to come in to perform them.⁶⁶⁶

2. SEVC Did Not Appropriately Notify Residents and/or their Designated Powers of Attorney of the Risks Associated with Hydroxychloroquine

The FDA EUA for hydroxychloroquine makes clear that hydroxychloroquine should be prescribed only after fully disclosing to patients or their caregivers the risks associated with the experimental treatment of COVID-19 with hydroxychloroquine. Similarly, Dr. Brangman explained that, because hydroxychloroquine was being prescribed outside of its normal usage, residents or their caregivers should have been informed of the medication’s risks, the fact that it was unknown whether it would help or harm those with COVID-19, and its potential interactions with other medications.

██████████ acknowledged that they did not provide any information to patients or POAs regarding the risks and potential side effects of the medication

⁶⁶¹ Interview of ██████████ (Aug. 12, 2020); Interview of D. Jackson (Aug. 19 & 26, 2020).

⁶⁶² DMVA Providers COVID Minutes (Apr. 9, 2020) ██████████.

⁶⁶³ For residents with heart conditions, such as Resident 7 who suffered from QT elongation, Dr. Brangman’s opinion was that, if hydroxychloroquine was going to be used at all – which it should not have been – the residents should be on constant cardiac telemetry.

⁶⁶⁴ Interview of S. Brangman (Aug. 28, 2020).

⁶⁶⁵ Interview of D. Jackson (Aug. 19 & 26, 2020).

⁶⁶⁶ Interview of ██████████ (Aug. 12, 2020).

before it was administered, and did not believe that any such information was necessary.⁶⁶⁷ Indeed, several nurses told us that they did not even have the knowledge base to provide that kind of information to residents or their POAs.⁶⁶⁸ Moreover, while everyone agreed that, at a minimum, notification of new medication was required, in several instances, there is no documentation of *any* notification given to POAs that the drug was ordered. Mullane explained that “COVID 19 became so big that it was difficult to ensure timely notification and provide the increasing care needs of the sick residents.”⁶⁶⁹ In other words, even basic notification was not deemed a priority.

Dr. Jackson explained that he had discussed with SVH providers the need to provide notice to POAs when residents were prescribed hydroxychloroquine. Specifically, Dr. Jackson explained that, in his view, “notice” included an explanation of what they were prescribing, why they were prescribing it, the potential side effects of hydroxychloroquine, and whether any of the potential side effects were significant.⁶⁷⁰ In that regard, in a medical provider meeting, the SVHs were instructed that the “[b]est practice is to get informed consent from family, document in chart.”⁶⁷¹ Our investigation revealed no evidence that Dr. Jackson, or anyone else at DMVA, conducted any follow up to ensure that SVHs were following this best practice. Dr. Jackson later learned that SEVC did not share that view of “notice,” and that, in their view, mere notification of the new medication was sufficient.⁶⁷² Despite the discrepancy between Dr. Jackson’s understanding and the practice at SEVC, he has not directed any training or discussed changing SEVC’s “notification” practices.⁶⁷³

⁶⁶⁷ Interview of [REDACTED] (June 17, 2020); Interview of [REDACTED] (June 17, 2020).

⁶⁶⁸ Interview of [REDACTED] (Aug. 14 & 18, 2020); Interview of [REDACTED] (July 17, 2020).

⁶⁶⁹ Email from D. Mullane to [REDACTED], A. Ruscavage, D. Jackson, R. Blackwood and [REDACTED] re SEVC Request (May 21, 2020) [REDACTED].

⁶⁷⁰ Interview of D. Jackson (Aug. 19 & 26, 2020).

⁶⁷¹ Providers COVID MINUTES 09APR20 (Apr. 9, 2020) [REDACTED]. “Medical informed consent law requires disclosure of the risks of the suggested medical procedure and the risks of the alternatives to enable patients to make knowledgeable decisions.” Timothy J. Paterick et al., *Medical Informed Consent: General Considerations for Physicians*, 83 Mayo Clinic Proceedings 313 (2008), available at [https://www.mayoclinicproceedings.org/article/S0025-6196\(11\)60864-1/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(11)60864-1/fulltext). On this point, however, there was internal disagreement within DMVA. [REDACTED]

[REDACTED] for instance, did not believe there was any requirement to notify families or POAs that a medication was being prescribed off-label and the risks associated with such use. She agreed, however, that it would be best practice to provide that information. Interview of [REDACTED] (July 20, 2020).

⁶⁷² Email from D. Mullane to [REDACTED], A. Ruscavage, D. Jackson, R. Blackwood and [REDACTED] re SEVC Request (May 21, 2020) [REDACTED]; Interview of D. Jackson (Aug. 19 & 26, 2020).

⁶⁷³ Interview of D. Jackson (Aug. 19 & 26, 2020).

G. The Investigation Did Not Uncover Evidence Substantiating Falsification of Medical Records or Underreporting of COVID-19 Deaths

Concerns have been raised that SEVC may have falsified medical records, or underreported COVID-19 related deaths. We investigated those concerns with the assistance of Dr. Brangman. We found no persuasive evidence of the falsification of medical records or underreporting of COVID-19 deaths.

1. Inaccurate Medical Chart Documentation

Several SEVC staff members reported during the course of this investigation that they had heard that staff was pressured not to document COVID-19 related symptoms.⁶⁷⁴ None, however, claimed that they had failed to document symptoms or vitals accurately, had ever been instructed to do so, or were aware of specific examples of improper documentation. Many others flatly denied feeling, or being aware of, any such pressure.⁶⁷⁵

The most concrete allegations came from two National Guard medics, who stated that they had taken residents' vitals, provided them to nursing staff (because the service members did not have access to the electronic medical records), only to observe later that the vitals had been changed.⁶⁷⁶ [REDACTED] identified a particular per diem nurse (not full-time staff) who had incorrectly documented vitals on unspecified residents.⁶⁷⁷ That nurse's supervisor, [REDACTED], however, reported that she had never heard any such allegations, did not receive any complaints about the nurse, and generally thought she was a good nurse. [REDACTED] also stated that she was unaware of any pressure to downplay or underreport COVID-19 symptoms. She did state that there were certain circumstances where vitals appeared to be facially unreliable, so they were retaken and reported accurately.⁶⁷⁸ Another nurse, [REDACTED], explained that inaccurate vitals was particularly an issue with respect to National Guard service members, many of whom did not have medical backgrounds. As an example, she recalled being given oxygen saturation numbers that were plainly wrong. In those situations, she would retake the vitals and only record what she believed to be the correct ones.⁶⁷⁹

In sum, we could not corroborate the specific accounts of improper documentation, and found no evidence that there was a systemic practice of not documenting COVID-19 symptoms.

We do note, however, that DMVA, including Adjutant General Carrelli, was made aware of the National Guard's concerns regarding the potential inaccuracies in SEVC's staff recording

⁶⁷⁴ E.g., Interview of [REDACTED] (Aug. 17, 2020); Interview of [REDACTED] (July 29, 2020); Interview of [REDACTED] (July 8, 2020); Interview of [REDACTED] (July 29, 2020).

⁶⁷⁵ E.g., Interview of [REDACTED] (July 29, 2020); Interview of [REDACTED] (July 29, 2020); Interview of [REDACTED] (Aug. 11, 2020); Interview of [REDACTED] (July 10, 2020).

⁶⁷⁶ Interview of [REDACTED] (July 8, 2020); Interview of [REDACTED] (July 22, 2020).

⁶⁷⁷ Interview of [REDACTED] (July 22, 2020).

⁶⁷⁸ Interview of [REDACTED] (July 23, 2020).

⁶⁷⁹ Interview of [REDACTED] (Aug. 20, 2020).

of vitals. DMVA leadership – Adjutant General Carrelli, DAG Weller and BVH Director Ruscavage – prevented the [REDACTED] from investigating those concerns, however, purportedly because DOH was conducting an investigation of SEVC around the same time. [REDACTED]

[REDACTED].⁶⁸⁰ We find that DMVA leadership’s reluctance to conduct a compliance investigation on this issue is indicative of DMVA’s failure of oversight and underscores the necessity of compliance independence, both of which we address below.

2. *Inaccurate Cause of Death Reporting*

In connection with SEVC’s reporting practices with respect to COVID-19 related deaths, we asked Dr. Brangman to review medical files of 14 SEVC residents who passed away in April and May from causes other than COVID-19 to attempt to determine whether SEVC underreported the number of COVID-19 related deaths. With the caveat that Dr. Brangman could not form any definitive opinion without COVID-19 testing, she identified only one resident whose symptoms indicated that he could potentially have been COVID-19 positive at the time of death.⁶⁸¹ Another resident had tested positive two weeks before his death, but later tested negative for COVID-19.⁶⁸² Dr. Brangman could not determine how much, if at all, COVID-19 had contributed to the latter patient’s overall declining medical condition.⁶⁸³

We also examined whether death certificates for COVID-19 positive residents were properly completed, accurately listing COVID-19 as a cause of death. DOH required that all COVID-19 related deaths had to be reported through the electronic death registration system (“EDRS”).⁶⁸⁴ We reviewed both SEVC’s EDRS entries and paper death certificates to determine whether COVID-19 related deaths were entered into EDRS and, where there were both paper and electronic records, whether there were any discrepancies.⁶⁸⁵

Based on our review, we found that almost all of the residents who passed away while at SEVC – whether confirmed positive or “epi-linked” – had EDRS records that listed COVID-19 as a cause of death.⁶⁸⁶ There were a few exceptions, however. In particular, we were unable to

⁶⁸⁰ Interview of [REDACTED] (Aug. 13 & 25, 2020).

⁶⁸¹ Resident 80 File [REDACTED].

⁶⁸² Resident 81 File, [REDACTED].

⁶⁸³ Interview of S. Brangman (Sept. 4, 2020).

⁶⁸⁴ Pa. Dep’t of Health, *Reporting of Deaths*, <https://www.health.pa.gov/topics/Reporting-Registries/EDRS/Pages/EDRS.aspx> (last visited Sept. 20, 2020).

⁶⁸⁵ Typically, there is no reason to complete both a paper record and an EDRS record. Interview of D. Jackson (Aug. 19 & 26, 2020).

⁶⁸⁶ SEVC is only responsible for filling out death certificates for residents who died at the facility. Thus, although SEVC residents who died due to COVID-19 at the hospital are included in the total number of SEVC COVID-related deaths, they are not included in SEVC’s EDRS records. Interview of D. Jackson (Aug. 19 & 26, 2020).

identify EDRS records for two “epi-linked” residents, although one of their medical records indicates that the death was registered in EDRS.⁶⁸⁷

A discharge note for another “epi-linked” resident who passed away indicated that the resident “succumbed to the pulmonary complications of Epi-linked positive COVID-19.”⁶⁸⁸ The resident’s death certificate listed only dementia as his cause of death and SEVC submitted no EDRS record for the resident. In response to an inquiry on May 21 regarding the number of non-COVID-19 deaths in April, DON Mullane wrote, regarding this resident: “His paper death cert states dementia, [REDACTED] wrote a discharge summary of epi link based on a social service note that was entered. [REDACTED] is amending [REDACTED] note to match the paper death certificate which is dementia.”⁶⁸⁹ On that same date, [REDACTED] amended the discharge note to state that the cause of death was solely dementia. The resident’s medical chart does note, however, that his family had been notified before his death he was “presumptive[ly] positive for COVID-19,” and, after his death, that he “had not received COVID testing and epi-linked status was therefor [sic] given prior to resident’s passing.”⁶⁹⁰

Another resident passed away after exhibiting COVID-19 symptoms. After her death, the resident tested positive for COVID-19.⁶⁹¹ While the test was pending, [REDACTED] registered the death in EDRS without listing COVID-19 as a cause of death.

We also identified two residents who had both paper death certificates and EDRS records. For one of the residents, the paper certificate listed only dementia as the cause of death. His EDRS record, however, listed both COVID-19 and dementia as causes of death. We are aware of no explanation for this discrepancy, but it appears to be an isolated incident. The other resident does not have COVID-19 listed in either. Notably, this is the one resident who, based on Dr. Brangman’s review, exhibited symptoms that she believed could be consistent with COVID-19.

While these incidents demonstrate a degree of sloppiness, we did not find that there was any intent or practice to fail to identify COVID-19 as a cause of death. Instead, the evidence suggests that any reporting errors were isolated and did not stem from an effort to hide COVID-19 cases. When there were discrepancies or gaps in SEVC’s cause of death designations, SEVC’s records suggest that families were correctly informed about their loved ones’ diagnoses and COVID-19 status. Nonetheless, families deserve to know the truth about the circumstances of their loved ones’ deaths. Thus, greater care should have been given to ensuring the accurate recording of causes of death.

⁶⁸⁷ Resident 83 File, at 181 [REDACTED]; Resident 21 File, at 383 [REDACTED].

⁶⁸⁸ Resident 82 File, at 181 [REDACTED].

⁶⁸⁹ Email from D. Mullane to A. Ruscavage, D. Jackson, R. Blackwood re Follow up (May 21, 2020) [REDACTED].

⁶⁹⁰ Resident 82 File, at 181-82 [REDACTED]

⁶⁹¹ Resident 37 File, at 236, 237-52 [REDACTED]

H. SEVC Leadership Was Hostile to Feedback and Direction and DMVA Abrogated Its Responsibility to Ensure that SEVC Followed Its Directives

We believe that a significant underlying cause for many of these deficiencies is a culture at SEVC of hostility to feedback. This was fostered by Commandant Blackwood and DON Mullane at SEVC. With few exceptions, SEVC staff members reported that the administration was not receptive to feedback or any discussion of decisions. One supervisor described a culture of “don’t ask questions.”⁶⁹²

An example is instructive. [REDACTED], almost universally respected among SEVC staff, told us that she was reluctant to offer differing opinions to the administration after having “learned her place.” She therefore “tended to keep [her] mouth shut.” As a result, she did not express her concerns about SEVC’s COVID-19 related policies, because she “did not feel free to express [her] opinion.” [REDACTED] had worked for five different Commandants and four different DONs, but only Blackwood and Mullane created a culture where she felt as though she had to keep her opinions to herself.⁶⁹³ The new administration recognized that [REDACTED] seemed “broken,” and “stifled,” and, that, had she been allowed to do her job, she could have done it well.⁶⁹⁴

[REDACTED] was far from alone. Although some staff expressed a willingness to speak up, the vast majority believed that dissent and input were strongly discouraged.

We believe this hostility to input is demonstrative of a pervasive “us versus them” attitude among SEVC leadership. Whether the “them” referred to DMVA, the National Guard, or the press, SEVC leadership’s instincts were to treat outsiders with suspicion and defensiveness. In that regard, the “them” could also refer to SEVC’s own staff, particularly as it related to SEVC’s staffing concerns. DON Mullane explained that she had some questions about certain staff members who used COVID-19 testing as a way to get off of work, especially when a staff member would test negative several times.⁶⁹⁵ Additionally, while Mullane requested that the State Employee Assistance Program (“SEAP”) be brought in to SEVC for emotional support,⁶⁹⁶ Mullane acknowledged that she had concerns about staff using SEAP counseling as a way to get out of work.⁶⁹⁷ Commandant Blackwood expressed frustration that any time a staff member reported a symptom during screening, they would be sent home but could not get tested, resulting in them being out of work for a prolonged period of time.⁶⁹⁸

⁶⁹² Interview of [REDACTED] (July 7 & 9, 2020).

⁶⁹³ Interview of [REDACTED] (June 25, 2020).

⁶⁹⁴ Interview of [REDACTED] (July 20, 2020).

⁶⁹⁵ Interview of D. Mullane (Aug. 20, 2020).

⁶⁹⁶ Email from D. Mullane to [REDACTED] re SEAP request (Apr. 14, 2020) [REDACTED].

⁶⁹⁷ Interview of D. Mullane (Aug. 20, 2020).

⁶⁹⁸ Interview of R. Blackwood (Aug. 19 & 21, 2020). DMVA leaders expressed similar distrust of SEVC staff. DAG Weller, for example, explained that staffing became more difficult when employees started taking Family and Medical Leave Act (“FMLA”) leave because they were

[REDACTED] recalled a particularly stark example of this distrust. [REDACTED] explained that there was an opportunity to have a mobile testing unit come to the facility to test all of SEVC's staff in the facility parking lot. [REDACTED] stated that Mullane turned the opportunity down due to concern that all the staff would get tested and a significant number of them would then be sent home.⁶⁹⁹ While neither Mullane nor Blackwood recalled SEVC being offered mobile testing for SEVC employees,⁷⁰⁰ [REDACTED] recalled the incident vividly, stating that refusing testing for employees was something that she would remember for the rest of her life.⁷⁰¹

DMVA staff noted that SEVC's resistance to input was also directed to them. SEVC consistently pushed back against DMVA input and guidance. CMO Dr. Jackson, for example, reported constant resistance from SEVC. [REDACTED] explained that Mullane had a "her way or no way" leadership style. As such, information [REDACTED] provided would go "in one ear and out of the other."⁷⁰² [REDACTED] also explained that SEVC under Blackwood and Mullane pushed back against DMVA guidance, portraying an attitude that they were a big facility and knew what they were doing. [REDACTED] observed that, while other SVHs pushed back on occasion, DMVA's relationship with SEVC was different in the degree and consistency of the pushback.⁷⁰³

DMVA staff believed that Andrew Ruscavage enabled this pushback.⁷⁰⁴ Blackwood and Mullane back-channeled complaints directly to Ruscavage, who typically sided with SEVC.⁷⁰⁵ Although Ruscavage reportedly was more supportive of Dr. Jackson and his team during the COVID-19 outbreak,⁷⁰⁶ this history of favoritism undoubtedly contributed to Blackwood's and Mullane's evident belief that DMVA guidance was optional.

The upshot was that, rather than exercise DMVA's authority and oversight over SEVC to insist on compliance, DMVA caved. Dr. Jackson stated that he and his team where "shut down" so many times, that they stopped pushing back. He claimed that they were "shell shocked."⁷⁰⁷ As Chief Medical Officer with oversight over the SVHs, however, it was his obligation to insist on compliance. As Director with oversight over the SVHs, it was Ruscavage's responsibility to

scared of COVID-19. Interview of E. Weller (Aug. 18, 2020). BVH Director Ruscavage similarly stated that employees were taking off 14 or 21 days to quarantine under FMLA even if they did not have signs or symptoms of COVID-19 or a positive COVID-19 test. Interview of A. Ruscavage (Aug. 13, 2020).

⁶⁹⁹ Interview of [REDACTED] (July 28, 2020).

⁷⁰⁰ Interview of D. Mullane (Aug. 20, 2020); Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁷⁰¹ Interview of [REDACTED] (July 28, 2020).

⁷⁰² Interview of [REDACTED] (June 11, 2020).

⁷⁰³ Interview of [REDACTED] (July 17, 2020).

⁷⁰⁴ Interview of D. Jackson (June 9, 2020); Interview of [REDACTED] (July 17, 2020).

⁷⁰⁵ Interview of D. Jackson (June 9, 2020); Interview of [REDACTED] (July 17, 2020); Interview of [REDACTED] (Aug. 13 & 25, 2020).

⁷⁰⁶ Interview of D. Jackson (June 9, 2020); Interview of [REDACTED] (Aug. 6, 2020).

⁷⁰⁷ Interview of D. Jackson (Aug. 19 & 26, 2020).

ensure that SEVC followed directives and guidance from DMVA. This was all the more necessary in connection with policies and procedures needed to address a pandemic of virtually unprecedented magnitude.⁷⁰⁸

The most significant issues we identified in SEVC’s COVID-19 response – the failure to stop communal dining, the blind compliance with misunderstood but controversial cohorting guidance, and the failure to utilize 3 West to isolate exposed residents – all resulted from the disregard of DMVA directives, the dismissal of objections to SEVC’s strategies, and the failure to question controversial guidance. We therefore believe that this culture of hostility to input and DMVA’s failure of oversight contributed to SEVC’s difficulties with COVID-19. Responsibility for those failures rests with Commandant Blackwood and DON Mullane for the culture at SEVC they created, and Dr. Jackson and BVH Director Ruscavage for failing to exercise sufficient oversight and ensure compliance.

We also note that the cultural aversion to question authority also seemed to exist to a degree at DMVA as well. BVH Director Andrew Ruscavage, for example, reported that the direction of what information to provide – including to the National Guard service members at SEVC – came from his superiors at DMVA. When asked whether he agreed with the direction, Ruscavage replied that “it did not matter what [he] thought,” because “it is the military and you do what you are told.” He explained that he “was not provided a reason and you do not question what you are told to do.”⁷⁰⁹

We find that this attitude, in conjunction with the generally contentious work environment at DMVA, contributed to DMVA’s oversight failings.

I. SEVC and DMVA Leadership Failed to Take Responsibility or Engage in Any Meaningful Self-Critical Analysis

Leadership at SEVC and up through DMVA also failed to take responsibility for the failures in SEVC’s COVID-19 response. Blackwood and Mullane disclaimed knowledge of or responsibility for much of SEVC’s COVID-19 response. They professed ignorance of virtually every significant issue regarding SEVC’s response. This lack of knowledge would itself reflect a complete abdication of leadership and responsibility as the crisis unfolded. While there is no doubt that both Blackwood and Mullane should have been much more proactive and involved, we find that their sweeping claims of ignorance are much more of an after-the-fact effort to avoid responsibility or accountability.

Blackwood, for example, claimed to not know what his team communicated to DMVA about its COVID-19 preparedness planning, but he was “sure” that his team sent whatever they had done.⁷¹⁰ He claimed that his infection control team had developed internal control policies,

⁷⁰⁸ To Dr. Jackson’s credit, he at least belatedly acknowledged that failing. Interview of D. Jackson (Aug. 19 & 26, 2020).

⁷⁰⁹ Interview of A. Ruscavage (Aug. 13, 2020).

⁷¹⁰ Interview of R. Blackwood (Aug. 19 & 21, 2020).

but could not identify them. He further claimed to be unaware what training had been done, or how SEVC's cohorting and isolation plans were communicated to staff. He voiced a lack of knowledge that SEVC made a conscious decision not to perform infection control competencies. He stated that he did not know whether every staff member who worked on a COVID-19 positive unit had been fit tested. He claimed that SEVC delayed communal dining because of logistical issues, but was unaware of what was being done or by whom. When asked about an April 17 update showing that SEVC was emptying its negative pressure rooms but still moving residents around, he could not explain what the isolation policy was at that point in time. Rather, it was "whatever the Chester County Health Department" told them to do. He claimed to be unaware of any policy about when residents should be placed on precautions and/or isolated, claiming that such decisions were left to the infection control team or the medical providers to make on a resident-by-resident basis.⁷¹¹

Blackwood further stated to the investigators that he did not know whether staff were informed of residents' COVID-19 status before serving on the unit. He instead argued that it must have been obvious to them. He also claimed to be unaware that, because of the lack of information provided to the National Guard, the Guard had to pull service members for an entire unit because of exposure to presumptively positive residents. He disclaimed any recollection of reactions to or discussions about CCHD's guidance not to isolate positive residents on epi-linked floors, even though it was "definitely a change" from what they had been doing. Blackwood said he "assumed" the [REDACTED] would have asked all the pertinent questions about the guidance, noting that he has to trust the people with whom he works, but he stated that he did not know what questions the [REDACTED] asked CCHD about the guidance.⁷¹²

Mullane, for her part, claimed that she was not aware of whether SEVC's COVID-19 Pandemic Plan was ever completed, because it was someone else's responsibility. When asked about a staff member's concerns about a lack of PPE on a potentially positive floor,⁷¹³ Mullane claimed she was not aware how it was addressed, and that she had to rely on her ADONs. She was also unaware of what SEVC's isolation policy was on or around April 17, and did not know why they had stopped using negative pressure rooms. Mullane also disclaimed responsibility for infection control measures – such as the timing of precautions – noting that those decisions were the exclusive domain of the medical providers.⁷¹⁴

This professed abdication of responsibility, however, is entirely inconsistent with other circumstances where Mullane micromanaged providers on other issues. For example, both [REDACTED]

⁷¹¹ As discussed above, the infection control nurses claimed to have no policy-making responsibilities at all.

⁷¹² Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁷¹³ Email from [REDACTED] to [REDACTED], [REDACTED], D. Mullane, R. Blackwood re PPE Request for Serving (Apr. 10, 2020) [REDACTED].

⁷¹⁴ Interview of D. Mullane (Aug. 20, 2020).

[REDACTED] and [REDACTED] noted that they were required to go to Mullane to order psychological consults for SEVC residents, which both [REDACTED] found highly unusual.⁷¹⁵

[REDACTED] also reported that, at the end of March into the beginning of April, there were many residents exhibiting symptoms for whom she ordered testing. [REDACTED] explained that all test orders had to be approved by a “committee,” consisting of SEVC’s Commandant, DON, and ICNs. [REDACTED] was informed that that the “committee” had overruled many of [REDACTED] testing orders after determining that the residents for whom [REDACTED] ordered testing did not meet the criteria for testing. [REDACTED] also explained that where [REDACTED] thought a test was particularly warranted, [REDACTED] continued to advocate for testing. In one instance, Mullane called [REDACTED] to provide the reasoning behind not testing and to explain that SEVC did not “want to go swab happy.”⁷¹⁶

Both Commandant Blackwood and Mullane denied that SEVC overruled [REDACTED] orders for testing.⁷¹⁷ Mullane specifically stated that SEVC left testing decisions entirely up to the [REDACTED], that SEVC was not permitted to override a [REDACTED] order to test a resident, and that she did not recall ever having a conversation with [REDACTED] regarding what SEVC’s reasoning was for not testing a resident pursuant to [REDACTED]’s orders.⁷¹⁸ At least one nurse supervisor, however, largely corroborated [REDACTED]’s account.⁷¹⁹ In light of Mullane’s willingness to interfere in [REDACTED] decisions, and the general consensus that she micromanaged the staff,⁷²⁰ we do not find it credible that she did not believe she had any role in infection control decisions affecting the facility.

DMVA leadership also disclaimed any accountability for the problems at SEVC. BVH Director Ruscavage claimed not to recall whether he disagreed with the guidance not to move COVID-19 positive residents. He stated that he was unaware of SEVC’s isolation plans beyond generally understanding that they were using negative pressure rooms.⁷²¹ DAG Weller was largely defensive of SEVC’s infection control response. However, he also denied knowledge of SEVC’s isolation plans, or awareness that there was a vacant unit at the facility, which SEVC had considered using as part of its infection control plan. With respect to hydroxychloroquine, he believed more information than mere notice to residents or family should have been provided, but did not know whether that type of communication occurred. In connection with many of these issues, DAG Weller stated that he had to rely on his staff.⁷²² While one would not expect someone in DAG Weller’s position to be aware of the day-to-day details, given that the

⁷¹⁵ Interview of [REDACTED] (Jun. 17, 2020); Interview of [REDACTED] (Jun. 17, 2020).

⁷¹⁶ Interview of [REDACTED] (June 17, 2012).

⁷¹⁷ Interview of R. Blackwood (Aug. 19 & 21, 2020); Interview of D. Mullane (Aug. 20, 2020).

⁷¹⁸ Interview of D. Mullane (Aug. 20, 2020).

⁷¹⁹ Interview of [REDACTED] (July 7 & 9, 2020).

⁷²⁰ E.g., Interview of [REDACTED] (June 10, 2020); Interview of [REDACTED] (July 15, 2020).

⁷²¹ Interview of A. Ruscavage (Aug. 13, 2020).

⁷²² Interview of E. Weller (Aug. 18, 2020).

deterioration in conditions at SEVC was well-publicized, greater engagement would have been expected.

Adjutant General Carrelli, while not denying responsibility for DMVA's COVID-19 response, was poorly informed on matters relevant to that response. For example, Adjutant General Carrelli accepted responsibility for directing SEVC not to share information with the National Guard. That direction, however, was based incorrect information about the National Guard's exposure to COVID-19 positive residents at the facility.⁷²³

In short, the culture at SEVC and DMVA was one where lower-level staff felt disempowered to contribute and question, and leadership claimed to rely on lower-level staff and others for key decisions and policies. Ultimate responsibility seemed to have rested nowhere.

On a prospective basis, what is most concerning is SEVC's and DMVA's leadership apparent unwillingness to engage meaningfully in discussions regarding whether mistakes had been made from which they could learn. Blackwood refused to consider whether there were any infection control decisions – not using 3 West, ceasing to use negative pressure rooms, not stopping communal dining – that, in retrospect, could have been made differently. The only thing he could imagine doing differently was “begging” for more testing.⁷²⁴ Ruscavage too rebuffed any attempt to “speculate” on whether 3 West could have been used, instead claiming that he does not believe in “Monday morning quarterbacking.”⁷²⁵ DAG Weller also focused more on defending what SEVC had done after the fact than engaging in whether there was anything that could have been done differently. For example, in discussing communal dining, DAG Weller pointed to DOH guidance about socially distanced dining where in-room dining was impractical. He acknowledged, however, that he did not discuss the guidance or SEVC's ability to transition to in-room dining at the time.

This unwillingness to accept responsibility or engage in meaningful self-reflection is deeply troubling from an infection control perspective. Forty-two residents died from COVID-19 at SEVC. COVID-19 has not been defeated, and medical professionals are predicting a “second wave” of the outbreak in due course.⁷²⁶

Despite these concerns, it appears that DMVA is now fully committed to a process of self-reflection and critique. It further appears that TAG, [REDACTED] and his staff are fully committed to continuing to implement processes designed to help ensure that things will be done differently in the future, and that the SVHs will be well-positioned should a second wave occur. The empowered and effective interim management put into SEVC in late May was a substantial

⁷²³ Interview of A. Carrelli (Aug. 14 & 17, 2020).

⁷²⁴ Interview of R. Blackwood (Aug. 19 & 21, 2020).

⁷²⁵ Interview of A. Ruscavage (Aug. 13, 2020).

⁷²⁶ E.g., Lisa Lockerd Maragakis, M.D., Johns Hopkins Med., *First and Second Waves of Coronavirus*, HopkinsMedicine.org (Aug. 14, 2020), <https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/first-and-second-waves-of-coronavirus>.

step in the right direction. Calling for and sanctioning a thorough investigation was as well. In that light, our recommendations follow.

VI. Recommendations

In light of the foregoing factual findings and analysis, we make the following recommendations that we believe will improve the functioning of DMVA and the SVHs.

A. Better Oversight of the State Veterans Homes by DMVA Is Necessary

Based on our observations from the investigation, we believe that better oversight of the SVHs by DMVA is needed. Part of that is personnel – DMVA leadership must insist on SVH compliance with its directives – but part of that is also structural. Without on-the-ground insight into what is happening at the facilities, DMVA is left to trust that the homes are doing what they are supposed to be doing.

Comparative SVH experience in COVID-19 planning has demonstrated that closer relationships between DMVA and the SVHs have resulted in better outcomes. For example, Dr. Jackson had previously been the Medical Director at DVVH, and had a good working relationship with the leadership there as a result. DVVH was therefore willing to accept guidance and input from Dr. Jackson. DVVH also had a COVID-19 outbreak in its facility, but it was brought under control much more quickly than the outbreak at SEVC.⁷²⁷ Similarly, [REDACTED] was asked by [REDACTED] to assist onsite with COVID-19 planning. Unlike at SEVC, HVH stopped communal dining in mid-March, was receptive to guidance provided by BVH, and started PPE and hand-washing training and audits in early March. Furthermore, the rapport that [REDACTED] was able to develop with HVH's leadership fostered a productive relationship even after [REDACTED] left the facility.⁷²⁸

We believe that there are certain structural changes – and certainly other possibilities as well – that could be made individually and in combination to provide that degree of structured cooperation and oversight.

- **Rigid Chain of Command.** While beneficial to a military organization, a rigid chain of command is not optimal for running what is essentially a healthcare organization. Medical, compliance and quality professionals should have greater say in policy-making. DMVA, BVH, and SVH management should regularly communicate on issues significant to the homes. Formations of committees should be considered to address significant issues, similar to non-governmental healthcare organizations. The TAG, DAG, and Commandants should have open-door policies encouraging communication of concerns and creative thinking. Questioning of decisions and existing practices should be encouraged and fostered in a well-organized way, rather than chilled or overly bureaucratized.

⁷²⁷ Interview of [REDACTED] (July 17, 2020).

⁷²⁸ Interview of [REDACTED] (July 20, 2020).

- **Chief Medical Officer.** The CMO should sit within DMVA and regularly communicate on significant issues directly with the TAG and DAG. Currently, there is no one at the SVHs who reports directly to the DMVA Chief Medical Officer. The DON reports to the Commandant. At SEVC, the medical director is part of a third-party practice and does not technically report to the Commandant or the Chief Medical Officer. We believe that there should be some level of coordination between the clinical leadership at the SVHs and DMVA and some degree of accountability to clinical leadership at DMVA. This could be accomplished in a number of different ways. The DONs, for example, could have dotted-line reporting responsibility to the Chief Nursing Officer or the Chief Medical Officer. Similarly, the SVH medical directors could have dotted-line reporting responsibilities to the DMVA Chief Medical Officer.
- **Compliance.** Currently, the Chief Compliance and Ethics Officer [REDACTED] has no compliance personnel at the homes. Having compliance officers at each home who report directly to the Chief Compliance Officer would allow DMVA to have better insight into whether the homes are complying with departmental policies and procedures. In turn, the Chief Compliance and Ethics Officer does and should continue to have, at a minimum, a dotted line directly to TAG. This should be accompanied by regular reporting on significant compliance issues.
- **Quality Assurance.** Similarly, there exist Quality Assurance personnel at both DMVA and the SVHs, responsible for ensuring that the homes operate within mandated parameters. The BVH Quality Assurance officer, [REDACTED] however, reports directly to the Chief Operating Officer, but has no direct reports. Instead, the SVH quality assurance personnel report to their Commandants, with the BVH officer acting only as a consultant.⁷²⁹ Changing this reporting structure would again give BVH better insight into and control over SVH practices.
- **Infection Control.** Infection control nurses at the SVHs are not required to have any prior infection control experience, although on-the-job infection control certification is required. It is a position that typically goes to the most senior RN who puts in for an opening. There is no infection control position at BVH. We believe there should be an infection control coordinator position at BVH, with a necessary qualification of prior infection control experience. Such a position would ensure infection control oversight by someone with relevant prior experience, as well as on-the-ground insight into the infection control practices occurring at the SVHs.
- **Crisis Management Plan.** A crisis management plan should be put into place, with key roles, and reporting responsibilities identified. That will help ensure that, when the next crisis occurs, an infrastructure will be ready for nimble and well-informed

⁷²⁹ Interview of [REDACTED] (June 26, 2020).

decision-making, well-informed oversight, and accountability to the very top of the organization.

These are just examples, and there very well could be alternatives that would accomplish the same ends, while also not depriving the SVH Commandants of their ability and responsibility to run their individual facilities. We do believe, however, that these changes will help foster more coordination among the SVHs and better compliance by the facilities. Indeed, we believe what the new SEVC administration – involving an Acting Commandant from a different facility, an Acting DON from BVH, and additional on-the-ground involvement by BVH’s Chief Nursing Officer and Nurse Administrator – was able to accomplish in such a short period of time demonstrates the utility of these structural changes. We also believe that having these structures in place, with more insight by DMVA into what is happening at the facilities, will allow DMVA management – including the BVH Director and Chief Medical Officer – to be held more directly accountable for their actions and failures to act.

B. BVH Should Be Restructured to Ensure that Someone with Long-Term Care Experience Has Decision-making Authority for the Homes

As currently structured, the SVHs – through their Commandants – report to the BVH Director. The BVH Director in turn reports to the DAG for Veterans Affairs. While the BVH Director is required to have long-term care administration experience, the BVH Director is not a final decision maker. For example, he does not have authority to implement policy, approve budgets, or hire and fire personnel.⁷³⁰ That authority rests with the DAG, who is not required to have any medical or long-term care administration experience. The current DAG, Major General Eric Weller, has none. Indeed, the only qualifications for the DAG of Veterans Affairs is that “[h]e shall be a veteran and an active member of at least one . . . veterans’ organization[].”⁷³¹ The BVH Director serves only as an advisor to the DAG in matters regarding the provision of healthcare to veterans. Furthermore, as currently structured, the DAG has no one in his reporting structure with clinical medical expertise.

We believe ultimate authority for the SVHs should rest with someone with long-term care administration experience. That could be accomplished in one of at least two ways. First, there is no requirement that the SVHs be run by the DAG for Veterans Affairs. The Adjutant General could create a new Deputy position with oversight responsibility for the SVHs and with the recommended qualifications.⁷³² Alternatively, the required, statutory qualifications for the

⁷³⁰ Interview of [REDACTED] (August 13 & 25, 2020).

⁷³¹ 51 Pa. Stat. § 1711(b); *id.* § 901(b) (“No Adjutant General, Deputy Adjutant General or Assistant Adjutant General shall be appointed who shall not have served at least ten years as a commissioned officer in the Pennsylvania National Guard, or any of the armed forces of the United States or their reserve components; the aforesaid service may be cumulative.”); *see also* Interview of [REDACTED] (August 13 & 25, 2020); Interview of [REDACTED] (Aug. 24, 2020).

⁷³² 51 Pa. Stat. § 901(a) (“The Adjutant General may appoint a Deputy Adjutant General for Army and a Deputy Adjutant General for Air, and such other Deputy Adjutants General and

DAG of Veterans Affairs could be amended to require the relevant experience, although that change would require legislative involvement.

Again, other options may be available. What we believe is important is that ultimate responsibility for the SVHs rests with someone with appropriate qualifications.

C.

This image consists of three horizontal bands. The top band is a solid black rectangle. The middle band is a solid white rectangle. The bottom band is a solid black rectangle. The boundaries between these bands are rough, stepped edges, giving the appearance of a binary or high-contrast digital signal.

VII. Conclusion

SEVC's experience with COVID-19 was tragic. Forty-two lives were lost, and many others became ill. We recognize that it is always easier to assess and second-guess with the perspective of hindsight and the luxury of time. Indeed, many of SEVC's staff members put their own wellbeing at stake and worked nonstop only to lose residents they knew and cared for deeply. We also recognize that it is impossible to know definitively what would have happened had things been done differently.

Nevertheless, it did not need to be this way. There were many things that could and should have been done differently, and which could have helped avoid the full scope of the horrible events that unfolded at SEVC. Given the steps already underway, and careful

Assistant Adjutants General as in his discretion are needed for the efficient functioning of the department.”).

consideration of the lessons learned, we are hopeful these issues can and will be addressed in order to prevent similar tragedies from occurring in the future.⁷³³

⁷³³ Attached are further responses from Rohan Blackwood, Deborah Mullane, and [REDACTED] [REDACTED], provided through their counsel. Those responses have been considered and certain clarifications and modifications made as a result.



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PRACTICE DEDICATED
TO LITIGATION AND
NEGOTIATION MATTERS

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December 28, 2020

VIA EMAIL [REDACTED]
[REDACTED]

PA Department of Military
and Veterans Affairs
[REDACTED]

Fort Indiantown Gap
Annville, PA 17003-5002

Re: Dissemination of Investigation Findings for Covid-19 Response by Southeastern Veterans' Center ("SEVC")

Dear [REDACTED]:

As you know, I represent Rohan Blackwood and Deborah Mullane in connection with the above referenced Investigation. I was retained about 10 days ago, on or about December 17, 2020, a day after your Office released a draft version of the Investigation Report to Mr. Blackwood and Nurse Mullane, setting a deadline for them to respond to the 122 page, single spaced report by 5 PM, December 28, 2020.

The Investigation was conducted by a private law firm – Morgan Lewis & Bockius LLP (“Morgan Lewis”) – which was retained by the Governor’s Office of General Counsel (“OGC”). Morgan Lewis is one of the largest private law firms in the World, which has “2,000 lawyers . . . in 29 offices across the United States, Europe, Asia and the Middle East.”¹ Morgan Lewis had over seven months to investigate SEVC’s response to the Covid-19 pandemic, which included the full and complete cooperation of both Mr. Blackwood and Nurse Mullane.

¹ <https://www.morganlewis.com/careers/law-students-and-law-graduates/~media/7d1ebd7657ef4ac9abfb11cb0cff17bc.ashx#:~:text=We%20value%20individuals%20from%20diverse%20cultural%2C%20economic%2C%20and%20personal%20backgrounds.&text=Founded%20in%201873%2C%20Morgan%20Lewis.%20Asia%2C%20and%20the%20Middle%20East.>

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I wrote to you on December 17, 2020, advising that I had just been retained. I noted that I did not have access to the Investigation Report because it was sent through an encrypted email with a prohibition of sharing it with any third-parties. I respectfully requested access to the report and a 10-day extension under the circumstances, which included the fact that the current response deadline was over the Christmas Holidays. Later that evening, on December 17, you provided me access to the encrypted report – although I was still prohibited from downloading or copying it to share with any others in my office – and bluntly denied the reasonable request for a 10 day extension without explanation.

In the meantime, on December 23, 2020 – two days before Christmas and before receiving any reply or rebuttal to the draft Investigation Report – Mr. Blackwood and Nurse Mullane were both notified that they were terminated from their respective jobs.

The above heavy handed government conduct, together with the incomplete Investigation Report submitted by Morgan Lewis (which omits numerous material facts and is completely lacking factual context) demonstrates the clear political scapegoating of Mr. Blackwood and Nurse Mullane, all designed to detract attention from the systematic failures of the Governor’s Office, the Department of Health (“DOH”), and the leadership of the Department of Veteran’s Military Affairs (“DMVA”) in properly responding to this pandemic’s catastrophic effects on the elderly veterans residing in the Department’s nursing homes. Indeed, on countless occasions during the beginning of the pandemic – from Mid-March onward -- both verbally and in writing, Mr. Blackwood and Nurse Mullane pleaded with leaders for additional staffing resources and the deployment of the National Guard, but such pleas went unanswered until the arrival of the National Guard at the SEVC on April 15, 2020.

This letter attempts to provide the necessary context and highlight the fallacies in the Morgan Lewis Investigation Report and the systemic failings of the Governor’s Office, the DOH and the DMVA. But, this document is by no means an exhaustive rebuttal since my clients were purposely deprived of any meaningful opportunity to do so.

1. Rohan Blackwood and Nurse Deborah Mullane

Mr. Rohan and Nurse Deborah Mullane are both highly qualified, experienced nursing home administrators who have served SEVC and their residents for several years with distinction, each uniformly receiving high praises for their work at SEVC.

Nurse Mullane has over 25 years nursing home experience and served as SEVC’s Director of Nursing (“DON”) for the past five years. She has repeatedly received favorable performance reviews, noting her “commendable” knowledge, skills, communications, work results, work habits, and problem solving. Her written performance reviews over the past five years include comments such as:

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- “Debbie has exceptional work habits and places a premium on customer service.”²
- “Debbie is clinically strong and ensures quality care for SEVC veterans and spouses.”³
- “Debbie is a strong and effective partner in support of SEVC and DMVA initiatives. She continues to effectively manage complaint and annual surveys with great results.”⁴
- “Debbie is a strong and effective partner in support of SEVC and DMVA initiates. Regulatory compliance remains her focus with strong results.”⁵

Mr. Blackwood is a licensed nursing home administrator, who has served as the Commandant of SEVC for the past five years. He is proud to be the first African American Commandant for SEVC.⁶ In March 2016 – after serving as the Commandant for approximately one year – Mr. Blackwood was recommended by his supervisor for a merit based raise. The basis for the recommendation was set forth in a March 1, 2016 Memo from Andrew R. Ruscavage, the Director of the Bureau of Veterans’ Homes, who noted:

- “[Rolan’s] attention to detail and hands-on approach to management hav[ing] led to success of the facility in not only regulatory aspects but in all venues both internal and external to the organization. Prior to his arrival the facility was under regulatory scrutiny and on a Provisional License directed by the DOH.”
- “SEVC has seen major improvements in regulatory compliance since Rohan established policies and procedures to guide the home on a daily basis.”
- “SEVC also undergoes an annual inspection from the Veterans Administration and during this year’s inspection SEVC did not receive any identified deficiencies. A deficiency free survey shows the dedication and determination to provide the highest quality care for our veterans.”
- “SEVC under Rohan’s guidance was able to logically conduct two major renovation projects for the Coates Hall Building. . . . Upon completion of projects SEVC was able to

² Mullane Evaluation, 6/30/16

³ Mullane Evaluation, 6/19/17

⁴ Mullane Evaluation, 7/25/18

⁵ Mullane Evaluation 7/29/19.

⁶ Here, it must be noted that, prior to the Covid-19 pandemic, Mr. Blackwood has endured consistent racist comments and innuendo by several members of the SEVC staff, some involving the use of the word “N*****” on several occasions. These instances have been brought to the attention of Mr. Blackwood’s supervisors. Although the names of many of the individual sources cited by the Morgan Lewis Report were redacted, Mr. Blackwood believes that several of the staff members on whom the Morgan Lewis Report relies for negative comments about his performance are the same individuals who have demonstrated a racist bias toward him. This, indeed, is unfortunate given that Mr. Blackwood is the first African American to serve in the Commandant post for the SEVC.

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obtain the authorization from regulatory agencies to increase the bed count for Coates Hall adding fifty-four beds for veterans and spouses.”

- “SEVC has clearly exceeded all expectations. His tireless efforts have not only maintained operations, but have enhanced the overall performance of SEVC. His dedication and devotion to serving our veterans and ensuring not only the delivery of quality healthcare but ensuring the financial stability of the home. He sets the standard for others to emulate.”⁷

Mr. Blackwood’s annual performance reviews also gave him the highest marks across the board, noting he “far exceeded expectations” in his leadership, planning, management, interpersonal relationships, and results. His reviews included comments such as:

- “Commandant Blackwood’s performance has far exceeded the expectations that have been set forth. I can count on the SEVC to be in regulatory compliance, under budget, and to deliver high quality care to our Veterans. The best Commandant out of six that I rate.”⁸
- “Rohan has demonstrated great regulatory compliance through Inspection and Survey results. To date, SEVC is the best performing home financially. Of note, Rohan has overseen the development of new and innovative programs for SEVC on CLC 1 regarding dementia residents. He continues to provide excellent mentorship as he develops multiple new management staff.”⁹
- “Commandant Blackwood you have not only met, but exceeded the Bureau’s expectations with regard to productivity, the results of the regulatory inspections for SEVC have been outstanding. SEVC has gone from the worst financially performing facility to the best consistently year over year. SEVC can be counted on to support the Bureau with mission accomplishment.”¹⁰
- “Special note of thanks for the excellent financial control of SEVC which has been noted as the best performing home financially. All survey results have consistently exceeded expectations. Rohan is willing to take on any and all challenges such as the new initiative re Dementia training in the CLC and also expansion of capabilities with Adult Day Healthcare. He willingly volunteers his expertise wherever needed as cited with his membership in the LTCC and Nursing Home working group. Rohan continues to find innovative ways to motivate his employees and sets a great example re productivity.”¹¹

⁷ Ruscavage March 1, 2016 Memo to HR Director, [REDACTED].

⁸ Blackwood Evaluation, 7/24/18

⁹ *Id.* (Reviewing Officer’s Comments, 7/26/18).

¹⁰ Blackwood Evaluation, 7/29/18

¹¹ *Id.* (Reviewing Officer’s Comments, 7/29/18).

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**2. The Covid-19 Pandemic and Its Disproportionate Impact
on Veteran's Homes and Inconsistent Guidance And Testing Restrictions
from DOH**

A glaring omission from the Morgan Lewis Report is the lack of any mention of the Covid-19 national impact on Veteran's Homes and the inconsistent, ever changing guidance provided by government authorities. These omissions are important because only when considered in context can the unfortunate events at the SEVC be properly understood.

In the face of an unanticipated, once-in-a-century pandemic, complicated by inconsistent guidance from state and federal authorities, nursing homes were particularly hard-hit by COVID-19. By November 2020, of 260,000 deaths in the United States from COVID-19, more than 100,000 (40%) occurred in long-term care facilities.¹² Every state had issues in its long-term care facilities, especially early in the pandemic: for example, 86% of deaths in Minnesota from COVID-19 were in long-term care facilities early in the pandemic.¹³

The late efforts of states to assist care facilities and provide necessary guidance speaks for itself as a contributing factor in harm from the pandemic. Pennsylvania, for instance, did not set up its Regional Response Health Collaborative to support long-term care facilities until late July 2020, well *after* COVID-19 tore through its nursing homes.¹⁴ The Governor of Kentucky placed the deaths in long-term care facilities squarely on the community as a whole, recognizing the role of community spread in placing nursing home residents in danger: “Because we, Kentuckians, have failed to stop community spread thus far, we can't keep it out of places like this[.]”¹⁵

¹² Jon Kamp and Anna Wilde Mathews, “Covid-19 Deaths Top 100,000 in U.S. Long-Term Care Facilities,” *Wall Street Journal* (Nov. 25, 2020), available at <https://www.wsj.com/articles/covid-19-deaths-top-100-000-in-u-s-long-term-care-facilities-11606333186> (hereinafter “Kamp and Mathews, ‘Covid-19 Deaths Top 100,000’”).

¹³ FOX 9 Staff, “‘Time to dig deep’: Concern for long-term care facilities amid increased community spread,” FOX 9 KMSP, available at <https://www.fox9.com/news/time-to-dig-deep-concern-for-long-term-care-facilities-amid-increased-community-spread>.

¹⁴ 69 News, “Pa. health, medical officials discuss more support for program that helps long-term care facilities,” WFMZ-TV (Nov. 16, 2020), available at https://www.wfmz.com/news/area/pennsylvania/pa-health-medical-officials-discuss-more-support-for-program-that-helps-long-term-care-facilities/article_219b29de-2849-11eb-b206-8ffec700abc5.html.

¹⁵ Meredith Deliso, “Kentucky veterans center hit hard by coronavirus surge in state,” ABC News (Nov. 13, 2020), available at <https://abcnews.go.com/Health/kentucky-veterans-center-hit-hard-coronavirus-surge-state/story?id=74132192>.

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Pennsylvania Secretary of Health Dr. Rachel Levine agreed with this, stating, “The introduction of COVID-19 into a long-term care facility is a reflection of the number of cases in the community, which is why all Pennsylvanians have a role in helping protect these facilities.” The late recognition of the need for assistance, combined with the admission by state officials that community spread is the culprit behind long-term care facility deaths, is of serious concern when blame for the spread of the virus is attempted to be placed at the door of individuals such as Mr. Blackwood and Nurse Mullane.

The particular problems in veterans’ homes, in fact, have been ignored by the Commonwealth of Pennsylvania. Among the nursing home populations that suffered the most, those in state-run facilities for servicemen and women stand out.¹⁶ Some facilities, such as the Menlo Park Veterans Memorial Home in New Jersey, lost 101 people to the virus, amounting to approximately one-third of the residents. *Id.*; Kamp and Mathews, “Covid-19 Deaths Top 100,000.” Similar death rates have occurred in veterans’ care facilities around the country: at the Bill Nichols State Veterans Home in Alabama, almost two-thirds of the residents tested positive for COVID-19, and almost one-third—46 elderly veterans—died due to COVID-19. Koh, “Veterans Homes Struggled.” A New York veterans home had 72 residents die to the virus; Massachusetts’ Holyoke Soldiers’ Home suffered 76 COVID-19 deaths, or about one-third of its population. *Id.*

SEVC, on the other hand, kept its infections down and, while any death from the virus is regrettable, only lost 42 residents in a facility with 292 beds, or less than 15%.

Nursing homes even continue to report limited supplies of such pandemic care essentials as N95 masks. Kamp and Mathews, “Covid-19 Deaths Top 100,000.” An organization representing nonprofit aging care providers asserted that it has been beating the drum for such basic needs as testing, staffing support, and PPE. *Id.* In Pennsylvania, long-term care providers have dozens of facility employees testing positive at once, and some workers are operating on waivers to serve in positions requiring greater training.¹⁷

Veterans’ homes, however, have been found to be particularly vulnerable to COVID-19. Koh, “Veterans Homes Struggled.” In addition to chronic staffing shortages, lack of testing and PPE at the outset of the pandemic created risk in veterans homes generally. *Id.* Given a population that is disproportionately male (more than half) and elderly, and the fact that COVID-

¹⁶ Elizabeth Koh, “Among Nursing Homes Hit by Covid-19, Veterans Homes Struggled the Most,” *Wall Street Journal* (Dec. 15, 2020), at A1 (hereinafter “Koh, ‘Veterans Homes Struggled’”).

¹⁷ Andrew Forgoth, “Long term care facilities face staffing issues, ask for more help,” ABC27 (Nov. 20, 2020), available at <https://www.abc27.com/news/long-term-care-facilities-face-staffing-issues-ask-for-more-help/>.

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19 is deadlier to men and the aged, veterans' homes faced a grim situation in a pandemic more deadly to its residents than those in other long-care facilities, which generally care for populations only one-third male. *Id.* The lack of consistent regulatory oversight has become apparent during the pandemic, also, as the Department of Veterans Affairs disclaimed any responsibility to oversee state-run homes prior to COVID-19. *Id.*

What is more, as explained by Dr. Darrell Jackson (the DMVA Medical Director) during the Pennsylvania Democratic Senate Policy Hearing on May 6, 2020, the lack of availability of Covid-19 testing and the lag time for test results was a substantial contributing factor in the disease's spread in the DMVA homes, including SEVC.¹⁸ As Dr. Jackson explained, DMVA had no control over which residents or staff could be tested – the DOH made such determinations as to who could be tested:

"As everyone knows, when you lockdown a nursing home, you cannot prevent the staff from coming in. You can screen the staff the best you can but there is no guarantee that they are not asymptomatic carriers and we know that's what has been happening at SEVC and any of the veterans' homes that actually have infections right now. The problems are those carriers can move around the home in the various units and infect other staff, infect other residents and then you look up a week, two weeks later and the infection is out of control."

We started the interventions of doing the screening from the very beginning of March. We were taking temperatures in the beginning of March. We tried to do the best we could to get this under control as quickly as possible. *The biggest problem was we did not have control over the testing, whether it was testing for the residents or the testing for the staff. That was being controlled by the Department of Health and they basically told us who we were allowed to test. Because we wanted to test more people to be able to figure out how we could move the residents to a clean unit instead of having residents on a unit where they may get exposed.* We've done the best we could possibly do and we are still going forward to make sure we are providing the best care to the veterans and family members that are in our care."¹⁹

In the end, in a situation where even respected federal officials change their guidance on whether such basic measures as masks are advisable, the availability of testing was extremely limited and restricted by the DOH, and COVID-19 presented a learn-as-you-go response scenario where daily updates from Dr. Levine were necessary, it is irresponsible to scapegoat a pair of individuals in a facility that managed to contain an early outbreak and avoid the dramatic

¹⁸ <https://www.pasenate.com/the-impact-of-covid-19-on-nursing-and-veterans-homes/>: Zoom hearing video of Pennsylvania Democratic Senate Policy Hearing, May 6, 2020.

¹⁹ *Id.* (Dr. Jackson Testimony at 1:21:30-1:23:38).

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loss of life that occurred in other veterans' homes.²⁰

3. Mr. Blackwood and DON Mullane's Repeated Pleas for More Resources

Starting in the early stages of the pandemic, Mr. Blackwood had at least three conference calls per week with DMVA headquarters ("HQ") concerning pandemic response protocols. During these conference calls, Mr. Blackwood made repeated pleas to DMVA HQ for additional staffing resources and testing. It was explained to HQ that it was proving to be impossible to fully implement all recommended guidance and protocols with just the current nursing and CNA staff available at SEVC, and that the lack of testing exacerbated the staff shortages. These pleas were made starting in Mid-March, but the National Guard was not deployed to SEVC until April 15, 2020, and enhanced testing was not made available by DOH until late April.

As Dr. Jackson explained during his Senate Testimony on May 6, 2020:

"We originally made recommendations to the SEVC that they should have dedicated staff to each of the Units. And what that means is that if you have an activities person going in there, if you have an aide, if you have a nurse, they should be dedicated to that one Unit. They could not guarantee that could happen because as you know *they had a significant nursing shortage and that's why we brought in the National Guard because we were having such a significant nursing shortage we were concerned about being able to provide the appropriate and best care to the veterans in our care*. If we were able to test more of the staff to get this under control, yes if we were able to test the staff ourselves it would have been easier for us to dedicate each staff to those Covid Units to say those who were not infected you'll be on the clean Unit. It probably would have made it easier to control that process. But we didn't control the testing upfront. That testing was controlled by the Department of Health and it wasn't until a couple of weeks ago that we were allowed to go outside of the Department of Health to get that testing done."²¹

²⁰ Holly Yan, "Top health officials have changed their minds about face mask guidance -- but for good reason," CNN Health (July 20, 2020), *available at* <https://www.cnn.com/2020/07/19/health/face-masks-us-guidance/index.html>.

²¹ <https://www.pasenate.com/the-impact-of-covid-19-on-nursing-and-veterans-homes/>: Zoom hearing video of Pennsylvania Democratic Senate Policy Hearing, May 6, 2020, Dr. Jackson Testimony starting at 1:50:54.

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4. Communal Dining

The Morgan Lewis Report states that in mid-March, CMS, DMVA and PA DOH instructed long term care facilities to cancel communal dining. The Report then notes that SEVC did not do so until April 1. The Report's conclusions in this regard are completely lacking in context and ignore the facts occurring on the ground as the pandemic was happening, as well as the fact that SEVC had major staff shortages that made it extremely difficult to monitor all residents eating in their rooms as many residents required continued supervision (because they were at risk of choking) and assistance with eating.

On March 18, the DOH issued supporting guidance on critical measures released by CMS for all nursing facilities. This 3-page guidance addressed many issues and processes that homes should start to address, including restrictions to home, screening of staff, restriction of cross over from personal care residents and health care providers. The guidance went on to address admissions and readmission process of current residents from hospital, infection control specialist reviews of PPE guidelines, cleaning protocols, group activities, resident interaction with service providers and what to do when a staff member becomes sick.

SEVC leadership began addressing **all** these processes issues immediately (in fact, many had already been implemented). It is unfair not to acknowledge the tremendous amount of work needed to change multiple processes due to a global pandemic and the difficulties in achieving the changes given the limited resources at SEVC.

As it pertains to communal dining the guidance included the specific statement: "**When there is evidence of community spread within your county or adjacent counties, nursing care facilities should cancel all communal dining.**" The guidance also instructed nursing homes to identify high risk choking residents and those at risk for aspirations. The guidance provided that homes should "**not engage in communal dining activities unless doing so is necessary to maintain the health and welfare of the residents.**" The guidance also described other steps that can be taken if residents were brought into a dining room, such as staggering arrival times and social distancing, attempting to separate tables as far apart at possible and that staff take appropriate precautions, all of which SEVC did immediately.

At no point in time were symptomatic residents or COVID suspected residents allowed into dining areas. At SEVC, the most populated of 8 dining areas was already operating at only 50% occupancy. This dining area had ample space to provide social distancing. The other dining rooms in CLC also were sufficiently large that they too had plenty of room for social distancing. Resident eating clubs that routinely order takeout food were immediately canceled.

Also impacting dining was the removal of the **All Hand On Deck** team. This well-known and documented program enlisted well over 40 non nursing staff members to assist with serving of meals. This program had been in effect for over 5 years and was strongly endorsed by SEVC family members and DMVA headquarters. These staff members were specifically assigned to

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units during mealtimes and knew the residents better than most. Out of the abundance of caution, these AHOD teams were no longer to report to units during the pandemic so as to reduce the number of staff members interacting with patients. Without AHOD, and with only the limited medical staff, it was not possible to completely end communal dining and still safely provide meals to residents. Again, at this point in Mid-March through early April, none of the requested-on site supplemental National Guard nor VA nurses were on-site, despite repeated requests for such assistance.

Lastly, it is important to note that all of this was going on with SEVC Director of nursing out on medical leave for almost two weeks mid-March and one assistant director being out for a portion of that same time. To simply compare SEVC and all its mitigating circumstances to Hollidaysburg or any other home without looking at the totality of what was going on the ground is dishonest. It was widely known that some facilities were hit harder than others. Even highly rated 5-star facilities like SEVC. When contacted, the DOH acknowledged that many other facilities were facing outbreaks and doing everything in their power to control them.

5. The Morgan Lewis Report Falsely states SEVC began its preparation for COVID-19 in the first week of March, and planning for the isolation of COVID-19 did not start until late March.

This timeline is completely inaccurate. SEVC's administration began in-house discussions surrounding supplies, IV solution, PPE, pain medication, among other planning in February 2020. SEVC also opened documented communication regarding COVID-19 concerns with local health departments in late February.

6. The Morgan Lewis Report Falsely States that SEVC Ignored DMVA Planning Directives.

SEVC did not ignore DMVA planning guidelines. SEVC completed the infection control self-assessment, which included interaction with several departments and was made a priority. There is a documented binder of that assessment and all that associated work SEVC completed.

It is apparent that the Morgan Lewis "investigation" largely looked at emails, not the fact that work did occur. In addition, SEVC had multiple conversations and meetings with headquarters discussing progress on a multitude of directives. HQ had regular (originally 3x per week) meetings on progress on all COVID-19 topics. In addition, the Director of Bureau had a good working relationship with everyone in administration and did not hesitate to call administrators, assistant administrators, the director of nursing or assistant director of nursing. This would happen every day, several times a day.

At **no time** during these communications were administration advised that they were not following guidance or planning directives. On the contrary, the Bureau Director set up

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conference calls with all the homes to address the repeated and overlapping requests that overwhelmed all the homes not just SEVC.

SEVC asked repeatedly on calls and via email for assistance onsite from HQ. Originally, 4 people signed up to come onsite to SEVC, but ultimately only one came due to their concerns of catching COVID-19. The leaders of the other veterans home also suggested that more help should be on its way to SEVC.

As far as planning, SEVC followed planning directives timely as it relates to ordering requested supplies, medication, O2 concentrators and requested PPE through all available means. **It is important to know that administration had to complete and verify a daily line listing with resident and staff symptoms to headquarters, a daily line listing with symptoms to local health department and daily VA change report and line listing report in a separate format.** In addition, SEVC administration split responsibilities to the best of their abilities to follow and listen Dr. Rachel Levine's daily updates, participate in each HAP regional coalition call normally lasting one hour (then reduced to 30 min), log into PA state knowledge center to request PPE, keep local DOH field office up to date on issues **and** complete electronic event report for each positive resident and staff member. The securing of PPE and calculating burn rate of items also fell to administration as both supply employees took extended medical leaves due to the pandemic.

The main vehicle of communication with HQ, however, was the time-consuming SITREP that was required to be submitted **each day** including weekends by 3 PM. On occasion, SEVC submitted this report beyond the deadline, but not one was missed. This SITREP would elicit feedback, calls and updates. Again, at no point in time were administration advised they were failing in requested information or directives. To contrary, there are several emails from HQ and the General himself acknowledging he and HQ were receiving and reading daily reports.

This was all occurring on top of the regular duties required for maintaining the SEVC home. There were times where initial guidance or directives from HQ would need to be revised or tweaked based on what was happening on the ground.

For example, screening of staff members outside facility prior to entrance in home had to be revised. SEVC originally followed this directive and it is even documented with pictures in the newsletter. This practice had to be tweaked slightly as staff members started to have thermometer failures due to cold temperatures outside, even under the tents erected. The screening was moved indoor with appropriate social distancing, still at front entrances between lobby doors. This change was communicated to the SEVC Director. Even when General Weller and Andrew Ruscavage entered the SEVC home, this screening was in place for them. General Weller made frequent trips to the SEVC home to bring supplies, support, do rounds, meet with national guard, and check on PPE supplies. At no point in time did he mention any planning directives not being followed. SEVC leadership met with him each time and accompanied him on most tours around the home. The one HQ staff that came to assist with our screening, [REDACTED]

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[REDACTED] from education completed screenings in this manner for three weeks.

To describe these things as a failure to follow BVH instructions is completely inaccurate. The chain of command was highly regarded and enforced throughout DMVA. The PIM outlining expectations is reviewed upon hire and annually. SEVC leadership strived to be consistent on that expectation.

7. The Morgan Lewis Report Falsely States SEVC Leadership Failed to Clearly Define The Infection Control Nurses Responsibilities.

Prior to the COVID-19 pandemic, SEVC was assigned only one infection control position. The position was a combination of Infection Control and Wound nurse. This position was previously held by [REDACTED], RN since 2009. In 2017, [REDACTED] RN was promoted to a Registered Nurse Supervisor. To fill the infection control position, per state and union contract, this position was posted in house to allow for all RN's to bid on the open position. The position was filled by [REDACTED] RN, who fulfilled this role until 2019.

In 2019, and upon the new CMS Final Phase regulations, the two responsibilities were split resulting in the infection control position being posted in house. The position was filled by [REDACTED] RN, as she was the most senior bidder in house. DON Mullane voiced concern to BVH at the time regarding the need for this position to be filled by a registered nurse with infection control experience. Due to the SEIU contract and the required Minimum Experience and Training, BVH advised that this was not possible. DON Mullane was looking for the position to be amended the same way as the RNAC position that recently had been updated to require RNAC certification. Unfortunately, this position was required to be offered to [REDACTED] RN, even though she had no experience.

[REDACTED] RN received training for the position by [REDACTED] RN with guidance from [REDACTED] ADON, a 25-year employee who was also a previous state department of Health surveyor. [REDACTED] RN showed the ability to perform the basic duties of the job which included reviewing the Infection Control Policy and Procedure Manual with guidance from both ADON's and DON Mullane. [REDACTED] RN also successfully completed the Infection Control Certification course.

In February 2020, SEVC administration started discussions in preparation for the possibility of COVID-19 entering the facility. On or around March 9, 2020, Mr. Blackwood insisted that the previous Infection Control Nurse, [REDACTED] RN join and take lead in the response to COVID- 19 preparations along with [REDACTED] RN who had less experience. Headquarters was supportive of adding [REDACTED] to the infection control team because of her previous work, performance evaluations and attention to detail. [REDACTED] RN was also certified in Infection Control practices and familiar with Infection Control Policy and Procedures within the SEVC manual.

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By Mid-May, [REDACTED] RN retired in the middle of this crisis. This was not surprising as many false allegations had been publicized in the media and endorsed by local politicians. Many of these falsehoods surrounded work that she had been responsible for or was a part of. This included public misrepresentations that SEVC did not report residents who expired due to COVID or presumptive COVID which was a complete and total falsehood.

There were also false allegations that residents with positive tests or presumed COVID positive were not reported to appropriate family members. In review of clinical records, this also has been proven to be **definitively false**. SEVC administration and ICN was also accused of forcing sick staff members to return to work, thus furthering this outbreak, but this too was **definitively proven false** as evidenced by Pennsylvania Department of Health PAHAN-499, which addressed Return to Work Guidelines.

These false allegations repeated to the press without context had real world consequences in that it wasted time that should have been devoted to this crisis and caused SEVC to lose experienced and valuable staff in the middle of a pandemic. Now, the narrative appears to be quickly moving away from these debunked allegations to other areas of criticism. But the result of the false allegations definitely caused this ICN's departure and further handicapped SEVC's ability to monitor the outbreak.

8. The Morgan Lewis Report Falsely Claims the ICN's View of Their Responsibilities to be Deficient.

It is simply not true that the infection control nurses did not fully understand their job responsibilities as ICN's. When ICNs were given their annual reviews, they signed off on receiving their job description which explained their roles and responsibilities. The ICN's were part of every planning session and they were offered to participate in the daily televised updates from Dr. Levine which they did on several occasions.

ICNs were also present at the daily 9am meeting where expectations were specifically conveyed. They gave updates on the number of COVID-19 positive residents and staff identified along with the units affected. Any concerns that were identified were discussed in these meetings and plans of action created based on current information available from the CDC, HAN and CCHD at that moment. The plans of action were implemented along with identifying who was responsible for follow up and completion of the task. In addition, one of the two infections control nurse would lead off at over 20 stand down meetings to inform 30-40 middle management as to what steps the home was taking. The meeting minutes remain at the SEVC home.

SEVC over the years has not received any repeat or serious infection control deficiency by the annual Department of Health nor Federal VA survey. DON Mullane has had 13 years of experience in nursing administration, has worked with several infection control nurses and has never had any issues with the job roles and expectations required of an infection control nurse. It

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is completely unfair that SEVC administration is being wrongfully accused of lack of planning and implementation of the COVID-19 response.

SEVC has always had an Infection Control Policies and Procedures Manual that includes policies and procedures for “a system for preventing, identifying, reporting, investigating and controlling infections and communicable diseases” and written standards, policies, and procedures for the program, including policies for standard and transmission-based precautions to be followed to prevent spread of infections, and how isolation should be used for infected residents. In addition to the manual, staff were reeducated annually as required by regulation on infection control practices and handwashing. The infection control policy and procedure manual are the basic building blocks for the response to an outbreak.

9. The Morgan Lewis Report Falsely Claims The Infection Control Nurses Performance was Inadequate.

It was the responsibility of both infection control nurses to monitor for public health guidance and keeping SEVC updated on the most recent developments. Mr. Blackwood and DON Mullane were also participating in the HAP calls, BVH calls and listening to Dr. Rachel Levine’s daily updates which included CDC updates and changes, which could change several times in one day.

Any suggestion that [REDACTED] RN was not qualified as an infection control nurse is inaccurate. [REDACTED] is a 25 yr. plus employee and as a previous infection control nurse, has led SEVC through numerous outbreaks including Norovirus, Flu and any other outbreaks that required a line listing to the Health Department.

Over the years, [REDACTED] had built up a strong working relationship with the Chester County Health Department. Since the COVID 19 virus was a NOVEL virus, the WORLD was learning information as they went. This was not a situation where you could educate on COVID 19 before it came. EVERYONE was learning as they went. The infection control nurses spent a lot of time researching information, adjusting planning, and implementing changes in guidance from the CDC and HAN to name a couple of sources, that were ever changing.

For instance, Pennsylvania Department of Health, Health Alert Network (HAN) Advisory 502 presents changes on Discontinuation of Transmission Based Precautions for Patients with COVID-19. Pennsylvania Department of Health, Health Alert Network (HAN) Advisory 492 changed its guidelines regarding Universal Masking of Health Care Workers and Staff in Congregate Care Settings, all of which were rolled out immediately by the infection control nurses. Prior to the universal masking guidance was issued, Mr. Blackwood went unit to unit handing out 300 homemade cloth masks for staff and their families to utilize in community while not at work.

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The infection control policy and procedure manual is the basic building block for the response to an outbreak. As COVID-19 had never been identified, the infection control nurses used this manual to train on the basic requirements of handwashing, droplet precautions, what PPE was required and how to don and doff PPE, all of which were relevant to the NOVEL virus. Assistance with training on donning and doffing PPE was also provided by [REDACTED] RN and [REDACTED] QA analyst, who were delegated the task of monitoring the daily burn rate for PPE, restocking the units with PPE and issuing new masks when due.

It is important to note that SEVC received two on site COVID19 surveys where the SEVC leadership spoke directly to the two surveyors. During both surveys, the surveyors looked at the infection control education that was provided and went on the units in full PPE to observe infection control practices. They stated there were no infection control issues or problems. In fact, upon survey exit, both surveyors stated that SEVC was doing more than other nursing homes they had visited.

In addition, DMVA HQ requested the Federal VA to visit the SEVC home to review infection control protocols. These PEMA trained surveyors also agreed with infection control protocols being used at SEVC. They did make a few recommendations that were quickly followed up on. **An example of this was to seat residents dining on our dementia unit back-to-back, as these residents would not be able to stay in their respective rooms as they explored the unit.**

Any suggestion that infection control protocols were weak at the SEVC home up until this point is not accurate. There were no other homes in Commonwealth that received as much scrutiny, by now having in essence 3 on-site surveys by May during a pandemic, all of which **confirmed good practices**. It was not until SEVC leadership had been suspended, where a fourth DOH survey found observations that broke infection control practices. That survey occurred without key persons involved such as the seasoned ICN, ADON x2 or DON.

This last survey is filled with factual inaccuracies. One example of this is the allegation of a lack of signatures at two of four quarterly QA meetings by an administrator and nursing director. SEVC held QAPI meetings **monthly** with administrator and DON attending and signing well over regulatory requirement of four. Again, this is something that should have easily been addressed while the survey team was in facility, yet somehow it was not.

10. The Morgan Lewis Report's Suggestion that Doctor Jackson Was Somehow "Intimidated" by Mr. Blackwood Is a False, Racist Narrative.

This type of comment continues a racist narrative Mr. Blackwood has had to endure throughout his tenure of DMVA. As the Commonwealth's first African American Commandant, there has been consistent disparate treatment towards Mr. Blackwood that has racist undertones. Although Mr. Blackwood's professionalism is repeatedly credited on his written evaluations, there is a consistent theme amongst some at SEVC that Mr. Blackwood somehow must be feared

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for simply doing his job.

Mr. Blackwood's annual reviews along with SEVC homes track record of success have been impeccable under his leadership. While most staff, residents and HQ have been supportive, there has been a contingent of individuals that have sought to undermine Mr. Blackwood at every turn. Having an Covid-19 outbreak in which many other veteran homes across the country have had, has only provided another opportunity for this contingent to attack Mr. Blackwood.

As others at DMVA can attest, during his tenure, Mr. Blackwood has had to defend himself from a multitude of unsubstantiated allegations both personally and in respects to the SEVC home. Although SEVC has received the best results in their history under a diverse leadership team, documented allegations of hiding resident information and conditions persisted. One such documented allegation occurred at a 2018 quarterly advisory meeting in which Mr. Blackwood and SEVC were accused of somehow hiding the number of resident falls. This allegation was proven to be false.

Now under this global pandemic, again Mr. Blackwood and SEVC are being accused of hiding deaths, not reporting deaths, changing medical records, all of which have been proven to be false. These false allegations have real consequences as it pertains to time being wasted as opposed to providing the best possible care.

During this pandemic it is widely known within the SEVC home that this small contingent of staff broke HIPAA regulations and accessed resident records [REDACTED] [REDACTED]. This was done presumably to "find" inaccuracies which could be fed to the media and politicians.

Similarly, it is also widely known that Mr. Blackwood was illegally taped without his consent during staff huddles again presumably to "find" inaccuracies which could be turned over to media and local politicians. This type of undermining with strong racial undertones has been consistent during Mr. Blackwood employment and has been brought to HR's attention. It is unfair for anyone to work under these circumstances.

On a personal level, Mr. Blackwood has had to operate effectively despite the frequent use of the "N" word and other derogatory terms during his job by several residents and staff alike. One former disgruntled social worker quoted in these false media reports is known to have made racially charged statements towards Mr. Blackwood and another black employee. This includes laughing while a resident repeatedly called Mr. Blackwood the "N" word. Another resident, made repeated threats against Mr. Blackwood to this same social worker who thought it was funny. It was only after the resident made threats to kill Mr. Blackwood by blowing up his car were these threats taken seriously, leading to local police report being filed.

Many African American staff have seen and complained about the disparate treatment Mr. Blackwood has received. Mr. Blackwood was given guidance to have a second person

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witness certain interactions with certain staff members known to make false allegations. Mr. Blackwood has good reasons to believe that much of the negative information supplied to the press – and likely to Morgan Lewis investigators – came from sources who have already exhibited racially charged biases against Mr. Blackwood.

11. The Morgan Lewis Report Falsely Concludes that SEVC “Misinterpreted and Misapplied CCHD’s ‘epi-linking’ Guidance.”

SEVC administrators participated in daily phone calls to CCHD, and sometimes multiple calls a day occurred. On **more** than two occasions, the ICN’s and DON Mullane clarified with CCHD “epi-linking” and what it meant. The understanding was, due to the shortage of test kits at this time, when two residents test positive on one unit, no other residents were to be tested. If a resident became symptomatic, they were assumed or “epi-linked” and treated as if they were COVID-19 positive. This was determined by the physician or Certified Registered Nurse Practitioner (CRNP). If a resident without symptoms was on the unit, they were considered exposed and NOT “epi-linked.”

A discussion was also held with CCHD to determine that any asymptomatic residents should not be moved off the unit as they could be asymptomatic carriers and spread the virus to residents on another unit. In early preparation, the empty unit was staged for the potential of placing Covid-19 positive residents there. However, as with many things early on in pandemic, guidance changed. Negative pressure rooms were the preferred method of isolation during the HAP regional calls for nursing homes. For nursing homes that had them available, the negative pressure rooms should use them. As the pandemic unfolded, conversations with headquarters started to look at providing staff members a place to stay if needed. This is why employees were offered to stay on 3 West with headquarter’s knowledge and blessing.

This was well documented via emails and is a protocol that SEVC has used in past during inclement weather situations. At no point in time were SEVC leadership advised to move potentially exposed asymptomatic carriers’ residents without testing by anyone including by Dr Jackson CMO. Although some staff took advantage of these rooms it was not many.

SEIU union delegates expressed concern about ventilation and air flow on the unit. The concern was that virus could now travel “through the air” and staff may not believe it is safe. SEVC leadership responded in writing (via email) to delegates that the home was installing Merv 13 air filters the highest ones available to try to address any concerns. Once installed, email was also sent out to the entire staff.

As it is and was widely known, testing is the best measure to make decisions concerning isolation. If test kits were available and every resident could have been tested, this would have enabled SEVC to determine COVID negative and positive units. Unfortunately, adequate testing was not available and was out of SEVC’s control, as noted by Dr. Jackson in his testimony before the Senate hearing in May.

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No one ever stated that any UNIT was a “epi-linked unit.” This was discussed with the ICN’s, ADON’s, DON and Commandant several times to ensure all understood the guidance.

Mr. Blackwood and DNO Mullane fully disagree that these guidelines obtained from CCHD were misinterpreted or misapplied at any time. The negative pressure rooms had already housed 6-7 of SEVC’s COVID-19 positive residents with the capacity of housing 18 residents. As soon as Chester County made antibodies testing kits available, **SEVC was one of the first, if not the first nursing home in Chester County, to offer antibody testing to all of its employee’s. At that time, SEVC also filed an application for a Clinical Laboratory Improvement Amendment (CLIA) waiver to administer this antibody test to all residents. That written request was denied** with the stated reason that Medical Director did not have the appropriate credentials.

Finally, at the beginning of May, SEVC was able to secure enough test kits to allow for PCR testing of every resident. At this point, as the results came in, SEVC identified positive and negative units and transferred residents accordingly. Again, SEVC understood that testing was the most critical factor. It was SEVC leadership’s sole purpose to apply the guidance appropriately and do whatever was possible to protect the residents from this aggressive virus.

12. The Morgan Lewis Report Contains False Statements Concerning PPE Deficiencies at SEVC.

Initially, SEVC staff were informed that a mask was not required per the Center for Disease Control (CDC) guidelines. Healthcare coalition calls were held twice a week with approximately 700 people in attendance. It was during these calls SEVC administrators were given updates from the CDC and how to handle different situations as they arose. As more information and understanding about COVID 19 emerged, so did the guidelines change.

It was on one of these calls Dr. [REDACTED] made SEVC aware of the new guidelines that changed on April 3rd (HAN 492) to wear a mask at all times. By the next day, the facility was universally masking. Some administrative personnel including clerks, revenue, business office and human resources were issued N95 masks to keep them out of rotation and would not have to come back for a new mask as frequently.

This was to decrease crowding where PPE was issued and not to conserve PPE supply as stated. In addition, the N95s issued to non-nursing staff mostly came from an expired batch from the maintenance storage room. SEVC was not even sure that these masks would be allowed on nursing units. Ultimately, the CDC gave guidance on using expired masks as many places across the country had expired N95s.

Staff on COVID-19 positive floors were always issued N95 masks. These masks were issued in some cases without FIT testing as the FIT testing kits were not available and SEVC was unable to secure the chemicals required for FIT testing at this time. The PPE was managed

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according to CDC guidelines for extended use. All other staff were given the option of an N95 or surgical mask as some employees complained they were too uncomfortable and not because this was Mr. Blackwood's "illogical explanation."

As it relates to administration, each member entered COVID-19 positive units on several occasions using the appropriate PPE. A simple review of the medical record would show nursing leadership care of the Covid-19 positive resident in relief of nurses. These selective comments about not being on the Covid units are insulting. Around mid-March, prior to one single case of Covid-19, SEVC randomly selected several employees which included other departments such as housekeeping, maintenance and dietary to get FIT tested for N95 masks and be a part of a team that would be ready to provide care in the negative pressure rooms if needed.

DON Mullane along with the ICN's spoke with CCHD via phone regarding the use of PPE and how to best preserve it without exposing staff and residents to the virus. To reiterate, there were no "epi-linked" units. CCHD was fully aware of the status of the SEVC units and the COVID-19 status of each resident affected as the line listing that was sent to them daily identified both the unit and the room number of residents affected.

During these discussions, DON Mullane specifically asked if the same PPE could be used for all residents on the same unit as residents were separated by exposed and non-exposed. This included gowns, goggles, and masks. The response from CCHD was an unequivocal "yes" and only gloves need to be changed. The only time the PPE was to be changed was if the employee left the unit for any reason.

In a further attempt to conserve PPE safely, SEVC gave the employees on affected units the option of taking their lunch break on the unit or off the unit. Those who chose to stay on the unit were provided a free meal and paid for their 30-minute lunch break.

Early on in the pandemic, SEVC did not know how many N95 mask it would receive amid the national shortage. Many nursing homes tried to stretch their supplies as many homes had NO N95 masks. In addition, the state veterans' homes were cross shifting supplies between the six homes. SEVC had no idea if at that early stage if N95s would be moved to other homes in event of outbreaks there. The PA HAP emergency teams also spoke of cross-leveling supplies to other facilities in the area. BVH actively pursued vendors that could decontaminate N95 masks. As you can imagine so was everyone else, it simply was not available at that time. To describe this as a "violation" of CDC guidelines is a misrepresentation since it was a situation that was occurring across the state.

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Closing Remarks

While it is easy to Monday morning quarterback, SEVC leadership made the best decisions based on available information from sources at that time. This included CCHD, daily televised Dr. Levine updates, BVH, HAN guidance, HAP regional calls, VA infection control and CDC. Over 700 nursing homes in the state of Pennsylvania attended HAP calls and asked similar questions. All homes were trying to manage this situation to the best of their ability.

Many times, SEVC administrators were told to communicate with local health departments, which SEVC repeatedly did. Many nursing homes were following the same guidance as SEVC, such as epi-linking, use of PPE and making the best decisions possible based on information and situations existing at the time with no test kits available.

Congregate care settings, especially long-term care facilities were and still are being hit the hardest. Nursing homes are STILL having severe outbreaks with all the testing, supplies and lessons learned. To say that some homes managed Covid-19 outbreaks better, shows how political and strongly biased this investigation is towards SEVC leadership. Public reporting now mandated by the state, shows that the closest nursing facility to SEVC (Manatawny Manor) went from having 1 positive resident in early December 2020 to over 72 positives residents within three weeks.

This virus is a deadly enemy that has not been controlled. One cannot compare lessons learned with current knowledge ten months into a pandemic to what the facility was facing in March and April. The SEVC leadership team worked countless hours putting themselves and their families at risk on behalf of the residents they have served faithfully over many years. No one was more devastated than this virus was so unforgiving to SEVC residents than the leadership team, including Mr. Blackwood and DON Mullane.

These are the same residents that every member of SEVC leadership team served meals to on daily basis. It is absurd to believe that SEVC acted independently in a situation involving this *novel* virus. It is unfortunate that political scapegoating, finger pointing and blaming individuals on the front lines has predominated.

As General Carrelli noted during the Senate Hearing in May:

“We are in the midst of an emergency; ***none of us have experienced anything like this in our lifetimes,***” said Maj. Gen. Anthony Carrelli. “Our National Guard is actively assisting homes on the verge of collapse, in dire need to regroup. The presence of the National Guard provides the facilities critical time to regroup its staff, PPE, and contracts to prepare to take on the next day. These are very challenging times, and the circumstances are far less than ideal. I am confident, however, that our SVH staff and National Guard members are doing the best that they can every day, their commitment, and the selfless care they bring to others is

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exceptional.”

Instead of noting the exceptional efforts of Mr. Blackwood and DON Mullane, what has occurred is selective investigation and false allegations designed to cover up systemic failures. While the facts prove that SEVC did not hide any deaths, alter any records, force sick staff to return to work or run under required staffing levels, the damage from those false and debunked allegations are real, not only to the hard-working people involved, but most importantly, taking critical time away from resident focus.

The incomplete and false narratives trumpeted by the Morgan Lewis Report only highlights these unfortunate circumstances. The Report should not be released in its current form given these false inaccuracies.

Sincerely,

BOCHETTO & LENTZ, P.C.

/s/ David P. Heim

By:

David P. Heim, Esquire