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COVID-19 Outbreak Leads to Handcuffs for Holyoke Soldiers' Home Leadership

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COVID-19 hit Holyoke Soldiers' Home in March of 2020 when most of us were learning the new term "social distancing" and had no awareness of asymptomatic positives. While the global medical community scrambled to play catch-up and understand this world-wide pandemic, it raged through Soldiers' Home and killed 76 veterans; 84 more tested positive and recovered. As elected officials scrambled for solutions and, in some instances, scapegoats, the governor of Massachusetts ordered an investigation into the causes of the outbreak. Other state and federal agencies launched their own investigations. Soldiers' Home came under scrutiny for the decisions of its leadership during the last two weeks of March 2020. The decision receiving the most scrutiny was the consolidation of 40 residents from two locked dementia units into one unit, when some were showing symptoms, and some were not. Leaders of the nursing home argue that they made the decision to consolidate the units because they did not have enough staff to cover both units and so were forced to consolidate in order to provide care. The Chief Nursing Officer, Vanessa Lauziere, made the recommendation to consolidate, and superintendent, Bennett Walsh, approved it without questioning it. Medical Director, Dr. David Clinton, was present the day the consolidation occurred but disavowed any knowledge of it and claimed to disagree with it.

Whether a long-term care provider did everything right, or made missteps during the chaos, any home that faced an outbreak with resulting deaths was a tragic, war-like scene of suffering and death. Soldiers' Home was no exception, and the body bags were insufficient to keep up with the dozens dying. The investigation showed that there was no failure to report or attempt to conceal the COVID-19 cases or deaths from authorities. Given the catastrophic consequences of the outbreak, however, the leadership team of the Soldiers' Home became the focus of the investigation.

The attorney leading the independent investigation, Mark Pearlstein, was asked to determine (1) the causes and contributing factors of the outbreak; (2) whether the Soldiers' Home leadership complied with applicable reporting requirements; and (3) what, if anything, could be done to prevent or reduce the likelihood of a similar outcome in the future. Mr. Pearlstein and his team conducted 111 video or telephone interviews with 100 different witnesses and reviewed more than 17,000 documents. They interviewed all critical witnesses, including Superintendent Walsh (three times), Dr. Clinton and Ms. Lauziere.

The investigation identified several critical errors made by key leaders at the Soldiers' Home in response to the COVID-19 outbreak. The most egregious and fatal decision was combining the two locked dementia units consisting of veterans with mixed COVID-19 statuses. During witness interviews, no other employee besides Ms. Lauziere admitted involvement in this decision. Ms. Lauziere, a nurse with 24 years of experience, claimed she had no other choice but to consolidate the units due to staffing shortages. Superintendent Walsh admitted Ms. Lauziere notified him of her decision. Even though he knew the units housed veterans with mixed COVID-19 statuses (some positive, some asymptomatic, and some awaiting test results), he did not question this decision, nor did he consult Dr. Clinton or anyone else to determine whether it was appropriate. Although Dr. Clinton insisted the units were consolidated without his knowledge or approval, the investigators did not find his statement to be credible, particularly because final clinical decision-making authority rested with him. The investigators also roundly rejected Superintendent Walsh's and Ms. Lauziere's claim that the combination

was unavoidable due to staffing shortages, as they could have (and ultimately did, when state officials assumed control of the facility on March 30) sent the patients out to different hospitals and skilled nursing facilities.

The investigation concluded that the combination of the dementia units resulted in nightmarish, inhumane conditions that one staff member described as a "war zone." Investigators found that this was not the only decision that contributed to the COVID-19 outbreak, however. The facility also failed to follow the CDC and Massachusetts Department of Health's written guidelines that required isolation of confirmed and *suspected* COVID-19 patients. Although several residents suspected of COVID-19 were tested between March 17 and March 20, 2020, these residents were never separated from asymptomatic residents while awaiting test results, and they were allowed to remain in their units even *after* testing positive. Although the Soldiers' Home created isolation rooms, these rooms were never used. The justifications offered for not isolating residents (inadequate staff to cover the isolation unit, and futility) were rejected, as investigators determined the Soldiers' Home could have – but did not – request more staff until much later and (contrary to Dr. Clinton's apparent belief) isolation could have slowed the transmittal rate within the dementia units even though the first few COVID-19 positive residents were not timely isolated. The investigation concluded that Soldiers' Home's delay in closing communal areas was also "inexcusably slow" and further contributed to the spread of COVID-19.

Another alleged error that created a "substantial and obvious transmission risk" was the failure to prevent floating of staff members between units. On March 29, the now-former Secretary of the Massachusetts Department of Veterans' Services (Francisco Urena) asked Superintendent Walsh if he had halted rotation of staff between units, and Mr. Walsh allegedly responded – falsely – that they had attempted to keep the same staff on each unit. Not surprisingly, several "floaters" later tested positive for COVID-19.

Investigators found that the Soldiers' Home also ignored infection control guidelines regarding personal protective equipment (PPE). The facility not only neglected to institute a consistent and compliant PPE policy and practice, it limited access to PPE due to concerns of pilfering and, in one instance, disciplined a staff member for using PPE. The investigation concluded that this PPE protocol was at least partially responsible for the 80 or so staff members who ultimately tested positive for COVID-19.

Superintendent Walsh's seemingly blind acceptance of Ms. Lauziere's decision to consolidate the two dementia units and his lack of meaningful involvement or intervention with respect to the Soldiers' Home's COVID-19 response were not altogether unexpected. Superintendent Walsh was a political appointee and, according to the investigation, a polarizing figure with a history of poor performance who was unqualified to run the Soldiers' Home. His staff made the wrong clinical decisions, and he failed in his duty to oversee them. He also lacked the clinical and administrative skill set needed to supervise his leadership team because he (1) had no background in health care and (2) was not a licensed nursing home administrator. As it turns out, neither was required by Massachusetts law.

Superintendent Walsh's shortcomings notwithstanding, the investigation did not uncover any material violations of the COVID-19 reporting requirements. That said, Mr. Walsh did apparently omit key information and relayed inaccurate information in his communications with the Department of Public Health and Department of Veterans' Services. The "evolving reporting requirements" did not help matters, either. Early on, only confirmed COVID-19 cases were required to be included in certain death tolls; the Soldiers' Home was not required to (and did not) include individuals awaiting test results at the time of death in early reports. As a result, the Massachusetts Executive Office of Health and Human Services did not have an accurate picture of the COVID-19 crisis that was rapidly unfolding at the Soldiers' Home until several weeks (and deaths) into the pandemic.

The Massachusetts State Attorney General's Office conducted its own investigation alongside the independent investigation and determined that the decision to combine the two dementia units was not just reckless, it was

criminal. The AG's Office said this and other infection control failures were the responsibility of Superintendent Walsh and Dr. Clinton, both of whom were charged with five counts each of criminal neglect, specifically being a "Caretaker Who Wantonly or Recklessly Commits or Permits Bodily Injury to an Elder or Disabled Person," and five counts each of being a "Caretaker Who Wantonly or Recklessly Commits or Permits Abuse, Neglect, or Mistreatment to an Elder or Disabled Person." They were charged ultimately based upon what prosecutors characterize as their "deadly decision to consolidate these two units." Chief Nursing Officer Lauziere admits to making the decision to consolidate the units and yet was not charged. While Ms. Lauziere evidently told independent investigators that she could not recall who else participated in the meeting culminating in this fateful decision, she now maintains that she did not act alone and that the decision was jointly made by a clinical team that included Mr. Walsh and Dr. Clinton. The Attorney General's Office, focused on holding those at the top responsible, offered Ms. Lauziere immunity from criminal prosecution in exchange for her testimony.

The tragic outcome at Soldiers' Home is one that prosecutors have determined could have been avoided and rises to the level of criminal misconduct. As we search for lessons learned amidst this tragedy, the following are suggestions for putting your caregiving teams in the best possible position to avoid a criminal investigation and for defending your decisions if necessary.

First, it is no secret that proper documentation is critical. Memories fade, and each witness' truth may look quite different, but contemporaneous documentation is steadfast, and often, life-saving. Here are some critical items to document:

- Your response team
- Your response plan
- Your screening procedures
- Your visitor policy
- Excellent medical director and primary care physician notification
- Prolific family and staff communication
- Daily staff screening

Second, while it is imperative for facilities to ensure their internal processes are well documented (particularly as they evolve), it is equally important to document the specific guidance from the CDC, CMS and the facility's local Department of Health informing these processes. After the dust settles, memories will fade of those accusing as to the rapidly changing, and often conflicting, guidance. Contemporaneous documentation brings that critical piece of information back into laser-sharp focus and could be the difference between a non-prosecution decision and an indictment.

Lastly, if your facility does find itself in the crosshairs of a federal or state investigation, it is never too early to contact outside counsel who can take the lead on responding to records requests, scheduling employee interviews (and, if appropriate, retaining separate counsel), and communicating with law enforcement or other officials while your facility focuses on providing – and documenting – the quality care that your residents deserve.

For more information, please contact Christy Tosh Crider or any member of Baker Donelson's Health Care Litigation or Long Term Care teams.