| COVID-19 OUTBREAK |

MISSOURI VETERANS HOMES

Summary of the Independent Investigation
Conducted for the Missouri Veterans Commission

November 16, 2020

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I. INTRODUCTION

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

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

Commencing in September 2020, the Homes experienced a prolonged and rapidly escalating outbreak of COVID-19.[2] On October 2, 2020, Governor Mike Parson instructed MVC Chairman Tim Noonan to "conduct a rapid, independent, external review of all seven Missouri Veterans Homes to assess their performance to date and identify what steps, if any, should be taken to improve their management of COVID-19."[3] On October 7, 2020, the State of Missouri Office of Administration's Division of Purchasing issued Emergency Request for Quote No. ERFQ30034902100586 ("RFQ") seeking an independent external investigation to conduct a root cause corrective action investigation regarding the recent outbreak of COVID-19 in the MVC Homes. Following its review of the responses to the RFQ, MVC retained Armstrong Teasdale, LLP ("Armstrong Teasdale") to conduct this rapid independent investigation into the cause of and response to this outbreak with the goal of preventing further Veteran illnesses and deaths at the Homes. As of November 13, 2020, there were 103 deaths related to COVID-19 among the seven Homes.

Armstrong Teasdale's investigation included analyzing data and trends of COVID-19 in the Homes and in the communities in which the Homes are located; assessing leadership and management's preparations for and responses to the outbreak; reviewing communication strategies and procedures between the Homes' staff, MVC Headquarters, and other state programs; analyzing compliance with protocols (including testing, mask wearing, etc.); the appropriate use and management of isolation and quarantine spaces in each Home; compliance with and consistent application of the Centers for Disease Control and Prevention ("CDC"), The United States Department of Veterans Affairs ("VA") and other published guidelines for long-term care facilities in preventing and responding to COVID-19; and any additional tasks deemed appropriate to understanding the root cause of the outbreak.

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

Additionally, Armstrong Teasdale identified Veterans' family members as an essential element of its inquiry. Based on the initial reports from various family members, and as noted above, Armstrong Teasdale recommended the creation of a telephone hotline. MVC adopted the recommendation in accordance with the additional consulting services contained in Exhibit F to Contract Number CS210586001. Accordingly, a hotline was established and was open from October 29 through November 4, 2020 to collect reports and valuable inputs from Veterans' family members. MVC issued a press release publicizing the hotline at the recommendation of Armstrong Teasdale. In total, through this hotline, Armstrong Teasdale attorneys spoke to an additional 75

individuals, including spouses and children of Veterans in the Homes, Veterans, volunteers, and a nurse.

To supplement this investigation, the Emergency RFQ required the utilization of a subject matter expert in the folllowing areas of long-term care: "clinical management, prevention and control of infectious disease, geriatric medical care and treatment of infectious disease, management and communications." As directed by the MVC, Pathway Health was selected as the qualifying subject matter expert in accordance with the terms of the Emergency RFQ. At the direction of Armstrong Teasdale, Pathway conducted an on-site audit of each Home and followed all recommended and necessary safety protocols. Pathway's findings provided further context to the observations and conclusions gleaned from interviews and document review.

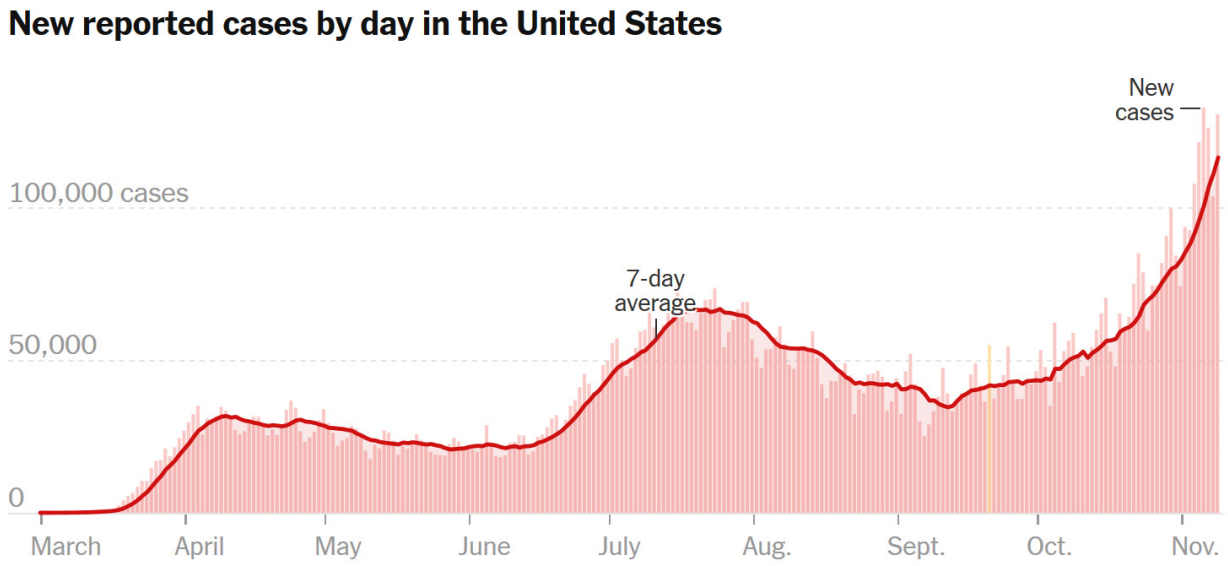
This summary level report for public distribution is issued pursuant to RFQ Section 2.2.3. Armstrong Teasdale conducted this investigation independently from any state government officials. No redactions or revisions to this report were made by any individual outside of Armstrong Teasdale.

II. COVID-19

A. COVID-19 Outbreak Timeline and Current Data

On March 13, 2020, President Donald Trump declared a national emergency concerning COVID-19, a novel virus discovered in Wuhan, China in December 2019 ("COVID-19").[4] Per the President's proclamation, 1,645 people from 47 states had been infected with COVID-19 as of March 12.[5] By April 2, the CDC had reported 213,144 COVID-19 total cases and 4,513 deaths nationwide.[6]

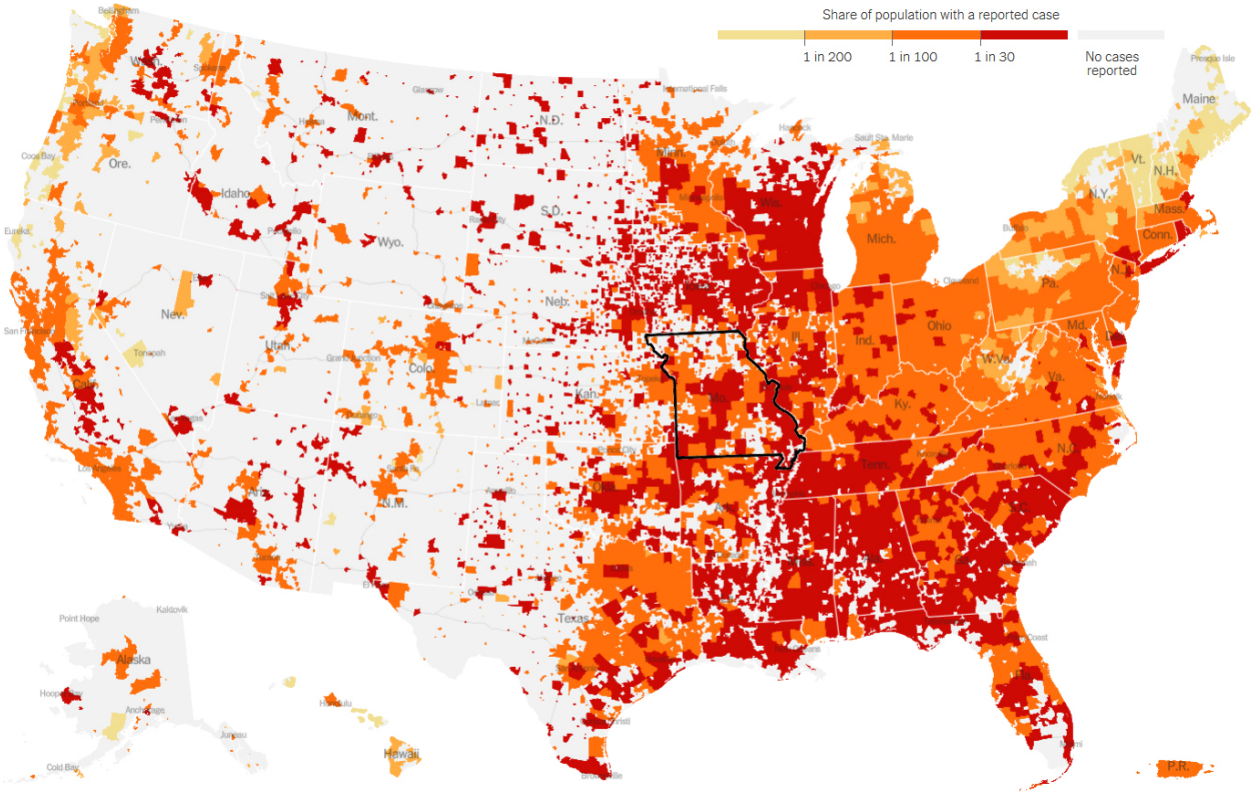
The CDC reports that as of November 13, 2020, there have been 10,314,254 total COVID-19 cases in the United States and 241,069 COVID-19 related deaths,[7] with an overall positivity rate of 7%.[8] According to the New York Times database, the sharp upward trajectory of daily new COVID-19 cases continues:[9]



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

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

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



B. COVID-19 in Missouri

1. Timeline

The first positive COVID-19 case in Missouri was announced on March 7, 2020.[11] Six days later, on March 13, 2020, Governor Michael Parson signed an Executive Order declaring a state of emergency in Missouri in response to COVID-19.[12] Missouri's first COVID-19 death was announced on March 18, 2020.[13] On March 21, 2020, the Director of the Missouri Department of Health and Human Services ("DHSS") ordered state-wide social distancing, stating all Missourians "shall avoid social gatherings of more than ten people."[14]

On April 3, 2020, Governor Parson issued a state-wide "stay home" order stating: (1) individuals shall avoid leaving their homes or places of residence; (2) individuals shall avoid social

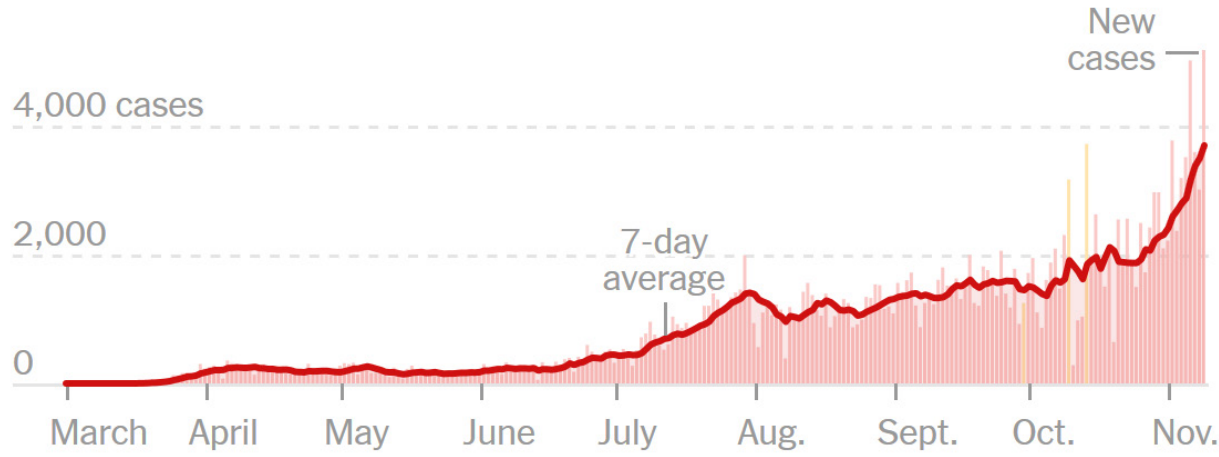
gatherings of more than ten people; (3) all public and charter schools must remain closed for the duration of the Order; (4) non-essential businesses must adhere to social distancing limitations; and (5) businesses providing essential services may operate with limited capacity.[15]

The "stay home" order was lifted in two phases as part of the "Show Me Strong Recovery Plan." Phase 1 was implemented on May 4, 2020 and continued through June 15, 2020. During this Phase, (1) citizens were allowed to re-engage in economic and social activities but with adherence to social distancing requirements, including maintaining six feet of space between individuals in most cases; (2) there were no limitations on social gatherings as long as necessary precautions were taken and six feet of distance could be maintained between individuals and/or families; and (3) all business could open provided social distancing guidelines were followed.[16]

On June 16, 2020, Phase 2 of the "Show Me Strong Recovery Plan" was implemented, which removed the state-wide health order and lifted state-wide restrictions. However, local officials were given the authority to enact further rules, regulations, or ordinances.[17] While Missouri is currently one of seventeen states without a state-wide mask mandate,[18] seventeen Missouri counties have implemented policies requiring masks. Additionally, the Missouri DHSS has provided guidance concerning masks and recommends Missourians wear masks in public settings where social distancing measures are difficult to maintain.[19]

2. Data

As of November 16, 2020, Missouri has had 249,403 total reported cases of COVID-19 and a total 3,463 deaths.[20]



The above graphic depicts Missouri's daily rate of new COVID-19 cases. As demonstrated, and as consistent with the national trend, Missouri has experienced a consistent rise in COVID-19 cases in recent months. Daily new COVID-19 cases in Missouri have increased from a 7-day average of 1,386 new cases per day on August 1, 2020 to a 7-day average of 4,949 new cases per day on November 14, 2020.[21]

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

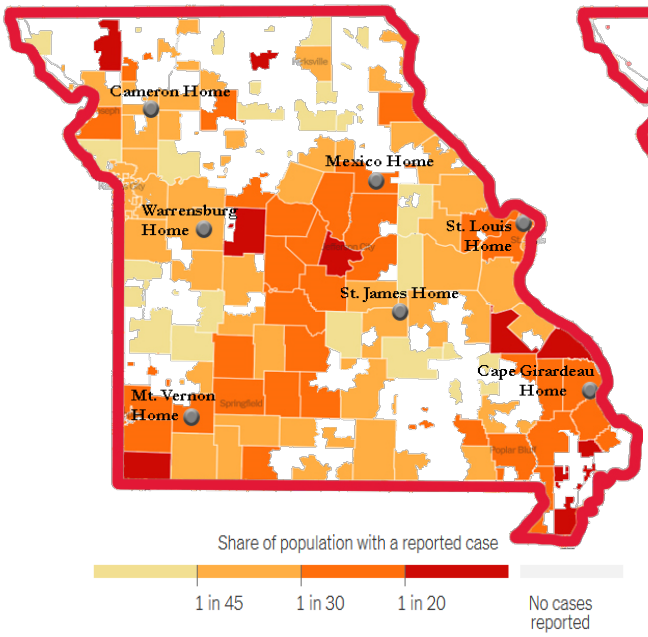
> "A higher percent positive suggests higher transmission and that there are likely more people with coronavirus in the community who haven't been tested yet…. a high percent positive can indicate it may be a good time to add restrictions to slow the spread of disease"[22]

According to the World Health Organization, the threshold for a high positivity rate is 5%.[23] Missouri's positivity rate has increased from 6% in June, to 8% in August, 10% in September, 11% in October, and 12% currently.[24]

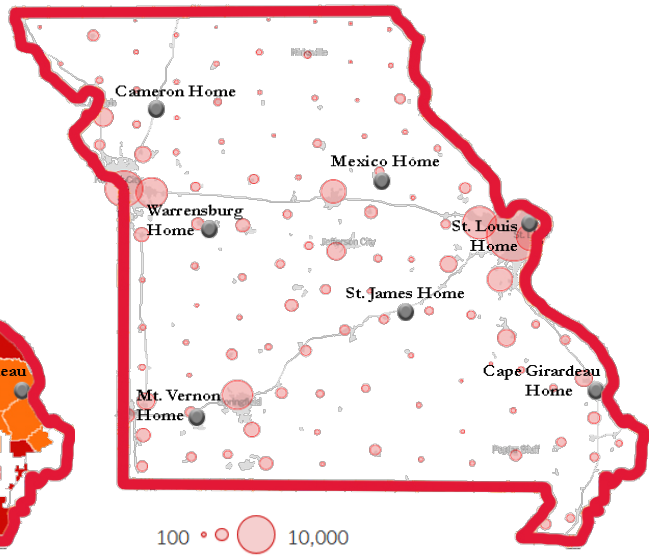
In addition to examining state-wide metrics, there are regional differences with respect to the number of positive COVID-19 cases, the share of population infected with COVID-19 (i.e., number of cases per number of people), and the death rates.[25] The below heat maps demonstrate the pandemic severity in the areas of each of the seven MVC Veterans Homes. The positive cases by share of population map (left) shows the areas of the State that have known positive cases in 1-out-of-20 people (red), 1-out-of-30 people (dark orange), 1-out-of-45 people (light orange), or fewer (yellow and white).

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

Positive Cases by Share of Population:



Total Positive Cases:



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

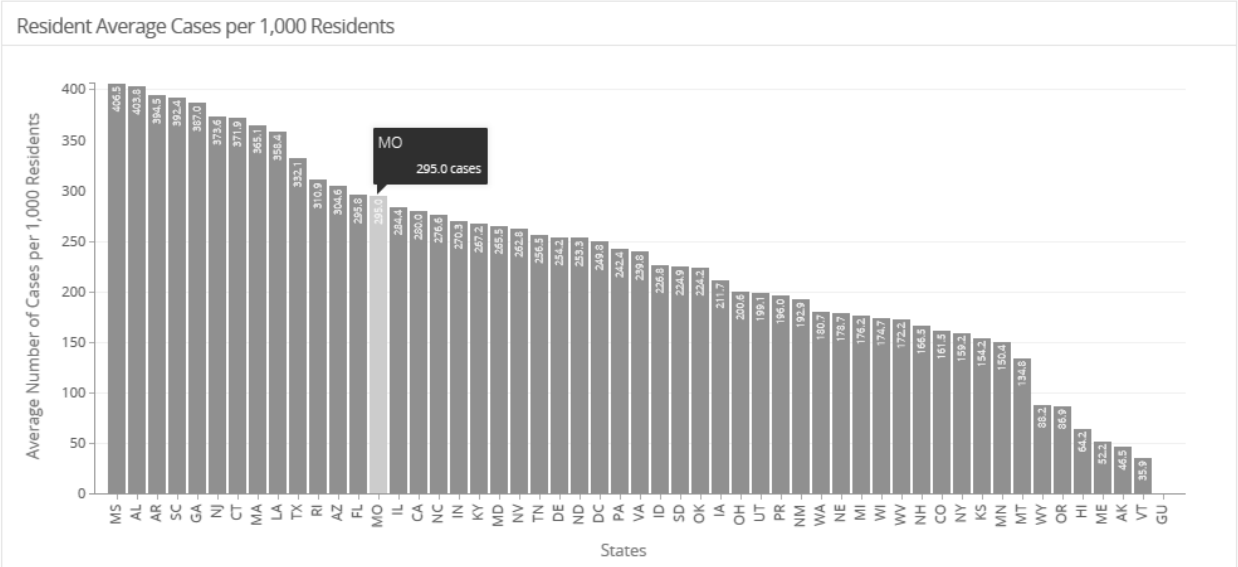
Finally, in a national comparison, Missouri ranks 18th highest in total COVID-19 case count and 23rd highest in deaths.[26] Missouri's positivity rate range is similar to all of its bordering states, except Nebraska, which has experienced a slightly higher positivity rate.[27]

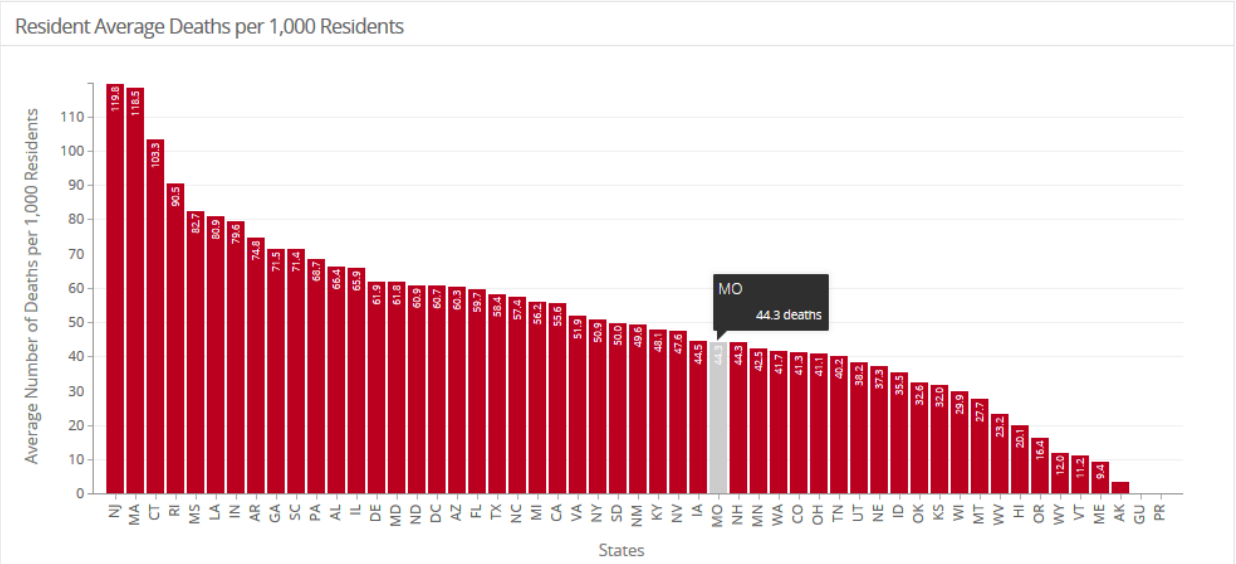
C. COVID-19 in Nursing Homes

Nationally, as of November 1, 2020 (the most current publicly accessible data), 294,438 residents of federally licensed nursing homes had tested positive for COVID-19 and 65,446 had died as a result.[28] Within VA Homes overall, as of November 13, 2020, there have been 86,304 cumulative COVID-19 cases with 4,254 known related deaths.[29]

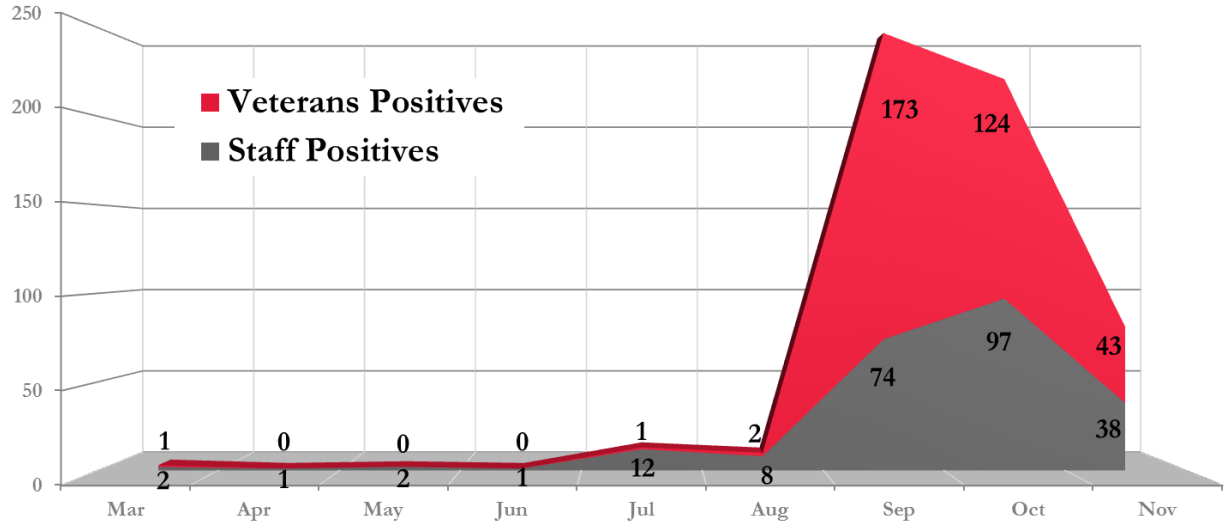
In Missouri, as of November 1, 2020 November 1, 2020 (the most current publicly accessible data), 10,008 nursing home residents had tested positive for COVID-19 and 1,511 had died as a result.[30] Statistically, in Missouri, nursing home residents comprise 4.26% of the total number of COVID-19 cases in the State but account for 43.9% of the total deaths.

The below graphics demonstrate that Missouri's COVID-19 nursing home positivity rate is comparable to other nursing homes nationally and its COVID-19 related nursing home death rate is lower than the national average.[31] Stated another way, these national rankings suggest that Missouri is slightly above average at reducing the death rate, but is slightly below average at preventing spread among residents.



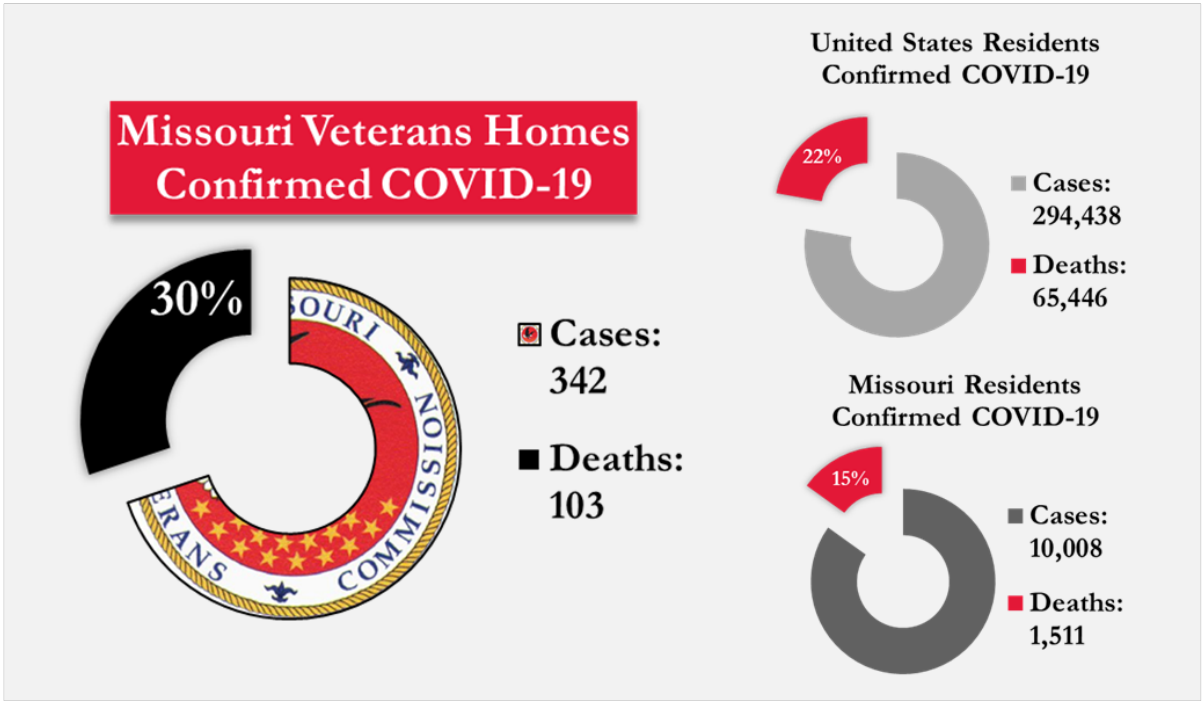


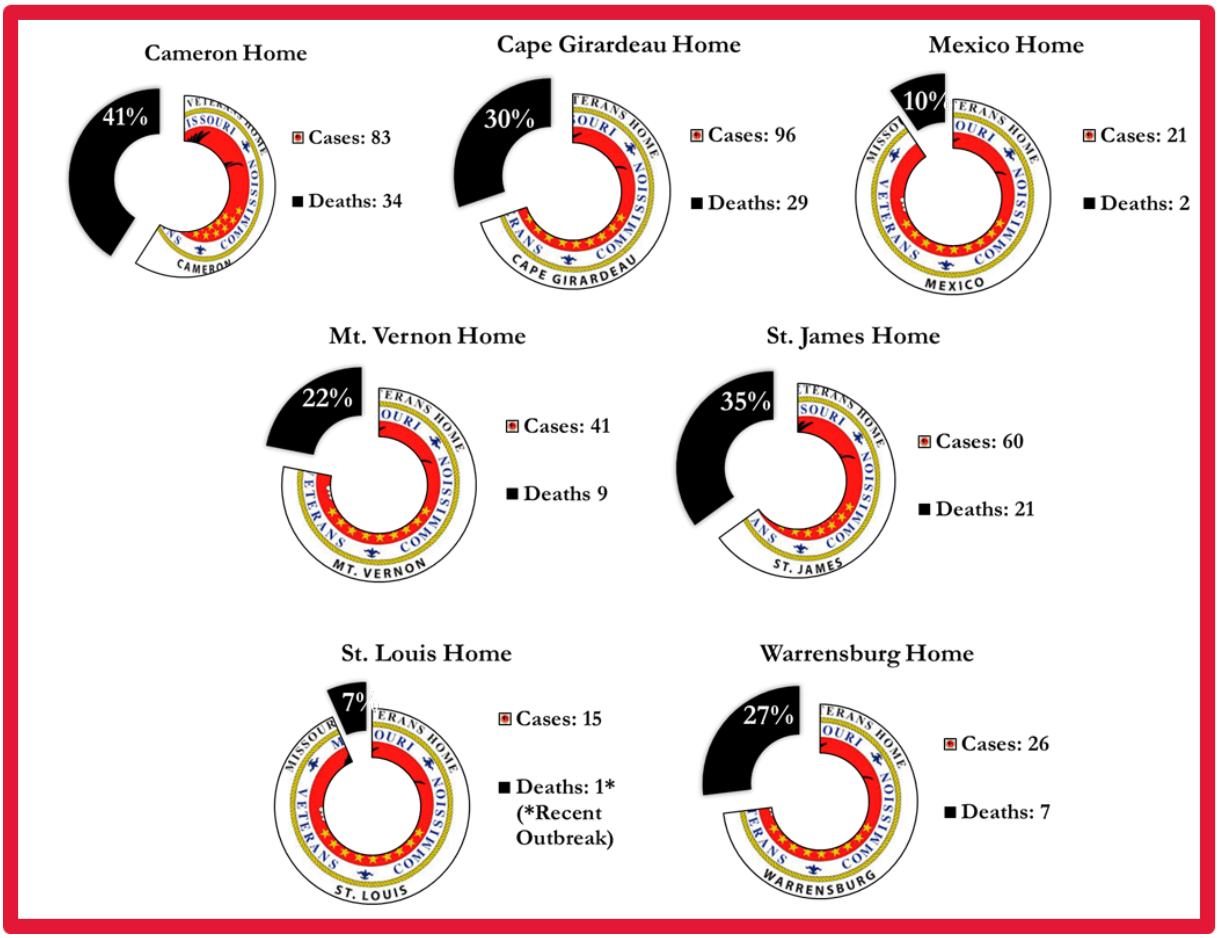
Comparatively, within VA Homes as of November 16, 2020, in Missouri, there have been 3,314 cumulative COVID-19 cases with 149 known deaths.[32] The below figure graphically illustates the timing and severity of the current COVID-19 outbeak in the Missouri Veterans Homes as a unit.



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

As of November 13, 2020, 342 Veterans at the Missouri Veterans Homes have tested positive for COVID-19 and 103 have died as a result.[33] Comparatively, these statistics reveal the Missouri Veterans Homes have experienced a greater percentage of deaths-to-cases than both the State and national averages, as the below figures demonstrate:





*As of November 13, 2020

III. BACKGROUND: THE MISSOURI VETERANS HOMES

A. Organization and Duties

Missouri has provided care to Veterans in some form since 1896 when the State Federal Soldier's Home was established.[34] Today, the seven Missouri Veterans Homes are managed by the MVC, a state agency established by legislature and governed by Chapter 42, RSMo. The MVC operates three core programs: the Veterans Service Program, the Veterans Homes Program, and the Veterans Cemeteries Program.[35] The MVC aids Veterans, their dependents, and legal representatives by providing information regarding their rights as Veterans and assistance in accessing the benefits available through state and federal government.[36] The MVC serves more than 458,000 Veterans through its operation of these programs.[37] The MVC's duties are enumerated by statute and include assisting Veterans in obtaining benefits earned following their service.[38]

The MVC is composed of nine members.[39] Two are members of the Senate with one appointed by the President Pro Tem of the Senate and one appointed by the Senate Minority Floor Leader. Two are members of the House of Representatives with one appointed by the Speaker of the House of Representatives and one appointed by the House Minority Floor Leader.[40] These four members serve a two-year term or until a successor is appointed. These members may be reappointed to the Commission.[41] Preference must be given to current or former members of the military and their spouses, parents, and children.[42]

The remaining five members consist of Veterans appointed by the Governor, with the advice and consent of the Senate, for a four-year term.[43] The MVC members are not compensated for their services, but may be reimbursed from funds appropriated therefor for actual and necessary expenses incurred in the performance of their duties.[44]

Currently, the MVC's members are Senator Jill Schupp, Senator Wayne Wallingford, Representative Steven Lynch, Representative Robert Sauls, Dr. John Buckner, Dr. Jose Dominguez, Meredith Knopp, Tim Noonan, and Tim Smith.[45]

The MVC is also required to have an Executive Director as its "Chief Administrative Officer."[46] The Executive Director is "in charge of the staff of the commission and responsible for execution of the duties vested in the commission."[47] The Executive Director is appointed by the nine MVC commissioners and must have served in military forces of the United States.[48] The Executive Director is not required to have a medical or nursing background nor any prior

experience operating or managing long-term care facilities. The Executive Director's compensation is fixed by the MVC as provided by law.[49]

In July 2020, COL. Paul Kirchhoff was appointed Executive Director of the MVC.[50] His predecessor, Col. Grace Link, resigned effective May 31, 2020, after accepting a position with the VA.[51]

B. Veterans Homes

Pursuant to RSMo. § 42.100, the MVC is required to maintain "facilities for the care of Veterans who require institutional health care services as shall be funded by appropriations of the general assembly." The MVC manages 1,238 beds with more than 500 employees across its seven Veterans Homes, which are located in Cameron, Cape Girardeau, Mexico, Mount Vernon, St. James, St. Louis, and Warrensburg.[52] In addition to residential services, the Veterans Homes provide physician care; physical, speech, occupational and recreational therapy; medications; cosmetology; maintenance, environmental and social services; dietary specialists; and specialized programming for dementia care.[53]

C. Rules and Regulations Applicable to the MVC Homes

Missouri Veterans Homes are exempt from the licensing requirements for state residential care facilities located in Missouri.[54] Missouri law requires the MVC to make all rules regulating the necessary management of the Homes, including sanitary standards and funding.[55] Missouri law requires the Missouri Veterans Homes to participate in the per diem grant program administered by the VA.[56] To receive the per diem, the Missouri Veterans Homes must meet the VA standards set forth at 38 C.F.R. § 51.100, *et seq.* These VA regulations require the Homes to meet several safety standards and outline the facility, staffing, and service requirements applicable to state-sponsored Veterans Homes. More specifically, these standards require Missouri Veterans Homes to protect the health and safety of Veterans, personnel, and the public by providing "[a] safe, clean, comfortable, and homelike environment" that has "a sanitary, orderly, and comfortable interior." [57] Additionally, these regulations require the Homes to establish a Resident Council to raise concerns to the facility's management team.[58]

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

> **(a) Infection control program.** The facility management must establish an infection control program under which it—
>
> (1) Investigates, controls, and prevents infections in the facility;
>
> (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
>
> (3) Maintains a record of incidents and corrective actions related to infections.
>
> **(b) Preventing spread of infection.**
>
> (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident.
>
> (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease.
>
> (3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

38 C.F.R. § 51.190(a-b)

In addition to the VA per diem grant, funding is also provided pursuant to Missouri statute and constitutional amendments[59] as well as from appropriations of the General Assembly.[60] The Veterans Commission Capital Improvement Trust Fund, established by statute, is administered by the Missouri Treasurer and may be used solely, upon appropriation, for purposes provided by statute including, *inter alia*, the construction, maintenance, renovation, equipment, and operational needs of the Veterans Homes and cemeteries and administration of the MVC.[61]

A financial summary of DPS as included in Missouri's 2020 Executive Budget outlines the MVC's 2018 fiscal year expenditure, 2019 fiscal year appropriation, and the Governor's recommended budgeting for the 2020 fiscal year:[62]

DEPARTMENT OF PUBLIC SAFETY
MISSOURI VETERANS' COMMISSION

FINANCIAL SUMMARY

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

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

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

1. Centers for Disease Control and Prevention

Since February 2020, the CDC has consistently published guidelines directed at preventing the spread of COVID-19 infections. While the Homes are not required to comply with CDC

guidelines, universally each of them strives to do so and has used the CDC guidelines in responding to the COVID-19 pandemic. The guidelines pertinent to the investigation are identified herein, have not been substantially altered since being issued, and remain in effect.

i. Guidance Issued April 29, 2020

The CDC published its initial guidelines specific to nursing homes and long-term care facilities on April 29, 2020.[63] These guidelines recommend facilities identify a location for a specific COVID-19 care unit and create a contingency staffing plan to implement when residents or healthcare personnel with COVID-19 are identified in the facilities.[64]

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

- Physically separating the COVID-19 unit from rooms or units housing residents who have not been confirmed to have COVID-19.
- Assigning dedicated healthcare professionals to work only on the COVID-19 care unit, including at least the primary nursing assistants and nurses assigned to care for the residents, and restricting access of ancillary personnel (e.g., dietary).
- Ensuring health care providers practice source control measures and social distancing in common areas.
- Utilizing signage at the entrance to the COVID-19 care unit instructing healthcare personnel to wear eye protection and an N95 or higher-level respirator (or face mask if respirator is not available) at all times while on the unit.
- Requiring gowns and gloves to be worn when entering a resident's room.
- Ensuring healthcare personnel are trained on infection prevention measures, including the use of and steps to properly put on and remove recommended personal protective equipment ("PPE").
- Implementing strategies to optimize PPE supply in the event of a shortage, including considering extended use of respirators, eye protection, and gowns, to the extent necessary.
- Creating a plan for managing new admissions and readmissions of residents whose COVID-19 status is unknown, including by placing these individuals in a separate observation to be monitored for evidence of COVID-19.[65]

Infections among Staff Members: Upon discovery of personnel with a suspected case of COVID-19, facilities should identify which residents received direct care from, and which personnel

had unprotected exposure to, the COVID-19 infected personnel in the 48 hours prior to the individual's onset of symptoms.[66] Additionally, residents who were cared for by the infected individual should be restricted to their rooms with care being provided utilizing all recommended COVID-19 PPE until it is determined whether the resident is infected with COVID-19. If the resident tests positive for COVID-19, the resident should be cared for utilizing full PPE until 14 days after last exposure to the individual infected with COVID-19.[67] CDC guidance further directs facilities to consider testing asymptomatic residents and personnel who were exposed to the individual infected with COVID-19.[1]

Infections among Residents: Upon discovery of a resident with a confirmed COVID-19 infection, facilities should isolate the resident in a dedicated COVID-19 care unit and care for the resident using all recommended PPE.[68] Residents with a suspected COVID-19 infection or exposure to a COVID-19 infected person should be quarantined and monitored unless the residents remain asymptomatic and/or test negative for COVID-19 14 days after their last exposure.[69]

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

- Consider temporarily halting admissions to the facility, at least until the extent of transmission can be clarified and interventions can be implemented.
- Increase monitoring of ill residents, including assessing symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, at least 3 times daily to identify and quickly manage serious infections.
- Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms.
- Counsel all residents to restrict themselves to their room to the extent possible.
- Use all recommended COVID-19 PPE when caring for any resident on affected units (or facility-wide if cases are widespread), this includes symptomatic and asymptomatic residents.
- If PPE supply is limited, implement strategies to optimize PPE supply, which might include extended use of respirators, facemasks, and eye protection and limiting gown use to high-contact care activities and those where splashes and sprays are anticipated.

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

- Notify personnel, residents, and families and reinforce basic infection control practices within the facility (e.g., hand hygiene, PPE use, environmental cleaning)."[70]

In addition to these steps, the CDC addressed testing: "If testing capacity allows, use of facility-wide testing following identification of newly identified SARS-CoV-2 infected residents or [personnel] could be particularly important. Facility-wide testing can help identify asymptomatic or pre-symptomatic residents with COVID-19 to guide movement into COVID-19 designated spaces."[71]

ii. Memory Care Guidance Issued May 11, 2020

On May 11, 2020, the CDC issued specific infection prevention and control guidelines for memory care units[72] (each Home has a memory care unit). Recognizing infection prevention strategies to mitigate the spread of COVID-19 "are especially challenging to implement in dedicated memory care units where numerous residents with cognitive impairment reside together," the CDC recommends long-term care facilities with memory care consider the following recommendations:

- Routines are very important for residents with dementia. Try to keep their environment and routines as consistent as possible while still reminding and assisting with frequent hand hygiene, social distancing, and use of cloth face coverings (if tolerated). Cloth face coverings should not be used for anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

- Dedicate personnel to work only on memory care units when possible and try to keep staffing consistent. Limit personnel on the unit to only those essential for care.

- Continue to provide structured activities, which may need to occur in the resident's room or be scheduled at staggered times throughout the day to maintain social distancing.

- Provide safe ways for residents to continue to be active, such as personnel walking with individual residents around the unit or outside.

- Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel.

- Frequently clean often-touched surfaces in the memory care unit, especially in hallways and common areas where residents and staff spend a lot of time.

- Continue to ensure access to necessary medical care, and to emergency services if needed and if in alignment with resident goals of care.[73]

- Given the unique challenges with restricting residents in a memory care unit to their rooms, all personnel on the unit should utilize eye protection and N95 respirators (to the extent available).[74]

Further, while moving infected residents to a designated COVID-19 care unit can help decrease the risk of exposure, the CDC acknowledged that moving residents with cognitive impairment to new locations within a facility "may cause disorientation, anger, and agitation."[2] Accordingly, facilities "may determine that it is safer to maintain care of residents with COVID-19 on the memory unit with dedicated personnel."[75]

iii. Testing Guidance Issued May 18, 2020

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

- Bystanders should not be present for specimen collection.
- Swabbing of multiple individuals should not be performed in the same room at the same time unless swabbing stations are greater than 6 feet apart.
- When testing is taking place in succession in a single room, consider the use of portable HEPA filters to increase air exchanges and to expedite removing infectious particles and minimize the amount of time healthcare personnel spend in the room.
- Consider whether self-collection is appropriate, including whether the tested individuals can correctly self-swab in a way that avoids contamination.
- Healthcare personnel in the room should wear N95 respirators and eye protection, and the individual responsible for specimen collection should wear gloves and a gown (gloves should be changed and hand hygiene performed between each person swabbed).
- Surfaces within 6 feet of where specimen collection was performed should be cleaned and disinfected using an EPA-registered disinfectant if visibly soiled and at least hourly.
- Terminal cleaning and disinfection of all surfaces and equipment in the specimen collection area should take place at the end of each day.[76]

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

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

The CDC issued its most recent guidance on the subject of COVID-19 transmission in nursing homes and long-term care facilities on June 25, 2020.[77] The CDC stated, "[g]iven their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 and other pathogens, including multidrug-resistant organisms (e.g., Carbapenemase-producing organisms, Candida auris)."[78] For that reason, a strong infection prevention and control ("IPC") program is critical to protect residents and healthcare personnel. Accordingly, the CDC directed nursing home and long-term care communities to implement the following "core practices," practices which should remain in place even as facilities resume normal activities:

- Assign one or more individuals with training in infection control to provide on-site management of the IPC program.

- Report COVID-19 cases, facility staffing, and supply information to the National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module weekly.

- Educate residents, healthcare personnel, and visitors about COVID-19, current precautions being taken in the facility, and actions they should take to protect themselves.

- Implement source control measures, including ensuring healthcare personnel wear a facemask at all times when they are in the facility, residents wear a cloth face covering or facemask (if tolerated) whenever they leave their room, and visitors wear a cloth face covering while in the facility.

- Have a plan for visitor restrictions, including by facilitating and encouraging virtual methods for visitation and screening visitors prior to entering the facility.

- Create a plan for testing residents and healthcare personnel for COVID-19, including expanded viral testing of all residents if there is an outbreak in the facility (i.e., a new COVID-19 infection in any healthcare personnel or resident) and repeat testing to ensure there are no new infections among residents.[79]

- Evaluate and manage healthcare personnel, including asking staff to regularly monitor themselves for fever and symptoms for COVID-19, screening all healthcare personnel at the beginning of their shift for fever and symptoms of COVID-19 and developing plans to mitigate staffing shortages from illness or absenteeism.

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

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

- Evaluate and manage residents with symptoms of COVID-19, including (1) asking residents to report if they feel feverish or have symptoms consistent with COVID-19; (2) actively monitoring all residents at least three times daily for fever and symptoms consistent with COVID-19; and (3) transporting residents to another facility if the resident requires a higher level of care or the facility cannot fully implement all recommended infection control precautions.[80]

In addition to these "core practices," and in conjunction with state and local guidance, the CDC recommends additional strategies depending on the facility's reopening status, including: (1) implementing aggressive social distancing measures and remaining at least 6 feet apart from others by cancelling communal dining and group activities and reminding residents and healthcare personnel to practice social distancing; (2) implementing visitor restrictions by prohibiting all visitation to the facilities except for certain compassionate care reasons and end-of-life situations; and (3) restricting non-essential healthcare personnel and volunteers from entering the building.[81]

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

The CDC's most current guidance allows personnel to return to work following a COVID-19 infection under the following circumstances:[82]

- Healthcare personnel with mild to moderate illness who are not severely immunocompromised may return to work following:
    - At least 10 days have passed since symptoms first appeared; and
    - At least 24 hours have passed since last fever without the use of fever-reducing medications; and
    - Symptoms (e.g., cough, shortness of breath) have improved.
- Healthcare personnel with severe to critical illness or who are severely immunocompromised, in consultation with infection control experts, may return to work following:
    - At least 10 days and up to 20 days have passed since symptoms first appeared; and

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

- Healthcare personnel who are not severely immunocompromised and were asymptomatic throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test.
- Healthcare personnel who are severely immunocompromised but who were asymptomatic throughout their infection may return to work when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.[83]

Alternatively, a test-based strategy may be used which permits healthcare personnel to return to work when: (1) the fever (if any) is resolved without the use of fever-reducing medications; (2) symptoms (if any) have improved; and (3) results are negative from at least two consecutive respiratory specimens collected at least 24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect COVID-19.[84]

2. Missouri Department of Health and Senior Services

While not required to comply with the DHSS licensing standards applicable to Missouri long-term care facilities, DHSS guidance is relevant to long-term care facilities located within Missouri and is something with which the Homes strive to comply. DHSS guidance, issued on August 31, 2020, details criteria the State deems necessary for reducing the transmission of COVID-19 in long-term care facilities. Specifically, DHSS guidance addresses the following topics: (1) administrative actions, (2) reporting and notification requirements, (3) PPE, (4) testing, (5) physical environment, (6) visitor management, (7) resident management, (8) considerations for special populations, (9) staff management, and (10) environmental management.[85] Essentially, DHSS guidance echoes that promulgated by the CDC as set forth above and, therefore, is not repeated herein.

3. Centers for Medicare and Medicaid Services

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

IV. FINDINGS

When COVID-19 first reached the State of Missouri, the MVC took a number of steps to protect Veterans living in the Homes. At the end of February 2020, faced with evidence of the life-threatening risk COVID-19 posed to Veterans requiring long-term care, the MVC mobilized to prepare the Homes for the impending pandemic. The MVC evaluated and adjusted nearly every aspect of the delivery of care to Veterans in order to protect the men and women in the Homes. Throughout the month of March alone, the MVC Headquarter and Home staff took a number of steps in order to provide the Veterans and staff the best possible protection from the virus.[86] The following is just a small non-exhaustive sample of the proactive steps Headquarters staff quickly undertook in less than 30 days:

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

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

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

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

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

March 10, 2020: Implemented quarantine and isolation directives.

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

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

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

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

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

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

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

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

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

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

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

March 28, 2020: Collected additional data for a dashboard.

March 31, 2020: Adjusted guidance regarding how Homes should handle positive Veterans returning to the Home after a hospital stay.[87]

The efforts by the Headquarters and the Home staff paid early dividends as evident by the fact that, with the exception of one positive Veteran in St. Louis in April (the origins of that case remain undetermined), no Homes reported any positive cases until the late summer.[88] These initial positive cases in April, July, and August were successfully identified and contained within each Home without causing a prolonged, facility-wide outbreak.[89]

Comparatively, over that same period, other long-term care facilities experienced multiple outbreaks with tragic results.[90] For example, in the St. Louis area during this same period, long-term care facilities were reporting double digits deaths associated with acute COVID-19 outbreaks.[91] The cause of those outbreaks is not within the purview of this report and there is little value in drawing a direct comparison with the circumstances faced by those Homes. However, in an environment where other long-term care facilities experienced multiple outbreaks, the nearly six month record of the MVC Homes without a significant outbreak of cases, serves as at least some anecdotal evidence that MVC Headquarters staff and the Homes were taking appropriate steps to protect the Veterans and staff from early infection. At a minimum, it also serves as evidence that the front line staff members (i.e., the nurses, the restorative aids, the CNAs, the custodial staff, the food services staff, the maintenance staff, and the housekeeping staff) were dedicated to the Veterans they served and

dedicated to each other. The men and women who serve our Veterans during these incredibly difficult times should be commended for their dedication to duty.

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

While the investigation revealed that the MVC Headquarters and Home staff genuinely care for the Veterans, three major lapses contributed to the COVID-19 outbreak in the Homes this fall: (1) failure to recognize and appreciate the problem at the first sign of an outbreak; (2) failure to plan for the outbreak; and (3) failure to properly respond to the outbreak. The investigation also exposed the unintended negative consequences of isolation due to the restrictive measures intended to protect Veterans.

A. Failure to Recognize the Outbreak

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

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

Perhaps most significantly, the MVC failed to fully engage with the Fusion Cell. The Fusion Cell is part of Missouri's collective response to COVID-19 and is meant to be a single point of information for all Missouri agencies. According to a press release issued by the Governor of the State of Missouri: "The state's cross-governmental COVID-19 Fusion Cell helped coordinate development of the dashboards, which include data from the Missouri Department of Health and Senior Services, the Department of Economic Development, the Department of Social Services, and the Department of Elementary and Secondary Education, among others."[92] It is led by the Missouri Chief Operating Officer ("COO"), the Missouri Medicaid Director, and an outside consulting company. A morning Fusion Cell meeting currently occurs four days a week for one-and-a-half-hour. Typically, 100-250 individuals attend these meetings representing personnel from various Missouri agencies, commissions, and outside stakeholders like hospital associations. While MVC Headquarters attended the Fusion Cell meetings and provided information regarding positive test results among staff and Veterans, they failed to raise concerns to the Fusion Cell about the state of the outbreak in the Homes. When the MVC Headquarters disclosed the number of COVID-19 positive staff and Veterans at a September 10, 2020 meeting, no one from the Fusion Cell asked any questions or requested any follow up on the data that was presented.

The Fusion Cell, the Office of the Governor, and the Office of Administration, along with the leaders from DSS, DHSS, and DPS have since provided a number of resources to the MVC, including rapid antigen tests, access to a visual analytics platform to better review and analyze positivity rates, testing statistics and other metrics, as well as other support. Going forward, the

MVC should establish a more direct line of communication with the Fusion Cell. This should include a report of more specific data and a mechanism to report any concerns in order to draw on the collective expertise of Fusion Cell leaders. In addition, external stakeholders, like those who lead the Fusion Cell, must ensure there are better mechanisms in place to ensure data from the MVC and other commissions and agencies are not only reviewed but analyzed.

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

B. Failure to Plan for an Extensive Outbreak

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

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

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

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

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

C. Failure to Respond to the Outbreak

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

The timing of test results facilitated the spread of COVID-19. In August 2020, the Homes implemented routine nasopharyngeal PCR testing of all Veterans and staff twice a week. PCR tests take anywhere from 24 to 48 hours to process. This is significant because approximately sixty percent of individuals who are COVID-19 positive are either pre- or asymptomatic at the time they are tested.[93] This meant that while awaiting test results, infectious staff and Veterans interacted with one another, some without any personal protective equipment ("PPE"). Asymptomatic Veterans and some symptomatic Veterans were not quarantined pending the results and moved freely among the Homes, dined together, interacted with each other, and remained lodged with their roommates. Asymptomatic staff continued to work, engage with Veterans, and take breaks with other staff members pending test results.

Beginning in October, and with the assistance of the Fusion Cell and the Office of the Governor, Veterans now undergo rapid antigen testing on the days of the week they do not receive PCR testing. Rapid test results are available in approximately 15 minutes, and allow the Homes to send infected staff home sooner, isolate infected Veterans immediately, and more rapidly quarantine exposed Veterans. While the rapid test can have a high rate of false negatives, and this perceived unreliability contributed to some mistrust of the results initially, use of the rapid tests in conjunction with the routine PCR tests has had a positive impact on managing the outbreak. It allows for faster diagnosis, faster isolation, faster quarantine, and reduced spread. Other changes to the Homes practices include increased monitoring of Veterans' vital signs to every four hours, in order to identify changes in a Veteran's condition for earlier medical intervention. This practice should be standardized across the Homes.

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

A delay in closing common spaces also contributed to cross-contamination and the spread of COVID-19 within the Homes. In the early days of the outbreak, Veterans were allowed to move freely about the Homes. Many did so without wearing masks, even while exhibiting COVID-19

symptoms. Veterans have since been confined to their own units or rooms, and common spaces like dining rooms have been closed. Most of the Homes have prohibited meal carts from being brought onto the units. Instead, the carts are left at the entryway to the unit and nursing staff distribute the meals on disposable plates and with disposable utensils.

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

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

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

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

Finally, although the frequency of cleaning the Homes increased after the outbreak, disinfectant products were not being used according to the manufacturer's recommendations. Specifically, staff was only letting the products sit for 1 minute, when the products must sit for 10 minutes to be effective against viruses, including COVID-19. Thus, while the Homes were clean, they were not disinfected.

D. The Unintended Consequences on the Veterans

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

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

Further, physical therapy, occupational therapy and speech therapy are no longer being provided in the Homes nor are exercise classes, art classes or therapy dogs. The absence of these

physically and mentally stimulating activities, is contributing to the deterioration of the Veterans' conditions. Several family members described their loved ones now being wheelchair bound where they did not need a wheelchair prior to the lockdown. Several family members also described a lack of appropriate medical care in that they cannot attend physician visits with their loved ones and Veterans who have difficulty communicating have attended virtual physician visits in which the Veteran was not able to communicate his condition and, as a result, received inappropriate care.

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

Given the important role family members play in the social and emotional health of Veterans, the Homes should establish a protocol by which a limited number of designated family members be allowed to visit their loved one at an appropriate time. While there is some risk to allowing family interaction inside the Home, if proper protocols are established and enforced, the risk is no greater than a staff member reporting to work. Doing so will provide the Veterans the contact they desperately need and will also provide the staff some relief.

V. RECOMMENDATIONS

In the course of the investigation, Armstrong Teasdale issued early recommendations to the MVC intended to induce immediate action to reduce the spread of COVID-19 in the Homes which are included below. The following additional recommendations are designed to prevent another outbreak of COVID-19 in the Homes; identify various improvements necessary in the communication and management structure of MVC Headquarters; and encourage the MVC to develop mechanisms by which infections can be recognized, isolated, and remediated as quickly as possible:

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

1. Corrective Action

i. MVC Headquarters should develop specific trigger points that identify threshold conditions to take further action. Once these thresholds are established, MVC Headquarters should create action plans which correspond to each trigger point and ensure all staff are trained to the same standard.

ii. MVC Headquarters should continue to expand their use of data analytic platforms and dashboards to ensure data collected by the Homes is properly analyzed. The MVC should ensure Headquarters staff is trained to identify trends and task key personnel with the responsibility of tracking and analyzing such data. In addition, Headquarters leadership, led by the Executive Director, must compare MVC data to information provided by the Fusion Cell, local health departments, and other available sources to engage in meaningful decision-making.

iii. MVC should explore methods to streamline the reporting burdens on Homes and its Headquarters staff. Specifically the MVC and other state stakeholders should look for ways to reduce duplicative reporting, in order to minimize the risk of data errors.

B. Root Cause: Lapse of Broader Reporting and Communication

1. Corrective Action

i. MVC Headquarters should develop a plan outlining a delegation of duties among MVC Headquarter staff. Duties related to data management, analysis, resource procurement, and contingency planning must be clearly assigned to prevent lapses in responsibility. MVC Headquarter leadership should create unity of command and clearly defined responsibilities related to the continued COVID-19 response.

ii. MVC Headquarters should improve communication and analysis between it and the Fusion Cell, including an "After Action Review"[3] of the lessons learned from the prolonged outbreak, the identification of who at the MVC and the Fusion Cell are responsible for analyzing data, and the establishment of a clear line of communication between such individuals.

iii. The MVC should work with other external stakeholders like the COO of Missouri, the Fusion Cell, DPS, and other agencies to examine the structure of the "independent" MVC and its administrative position in the State of Missouri. Accountability measures and a clear structure involving direct oversight may be necessary to ensure better communication exists between MVC, DPS, and other stakeholders.

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

1. Corrective Action

i. MVC Headquarters and Homes should develop a comprehensive COVID-19 outbreak plan based on other infectious disease protocols. The plan should be vetted by other external agencies and compared to guidelines such as those issued by the CDC, VA, DHSS, and CMS. The plan must be tested and tailored

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

to each Home as appropriate. Once final, all MVC Headquarter and Home staff should be trained and have access to the plan for reference.

ii. Part and parcel to the outbreak plan is the development of clear and consistent policies regarding when staff need to quarantine or isolate and the conditions that must be met before staff may return to work following COVID-19 infection or exposure. In addition, each Home should have a detailed plan it can implement in the event of staffing shortages and a dedicated infection prevention nurse.

iii. MVC Headquarters and Homes should develop immediate response checklists that can be executed by any member of the Home's management team if the Home receives a report of a COVID-19 positive staff and/or resident.

iv. MVC Headquarters should acquire PPE necessary to ensure appropriate availability through at least April 2021, as well as staff training and education at each Home on the proper use of PPE. To ensure this recommendation is completed on a regular and ongoing basis, the Executive Director of the MVC should make written, monthly reports to the MVC Commissioners, the DPS Director, and the COO of Missouri when this education is completed.

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

vi. MVC Headquarters should secure rapid antigen testing through at least April 2021 to protect against the transmission of COVID-19. The procurement of such tests will ensure the Homes are able to quickly identify and isolate positive staff members before they interact with Veterans and other staff in the Homes.

vii. Through the Fusion Cell, MVC Headquarter should work to ensure that when a safe and effective COVID-19 vaccination becomes available, the Veterans in the Homes (along with other long term care Veteran) receive priority. Logistical planning, in consultation with the Home's respective medical directors, should begin as to the means and methods of distribution and delivery. Specific

attention must be given to the projected vaccination restrictions and requirements.

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

1. Corrective Action

i. All Homes staff should undergo a "COVID-19 Reset", meaning fundamental education regarding COVID-19 and how to prevent its spread. This would also include partnership with local public health departments to monitor community-specific incidents and information.

ii. MVC Headquarters and Homes should develop COVID-19-specific policies and a specific infection control manual, followed by the immediate education and demonstration among staff of the contents of these policies. The policies should be placed in binders accessible to all staff members, and they should be reviewed and updated annually to ensure compliance with VA, CDC, and other guidance.

iii. The MVC should consider retaining an Occupational Health Nurse on the Headquarters staff, through the end of the pandemic, in order to help develop specific policies related to the safety and health of the staff. In addition to infectious disease control considerations, an Occupational Health Nurse would assist in developing policies and programs to support the mental health and well-being of the staff.

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

v. MVC Homes should transfer COVID-19 positive Veterans to an isolation area, whether the positive result is from PCR or rapid antigen testing, and transfer Veterans with suspected cases of COVID-19 to quarantine status. A Veteran must quarantine alone to avoid the risk of infecting others. In order to act quickly, staff members should be permitted to facilitate these transfers without

approval of the Medical Director or Headquarters. If the Veteran's condition makes such a move difficult, the Veteran should be transferred to a hospital.

vi. To the extent possible, Veterans should reside in private rooms with private bathrooms, and the Homes should evaluate the rooms' ventilation units and the use of HPEA filters with 99.9% efficiency to remove infectious particles. In addition, Homes should consider adjusting the assignment of Veterans that frequently leave the Homes for outpatient medical care, such as for weekly dialysis treatment. Such Veterans should be in private rooms and proper consideration should be given to their location within the Home and whether the Veteran must pass through other areas upon exiting and returning to the Home.

E. Incidental Recommendations

1. Family member considerations

i. MVC Headquarters and Homes should ensure better publication of the telephone number family members may call if they have concerns or issues with the Homes, as well as more timely responses to these family member calls.

ii. MVC Headquarters and Homes should consider the development of a protocol by which a limited number of designated family members may be allowed to visit their loved ones. The designated family members should commit to follow the COVID-19 protocols put in place by local and state health departments, including social distancing, mask wearing, and hand washing. They must also undergo appropriate training and education on the use of PPE and infection control measures, and should be subject to the same testing and screening processes as the staff.

VI. CONCLUSION

While this investigation identified several deficiencies, it is clear the MVC Headquarters and Homes staff genuinely care for the Veterans and are working diligently in this stressful and rapidly changing situation to protect the men and woman who have kept them safe. As expressed by one family member referring to her Veteran: "They treated him like a hero." Indeed, many family members expressed their gratitude toward the MVC and their treatment of the Veterans: "I couldn't ask for a better place for him to be," "I'm thankful my brother is where he is through this time;" and "I can't express how grateful I am that these people are there taking care of him when I can't." Missouri citizens should be proud of how their Veterans are taken care of in these unique long-term care facilities, where our inspiring men and women live out the remaining sunset of their lives.

Ordering this rapid independent external investigation is only the first step in a series of future endeavors the MVC and other external stakeholders should take in order to ensure the protection of the Veterans under their care. It is our hope that these findings and recommendations will serve as a launching point of positive change for those who deserve it the most. On behalf of our entire investigatory team we wish to express our deepest gratitude and humility in being a part of this critical mission.

I. APPENDIX A. TABLE OF INTERVIEWS CONDUCTED

#	*POSITION/ROLE*	*INTERVIEW DATE*
1.	Home Assistant Administrator	October 15, 2020
2.	Home Administrator	October 15, 2020
3.	Home Administrator	October 15, 2020
4.	Home Administrator	October 16, 2020
5.	Home Assistant Administrator	October 16, 2020
6.	Home Administrator	October 17, 2020
7.	Home Administrator	October 18, 2020
8.	Home Assistant Administrator	October 18, 2020
9.	Home Assistant Administrator	October 18, 2020
10.	Home Administrator	October 19, 2020
11.	Home Assistant Administrator	October 19, 2020
12.	Home Assistant Administrator	October 19, 2020
13.	Home Administrator	October 19, 2020 (pt. 1)
14.	Home Director of Nursing	October 20, 2020
15.	Home Medical Director	October 20, 2020
16.	Home Administrator	October 20, 2020 (pt. 2)
17.	Home Infection Control Nurse	October 20, 2020
18.	Home Staff Development Coordinator	October 21, 2020
19.	Home Social Worker	October 21, 2020
20.	Home HR Director	October 21, 2020
21.	Home Food Service Manager	October 21, 2020
22.	Home Food Services Manager	October 22, 2020

#	*POSITION/ROLE*	*INTERVIEW DATE*
23.	President of Residents Council	October 22, 2020
24.	Home Medical Director	October 22, 2020
25.	Home Director of Nursing	October 22, 2020
26.	Home HR Director	October 22, 2020
27.	President of Residents Council	October 22, 2020
28.	HQ Assistant Homes Director	October 23, 2020
29.	Home HR Director	October 23, 2020
30.	Home Staff Development Coordinator	October 23, 2020
31.	Home Social Worker	October 23, 2020
32.	Home Social Worker	October 23, 2020
33.	HQ Director of Operations	October 23, 2020 (pt. 1)
34.	Home Staff Development Coordinator	October 23, 2020
35.	Home Social Worker	October 23, 2020
36.	Home Food Service Manager	October 23, 2020
37.	Home Social Worker	October 24, 2020
38.	HQ Director of Human Resources	October 24, 2020
39.	Home Environmental Services Director	October 26, 2020
40.	Home Shift Supervisor	October 26, 2020
41.	Home Staff Development Coordinator	October 26, 2020
42.	Home Assistant Administrator	October 26, 2020
43.	Home Medical Director	October 26, 2020
44.	HQ Director of Homes	October 26, 2020
45.	Vice President of Residents Council	October 26, 2020

#	*POSITION/ROLE*	*INTERVIEW DATE*
46.	Home Social Worker	October 27, 2020
47.	President of Residents Council	October 27, 2020
48.	Home Environmental Services Director	October 27, 2020
49.	Home Staff Development	October 27, 2020
50.	Home Custodial Manager	October 27, 2020
51.	Home Director of Nursing / Infection Control	October 27, 2020
52.	Home Staff Development Director	October 27, 2020
53.	Home Director of Nursing / Infection Control	October 27, 2020
54.	Home Senior Clinical Case Worker	October 27, 2020
55.	Home HR Manager	October 27, 2020
56.	Home Food Service Manager	October 27, 2020
57.	HQ Director of Operations	October 27, 2020 (pt. 2)
58.	Home Administrator	October 27, 2020 (pt. 3)
59.	Home Director of Nursing	October 27, 2020
60.	HQ Deputy Director	October 27, 2020
61.	HQ Emergency Management Coordinator	October 28, 2020
62.	Home Certified Nursing Assistant	October 28, 2020
63.	Home Certified Nursing Assistant	October 28, 2020
64.	Home Medical Director	October 28, 2020
65.	Home Infection Prevention Nurse	October 28, 2020
66.	President of Residents Council	October 28, 2020
67.	Home HR Specialist	October 28, 2020

#	*POSITION/ROLE*	*INTERVIEW DATE*
68.	Home Staff Development Coordinator	October 28, 2020
69.	Home Director of Nursing	October 28, 2020
70.	Home Environmental Services	October 28, 2020
71.	Home HR Specialist	October 28 2020
72.	Home Food Service Manager	October 28, 2020
73.	Home Medical Director	October 29, 2020
74.	Home Director of Nursing	October 29, 2020
75.	Home HR Specialist	October 29, 2020
76.	President of Residents Council	October 29, 2020
77.	Home Custodial Supervisor	October 29, 2020
78.	Non-MVC State employee	October 29, 2020
79.	Home Certified Nursing Assistant	October 29, 2020
80.	Home Certified Nursing Assistant	October 30, 2020
81.	Home Medical Director	October 30, 2020
82.	State Epidemiologist	October 30, 2020
83.	Non-MVC State employee	October 30, 2020
84.	Home Environmental Services Supervisor	October 30, 2020
85.	Home Food Service Supervisor	November 2, 2020
86.	Home Certified Nursing Assistant	November 2, 2020
87.	Home Food Service Supervisor	November 2, 2020
88.	President of Residents Council	November 2, 2020
89.	HQ Executive Director	November 2, 2020
90.	Home Infection Control	November 3, 2020

#	*POSITION/ROLE*	*INTERVIEW DATE*
91.	Non-MVC State employee	November 3, 2020
92.	Non-MVC State employee	November 4, 2020
93.	Non-MVC State employee	November 5, 2020
94.	Non-MVC State employee	November 9, 2020
95.	Non-MVC State employee	November 9, 2020
96.	Non-MVC State employee	November 9, 2020
97.	Non-MVC State employee	November 10, 2020
98.	Non-MVC State employee	November 10, 2020
99.	Non-MVC State employee	November 10, 2020

II. APPENDIX B. TABLE OF HOTLINE CALLS

#	*RELATIONSHIP TO VETERAN*	*DATE OF INTERVIEW*
1.	Son	10/29/2020
2.	Wife	10/29/2020
3.	Wife	10/29/2020
4.	Wife	10/29/2020
5.	Wife	10/29/2020
6.	Daughter	10/30/2020
7.	Daughter	10/30/2020
8.	Son	10/27/2020 & 10/30/2020
9.	Wife	10/30/2020
10.	Wife	10/30/2020
11.	Daughter	10/30/2020
12.	Wife	10/30/2020
13.	Daughter	10/31/2020
14.	Son	10/31/2020
15.	Daughter	10/31/2020
16.	Wife	11/2/2020
17.	Wife	11/2/2020
18.	Veterans Assistance League	11/2/2020
19.	Daughter	11/2/2020
20.	Sister	11/2/2020
21.	Wife	11/2/2020
22.	Stepdaughter	11/2/2020

#	*RELATIONSHIP TO VETERAN*	*DATE OF INTERVIEW*
23.	Daughter	11/2/2020
24.	Veterans Assistance League	11/2/2020
25.	Daughter	11/2/2020
26.	Son	11/2/2020
27.	Granddaughter	11/3/2020
28.	Veterans Assistance League	11/3/2020
29.	Daughter	11/3/2020
30.	Veterans Assistance League	11/3/2020
31.	Wife	11/3/2020
32.	Veteran Resident	11/3/2020
33.	Daughter	11/3/2020
34.	Veterans Assistance League	11/3/2020
35.	Veterans Assistance League	11/3/2020
36.	Veterans Assistance League	11/3/2020
37.	Sister	11/3/2020
38.	Son	11/3/2020
39.	Brother	11/4/2020
40.	Wife	11/4/2020
41.	Daughter	11/4/2020
42.	Nephew	11/4/2020
43.	Veterans Assistance League	11/4/2020
44.	Daughter	11/4/2020
45.	Veterans Assistance League	11/4/2020

#	*RELATIONSHIP TO VETERAN*	*DATE OF INTERVIEW*
46.	Wife	11/4/2020
47.	Granddaughter	11/4/2020
48.	Veteran Resident	11/4/2020
49.	Veterans Assistance League Board	11/4/2020
50.	Veteran Resident	11/4/2020
51.	Outpatient Nurse	11/4/2020
52.	Veterans Assistance League	11/4/2020
53.	Daughter	11/5/2020
54.	Granddaughter	11/5/2020
55.	Daughter	11/5/2020
56.	Daughter	11/5/2020
57.	Wife	11/5/2020
58.	Son	11/5/2020
59.	Son	11/5/2020
60.	Wife	11/5/2020
61.	Son and Daughter-in-law	11/5/2020
62.	Wife	11/5/2020
63.	Ex-Husband	11/5/2020
64.	Wife	11/5/2020
65.	Son	11/5/2020
66.	Daughter	11/5/2020
67.	Wife	11/6/2020
68.	Granddaughter	11/9/2020

Returned calls and left voicemails for six (6) additional callers.

[1] https://mvc.dps.mo.gov/about/ (last visited on November 12, 2020)
[2] COVID-19 is official name for the disease that is causing the 2019-2020 global coronavirus outbreak, first identified in Wuhan China. The virus can spread through close contact, respiratory droplets, or touching an infected surface and then touching one's face. To date, there have been over 9 million cases and 230,000 deaths. https://www.cdc.gov/coronavirus/2019-ncov/downloads/2019-ncov-factsheet.pdf; https://covid.cdc.gov/covid-data-tracker/#cases_casesinlast7days (last visited November 16, 2020)
[3] https://governor.mo.gov/press-releases/archive/governor-parson-orders-external-review-missouri-veterans-homes-regarding (last visited November 13, 2020)
[4]https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/ (last visited November 13, 2020)
[5] *Id.*
[6] https://www.usnews.com/news/top-news/articles/2020-04-02/us-cdc-reports-213-144-coronavirus-cases-4-513-deaths (last visited November 13, 2020)
[7]https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days (last visited November 13, 2020)
[8] https://covid.cdc.gov/covid-data-tracker/#testing_testsperformed (last visited November 13, 2020)
[9] https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (last visited November 13, 2020)
[10] *Id.*
[11] https://governor.mo.gov/press-releases/archive/governor-parson-state-and-local-officials-confirm-first-case-covid-19-test (last visited November 13, 2020)
[12] https://governor.mo.gov/press-releases/archive/governor-parson-signs-executive-order-20-02-declaring-state-emergency (last visited November 13, 2020)
[13]https://www.stltoday.com/lifestyles/health-med-fit/coronavirus/first-covid-19-death-announced-in-missouri/article_90e696f3-4173-58c4-bb2c-992f90bd8c83.html (last visited November 13, 2020)
[14] https://governor.mo.gov/press-releases/archive/governor-parson-directs-dhss-director-require-social-distancing-statewide (last visited November 13, 2020)
[15]https://governor.mo.gov/press-releases/archive/governor-parson-issues-statewide-stay-home-missouri-order-control-contain (last visited November 13, 2020)
[16] https://governor.mo.gov/press-releases/archive/governor-parson-announces-first-phase-show-me-strong-recovery-plan-begin-may (last visited November 13, 2020);
https://governor.mo.gov/press-releases/archive/governor-parson-extends-phase-1-show-me-strong-recovery-plan-through-june-15 (last visited November 13, 2020)
[17]https://governor.mo.gov/press-releases/archive/governor-parson-announces-missouri-will-fully-reopen-enter-phase-2-recovery (last visited November 13, 2020)
[18] https://www.aarp.org/health/healthy-living/info-2020/states-mask-mandates-coronavirus.html#Missouri (last visited November 13, 2020)
[19]https://www.aarp.org/health/healthy-living/info-2020/states-mask-mandates-coronavirus.html#Missouri (last visited November 13, 2020);
https://www.arcgis.com/apps/opsdashboard/index.html#/59135fbe6eb24581b8d5dd78964ec1e4 (last visited Novem 13, 2020)
[20] https://www.nytimes.com/interactive/2020/us/missouri-coronavirus-cases.html (last visited November 16, 2020)
[21] https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (last visited November 16, 2020)
[22] https://www.jhsph.edu/covid-19/articles/covid-19-testing-understanding-the-percent-positive.html (last visited November 13, 2020)
[23] *Id.*
[24] https://showmestrong.mo.gov/public-healthcare-testing/ (last visited November 13, 2020)
[25] https://www.nytimes.com/interactive/2020/us/missouri-coronavirus-cases.html#cases (last visited November 13, 2020)
[26] https://covid.cdc.gov/covid-data-tracker/#cases_totalcases (last visited November 13, 2020) ;
https://covid.cdc.gov/covid-data-tracker/#cases_totaldeaths (last visited November 13, 2020)
[27] https://covid.cdc.gov/covid-data-tracker/#testing_totalpercentpositive (last visited November 13, 2020)
[28] https://data.cms.gov/stories/s/bkwz-xpvg (last visited November 16, 2020);
https://www.stltoday.com/news/local/metro/more-than-650-missouri-nursing-home-residents-dead-of-covid-19-as-infection-rate-climbs/article_27ea371d-9ccd-543f-bc73-202a03bedb2e.html (last visited November 16, 2020) ;
https://stlcorona.com/sites/default/assets/pdfs/resources/st-louis-county-resources-july-monthly-covid-ltc-report-

08042020-0.pdf (last visited November 16, 2020); https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/ (last visited November 16, 2020)
[29] https://www.accesstocare.va.gov/Healthcare/COVID19NationalSummary (last visited November 16, 2020)
[30] https://data.cms.gov/stories/s/bkwz-xpvg (last visited November 16, 2020)
[31] *Id.*
[32] https://www.accesstocare.va.gov/Healthcare/COVID19NationalSummary (last visited November 16, 2020)
[33] Daily COVID Report to HQ – 11.3.2020 (MVC Spreadsheet November 13, 2020)
[34] https://mvc.dps.mo.gov/about/history.php (last visited November 13, 2020)
[35] https://mvc.dps.mo.gov/index.php (last visited November 13, 2020)
[36] https://mvc.dps.mo.gov/about/ (last visited November 13, 2020)
[37] https://mvc.dps.mo.gov/news/newsitem/uuid/10a496ea-1e2a-4cb9-97fa-0d9e9383fe23 (last visited November 13, 2020)
[38] RSMo. § 42.007.5(2).
[39] RSMo. § 42.007.2
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] RSMo. § 42.007.3.
[45] https://mvc.dps.mo.gov/about/commissioners.php (last visited November 13, 2020)
[46] RSMo § 42.012(1)
[47] *Id.*
[48] *Id.*
[49] *Id.*
[50] https://mvc.dps.mo.gov/about/execdirector.php (last visited November 13, 2020)
[51] https://mvc.dps.mo.gov/news/newsitem/uuid/da59c475-0512-434b-9f0a-bc8ca00a9ed2 (last visited November 13, 2020)
[52] https://mvc.dps.mo.gov/homes/ (last visited November 13, 2020)
[53] *Id.*
[54] *See* § 198.012.1(1), RSMo.; § 42.130, RSMo. ("[T]he provisions of sections 198.003 to 198.136 shall not apply to the Missouri Veterans' homes.").
[55] § 42.100.2, RSMo.
[56] § 42.127, RSMo.
[57] *See* 38 C.F.R. § 51.200 ("The facility management must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public."); 38 C.F.R. § 51.100(i).
[58] *See* 38 C.F.R. § 51.100(c) ("Resident Council. The facility management must establish a council of residents that meet at least quarterly. The facility management must document any concerns submitted to the management of the facility by the council.")
[59] A 2018 constitutional amendment legalizing medical marijuana in Missouri created the Missouri Veterans' Health and Care Fund, consisting of application fees and four percent tax on sales. These funds are then transferred to the MVC for its health and care services. Mo. Const. art. XIV, § 1.
[60] RSMo §§ 42.007; 42.010; 42.100
[61] RSMo § 42.100.1(1)-(8)
[62] https://oa.mo.gov/sites/default/files/FY_2020_EB_Public_Safety.pdf (last visited November 13, 2020)
[63] https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html/ (last updated April 30, 2020, last visited November 13, 2020)
[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] *Id.*
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html (last visited November 13, 2020)
[73] *Id.*

[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] *Id.*
[78] *Id.*
[79] https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html (last visited November 13, 2020)
[80] *Id.*
[81] *Id.*
[82] https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html (last visited November 13, 2020)
[83] *Id.*
[84] *Id.*
[85] https://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/ltcf.php (last visited November 13, 2020)
[86] MVC COVID-19 Timeline and Communication Update Tracker
[87] *Id.*
[88] Interview with Director of Operations; Interview with Director of Homes
[89] *Id.*
[90]https://news.stlpublicradio.org/show/st-louis-on-the-air/2020-06-05/more-than-250-missouri-nursing-home-residents-died-from-covid-19 (last visited on November 13, 2020)
[91]https://www.kmov.com/news/covid-19-outbreak-killed-494-residents-of-st-louis-county-long-term-care-facilities/article_82c6fcb8-c95a-11ea-8c03-63002ee1f978.html (last visited on November 13, 2020)
[92] https://governor.mo.gov/press-releases/archive/governor-parson-announces-expansion-state-covid-19-dashboards (last visited on November 12, 2020)
[93] Interview of State epidemiologist

Armstrong Teasdale

COVID-19 OUTBREAK AT MISSOURI VETERANS HOMES