FINAL

RE: Yukio Okutsu State Veterans Home (YOSVH) Hilo, Hawaii.
9/11/2020

Facility stats as of 9/11/20
95 total beds
Current census 67
COVID+ 63 cumulative
COVID+ 35 total in Ohana 1 COVID unit
PUI: 8 (symptoms and exposure)
Recovered: 17 (7 in COVID unit)
Hospitalized: 4
Expired: 10
Staff: 143 (contractors included)
Staff: 24 COVID positive total, 5+ recovered

Staffing
Standard 1:8-10 CNA, 1:30 RN
Pre-COVID 1:8 CNA, 1:23 RN, 1:46 RN night with Supervisor RN
Currently: 1:9-12 CNA due to lower census and sick staff, 1:10 RN days, 1:20 RN eves, 1:30 RN night with Supervisor RN

Medical Staff
4 medical staff, 2 co-medical directors [redacted], who care for the majority of patients.

PPE
Adequate. N95 size small possible shortage. Never had a shortage.

Community Situation
Liberty Dialysis outbreak on or about 8/5
Staff+ 8/1, 4 patients on 8/19, 1 patient on 8/20, 1 staff on 8/25, 4 patients on 8/28, 1 patient on 8/29. 4 patients on 8/28 were from Yukio Okutsu.
Kamehameha School opening on or about 2nd week of August
The "Funeral"
[redacted] Outbreak: [redacted] family in [redacted] (mid to late August) over 20 members
Hale Nani (Avalon) Honolulu (300 beds) dealing with their own large COVID outbreak around this time.

Sequence of Events
June, 2020
Full facility staff and resident mass testing – all negative.

East Hawaii SNFs agreed to start weekly COVID testing of all their HD patients after a COVID+ staff member at Liberty HD on or about 8/5/20. All cohort on 1st floor Ohana 1, Koa wing.

Thursday, 8/20/20
Hilo Medical Center requests Yukio Okutsu State Veteran's Home (YOSVH) to participate in random testing that HMC was initiating.
Initially 27 staff were selected
Same day:
[redacted] #1 reported daughter was COVID+, left facility immediately

[redacted] #2 felt sick and went home ([redacted] family cluster with family member also on HD)

In addition to above 27, decision was made to add all maintenance staff, housekeeping and medical records who all worked in the same wing on Ohana 2 were added to the random testing for a grand total of 40. (only 2 positive)

Friday, 8/21/20
[redacted] moved from Ohana 1 to Ohana 2 to make room for new admissions.

Saturday 8/22/20
[redacted] above started having URI symptoms. Didn't test right away. [redacted] felt it was due to AC. COVID neg on 8/23 test. COVID+ 8/29. Talkative and social butterfly. Possibly infectious 8/24-8/29. Husband turned COVID+ on 9/1.

2pm Results started to roll in. [redacted] #2 tested positive, #1 tested negative.
Break room in maintenance hall area where they often got together and ate lunch without masks almost daily. Suspect index case may have been one of these [redacted].
Also important to note that time clock for staff located in this very hallway.

6pm through Sunday: Entire staff/residents tested by their own staff (minus the HD patients (4) because they had been tested weekly, last tested on 8/19 (3/4) and 8/21 (1/4).

Decision made to stop all admissions. Everybody N95 and face shields.

Sunday 8/23/30
9am [redacted] #3 turned positive

Moved [redacted] from 1st to 2nd floor to make room, and turned positive on 8/27 (infectious 8/23-8/27)

Tuesday 8/25/20
7 residents positive - 2 sent to acute (both expired)
5 of 7 in Ohana 1, [redacted] wing [redacted]
1 of 7 in Ohana 1, [redacted] wing [redacted]
1 of 7 in Ohana 1, [redacted] wing [redacted]
Tested 1 HD patient
Only 1 staff positive - [redacted] same hall as [redacted]. [redacted]. Took patient [redacted] on 8/18 [redacted] and may have been infected by the employee.
Created COVID unit in the back of Ohia wing for COVID+ (16 beds)
PUI patients (roommates of COVID+ residents) were not cohorted to a PUI unit.
8 new onset respiratory illness on Ohana 1 and not immediately tested until 8/27 which was a scheduled mass testing event.

Wednesday 8/26/20
HD#1 tested positive

Thursday 8/27/20
Tested entire staff and residents again (2nd time) 8/27-8/28
Tested 3 remaining HD patients

Friday 8/28/20
All 3 remaining HD patients resulted positive
All 4 HD patients cohort in Ohana 1, [redacted] wing

[redacted] tested 8/26 in community and positive 8/28 first direct care positive case. Worked on Ohana 1.

[redacted] *lived in* [redacted] *wing and wandered throughout the floor. Question if COVID brought in originally from HD patients. Now expired.*
[redacted] *wing. Still hospitalized.*

Saturday 8/29/20-weekend
Results rolled in from 8/27/20 testing
21 positive
6 staff (1 [redacted] - Ohana 1, 3 [redacted] - Ohana 1 all night shift, 2 [redacted])
15 residents - 12 were on Ohana 1 and 3 on Ohana 2 (first positive cases on this unit)

Monday 8/31/20-9/1
Whole house testing again #3 staff/residents

Wednesday 9/2/20
20 positive
2 staff: ([redacted] , [redacted]) both Ohana 1
18 residents (7 from Ohana 2)

Thursday 9/3/20-9/4
Whole house testing #4 staff/residents

Friday 9/4 and 9/5
Results rolled in
1 staff ([redacted] worked night shift Ohana 1)
8 residents (2 Ohana 1, 6 Ohana 2)

Saturday 9/5
Tested all COVID negative residents on Ohana 2 - 24 total
By this time, Ohana 2 was considered all PUI since Ohana 1 was all COVID

Monday 9/7-9/8
16 negative residents
7 positive residents
1 pending

Wednesday 9/9/20
100% staff and resident testing with Premier Medical Group: Dr [redacted] and Dr [redacted].
74 public, 89 staff, 29 residents on Ohana 2 (some of which by this time were recovered)

Thursday 9/10/20
7 new cases in Ohana 2 out of 60 results. 132 pending.

Friday 9/11/20
Arrived with VA team

Expired
8/25 [redacted] 87M [redacted], limited, expired in acute 8/29
8/25 [redacted] 95M [redacted], expired in acute 8/31
8/25 [redacted] 85M [redacted], expired in facility 9/2
8/27 [redacted] 95M [redacted] expired in facility 8/29
8/27 [redacted] 74M [redacted], expired in acute 9/6
8/27 [redacted] 70M [redacted], expired in facility 9/2
8/31 [redacted] 84M [redacted], expired in facility 9/7
8/31 [redacted] 95M [redacted], expired in facility 9/8
8/31 [redacted] 96M [redacted], expired in facility 9/6
9/3 [redacted] 87M [redacted]
[redacted], expired in acute 9/4.

Nebulized patients: doors always closed.
Attending MD's converted all nebs to MDI except:

[redacted], Ohana 2 private room, scheduled did nebulizers for COPD. [redacted] non-compliant. On O2. COVID+ 8/27.
Patient refused to switch to HFA however, Albuterol nebs qid and Symbicort inhaler and Combivent MDI. No connection to spread.

[redacted], Ohana 1, palliative care, declined hospice. No transfer to acute. PRN albuterol nebs almost daily for wheezing, difficulty using MDI, PTSD paranoia. COVID+ 8/31.

[redacted], Ohana 1, PD, PTSD, CMO. PRN Albuterol. COVID+ 8/28

Release from COVID isolation criteria:
Follows CDC guidance and needs OK from Medical Director, [redacted].
10 days since COVID+ test date and no fever x 24hrs with improvement sx.
20 days if hypoxic or severe illness, O2 sats below 94%.
Judgement call on who is frail and who is not.

Concerns:
1. Biggest concern is why are staff still turning positive with each mass testing?
2. [redacted] Dialysis appears to be one of the origins of COVID outbreak. Question lack of transparency with community SNFs as to COVID+ patients and staff in the past. This issue of transparency appears to have resolved per staff.
3. [redacted] x 3 and [redacted] with known COVID contacts, gathering in break room without masks. [redacted] also worked [redacted] and had contact with first 7 positive cluster. Possible source.
4. Also noted time clock is in the same hall way where [redacted] work and is a high touch item. No signs warning staff nor is there a hand washing station or alcohol dispenser in the area,
5. Central nursing station with resident rooms in hallways designed like spokes on a wheel make it difficult for nursing staff to maintain distance and separate clean from dirty work stations on the second floor where one wing is a PUI unit and the other units are clean units.
6. Movement of [redacted] on 8/21 unwittingly from Ohana 1 to Ohana 2, [redacted] had URI sx, though tested negative 8/23. Tested positive 8/29. In retrospect, possibly infectious 8/24-8/29 on Ohana 2 floor.

7. Movement of [redacted] from Ohana 1 to Ohana 2 on 8/23, also unwittingly, appears to have been infectious 8/23-8/27 on Ohana 2.
8. On 8/22, all staff and residents were tested minus the HD patients who were last tested on 8/19 and 8/21. 7 residents and 1 staff positive (central supply). All HD patients turned COVID+ after 8/27 testing. In retrospect, HD patients may have been infectious and could have been tested earlier on 8/22. They appear to be a likely source.
9. Separate PUI unit not created on 8/25 when first cluster of 7 positive cases were identified on Ohana 1. Creation of a PUI unit or cohorting PUI patients, may have helped to stop the spread.
10. Probably closing doors on COVID+ and PUI rooms should be considered or creation of some sort of physical barrier like a plastic curtain to help maintain droplet precautions.
11. Staff at YOSVH are doing all their own testing of staff and patients
12. Staff ratio for COVID unit same as other units, but probably deserve a higher ratio of staff due to complexity of working in a COVID unit.
13. More than one demented known wandering residents remained wandering on Ohana 1, lived next to HD patients and probably also facilitated spread in Ohana 1.
14. Several wanderers existed on Ohana 1: [redacted]. No use of physical barriers or dementia designed stop signs to discourage wandering.
15. Several patients still use nebulizers, including one who uses both nebulizers and inhalers, although no evidence of spread via these residents. Nebulizer use should not be an option.
16. Some furniture being used is of a fabric that is not easy to clean.

Recommendations:

1. Recommend cohorting all PUI patients on one wing in Ohana 2 floor to avoid staff confusion, conserve PPE and keep clean apart from possible unclean items like med carts, computers, etc.… Addendum: on 9/11 cohorting was done but two PUI patients were not included because they did not want to. Recommend that this decision is not voluntary.
2. Move COVID recovered patients to Ohana 2 to make room in the COVID unit (Ohana 1). Perhaps even cohort them as well.
3. Allow Premier Medical Group to take over all COVID testing so that staff are free to care for patients.
4. Continue COVID unit on Ohana 1 floor.
5. Continue to halt all new admissions and require N95 and face shields for all staff.
6. Consider developing evidence-based guidance on who is released after 10 days and who needs 20 days. ie) define severe disease. Ok to be conservative. Would consider keeping all residents up to 20 days if space allows to be extra cautious.
7. Consider tracking and documenting where else your staff work outside of YOSVH to include those who operate their own care homes or foster homes.
8. Avoid gathering in large crowds and places like break rooms or lunch rooms.
9. Discontinue all nebulizer treatments. This decision is not voluntary.
10. Alcohol station and awareness signs around time clock and other high touch areas.
11. Recommend extremely low threshold to test. Do NOT wait until routine mass testing. Do NOT delay. Test ASAP for any suspicious clinical symptoms even behavioral changes. Do NOT wait for fever as some patients may never mount fever.
12. A central nursing station can be a risk factor on a floor where there is mixing of non-COVID wings with PUI or COVID wings. Staff need to be cautious when using common areas. Perhaps a separate work area is needed for staff working in these special isolation wings.
13. For infected or suspected resident rooms which are not cohorted in the same wing and are mixed with non-COVID rooms, consider either closing the door or installing a temporary partition or curtain to maintain better droplet isolation.
14. Consider a higher staff ratio for the COVID unit and PUI unit than usual for normal nursing room units due to the higher demand of work involved in full PPE.

Summary:

Multiple potential sources of infections brought into the facility by staff who appear to be connected to known community outbreaks, unknown asymptomatic but infectious carriers (staff), and community outbreak exposure at a dialysis center. Complacency by staff initially also played a part as evidenced by break room use and loose mask usage by some staff. Knowing exactly which staff may have had community exposure (ie. 2nd jobs, care home operator, home health, etc…) would have been useful to preempt suspected exposures.

It does not appear that nebulizer treatments contributed to spread at this time but the option of nebulizer use should be a non-issue.

Testing was conducted numerous times routinely but residents/staff could have been tested sooner on a as needed basis rather than wait for the next round of scheduled testing. Some staff did so by testing in other locations outside of the facility. Doing the same for residents may have caught infections sooner, in addition to maintaining a very low threshold for testing based on a growing list of subtle symptoms to include behavioral changes, non-respiratory symptoms like GI issues, etc…

Once infections were known, in addition to a COVID unit, a PUI unit should have been created or at least an attempt to cohort PUI patients. This should not have been a voluntary directive. I believe this would have served to slow spread.

Cohorting strategies should include separate work stations for staff dedicated to such units to avoid cross contamination issues.

The issue of wandering dementia patients is a complex issue in the nursing home and is difficult to deal with within current nursing home regulations which discourages physical or chemical restraints of any kind unlike in acute care facilities. More attempts like the use of physical barriers like dementia stop signs could be utilized or keeping them separated into a separate "unit" using plastic curtains should have been considered.

Conclusions:

I believe the nursing home culture at YOSVH was one that remained entrenched in pre-COVID norms of respecting individual resident rights over the health of the general population. This was evidenced by not cohorting residents due to resident refusal to move rooms, not stopping all nebulizer treatments due to resident refusal, and allowing dementia patients to wander without an attempt to restrict their movements. In this pandemic crisis, these were major errors that contributed to infectious spread, in addition to the many concerns already identified above.

As for the staff, despite all good intentions, new infections were identified among staff with every facility-wide testing, five to date. With community positivity rates in the Hilo area far below 5%, it is unlikely that this can be attributed to community acquired COVID. I believe that staff acquired COVID at the YOSVH due to less than optimal day-to-day personal prevention practices as well as the lack of good systemic practices which may have limited individual exposure like better cohorting strategies, stricter PPE use in common areas like the central nursing area or an alternate set-up made available for them that would limit contamination, and higher staffing ratios in the COVID unit.

My final recommendation is to schedule follow on visits and/or support the federal VA team's efforts to return, possibly embed with local staff, and monitor compliance with suggested recommendations to prevent further spread and hopefully, prevent further loss of life.

Respectfully Submitted,

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