HAWAIʻI COVID-19 JOINT INFORMATION CENTER

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NEWS RELEASE

FOR IMMEDIATE RELEASE
September 21, 2020

TWO OF THREE REPORTS RELEASED ON COVID-19 CLUSTER AND DEATHS AT YUKIO OKUTSU STATE VETERANS HOME

HONOLULU – Two reports detailing in-depth assessments of conditions and protocols at the Yukio Okutsu State Veterans Home (YOSVH) in Hilo, have been developed. The assessments were conducted separately by the U.S. Department of Veterans Affairs (VA) and the Hawaiʻi Emergency Management Agency (HI-EMA). The VA and HI-EMA assessment reports are attached with this release.

The Dept. of Health's (DOH) Office of Health Care Assurance (OHCA) is preparing a report on its inspection of infection control measures based on State and Centers for Medicare and Medicaid Services standards and requirements. The OHCA inspection report is still undergoing internal review and will be shared soon after YOSVH receives it. The home is operated by Avalon Health Group, under contract to the State of Hawaiʻi.

Each of the two assessments highlights different observations, and in some cases places more emphasis on certain factors over others. Dr. K. Albert Yazawa, conducted the HI-EMA assessment and wrote, "I believe the nursing home culture at YOSHV was one that remained entrenched in pre-COVID norms of respecting individual resident rights over the health of the general population." HI-EMA's involvement was requested by the Hawaiʻi Health Systems Corp. and Dr. Yazawa collaborated closely with the VA assessment team.

The VA report noted "There was very little proactive preparation/planning for COVID. Many practices observed seemed as if they were a result of recent changes. Even though these are improvements, these are things that should have been in place from the pandemic onset and a major contributing factor towards the rapid spread. A basic understanding of segregation and workflow seemed to be lacking even approximately 3 weeks after first positive."

The HI-EMA assessment indicates in June full facility staff and resident mass testing was conducted and all tests came back negative.

The VA team sent seven medical and health care experts to visit YOSVH on Sept. 11. At that time the team reported ten (10) residents had died from coronavirus and another 35 were positive. The number of recovered patients and the status of the home's staff members are contained in the VA report.

Neither the VA or HI-EMA report pinpoints the exact sources of infection. Both reports indicate some patients may have been exposed in early August after going for dialysis in Hilo.

Select Deficiencies

Veterans Administration Assessment	Hawai'i Emergency Management Agency Assessment
Residents not cohorted based on COVID status	Patient movement between units
Inconsistent mask usage by residents	Wandering residents (dementia)
Intermixing of housekeeping/maintenance staff between units	Staff gatherings at work and in the community
Little proactive preparation	Lack of physical distancing measures for staff & patients
Numerous examples of potential infection from cross-contamination	Concerns about continued staff positives after mass testing

Both the VA and HI-EMA assessments recommend immediate discontinuation of nebulizer use, with the HI-EMA report stating, "Discontinue all nebulizer treatments. This decision is not voluntary."

Select Recommendations

Veterans Administration Assessment	Hawai'i Emergency Management Agency Assessment
Additional hand sanitizer units	Outsource testing to free up staff
Encourage staff breaks outdoors	Continue to halt new admissions
Consistent staff assignments to avoid cross-contamination	Employ extremely low testing thresholds
Regular risk mitigation training	Higher staff ratio for COVID-19 unit
Leadership presence on all shifts for compliance, accountability & risk identification	Eliminate staff complacency toward safe practices, internally and externally

The Veterans Administration formed a 20-person "Tiger Team" to help implement recommendations, provide training and oversight, and to provide needed staffing support and respite, at YOSVH.

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