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PRESS RELEASE

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IDVA Launches Independent Investigation of Recent LaSalle Veterans Home COVID-19 Outbreak

Department immediately adopts all infection control recommendations in [newly released IDPH and U.S. VA reports](#)

LASALLE – The Illinois Department of Veterans Affairs (IDVA) released two reports today, in partnership with IDPH and the U.S. Department of Veterans Affairs that address the recent outbreak of COVID-19 at the Illinois Veterans' Home in LaSalle. IDVA is adopting all recommendations in the reports in all four of the Illinois Veterans' homes and is releasing the reports in their entirety to the public. The administration has also ordered the Acting Inspector General from the Illinois Department of Human Services, to conduct an independent investigation of the circumstances surrounding the outbreak at the LaSalle home and will immediately address any findings from that investigation.

"As a proud Army Veteran, I take the mission of safeguarding the wellbeing of our Veteran heroes very personally," said IDVA Director Linda Chapa LaVia. "These brave men and women sacrificed everything fighting for the freedoms we so often take for granted. It is our moral obligation to care for them just as they have cared for us. The recent outbreak of COVID-19 and subsequent loss of lives at the LaSalle Veterans' Home is a tragedy. My heart goes out to the families and loved ones of those who have become ill and those who have passed on. The IDVA is committed to a transparent review of the circumstances surrounding the outbreak and has adopted all recommendations from the IDPH, CDC, CMS and U.S. VA moving forward."

"Long-term care facilities, like our Veterans' homes, are at greater risk for COVID-19 spread," said IDPH Director Dr. Ngozi Ezike. "Increased spread of the virus in the community can also threaten residents in long-term care facilities as health care workers can be exposed to COVID-19 while away from work and then inadvertently introduce the virus into the facility. We can all help protect our honored heroes in our Veterans' homes by decreasing the amount of virus circulating in our communities by staying home as much as possible, wearing our masks, and watching our distance."

Consultative Infection Control Visit Illinois State Veterans Home at LaSalle 11/12/2020
VISN 12 Infection Control Lead: Amelia Bumsted, DNP, RN, CIC, FAPIC

Background:

The Illinois State Veterans Home at LaSalle is a free-standing long term and rehabilitative care facility serving veterans and their eligible dependents. It has four main residential units (W, NW, E, NE) with two having been activated to serve as isolation units for those on quarantine or isolation for suspected or confirmed COVID-19.

The following is a summary from interview notes for the purpose of guiding the on-site consultation—please reference the facility’s subsequent reports for exact timeline, actions and numbers.

On or around November 6, 2020, VISN 12 leadership was notified by Hines VA Hospital that the LaSalle state veteran’s home was experiencing an outbreak of COVID-19 in both veterans and staff. The initial discovery of the outbreak occurred when a resident was sent to the hospital for urosepsis on 11/1/2020 and was found to be COVID-19 positive. All residents were screened for symptoms and a few had been found newly symptomatic. Around 11/3/2020, routine surveillance testing results (performed 10/31/2020) were starting to return—identifying 2 positive staff members and 22 residents. LaSalle then performed campus-wide testing and found 8 positive staff and 48 positive residents. Positive residents were consolidated onto separate, newly established isolation units. Syndromic surveillance was used along with antigen testing to identify new potential cases for isolation. Exposed residents and units with identified transmission were all being placed on quarantine and symptomatic residents were promptly isolated. On 11/9/2020, LaSalle reported three residents who had tested positive for COVID-19 had died on 11/8/2020. Both through routine retesting as well as testing symptomatic veterans and staff, an expansion of the outbreak with significant numbers (59 residents, 65 staff) and ongoing transmission was identified. LaSalle was confirmed to have already been in communication with the Illinois Department of Public Health (IDPH). On 11/10/2020, four additional deaths were reported, and consultation was sought to explore potential opportunities for containment/control not otherwise previously implemented or identified. Infection Control lead reached out to administration on 11/10/2020 and conducted a telephone assessment on 11/11/2020. At the time, there were 73 positive residents in-house, 7 deceased, with a total current census of 121 residents (resident infection rate ~63%) and 84 positive staff after 12 newly reported cases out of ~200 staff (staff infection rate ~42%). Latest totals 93 positive veterans (78 in house), 15 deaths, and 90 positive staff with isolation periods/recovery status pending change to “recovered” status for a significant number of both staff and veterans.

Consultation:

The VISN 12 Infection Control lead performed a one-day, onsite consultation at the Illinois State Veterans Home at LaSalle on 11/12/202. Preparation for the consultation included reviewing submitted Issue Briefs from the Hines VA facility and obtaining background and history via telephone (11/11/2020) from the administrator at LaSalle State Veterans Home. The onsite consultation involved meeting with the facility administrator, the Infection Control nurse (Adam), the assistant director of nursing (Danielle), and the facility’s medical director (Dr. Morrow). A representative from the Illinois Department of Public

Health (IDPH) also arrived for a consultative visit on 11/12/2020 and performed tour and consultation in collaboration with VISN 12 Infection Control lead.

A building tour was conducted observing staff and resident behaviors as related to infection control. The LaSalle Infection Control nurse provided escort and explanation of processes and practices related to COVID-19 to both the VISN 12 Infection Control lead and the representative from IDPH.

At the conclusion of the onsite consultation, a joint out-briefing was conducted by the Infection Control lead and the IDPH representative with the facility administrator, the assistant director of nursing, Infection Control nurse, facility medical director, and representatives from logistics/purchasing, housekeeping and building/facilities management. Briefing prior to exit verbally provided all findings and included the immediate areas for intervention pending provision of this final written report.

BULLETED HIGHLIGHTS OF REPORT:

- *Tork* brand alcohol free foam hand sanitizer (main ingredient--Benzalkonium Chloride 0.13%, **not found to be an effective agent against COVID-19**) found stocked in all the mounted dispensers in the facility, including in resident rooms. This could have significant impact on the transmission of COVID-19 within the facility. This was brought to the immediate attention of the facility and plans for correction included:
 - immediately place alcohol-based hand sanitizer pumps in all the clinical areas (in process while on site);
 - remove all product from the dispensers so they are not inadvertently used while awaiting replacements
 - have purchasing contact the vendor about replacement of the product with alcohol-based version (confirmed that *Tork* does make this). Potentially arrange with vendor for an exchange of product already on site.
- Ensure appropriate protocols are followed for terminal cleans and time between positive patient vacating and negative patients being placed into a room.
- IDPH requesting testing with PCR every 3 days until transmission under control. May utilize antigen testing additionally and for ongoing surveillance
- Staff management—changing into/out of scrubs at work during outbreak, staggering breaks, avoiding smoking together in cars or socializing at gatherings outside of work, avoiding floating staff & promote unit-based staff “bubbles.”
- Appropriate use of PPE, and appropriate PPE (suspend use of the Viri-mask until IDPH provides feedback, don’t wear gowns in the common areas of non-COVID/non-cohorted units, gloves to be worn for isolation rooms and tasks—including when charting on Microsoft Surface felt-coated keyboard
- Recommend building engineering staff seek separate consultation regarding HVAC/ventilation and negative pressure concerns

1. Screening:

The screening process for all entering the facility through the main entrance was adequate for non-outbreak circumstances. There was signage posted and a controlled entry point. All appropriate symptoms and exposure-related questions were listed on a self-certification form and recorded by the visitor along with the visitor name and location/purpose of visit. Active temperature monitoring

was conducted. At the staff entry, however, a different form was used which did not list all the screening questions/symptoms. Although it was explained that there is a dedicated staff member to perform temperature monitoring, there was no one stationed there at the time of the visit.

Opportunity:

During an outbreak, active review of the symptoms which includes having someone ask the screening questions, should be done with both visitors and staff. All relevant symptoms should be included in the staff screening. The following document can be adapted and posted at all entry points and in break areas to assist with guiding screening (current symptom list as of 11/13/2020):



SCREENING
POSTER.pdf

Critical staffing shortage strategies should be reviewed and coordination with IDPH, administration and Infection Control staff to ensure appropriate actions taken for quarantine, isolation, or return to work.

2. Testing:

Discussion was had regarding testing strategies for outbreak investigation as well as ongoing surveillance activities. A big challenge with testing-related decisions in an outbreak is the ability to get those results back in a timely manner. This seems to be a challenge with tests sent out to Chicago IDPH lab, which was necessary at the beginning of the outbreak due to the Springfield lab being temporarily closed. Recognition of an outbreak is difficult when test results trickle in, as the correlation between time and location is hard to demonstrate without all the information available. IDPH representative suggested that the Springfield lab should place a priority on the LaSalle samples during the outbreak.

Per the IDPH representative, the state would like testing with **PCR test** at IDPH lab for all staff to be performed every three days (all tests collected and at lab in 24 hours). They specified that it should be 100% of the staff tested on a single day, and not spread over multiple days. There was concern from the facility that labor partners require more time/notice for testing. It was recommended by IDPH to seek advisement on emergency circumstances vs bargaining contract to ensure the health and safety of staff and veterans. Use of the point of care antigen test as a screening prior to work shift can be done as well, but per IDPH should not be substituted for the every 3 days PCR testing until the outbreak is under control. IDPH can provide further guidance on the frequency of testing in response to this outbreak depending on the results of the testing and time between positive tests.

3. Point of care testing:

The Abbott Binax-Now point of care testing system was been brought online at LaSalle (delivered at the end of the day on the date of consultation 11/13/2020). There were some questions as to how to best utilize this resource as a part of the overall testing strategies. The first thing to understand about this system is its limitations. There is a very specific timeframe (first seven days of symptom onset) for which the manufacturer indicates it is effective. It loses its correlative accuracy with its PCR counterparts after day 7. Therefore, one could argue its utility in serial testing would be greater

than as a prevalence study tool providing just a “point in time” snapshot—where a PCR test might have greater strength. A known limitation of this test is the time between obtaining the sample and time the test is run. Per manufacturer’s instructions (<https://www.fda.gov/media/141570/download>), it is best to test within a minute of obtaining the sample and no longer valid after 1 hour of obtaining the sample. This should be built into the process and policy/procedure for testing with the POC test, which was not reviewed during the consultation as the testing medium had just arrived on station.

Follow-up with molecular/PCR testing should be done for those with positives and clinical symptoms/suspicion of COVID-19. Repeat testing in 48-72 hours after a negative PCR test in a clinically symptomatic veteran is prudent while maintaining isolation precautions. Evidence supports the practice of maintaining isolation after just one negative PCR if there is clinical suspicion. Infection Prevention should develop algorithms for this process along with the medical director and in consultation with the health department in the context of this outbreak.

4. Environment of Care:

- a. The facility was very clean. There were no observed issues with high/low level dust, debris, or soiled surfaces in common areas or resident rooms. The resident rooms were very organized and generally free of clutter. Medication and nutrition rooms were sanitary, and supplies were appropriately stored. A terminally cleaned room was inspected, and all furnishings and high-touch areas appeared sanitized. Housekeeping staff provided the facility’s checklist for regular terminal cleaning of resident rooms and was able to appropriately speak to their process.
- b. Recently added UV light disinfection to the facility protocols—recommend developing written standard operating procedure/policy & procedure for its use that reflects manufacturer’s recommendations for cleaning prior to using UV light for disinfection.
- c. Limited hours of service of housekeeping (not available on 3-11 shift) could create a concern for the adequacy of terminal cleaning after moving patients, such as the many bed movements that were necessary when initially separating the positive patients from the negative patients and consolidating wards.
 - a. Ensure the appropriate amount of time elapses for the room to settle after a positive patient with aerosol-generating procedure (C-PAP) before turning over to place another patient in the room. With the air changes potentially low, the time required could exceed 90 minutes. It was stated that this may not have occurred with all the moves that were done.
- d. The janitor’s closet had opened, undated large containers of concentrated bleach, but there were no standard operating procedures available regarding the mixing and labeling of bleach solutions.
- e. **Tork brand alcohol free foam hand sanitizer (main ingredient--Benzalkonium Chloride 0.13%, not found to be an effective agent against COVID-19) found stocked in all the mounted dispensers in the facility, including in resident rooms. This could have significant impact on the transmission of COVID-19 within the facility.**

CDC does not have a recommended alternative to hand rub products with greater than 60% ethanol or 70% isopropanol as active ingredients. Benzalkonium chloride, along with both ethanol and isopropanol, is deemed eligible by FDA for use in the formulation of healthcare

personnel hand rubs. However, available evidence indicates benzalkonium chloride has less reliable activity against certain bacteria and viruses than either of the alcohols.

Recommendation:

This was brought to the immediate attention of the facility and plans for correction included:

- immediately place alcohol-based hand sanitizer pumps in all the clinical areas (in process while on site);
- remove all product from the dispensers so they are not inadvertently used while awaiting replacements
- have purchasing contact the vendor about replacement of the product with alcohol-based version (confirmed that *Tork* does make this). Potentially arrange with vendor for an exchange of product already on site.

5. Ventilation

There were multiple questions and potential concerns with the ventilation in the facility. Poorly ventilated indoor spaces increase the potential of transmission of COVID-19. Ineffective negative pressure or inadequate air-changes/exchanges can also increase the likelihood of transmission, especially in the case of patients undergoing aerosolizing-generating procedures. Appropriately fitted, medical-grade N95 respirators are a major component of worker safety in caring for patients with COVID-19.

- a. Hines VA provided an emergency supply of N95s. Supply should be evaluated, and purchasing should prepare to replenish to maintain contingency supply to support heightened PPE requirements/recommendations for the outbreak/quarantine management.
- b. Donated Viri-Mask sample was provided to IDPH representative to have health department consultant evaluate for appropriateness for use as PPE. Until a determination is made, discontinue use in the clinical setting where an N95 respirator is required for PPE.
 - a. Note—despite the product having verbiage indicating its use as a half-face piece respirator, it does not have the “universal fit” benefit that an elastomeric respirator has and may fail to provide an adequate seal. The model that was provided was a “medium” and did not seal on the bottom of the chin despite using the adjustment straps.
- c. Single-patient rooms connected by an adjoining bathroom raise an additional concern for COVID-19 transmission and should be considered as you would a dual-occupancy room as it pertains to contact tracing and placement decisions.
- d. Ventilation observed in some of the resident rooms (ex. on E unit): supply (either heat/cool) is manually turned on and only feeds the very far end of the room. The exhaust pulls air immediately into the wall system and may be recirculated—was not able to determine if this went through a filter in the wall unit, and if so, what level filter and how often was it changed. The supply near the entry of the room had very little air movement.
- e. Negative pressure—inform that rooms on the NW unit had been recently been converted to negative pressure. Staff explained that patients who were positive were moved to these rooms first when the outbreak began, then were prioritized for symptomatic patients and/or those who were undergoing aerosol-generating procedures like C-PAP or nebulizer treatments.
 - a. The rooms did not have ante rooms and many were dual occupancy.

- b. Room doors were left open with positive patients inside. Staff explained this was due to fall-risk if not directly observed.
- c. Observed the pressure monitors not alarming when doors open and continued to read compliant with -0.01" H2O pressure, however failed qualitative tissue testing.
- f. Not knowing the exact set-up of the HVAC, the vendor settings of installed equipment or other critical details, the full exploration of the facility ventilation is outside of the scope of the consultation provided. The recommendation would be that the facility arrange a separate discussion between infection control and the building engineering department with the vendor who set up the negative pressure. IDPH recommended follow-up in-servicing on the function of the negative pressure and how to assess based on the configuration and equipment. The Infection Control staff can reference ASHRAE for a resource in addition to the CDC guidelines.

<https://www.nafahq.org/covid-19-corona-virus-and-air-filtration-frequently-asked-questions-faqs/>

<https://www.ashrae.org/technical-resources/healthcare-faq>

6. Staff Management and Infection Control Practices

- a. Strict adherence to PPE guidelines is critical and should be reinforced by supervisors, administration, infection control and fellow staff.
 - a. Observed staff donned in full PPE (including gloves, gown, booties, bonnet, face shield and mask) walking through administrative area.
 - b. Observed three staff members in the facility's kitchen with masks around their chins, eating, and all <6 feet from each other.
 - c. Observed staff wearing gloves touch patients and multiple surfaces without changing or performing hand hygiene.
 - d. Respiratory and eye protection should be used in all clinical areas of the facility. Change out N95s at least daily, when wet/soiled or integrity of the mask is compromised, or when returning from breaks.
 - e. Gowns should not be universally used on non-COVID units in the common areas (but should be used for direct patient care in the non-COVID units, as indicated for quarantine PPE).
 - f. Gloves are task-based and should be donned/doffed for specific tasks with appropriate hand hygiene performed before and after. They are indicated for direct patient care for both quarantine and COVID positive isolation.
- b. Especially during an outbreak, consider having staff wear their street clothes into the facility, change into scrubs upon arrival and again changing out of them into clothes from home before leaving. If having everyone change into their scrubs at work is not feasible, prioritize this for those who may have a COVID positive close contact at home or who may be out in the community just prior to coming to work. Everyone should be wearing freshly laundered work attire daily. Also advise staff to have a pair of shoes that are facility-dedicated and changed for work if possible.
- c. IDPH requested during the time period while attempting to reach containment with the outbreak, that each unit be treated as an individual "bubble." Staff should not be floated between units and when possible, cleaning staff and equipment should be dedicated to the COVID units.

- d. Ensure sanitary practices with cell phones, electronics, or non-cleanable keyboards (Microsoft Surface keyboard—has felt coating) Perform hand hygiene and don gloves before touching electronics and doff gloves and perform hand hygiene after completing task.
- e. Staff breaks should be staggered and should not involve multiple people smoking together either outside or inside personal vehicles.
- f. Social gatherings outside of work should be avoided—especially during the outbreak and during times of high community transmission.
 - a. It was reported that a number of employees who eventually tested COVID positive were in attendance at a common Halloween party.
- g. Food and drink should only be consumed in designated areas, after proper hand hygiene is performed, and with appropriate social distancing for co-workers.
- h. EPA-approved disinfectant wipes should be available in all areas where staff work, handle equipment (electronics, phones, patient equipment), or take breaks.

The key for containment of this outbreak will be concentrating on slowing the spread amongst the staff. The recommendations made for strong screening, testing, sanitation, and adherence to social distancing in the workplace will all assist with this goal. Thank you for allowing me to come visit your facility and for all the time your team spent with me to help me understand your program and circumstances better. I am available for follow-up consultation or clarification of any of the observations or recommendations provided on-site and/or in this report.

In good health,

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Follow-up Site Visit to VA Home of LaSalle

Date of Visit: 11/17/2020

Follow-up site visit to VA Home of LaSalle, 11/17/2020, conducted by Michelle Ealy RN BSN MSN-PH, Infection Control Coordinator, IDPH

Also see report of findings and recommendations from initial site visit on 11/12/2020, performed in collaboration by Michelle Ealy and Amelia Bumstead DNP RN CIC FAPIC, Infection Control Manager, Hines VA Hospital, US DVA – document prepared by Amelia Bumstead, incorporating their joint findings and recommendations.¹

Case count: positive COVID individuals as of 11/17/2020

Staff = 92

Resident = 95

Deceased (resident only) = 21

Currently hospitalized (resident only) = 6

Current census: 103 residents as of 11/17/2020

74 COVID positive, all residing on COVID unit

39 COVID undetected, residing on Memory care and East Wing units

Staffing

Interview: Facility leadership states that contingency capacity strategies for staffing are in place and that critical capacity strategies are not required at the time of this visit. As of this visit date, 36 furloughed and quarantined staff have returned to duty.

PPE

Observation: All staff providing direct resident care were donned in disposable face shield, gown, mask, head and foot coverings. All COVID unit staff were wearing NIOSH-approved, fit-tested N95 respirators.

Comment: At the initial site visit, a question was raised as to the appropriateness of the ViriMask product that was in use by some staff members. At the conclusion of that visit, it was recommended to suspend use of the ViriMask in clinical settings where an N95 respirator is required, pending a determination on this question. Consultation with an industrial hygienist after the visit determined that the ViriMask is not an appropriate substitute for an N-95 respirator. Therefore, the facility was advised

¹ The initial site visit was dated as November 13 in the report; the actual date was November 12.

to discontinue use of the ViriMask, and to use only NIOSH-approved N95 respirators, where this item of PPE is needed. This recommendation has been followed.

Hand hygiene access

Observation: The facility has multiple free-standing pump bottles of alcohol-based hand rub (ABHR), at or near the wall-mounted dispensers, throughout the facility. The wall-mounted dispensers are now labeled "Do not use" and are now empty.

Interview: Dispenser refills of ABHR were ordered after the last site visit but they are out of stock at the usual supplier. Procurement from an alternate source is being explored.

Comment: On the initial site visit, it was observed that two types of hand sanitizer were in use. The product in the free-standing hand pumps was alcohol-based. The product in the wall-mounted dispensers was alcohol-free rather than alcohol-based. It was recommended to remove the alcohol-free product from use. This recommendation has been followed.

Symptom screening of staff & visitors

Observation: Since the initial visit, entry screening of staff and visitors has been modified as follows:

- Screening for symptoms is conducted verbally and face-to-face, rather than by a self-certification form. Staff members positioned at the entry point perform both the symptom screen and the temperature screen. This modification followed the recommendation from the initial visit.

Testing of staff

Interview: Facility reports that:

- They continue to do PCR tests of staff at weekly intervals with a time frame for sample collection of three days (Monday, Tuesday, Wednesday), due to staff schedules and days off. They have scheduled an increase of frequency to every 3-4 days (twice weekly), starting with the next test cycle.
- They received 640 *BinaxNOW™ COVID-19 lateral flow antigen test cards* and initiated daily pre-shift testing of all staff on November 13. This testing has identified two asymptomatic staff as carriers between November 13 and 17. Additional test cards have been ordered for delivery this week.

Comment: On the initial site visit, due to the recent increase in test positivity rates in both the community and at the facility, and consistent with new IDPH emergency rules, it was recommended to increase PCR test frequency, from weekly to every 3-4 days (twice weekly). Collecting these PCR samples on all staff on the very same day is not essential. The reason is that staff who are off duty on a PCR test day will still be screened upon return by the lateral-flow antigen test (and they can have a PCR sent at that time as well).

Recommendations:

- Continue both pre-shift rapid antigen testing of all staff and twice-weekly PCR testing for at least 14 days and until transmission has dropped dramatically; further recommendations on adjustment of test frequency will follow at that time.

- Begin daily rapid antigen testing of residents who have not been detected as COVID-positive, but who have potentially been exposed to infected staff or residents, for 10-14 days after exposure.

Compliance with masking and social distancing

Interview (Infection Preventionist and Facility Administrator): Opportunities for transmission among some staff may have occurred due to reported laxity of masking and social distancing while off duty and also during break periods while on duty. Increased monitoring has been initiated.

*Out-briefing of LaSalle DVA staff: 11/17/2020
Written report submitted: 11/23/2020*