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**INVESTIGATION OF THE NEW JERSEY  
VETERANS MEMORIAL HOMES AT  
MENLO PARK AND PARAMUS**

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United States Department of Justice  
Civil Rights Division

United States Attorney's Office  
District of New Jersey

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**TABLE OF CONTENTS**

- I. SUMMARY OF FINDINGS ..... 1**
- II. INVESTIGATION ..... 2**
- III. BACKGROUND ..... 2**
- IV. FINDINGS ..... 3**
  - A. The Veterans Homes’ Initial Response to COVID in 2020 Violated the Constitutional Rights of Their Residents ..... 4
    - 1. Though the Exact Number of Early COVID Deaths is Unknown, the Total Number of Veterans Homes Resident Deaths During the Pandemic’s First Wave in 2020 Was Extraordinarily High ..... 6
    - 2. The Veterans Homes Failed to Implement Basic Infection Control Practices: Personal Protective Equipment and Hand Hygiene ..... 8
    - 3. The Veterans Homes Failed to Implement Basic Infection Control Practices: Cohorting and Social Distancing ..... 9
    - 4. The Veterans Homes Failed to Monitor Exposed Residents for COVID Symptoms. 10
    - 5. The Veterans Homes Have Been Unable to Maintain the Progress Made in 2020 with the Assistance of the United States Department of Veterans Affairs ..... 11
    - 6. The Veterans Homes Failed to Maintain Staff Morale or Trust in DMAVA and Facility Leadership as COVID Emerged in 2020 ..... 12
      - a. Communication Failures ..... 12
      - b. Distrust between Management and Staff: Mask Wearing ..... 13
      - c. Paramus: Closure of Building 2’s Employee Entrance..... 14
    - 7. The Veterans Homes’ Poor Communication with Family Members Left Them Unable to Make Healthcare Decisions for Residents During the Pandemic’s Early Days ..... 15
  - B. Ongoing Conditions: The Veterans Homes’ Continued Inability to Implement Basic Infection Control Practices Exposes Their Residents to a Substantial Risk of Harm ..... 17
    - 1. The Veterans Homes Fail to Properly Train Their Staff to Ensure Compliance in Infection Control ..... 17
    - 2. The Veterans Homes Fail to Adequately Implement Measures to Prevent and Control the Spread of COVID..... 18
      - a. Both Facilities Fail to Properly Use Personal Protective Equipment ..... 18
      - b. Both Facilities Lack Appropriate COVID Testing Policies and Fail to Implement Their Existing Policies ..... 20
      - c. Both Facilities Use Inconsistent and Ineffective Contact Tracing..... 21
      - d. Both Facilities Fail to Properly Cohort, Isolate, and Monitor Residents..... 22

e.	Both Facilities Fail to Disinfect Surfaces or Ensure Proper Handwashing .....	23
f.	The State’s Reported Improvements to Disease Prevention are Inadequate .....	23
C.	Ongoing Conditions: The Veterans Homes Systematically Fail to Provide Adequate Clinical Care, Exposing Residents to a Substantial Risk of Harm.....	23
1.	The Veterans Homes’ Ongoing Failures to Adequately Monitor for Changes in Condition Expose Veterans Homes Residents to a Substantial Risk of Harm .....	24
2.	The Veterans Homes’ Ongoing Failures to Create and Adhere to Individualized Care Plans Expose Veterans Homes Residents to a Substantial Risk of Harm.....	25
3.	The Veterans Homes’ Ongoing and Systematic Failures to Implement Fall Prevention Measures Expose Veterans Homes Residents to a Substantial Risk of Harm .....	28
4.	The Veterans Homes’ Ongoing and Systematic Errors in Medication Administration Expose Veterans Homes Residents to a Substantial Risk of Harm .....	29
5.	Wound Care at the Veterans Homes Exposes Veterans Homes Residents to a Substantial Risk of Harm.....	31
6.	The Veterans Homes’ Ongoing Failure to Ensure Basic Medical Care Competency Among Staff Exposes Veterans Homes Residents to a Substantial Risk of Harm.....	32
D.	Ongoing Conditions: DMAVA’s Failure to Adequately Oversee Care in its Veterans Homes Exposes Residents to a Substantial Risk of Harm .....	33
1.	DMAVA Fails to Ensure Appropriate Oversight and Accountability.....	33
2.	DMAVA and Veterans Home Leadership Contribute to an Adversarial Culture and Low Morale.....	36
3.	DMAVA’s Self-Reported Efforts.....	37
4.	DMAVA’s Inadequate Cooperation Impeded DOJ’s Investigation .....	37
E.	The Veterans Homes Continue to Have High Mortality Rates.....	38
<b>V.</b>	<b>RECOMMENDED REMEDIAL MEASURES .....</b>	<b>39</b>
<b>VI.</b>	<b>CONCLUSION .....</b>	<b>40</b>

## I. SUMMARY OF FINDINGS

The United States Department of Justice finds reasonable cause to believe that the State of New Jersey has systematically violated the Fourteenth Amendment rights of the residents of the Veterans Memorial Homes at Menlo Park and Paramus, two state-run nursing facilities for veterans and their families. Those violations continue. Pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997b, we provide this report to notify New Jersey of the Department's conclusions with respect to those violations, the facts supporting those conclusions, and the minimum remedial measures necessary to address the identified violations.

The Coronavirus disease 2019<sup>1</sup> (COVID) outbreak in March and April of 2020 devastated the Veterans Memorial Homes at Menlo Park and Paramus (collectively, the Veterans Homes). One worker described the situation in Paramus as “pure hell.” Another described Menlo Park as “a battlefield.” Even by the standards of the pandemic's difficult early days, the facilities were unprepared to keep their residents safe. A systemic inability to implement clinical care policy, poor communication between management and staff, and a failure to ensure basic staff competency let the virus spread virtually unchecked throughout the facilities. During the first wave of the pandemic, the Veterans Homes had the first and fourth highest number of publicly reported resident COVID deaths of all long-term care facilities in the State of New Jersey. As discussed below, the actual number of COVID deaths was likely much higher.

This report will first recount the events of those early days and how the initial chaos decreased but did not end (Section IV.A). It will turn next to continuing issues that place the residents of the Veterans Homes at an ongoing risk of harm (Sections IV.B, IV.C, and IV.D). In summary, the initial crisis abated somewhat only when the United States Department of Veterans Affairs (U.S. Veterans Affairs) arrived at the Veterans Homes in late April 2020. U.S. Veterans Affairs implemented basic infection control protocols and provided needed leadership. The federal agency left the Veterans Homes with a set of detailed recommendations to continue the progress made. But the New Jersey Department of Military and Veterans Affairs (DMAVA), the state agency responsible for the Veterans Homes, failed to implement those recommendations or otherwise meaningfully reform their infection control practices.

DMAVA has since replaced its Director of Veterans Healthcare Services and the CEOs of each Veterans Home. But the agency did not charge its new leadership with examining what went wrong in 2020 or how the Veterans Homes should learn from those failures to prevent future crises. Without that assessment, the systemic deficiencies exposed by the initial COVID outbreak have continued. Notably, the Veterans Homes' ongoing inability to implement basic infection control protocols continues to place residents at risk of COVID and other serious infections. For example, during the COVID wave brought on by the Omicron variant in late 2021 and early 2022, the

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<sup>1</sup> Coronavirus disease 2019 is the Center for Disease Control's designation for what is commonly referred to as “COVID” or “COVID-19,” <https://www.cdc.gov/dotw/covid-19>.

Veterans Homes had the third and fourth highest death rates, of all recorded causes, of the forty-four similarly sized facilities in the region.

The current risks to residents extend beyond infection control. The Veterans Homes provide deficient basic medical care in several areas, including failures to monitor residents for acute changes in condition, to create care plans that adequately guide clinical care, to prevent falls, to administer medications properly, and to treat pressure injuries and wounds adequately. These ongoing and serious failures harm residents and place residents at risk of serious harm. Though the State reports recent efforts at reform in certain areas, discussed further in Section IV.D, these measures are insufficient to result in the fundamental changes necessary to keep the Veterans Homes' residents safe.

These ongoing failures to provide adequate care violate the residents' Fourteenth Amendment right to conditions of reasonable care and safety while in the custody of the State.

## **II. INVESTIGATION**

On October 27, 2020, the Department of Justice (DOJ or the Department) notified the State of New Jersey of DOJ's intent to investigate the Veterans Homes under the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997. The investigation considered whether the Veterans Homes violate the constitutional rights of their residents by failing to implement adequate infection control measures and by failing to provide adequate medical care. Expert consultants in infection control and medical care in long-term care facilities assisted with the Department's investigation. These experts have spent their careers in long-term nursing care facilities and have extensive clinical care experience. An expert biostatistician also assisted.

In the course of this investigation, we interviewed dozens of witnesses, including current and former staff, Veterans Homes management, and DMAVA leadership. We also spoke with family members, residents, and several U.S. Veterans Affairs staff members who assisted the Veterans Homes during the early days of the pandemic. We and our experts conducted five multiday, onsite visits to the facilities in 2021 and 2022, and reviewed tens of thousands of documents produced by the State.

We would like to thank the State for coordinating DOJ's onsite visits and witness interviews. We also thank all current and former staff members, family members, and residents who spoke with us.

## **III. BACKGROUND**

The State of New Jersey owns and operates three long-term care facilities that provide skilled nursing care to veterans and their families: the Menlo Park and Paramus Memorial Veterans Homes in the northern part of the state and the Vineland Memorial Veterans Home, which is not part of the Department's investigation, in the southern part. The facilities are Medicare providers and open to veterans honorably discharged from the United States military, their spouses, and spouses and parents of service members killed in action during wartime. The State opened the Veterans Memorial Home at Paramus (Paramus), which can house up to 336 residents, in 1986. The Veterans Memorial Home at Menlo Park (Menlo Park) opened in 1999 and has 312 beds.

The State operates the Veterans Homes through DMAVA. Specifically, DMAVA's Division of Veterans Healthcare Services, located in a central office in Lawrenceville, New Jersey, is responsible for the three homes. The CEOs in charge of each home report to the Director of the Division of Veterans Healthcare Services. The remaining staff members in each facility ultimately report to the CEO.<sup>2</sup> In each facility, the leadership structure consists of two assistant CEOs, one for clinical services and one for non-clinical services. Clinical managers, such as the director of nursing, report to the assistant CEO for clinical services. For non-clinical services, the department heads, such as the supervisors of social services, recreation, nutrition, and physical therapy, report to the other assistant CEO.

Before COVID, each facility had six active resident units. Today, some of those units house COVID-positive or COVID-exposed patients. Both facilities have secure, locked dementia units, which residents cannot leave on their own. In March 2020, both facilities were near capacity. In 2022, Menlo Park averaged 190 occupied beds and Paramus averaged 186.

Like the residents of many long-term care facilities across the State, the residents of the Veterans Homes require skilled nursing care. As of September 2022, 52 Menlo Park residents and 67 Paramus residents had "severe" cognitive impairment. For some, the ability to communicate was limited: five Menlo Park residents and seven Paramus residents were unable to speak.<sup>3</sup> Dozens of the Veterans Homes' residents also require substantial assistance with the regular activities of daily living. The Centers for Medicare & Medicaid Services (CMS) data that measures these activities considers a resident's ability to move while in bed, a resident's ability to transfer out of a bed, the level of assistance needed for toilet use, and the level of assistance needed while eating.<sup>4</sup> As of September 2022, 64 residents in Menlo Park needed hands-on assistance with these daily activities, including 26 who needed extensive assistance. In Paramus, 57 residents needed hands-on assistance, a number that included the 17 residents who needed extensive help.

Although this report primarily addresses the Veterans Homes' response to COVID in 2020 and care deficiencies continuing thereafter, infection control concerns at the facilities predated the COVID pandemic. CMS conducted reviews in 2019 and early 2020 in Menlo Park that identified and notified the facility of multiple failures among staff to adhere to proper infection control protocols. In Paramus, the facility's infection control nurse expressed concern about rising resident infection levels as early as September 2018, noting that infection rates had increased after DMAVA replaced full-time, in-house medical staff at the Veterans Homes with outside contractors.

#### **IV. FINDINGS**

We find reasonable cause to believe that New Jersey violated and continues to violate the constitutional rights of the residents of its Veterans Homes. DMAVA fails to ensure that the state-

<sup>2</sup> There is one exception to this general structure. Each facility's employee relations officer reports primarily to the administrator of DMAVA's Office of Employee Relations, bypassing the facility CEOs.

<sup>3</sup> Facilities submit this data to the United States Department of Health and Human Services' Centers for Medicare & Medicaid Services.

<sup>4</sup> These four activities are generally referred to as the "late loss" activities of daily living. They are typically the last physical capabilities people lose as they decline.

run Veterans Homes implement basic infection control practices, provide adequate medical care, or have competent leadership and oversight.

The residents of the Veterans Homes have a Fourteenth Amendment right to conditions of reasonable care and safety.<sup>5</sup> The State’s ongoing failure to implement basic infection control protocols and provide adequate medical care to the Veterans Homes’ residents violates the constitutional rights of individuals who live there.

Residents of state-run long-term care facilities have a Fourteenth Amendment substantive due process right to conditions of reasonable care and safety when they are involuntarily committed,<sup>6</sup> or when they enter into a “special relationship” with the state.<sup>7</sup> A “special relationship” with the state arises from the combination of a custodial relationship, even a voluntary one, plus a deprivation of liberty sufficient to trigger these due process protections.<sup>8</sup> The state also has a Fourteenth Amendment obligation to residents in its custody when there is a “state-created danger” and a state actor acts with a degree of culpability that shocks the conscience.<sup>9</sup>

The substantive due process rights of those in the Veterans Homes encompass the right to essential human needs, such as food, shelter, clothing, and medical care.<sup>10</sup> The state violates these rights when the care provided to those in its custody does not meet the professional judgment standard.<sup>11</sup> Care falls short of this standard “when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.”<sup>12</sup> “Professional judgment, like recklessness and gross negligence, generally falls somewhere between simple negligence and intentional misconduct.”<sup>13</sup>

#### **A. The Veterans Homes’ Initial Response to COVID in 2020 Violated the Constitutional Rights of Their Residents**

On January 21, 2020, the Centers for Disease Control and Prevention (CDC) reported the first confirmed case of COVID in the United States. On February 6, 2020, CMS urged healthcare facilities to prepare for the emerging COVID threat: “[b]ecause coronavirus infections can rapidly appear and spread, facilities must take steps to prepare, including reviewing their infection control

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<sup>5</sup> *Youngberg v. Romeo*, 457 U.S. 307, 315-16, 324 (1982); *Torisky v. Schweiker*, 446 F.3d 438, 443 (3d Cir. 2006).

<sup>6</sup> *Youngberg*, 457 U.S. at 324.

<sup>7</sup> *Ye v. United States*, 484 F.3d 634, 636-37 & n.1 (3d Cir. 2007).

<sup>8</sup> *See Torisky*, 446 F.3d at 446-47 (citing *Youngberg*, 457 U.S. at 319).

<sup>9</sup> *Ye*, 484 F.3d at 637-38.

<sup>10</sup> *Youngberg*, 457 U.S. at 324.

<sup>11</sup> *Id.* at 322-23; *see also Ali v. Ann Klein Forensic Ctr.*, No. 21-cv-00316, 2022 WL 138084, at \*2 (D.N.J. Jan. 14, 2022); *United States v. Commonwealth of Pennsylvania*, 902 F. Supp. 565, 582 (W.D. Pa. 1995).

<sup>12</sup> *Youngberg*, 457 U.S. at 322-23.

<sup>13</sup> *Shaw by Strain v. Strackhouse*, 920 F.2d 1135, 1146 (3d Cir. 1990).

policies and practices to prevent the spread of infection.”<sup>14</sup> The guidance emphasized the need for staff to “comply with basic infection control practices,” including hand hygiene.<sup>15</sup>

New Jersey reported its first confirmed case of COVID in Bergen County, where the Paramus facility is located, on March 4, 2020. Governor Phil Murphy declared a state of emergency and a public health emergency on March 9.<sup>16</sup> By March 16, 2020, Governor Murphy had announced expansive social distancing measures.<sup>17</sup> The order relied on the CDC guidance that “COVID-19 spreads most frequently through person-to-person contact when individuals are within six feet or less of one another.”<sup>18</sup> On March 21, 2020, the Governor ordered New Jersey residents to remain in their homes, with limited exceptions, to reduce the spread of the virus.<sup>19</sup>

COVID officially arrived at the Veterans Homes in late March. Menlo Park sent two residents to the hospital on March 28 and 29, 2020; by March 31, 2020, both had tested positive for COVID. One of those residents died in the hospital on March 31, 2020; the other returned to Menlo Park and died in early April. The leader of Veterans Healthcare Services notified his supervisor of the March 31 COVID death on April 1, 2020, inexplicably reporting the cause of death as pneumonia and writing that the facility had “0 death[s] COVID related.” By April 12, 2020, twenty-five more Menlo Park residents had died; thirteen of those twenty-five residents had tested positive for COVID. The resident population, which was approximately 300 before COVID began, dropped dramatically the next month: by April 25, 2020, sixty-three more residents had died, of numerous recorded causes, and Menlo Park’s total census was 205 residents.

In Paramus, a resident in the Valor Unit, one of the facility’s six active resident units at the time, went to the hospital on March 22 and tested positive for COVID on March 28, 2020. That resident returned to the facility’s Valor Unit on hospice care on March 31, 2020 and died on April 27, 2020. Meanwhile, as of March 31, 2020, six Paramus residents had tested positive for COVID, and one died that day of the virus. The leader of Veterans Healthcare Services reported the March 31 COVID death to his supervisor, writing that the resident had died “with COVID-19 not because of COVID-19.” By April 3, 2020, there had been three COVID resident deaths and four employees tested positive for COVID. From March 31 to April 25, 2020, 84 Paramus residents died; the facility recorded 51 of those deaths as COVID or probable-COVID deaths.

At the time the COVID pandemic began, the Veterans Homes’ policymaking seemed to occur on multiple tracks. Both DMAVA’s central office and the individual Veterans Homes drafted infection control policy documents. Regardless of policy source, DMAVA leadership viewed implementation of policy as the responsibility of the individual Veterans Homes, led by their CEOs. But the CEOs appeared to view themselves largely as intermediaries, passing new policy guidance from DMAVA’s central office to facility staff without assuming ownership over

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<sup>14</sup> CMS Center for Clinical Standards and Quality/Quality, Safety, and Oversight Group, Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (Feb. 6, 2020), <https://www.cms.gov/files/document/qso-20-09-all.pdf>.

<sup>15</sup> *Id.*

<sup>16</sup> Governor Murphy, Exec. Order No. 103, <https://nj.gov/infobank/eo/056murphy/pdf/EO-103.pdf>.

<sup>17</sup> Governor Murphy, Exec. Order No. 104, <https://nj.gov/infobank/eo/056murphy/pdf/EO-104.pdf>.

<sup>18</sup> *Id.*

<sup>19</sup> Governor Murphy, Exec. Order No. 104, <https://nj.gov/infobank/eo/056murphy/pdf/EO-107.pdf>.



the successful implementation of that policy. Likewise, DMAVA’s central office did not exercise significant oversight to ensure the facilities implemented policies safely and correctly. This multi-level leadership failure placed Veterans Homes residents at serious risk of harm.

**1. Though the Exact Number of Early COVID Deaths is Unknown, the Total Number of Veterans Homes Resident Deaths During the Pandemic’s First Wave in 2020 Was Extraordinarily High**

Due to limited testing and a failure to systemically track probable COVID deaths, it is impossible to determine the exact number of Veterans Homes residents who died of COVID during the pandemic’s first wave in 2020. But it is clear that the number of deaths during COVID’s early months was substantially higher than the numbers publicly disclosed, and substantially higher than at other facilities. Before the COVID pandemic, approximately 100 residents died in each Veterans Home in an entire year. In April 2020 alone, 98 Menlo Park residents and 92 Paramus residents died, of all causes.

As of July 2020, the last time the State of New Jersey published cumulative COVID data for long-term care facilities, the reported resident COVID death totals were 81 at Paramus and 65 at Menlo Park, the highest and fourth-highest reported totals in all long-term care facilities in the State at that time.<sup>20</sup> The actual number of residents who died of COVID was far higher. DMAVA based these totals on the cause of death listed on a death certificate. The facilities reported the cause of death as COVID only when there was a positive COVID test. But COVID tests were not readily available during March and April 2020. And residents often died before they were tested. The facilities did not begin universal resident testing until approximately April 20, 2020.

The publicized July 2020 totals therefore excluded probable COVID deaths. An internal accounting that included probable COVID deaths put the numbers higher: 89 residents at Paramus and 101 residents at Menlo Park. The extra 39 deaths in Menlo Park and 8 at Paramus were deaths that met the New Jersey DOH’s criteria for probable COVID deaths: (1) deaths in which COVID was mentioned on the death certificate as something other than the primary cause; and (2) deaths in which COVID testing was never performed but there was a clinical history indicating COVID and a resident did not have “a fully explanatory alternative cause of death” causally unrelated to COVID. Even these numbers, which were reported in the media in October 2020, are likely an undercount due to a failure to systematically monitor and document clinical symptoms of COVID for all residents during the early days of the pandemic.

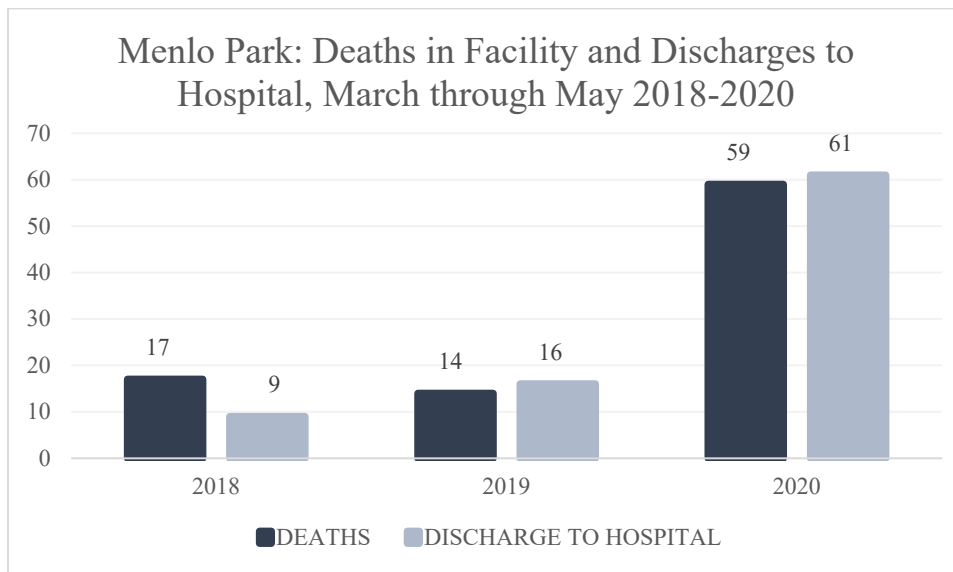
New Jersey’s Department of Health issued guidance, effective March 31, 2020, for tracking probable COVID deaths. According to that guidance, if Patient 1 in a long-term care facility tested positive for COVID, and Patient 2 in the same facility died after exhibiting COVID symptoms, the treating physician should sign the death certificate “listing the cause of death as ‘Probable COVID-19 Infection.’” But according to one medical director, he learned at some point, after using the designation a few times, that presumed COVID would not be accepted on a death certificate. There is no indication that the facilities systematically tracked probable COVID deaths over the early months of the pandemic.

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<sup>20</sup> New Jersey Dep’t of Health, New Jersey COVID-19 Cases (July 27, 2020).

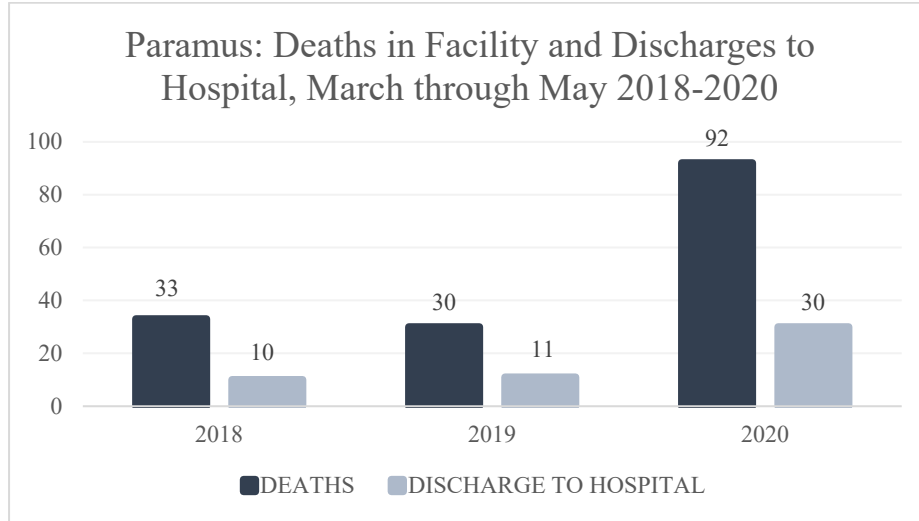
Because the Veterans Homes did not maintain probable COVID death data during the pandemic’s early months, overall death and hospitalization numbers reported to CMS at the time help put the magnitude of the crisis in context. The charts below compare the number of total deaths, of all causes, each facility reported to CMS for the three-month period when COVID began—March 2020 through May 2020—to the number of reported deaths occurring within each facility reported to CMS during the same time periods in 2018 and 2019. The charts also show discharges to a hospital over those same months. Discharges are also significant because many of the residents who were discharged to the hospital during the initial COVID outbreak died there and were not included in the facility death totals reported to CMS and shown in the charts below.<sup>21</sup>

The number of deaths in Menlo Park increased by 247% compared to the same time period in 2018, and discharges to a hospital increased by 578%:



<sup>21</sup> For instance, Menlo Park discharge records for an overlapping time period reflect that, between March 22 and June 8, 2020, 57 residents died, of all causes, while at the facility and 58 residents died after being transferred to the hospital. These 115 deaths are deaths from all causes, not just COVID.

The number of deaths increased by 179% and discharges to a hospital by 200% for the same time period at Paramus:



## 2. The Veterans Homes Failed to Implement Basic Infection Control Practices: Personal Protective Equipment and Hand Hygiene

On March 30, 2020, the New Jersey Department of Health ordered the “universal masking” of all nursing home staff, but the Veterans Homes did not successfully implement that policy. As late as mid-April, U.S. Veterans Affairs employees observed that staff members in both facilities were not wearing masks, were wearing them incorrectly, or did not understand that they needed to change personal protective equipment (PPE) when moving between resident rooms. U.S. Veterans Affairs staff in Paramus observed facility staff members on the units without any PPE, even masks, supervisors entering COVID-positive resident rooms without gowns, and food service workers delivering food onto the units without masks and gloves. Staff members from both facilities reported a lack of initial training on how to don and doff PPE. Many had not been fit tested for N95 masks. There was widespread confusion about when to wear and change gowns.

Other basic infection control measures were not in place well into April 2020. On April 19, 2020, DMAVA’s central office reminded the clinical leadership of both facilities that “[i]t is **extremely** important for staff to wash their hands between care of residents.” (Emphasis in original). But when U.S. Veterans Affairs staff arrived days later, they observed broad deficiencies in handwashing in both Veterans Homes. By late April, there were serious cleanliness issues at both facilities. Housekeeping staff in Paramus had not been properly trained on disinfecting resident areas, including the “terminal cleaning” of rooms required after a COVID-positive resident is transferred or discharged, or tracking which beds were clean and which were dirty. In Menlo Park, the nursing stations were dirty and there was no cleaning of common areas; one U.S. Veterans Affairs staffer reported “ants/bugs everywhere.”

### **3. The Veterans Homes Failed to Implement Basic Infection Control Practices: Cohorting and Social Distancing**

During an outbreak, standard infection control measures require facilities to group residents based on infection status, a practice called cohorting. Cohorting was a familiar concept to long-term care facilities before the pandemic. Paramus's 2020 infection control manual, for instance, contained 2009 guidance instructing staff to create three cohort groups if there is a respiratory outbreak: (1) ill, (2) exposed (not ill, but potentially incubating), and (3) not ill/not exposed. On March 20, 2020, the New Jersey Department of Health issued COVID-specific cohorting recommendations for long-term care facilities. The guidance instructed long-term care facilities to cohort residents, health care personnel, and, if possible, equipment and supplies into the three familiar infection groups—ill, exposed, and not ill or exposed. New Jersey's Department of Health *required* all long-term care facilities in the state to group residents by infection status on April 4, 2020. But by mid-April, both Veterans Homes had failed to cohort residents into those groups, resulting in the comingling of residents and staff and allowing the virus to spread throughout the facilities.

Paramus designated one wing of its Valor Unit to house COVID-positive residents and began to move residents there around March 31, 2020.<sup>22</sup> But the facility did not immediately transfer COVID-negative and asymptomatic residents out of the area, did not close the area to the other wing of the Valor Unit, which housed uninfected residents, and did not close the unit to the rest of the facility. Paramus changed course on April 11 and moved most positive residents to one side of their home units and housed additional COVID-negative residents on the Battalion Unit. But the facility was unable to track and account for its residents. In a widely publicized incident, the switch of the identification bracelets for two Paramus residents resulted in a heartbreaking mix-up for their families. Both residents were COVID-positive and had been transferred from the facility's secure dementia unit to the same room in the Valor Unit. Staff told the family of one resident that he was recovering well from COVID when he had in fact passed away on April 11, 2020. The family of that resident's roommate was incorrectly told he had died. The family of the resident who died on April 11, 2020 learned from the funeral home that their loved one was wearing his roommate's identification bracelet. The other resident—whose family was incorrectly told that he had died of COVID on April 11—died of COVID five days later, on April 16, 2020.

After the misidentification, Paramus stopped all room changes. By late April, it was clear to U.S. Veterans Affairs personnel that the facility had no process for separating COVID-positive residents. Positive and negative roommates were still sharing rooms. There was no clear procedure for housing exposed roommates of positive and presumptively positive residents, or others who would normally be placed in a unit of potentially infected individuals. Because Paramus had positive residents spread throughout the facility, it was impossible to provide dedicated staff for COVID-positive residents.

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<sup>22</sup> Units in Paramus are generally v-shaped and consist of two lettered wings. The Valor Unit, for instance, consists of the T-wing and V-wing, which join at a central nurses' station.

Consequently, when CMS surveyors toured Paramus on April 22, 2020, they found that the facility had failed to group residents by infection status and had no “effective procedure to identify presumptive positive COVID-19 residents from COVID-19 positive residents.” This inability to distinguish between infected and potentially infected residents “resulted in nursing and housekeeping staff’s failure to follow infection control guidelines.” Surveyors further observed that aides were unable to distinguish between COVID-positive and presumptively positive residents, which increased the exposure of residents awaiting test results.

Menlo Park had similar issues cohorting its residents. Sometime during the first week of April, the facility began to move COVID-positive residents to one side of its Stars & Stripes Unit, normally a secure unit for residents with dementia.<sup>23</sup> But the facility did not immediately move all asymptomatic residents away from that wing, exposing uninfected residents to the virus.

Like cohorting, social distancing during an infectious disease outbreak should have been a familiar concept for the Veterans Homes. But the facilities were unable to implement basic social distancing protocols. On March 13, 2020, CMS ordered long-term care facilities to cancel all group activities, including communal dining. On March 19, 2020, a Paramus nurse wrote that mealtime in the Battalion unit was “packed, residents VERY close to each other and staff as well.” As late as April 24, 2020, a visiting infection control nurse in Paramus observed a dining hall with at least two dozen residents without any social distancing. Around the same time, CMS surveyors found COVID-positive residents sitting alongside other residents in the day room of the dementia unit in Paramus.

#### **4. The Veterans Homes Failed to Monitor Exposed Residents for COVID Symptoms**

During the pandemic’s early months, the facilities lacked clear protocols to monitor exposed residents for COVID symptoms, which caused harm to the residents and risked further spread of the virus as likely COVID cases went undetected. The rapid decline of Resident C in Menlo Park provides one example. In early 2020, Resident C, a former Marine, was alert and oriented. He spoke to his family daily and led an art class for residents; his social worker described him as polite, cooperative, and sociable. On April 4, 2020, Resident C’s roommate was hospitalized with suspected COVID. Resident C’s roommate tested positive for COVID at the hospital and died on April 6, 2020. There is no evidence that Menlo Park monitored Resident C for COVID, even as his condition declined in the days after his roommate’s positive test. On April 5, 2020, without explanation, facility staff took Resident C’s motorized scooter and shut the door to his room. He could not leave, could not reach his buzzer to call for staff, and could not access the charger for his cell phone, which left him unable to speak to his family. By April 6, 2020, Resident C’s chart noted “confusion,” and the facility had started him on antibiotics for what was documented in his chart as pneumonia. By the evening of April 6, Resident C was yelling for help. By April 7, 2020, he had a low-grade fever. On April 9, 2020, Resident C was, according to his chart, “observed in bed screaming.” Resident C died on April 16, 2020. His death certificate lists

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<sup>23</sup> Like those in Paramus, resident units in Menlo Park are also v-shaped, with a nurse’s station where the two wings of each unit join.

respiratory failure as the cause of death. There is no mention of COVID anywhere in his chart, and the facility did not count Resident C as a COVID death or move him to a COVID unit. Resident C's family later asked the facility if Resident C's roommate had COVID; they were told "no."

#### **5. The Veterans Homes Have Been Unable to Maintain the Progress Made in 2020 with the Assistance of the United States Department of Veterans Affairs**

U.S. Veterans Affairs provided substantial support to the Veterans Homes between April 20, 2020, and June 1, 2020. Under the guidance of U.S. Veterans Affairs personnel, the situation at the Veterans Homes improved substantially. But DMAVA has been unable to maintain the improvements and declined to implement the comprehensive guidance provided as the federal agency departed the facilities.

Early in the pandemic, U.S. Veterans Affairs offered to house Veterans Homes residents in federal facilities, which had additional space. DMAVA declined the offer and asked for additional staff instead. When U.S. Veterans Affairs arrived at the Veterans Homes in April of 2020, it was clear that the facilities needed not just staff but additional direction and infection control planning. U.S. Veterans Affairs leadership observed that individual staff members at both facilities were trying hard to care for residents but lacked crucial training and an understanding of how to prevent infection. U.S. Veterans Affairs sent additional personnel, including nurses, to train the Veterans Homes staff members to use PPE correctly, perform housekeeping duties in accordance with basic infection control practices, staff appropriately for emergency operations, and track supplies. In addition, U.S. Veterans Affairs assisted in implementing universal testing of residents in late April. With guidance from the U.S. Veterans Affairs, both facilities began to properly cohort residents and implement social distancing.

The leaders of U.S. Veterans Affairs provided detailed recommendations as the agency's mission concluded. The recommendations included draft standard operating procedures for moving residents and for using PPE, along with standalone guidance for COVID testing, cohorting, and core infection control practices. Notably, U.S. Veterans Affairs also made leadership recommendations for both facilities. Those recommendations encouraged the CEOs to empower mid-level and front-line managers, to foster critical thinking, to delegate tasks, which would allow the use of staff expertise, and to improve the flow of communication from management. Regrettably, apart from some communication improvements at Menlo Park, we saw no evidence that either facility meaningfully implemented these recommendations. To the contrary, both facilities remain beset by structural issues that compromise resident care. As discussed below, *see* Section IV.B, the Veterans Homes remain unable to implement basic infection control practices, despite the early efforts of U.S. Veterans Affairs to identify areas where the facilities lacked basic protocols and to provide them with the tools and information to remedy those issues.

## **6. The Veterans Homes Failed to Maintain Staff Morale or Trust in DMAVA and Facility Leadership as COVID Emerged in 2020**

The Veterans Homes' dysfunctional management style and poor communication with staff members in the early days of the COVID pandemic contributed to staffing shortages, which decreased the facilities' ability to keep their residents safe. Upon their arrival in April 2020, U.S. Veterans Affairs staff identified several "critical deficiencies," including "[c]ommunication gaps with leadership [and] staff." Mistrust of management's ability to keep staff safe, fear, disagreements, and unclear communication fueled staffing shortages during the pandemic's early weeks and inhibited the Veterans Homes' capacity to respond to COVID. By April 1, 2020, after news of the positive cases in both homes, there were widespread absences at both facilities. Many absent employees were sick with COVID in April 2020, but others raised concerns to management about the facility's infection control protocols. Less than two weeks after the first positive tests, some Menlo Park shifts were operating with a ratio of one nurse to one hundred residents. By mid-April, a staff union representative raised concerns about the shortages and threats of disciplinary action if staff declined to work extra shifts, writing "[w]orkers are already burned out and people are crying and need counseling assistance and the management is unsympathetic or not helpful."

DMAVA faced staffing obstacles in responding to COVID that some private facilities did not, such as state-established budgetary constraints and low state-set pay rates for staff. But the agency failed to take steps related to staffing that were well within its control, such as communicating with staff members about pandemic precautions or permitting staff to wear masks in March 2020, as COVID spread throughout the country. The poor relationship between facility management and staff impeded the ability of the facilities to provide direct resident care, and, in certain cases, likely contributed to the spread of COVID throughout the facility. As discussed below, *see* Section IV.D, DMAVA has made little effort to remedy this dynamic, placing residents at risk of harm.

### **a. Communication Failures**

DMAVA failed to ensure that the management of each Veterans Home maintained adequate communication with staff during the pandemic's difficult early days and weeks. This left staff uncertain of the protocols that governed resident care and fearful that management was hiding information about the magnitude of the outbreak. DMAVA's Office of Employee Relations is responsible for labor relations and staff issues within the homes. Leadership at the Office of Employee Relations was aware of staff concerns about the Veterans Homes' pandemic response but appeared to leave the response to the facility CEOs. The CEOs were also aware of staff fears but did little to address them. Paramus department leaders raised concerns about communication between management and staff to the facility's CEO as early as April 3, 2020. According to meeting minutes, one participant informed management that "employees believe we are hiding something and we are in a conspiracy against them." Another added that staff "think we are neglecting them and putting them at risk[,] [t]hey are scared and *do not know the procedures* and are mis-informed." (Emphasis added).

When U.S. Veterans Affairs arrived at Paramus later in April, their leadership observed “a notable gap in the nurse leader communication and the nurse leader communication with other department heads at the facility.” At Menlo Park, U.S. Veterans Affairs observed that facility staff members were “fearful of retaliation.” And mid-level managers in both facilities felt that their own supervisors failed to keep them informed of what was happening on a facility-wide level. DMAVA’s Office of Employee Relations was aware of staff concerns about voicing their fears to leadership. Despite this, DMAVA took no significant action to improve communication between facility leadership and facility staff. Instead, DMAVA leadership often appeared indifferent and even hostile to the concerns of employees that provided direct resident care. In an April 7, 2020 email to DMAVA’s administrator of the Office of Employee Relations, a DMAVA leader considered discipline for employees calling out sick due to underlying health conditions in a way that evidenced a lack of understanding of the magnitude of the crisis the facilities faced:

My question is, what makes this different from the influenza, GI and other bugs that run through the homes at any given point during the year? If they are so immuno- compromised that they cannot don PPE and report to work to perform the functions they were hired for, what good are they for the home? When this has run its course, we will be requesting fit for duty physicals for every nurse that submitted such a note, and be looking to separate those that are deemed unfit. If they are so compromised that they cannot be around infection or sickness, why in Gods name are they in healthcare?

In April 2020, a union leader and staff licensed practical nurse at Menlo Park emailed management on April 22, 2020 to express infection control concerns about the process for transporting COVID-positive residents. The employee wrote:

This behavior, of not being transparent, has put the direct care staff at a greater risk. The residents are being herded from unit to unit. Covid-19 is all over the building on every unit. It’s spreading like wildfire. . . . Where is the concern for staff?

Discussing the employee’s concerns, the administrator of DMAVA’s Office of Employee Relations wrote “she’s ridiculous.” A day later, the employee wrote again: “[w]orking with residents without knowing their status, and having the proper training and gear is lethal.”

#### **b. Distrust between Management and Staff: Mask Wearing**

Conflicts between staff and management around COVID arose in 2020 before the Veterans Homes’ first positive cases, much of it centered on management’s decision to ban staff members, without exceptions for high-risk individuals, from wearing masks throughout March 2020, as COVID spread across the country. DMAVA leadership and facility management have provided varying explanations for the ban. But it is clear that the facility CEOs and DMAVA leadership ultimately viewed unauthorized mask wearing as a disciplinary issue, took an adversarial stance toward staff members, and contributed to a sense that management did not care about keeping its employees safe or about employee concerns that implicated both staff and resident safety.



Public health guidance issued throughout March 2020 encouraged mask wearing in long-term care facilities. Multiple staff members in both facilities wanted to wear masks; many wanted to wear masks they supplied themselves. But as the month wore on, and the Governor declared a public health emergency, management responded to employee mask wearing with threats of discipline. On March 25, 2020, staff members received in-service training that forbade mask wearing in the facility’s hallways and in any circumstance other than during direct contact with symptomatic residents.

The Veterans Homes’ decision in March 2020 to ban masks was out of step with outside healthcare providers, who raised concerns about entering the homes. In an email forwarded to Paramus’ director of nursing, one outside pharmacy provider wrote: “I’m a little concerned with what is going on here, the TV [Valor] unit is being quarantined due to several people having fevers, but the administration is telling everyone that they are not allowed to wear masks in the facility.” Despite these concerns, Veterans Homes management saw mask wearing by outside providers as a threat. Menlo Park’s CEO, for instance, asked outside pharmacy personnel and ambulance workers entering the facility to care for Veterans Homes residents to stop sending employees wearing masks: “[w]hen my staff see this they get worried and want to wear masks.” The facilities maintained this position even after the New Jersey Department of Health ordered vendors entering long-term care facilities to wear masks.

Concerns about PPE shortages do not fully account for DMAVA’s no-mask policy. On March 26, 2020, DMAVA considered the case of a Menlo Park kitchen staff employee who had asthma and a doctor’s note permitting him to wear a mask. It appears that the employee wanted to wear his own mask, not one provided by the facility. DMAVA’s Employee Relations Office decided that the kitchen employee would be ordered to return to work without a mask because “[i]t would be bad precedent to allow him to wear a mask, because everyone would just run out and get a doctor’s note and start wearing masks.” The next day, DMAVA’s Office of Employee Relations circulated an update to facility leadership: “I received some guidance from the Gov’s Office of employee relations. We are going to start progressive discipline for mask insubordination.” When asked by DOJ, DMAVA’s administrator of the Office of Employee Relations explained that the “mask insubordination” referenced in the email was theft of facility masks—seemingly meaning any person wearing a facility mask without permission—not unauthorized mask wearing in general. There is little evidence in the numerous communications on this topic, reviewed in detail by DOJ, to support this explanation. In any event, the facilities were ordered to begin universal mask wearing just days later, on March 30, 2020.

### **c. Paramus: Closure of Building 2’s Employee Entrance**

In Paramus, the March 2020 decision to close the employee entrance to building 2 worsened the distrust between employees and management and likely contributed to the spread of COVID throughout the facility. The resident units in Paramus are split between two buildings. Before the pandemic, employees who worked in building 2, which contains four resident units, had their own entrance. By March 15, 2020, the facility closed the building two entrance to create a single COVID screening point. After the closure of the building 2 entrance, the only route from

building 1 to building 2 required a walk, during each shift change, through what was then an active resident unit.

The Valor Unit, where the COVID outbreak began, was in building 2. Staff members, including those who worked on Valor, regularly passed through an active resident unit in March and April of 2020. Ill residents transported out of the facility to the hospital also traveled through resident units. The decision to have staff members who worked with COVID-positive residents walk through units with healthy residents created obvious infection control risks. Union leaders representing clinical staff raised those specific concerns to management: that Valor Unit staff was exposing workers elsewhere in the facility to the virus. But the facility declined to reopen the entrance. The closure of the building 2 employee entrance over the objections of many staff members contributed to a feeling among employees that management would not keep them safe from a virus that was spreading throughout the facility among both residents and staff.

### **7. The Veterans Homes' Poor Communication with Family Members Left Them Unable to Make Healthcare Decisions for Residents During the Pandemic's Early Days**

Family members of Veterans Homes residents had limited access to information in late March and April 2020. This left them desperate for updates and unable to make healthcare decisions for their loved ones. Facility leadership and DMAVA were aware of these widespread concerns. But despite the efforts of staff members in both homes to facilitate video visits and phone calls, families continued to face an information blackout due to DMAVA's failure to provide systematic updates.

DMAVA was aware of Paramus's first COVID case on March 28, 2020. The next day, the Director of Veterans Healthcare services updated the Veterans Homes Facebook page and website: "We have our first confirmed case of the virus in our Paramus home with a resident that has been in the hospital. . . . One unit remains closed in the home." The message did not specify which unit was affected and the facility sent no other communication or information to all family members in the following days. When the first Menlo Park resident tested positive for the virus on March 31, DMAVA did not update its Facebook page or website with that information. As late as April 6, 2020, DMAVA had not publicly confirmed the positive cases in Menlo Park or provided additional updates about the presence of the virus in either facility. This left family members without the information necessary to determine whether they should remove their loved ones from the Veterans Homes.

Family members pleaded for updates. One Paramus department head updated facility leadership about the issue early in the morning of March 30, explaining that the families had asked for more information and suggesting that leadership draft a standard letter or email to families with necessary information. When forwarded the suggestion, a DMAVA leader wrote to the CEOs of both facilities, dismissing the concerns with an inapt comparison: "Not sure what people expect. Do we blanket notify everyone, every time we get a case of the flu?"

DMAVA leadership instructed the CEOs that the facilities' social workers should serve as the primary contacts for residents and family members. But the social workers were not provided

with the necessary information to provide meaningful updates. A Paramus social worker emailed leadership on April 22, 2020, expressing concern that the facility planned to move COVID-positive patients onto a unit with COVID-negative residents and ending with a clear request: “[w]e at Social Services ask you all to please keep us informed as we are updating families all along, with **no** communication about what is going on.”

As the communication failures continued, so did the family inquiries. The daughter of one Paramus resident who died of COVID wrote to the CEO to express her disappointment that an early April 2020 communication to the families failed to mention positive cases in the facility and deprived them of the opportunity to relocate her father. She wrote: “Had we known of the serious situation in NJVHP [New Jersey Veterans Home Paramus] at the same time as you did, we would have had the option to remove my father immediately from your facility or to recommend that he be transferred to a special care unit set up at the hospital for particularly vulnerable patients.” She continued:

At best, this is a serious and heart-breaking failure to communicate candidly with the families of loved ones residing in NJVHP . . . . At worst, this is mismanagement of the most egregious kind. We trusted in you wholeheartedly to be transparent and take the very best care of our loved ones who also happen to be the most cherished and honorable veterans of our nation – but it seems a lethal combination of poor procedures and lack of adequate staffing led you to conceal the real issues you had with containing Covid-19 in your facility.

The families of Menlo Park residents faced a similar information blackout. Menlo Park’s CEO was aware of the issue. On April 6, 2020, the daughter of the first Menlo Park resident to die of COVID emailed facility leadership with a clear warning about the failure to notify the families of the other residents of the facility’s first positive COVID case: “I believe that as the CEO you have a moral and legal obligation to inform all families. This is a very serious matter.”

On April 9, 2020, the children of another Menlo Park resident wrote to the facility expressing concern about their father, noting that they had “left multiple messages asking for a return call to get an update” on the status of COVID in the facility and the condition of their father, who had dementia. They received no reply. Despite multiple requests to facility leaders, and to DMAVA, the resident’s family received almost no information until their father was hospitalized. On April 21, 2020, they wrote: “Our father is clinging to life over at JFK [Hospital]. It is absolutely unacceptable that we entrusted this nursing home to care for our Father and this has become a total disgrace.” Their father had tested positive for COVID when he was admitted to the hospital on April 14, 2020; he died on April 22, 2020. In internal DMAVA communications, a DMAVA legal specialist characterized the family member’s complaints as “legitimate.” Another Menlo Park family member only found out that her father was ill on the evening of April 10, two days after he developed a fever. He went to the hospital, where he tested positive for COVID, around 1:00 p.m. on April 11, 2020. He died two hours later.

DMAVA’s dysfunctional management style led to a defensive and occasionally hostile stance toward the inquiries of family members attempting to make healthcare decisions for their loved ones. On April 6, there was a discussion of hosting a Facebook live to update families, but DMAVA officials decided it was “too risky as the haters would . . . be able to post comments without our ability to hide them if needed.” On April 10, 2020, family members of residents in Paramus’ Valor unit asked “how is it that we found out about 37+ deaths at the VA . . . from the newspaper and not from the VA? . . . Please help us!” When discussing how to respond, a DMAVA leader dismissed the concerns: “[W]e are absolutely all hands on deck providing care, and all they want to do is rally and riot and create disturbance. . . . If they show up to protest, I will have Matt call the police and have them removed from the property.” Another DMAVA administrator responded: “That would require them to actually do something other than email and threaten.”

In Paramus, the family members of the residents who died during the pandemic’s first weeks faced one final heartbreak. Their loved ones’ belongings were piled outside the home, in garbage bags. They remained there until U.S. Veterans Affairs personnel arrived in late April. Some belongings had been damaged by rain.

## **B. Ongoing Conditions: The Veterans Homes’ Continued Inability to Implement Basic Infection Control Practices Exposes Their Residents to a Substantial Risk of Harm**

The systemic infection control breakdowns have continued to the present, including the pandemic’s Omicron wave in 2021 and 2022. Our investigation identified multiple ongoing infection control failures. Specifically, the Veterans Homes still fail to: train their staff properly; monitor staff compliance with infection control protocols; and regularly implement PPE usage, contact tracing, COVID testing, COVID isolation, and cleaning. These failures are substantial departures from generally accepted standards of care in long-term care facilities and inhibit the Veterans Homes’ ability to stop the virus from spreading inside the facilities, creating a serious risk of harm.

### **1. The Veterans Homes Fail to Properly Train Their Staff to Ensure Compliance in Infection Control**

Years into the pandemic, DMAVA still fails to ensure that the Veterans Homes adequately train their staff on infection prevention and control protocols. Without adequate training, Veterans Homes staff are unable to protect their residents from infection, including COVID. Infection prevention measures are critical during a pandemic—the CDC advises long-term care facilities to educate their staff, residents, and visitors about COVID, current precautions in the facility, and actions they should take to protect themselves.

While both Veterans Homes hold annual infection control trainings, neither facility offers comprehensive, updated education to staff in response to the pandemic and frequently updated public health guidance. Instead, the facilities’ in-service trainings to staff are ad hoc, with no reliable process for verifying full attendance. These measures are plainly insufficient. For example, we spoke with one staff member who, despite previously testing positive for COVID, was never told that she should refrain from coming to work if she was still experiencing symptoms

of COVID. In addition, the first Paramus staff member to test positive during a COVID outbreak that began in December 2021 had come to work with symptoms. In another case, a nursing assistant who was assigned to a COVID unit after being on leave for six months received no additional COVID education upon her return.

Although the Veterans Homes are responsible for training contract employees, these individuals do not receive adequate COVID-related training. For instance, a security guard and a receptionist in Paramus responsible for screening visitors to the facility received no training on how to screen visitors for signs and symptoms of COVID. A visiting hospice aide had received no guidance from the facility about caring for a resident during a COVID outbreak. Contract receptionists at Menlo Park did not provide consistent screening instructions and COVID information to visitors when DOJ personnel visited the facility in 2022.

The infection prevention training failures extend beyond COVID. Paramus's recent handling of a resident infected with *Clostridioides difficile* ("C. diff") provides another stark example of shortcomings in infection control training. C. diff is a highly contagious bacteria that causes severe diarrhea, colitis, and can be life-threatening, particularly for individuals in long-term care facilities. Paramus provided no consistent guidance to staff on appropriate infection control precautions for residents with C. diff, which led to staff using inconsistent—and inadequate— infection control precautions, which increased the risk that the infection would spread.

The Veterans Homes also fail to monitor compliance with their infection control protocols or to ensure staff competency. No one in the Veteran Homes' leadership or management has assumed responsibility for ensuring their infection control programs and guidelines are adequately implemented, and indeed, they lack even basic data to do so, as discussed in Section IV.D, below. Despite their best efforts, the Veterans Homes nurse educators have too much responsibility and too little support. Menlo Park's nurse educator, for instance, has not been given the resources to track and confirm in a systematic way that staff are competent in implementing basic infection control precautions. A September 2022 CMS survey of Menlo Park found not only inadequate training in specific areas of infection control, but a failure to ensure compliance as well.

The ongoing failure to ensure basic competency in infection control creates a risk of harm for residents in two ways. First, the staff cannot take basic measures to keep residents from spreading infection among themselves. Second, infections among staff spread, which creates an additional risk to the residents. Notably, in December of 2021, at the beginning of COVID's Omicron wave, we identified multiple COVID infections among the staff in Menlo Park followed shortly thereafter by new infections among residents in the same units. Were it not for these lapses in infection control, the spread of COVID would likely have been better contained.

## **2. The Veterans Homes Fail to Adequately Implement Measures to Prevent and Control the Spread of COVID**

### **a. Both Facilities Fail to Properly Use Personal Protective Equipment**

The early failures to use PPE properly continue in both facilities, even during new active COVID outbreaks. As discussed above, generally accepted standards of care have required personnel in long-term care facilities to wear a mask while in the facility and full PPE (mask, gown, gloves, and eye protection) to care for any resident with known or suspected COVID since the early days of the pandemic. In addition, public health guidance calls for both vaccinated and

unvaccinated residents to wear well-fitting masks during an outbreak, and for staff to encourage them to do so. The guidance also instructs facilities to remove, or distance from others, unvaccinated residents who refuse to wear a mask during communal activities. Our investigation revealed lax and inconsistent use of PPE among staff and residents at both facilities.

During a DOJ site visit in February 2022, deficient PPE practices were evident at Paramus's front door. Security guards were stationed in the reception area without masks or PPE of any kind. Those guards, typically responsible for ensuring that visitors had complied with screening protocols, did not impose uniform requirements. On some occasions, the guards encouraged testing for COVID; on others, there was no mention of visitor testing. The problems continued inside the facility. On the units under quarantine during an active COVID outbreak, we observed staff without full PPE despite highly visible signs directing them to wear gowns, N95 masks, eye protection, and gloves. In addition, some nurses—including the facility's infection control nurse—expressed a misunderstanding of standard PPE practices. For example, these nurses told DOJ that staff did not need to change gowns when entering and exiting resident rooms in units under quarantine if they were not administering direct care. But Paramus lacks a clear definition of "administering direct care," and even so, the guidance was incorrect: to minimize the spread of the virus, generally accepted standards—and applicable CDC guidance—require all staff to wear the required PPE for the unit and to change that PPE between rooms.

We observed similarly deficient PPE usage among Menlo Park staff. Some certified nursing assistants (CNAs) wore N95 masks below their noses and open at the bottom. A clerk in the COVID-positive unit wore no mask at all. CNAs going in and out of resident rooms in quarantined units wore their gowns improperly. Other staff members moved in and out of rooms on COVID-positive units without wearing gloves and provided services on those units without gowns. Food service workers also used PPE improperly. In a quarantined unit, food service workers went from room to room delivering lunch without wearing gowns or eye protection. These staff members did not uniformly wear gloves; many who did wear gloves did not change them between rooms.

The Paramus facility also fails to ensure or even encourage mask wearing among residents during an active COVID outbreak. While there are challenges to mask wearing among this population, we regularly observed residents across multiple units without masks or with masks worn below the nose, mouth, or chin, without any encouragement from staff members to use the masks properly. These PPE failures allowed infected residents to easily spread COVID to other residents and staff.

PPE usage among residents at Menlo Park during a COVID outbreak is similarly deficient. We have observed erroneous and incomplete PPE use across multiple units. When asked about resident mask requirements, staff has provided varying explanations, including that residents were encouraged, but not required, to wear a mask. In one unit, the nurse manager told us that they did not believe they were supposed to ask residents to wear a mask. Another unit nurse directed residents to put on masks because "the Department of Justice is here." In general, however, we observed little to no encouragement of mask wearing.

These failures are particularly alarming given the nature and number of staff and units involved. DMAVA has also had months, and in some instances years, of notice of these infection control issues: many of these failures centered on the same concerns raised in 2020 by the U.S. Department of Veterans Affairs. But at no time did we see managers or other leadership intervene

to correct these deficiencies. Instead, improper PPE use in COVID and quarantined units—where the risk of transmission is highest—has continued, leaving residents exposed to an increased risk of infection. Such a fundamental breakdown in basic infection control precautions during an outbreak demonstrates a lack of training, supervision, and leadership at the Veterans Homes and jeopardizes the health and lives of residents in their care.

### **b. Both Facilities Lack Appropriate COVID Testing Policies and Fail to Implement Their Existing Policies**

During a COVID outbreak in a long-term care facility,<sup>24</sup> effective testing is crucial to minimizing the spread of the virus. After COVID tests and vaccines became more widely available, the CDC advised long-term care facilities to create a plan for testing residents and staff for COVID. There are different public health guidelines depending on the status of the resident. Those testing protocols account for COVID’s incubation period and seek to stop the spread of the virus by testing at a time when the virus can be detected. At the time we visited the Veterans Homes in 2022, public health guidance instructed that asymptomatic residents who came into close contact<sup>25</sup> with someone with COVID receive a COVID test. Because COVID symptoms could take two to fourteen days to appear after an exposure to the virus, the CDC recommends that the first test occur no earlier than two days after the initial exposure. If those results are negative, residents should receive a follow-up test five to seven days after the exposure. If symptoms persist after a negative rapid test, the guidelines require the administration of the more sensitive PCR test.<sup>26</sup>

While both facilities administer regular weekly tests, neither facility currently employs the appropriate outbreak testing protocol when confronted with a COVID outbreak.<sup>27</sup> Rather than waiting at least two days to test following a COVID exposure, as advised by the CDC, the Veterans Homes’ infection control manual requires residents to be tested upon identification of an individual with COVID symptoms in their unit or following a positive test result among the staff. Nursing leadership and staff echoed this policy, advising DOJ personnel that residents exposed to an individual with COVID would be given a rapid test the same day. If the exposed resident displays symptoms of COVID, the facility may administer a PCR test as well. Otherwise, if the initial rapid test is negative, the exposed resident would not be tested again until their routine testing day, which may not be until the following week.

The facilities’ ongoing failure to wait at least two days after exposure means that the first test—administered right away—is less likely to identify COVID. And waiting another week for the second test risks substantial spread of the virus by asymptomatic residents in the meantime. This failure to employ appropriate outbreak testing protocols is a clear departure from the

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<sup>24</sup> According to the CDC, a single new case of COVID in a long-term care facility should be treated as a potential outbreak.

<sup>25</sup> Close contact refers to someone who has been within six feet of a COVID-positive person for a cumulative time of fifteen minutes or more over a twenty-four-hour period.

<sup>26</sup> Rapid, or antigen, tests search for the body’s immune response to the coronavirus and can produce results within fifteen minutes. PCR tests amplify genetic material to detect even the smallest amount of the coronavirus in a patient sample. As a result, PCR tests take much longer to produce results but are far more sensitive and accurate than rapid tests.

<sup>27</sup> In addition, neither facility adheres to their purported policy of testing based on contact tracing rather than a broad-based testing model.

appropriate standard of care. Because less sensitive rapid tests can miss COVID infection in asymptomatic individuals, the lack of timely follow-up testing creates a serious risk that an infected resident will spread the virus for up to a week before detection.

In addition to deficient testing, staff understanding and implementation of the Veterans Homes' testing protocol have been incorrect or inconsistent. For example, a Menlo Park staff member told us that an entire unit would not be tested for COVID until at least two residents test positive. A nurse at the same facility reported that a roommate of a COVID-positive resident would immediately receive a PCR test. Yet, a different nurse told us that an asymptomatic roommate of a positive resident would not be tested within forty-eight hours of exposure but instead would simply receive their regularly scheduled test the following week. Each of these examples departs from the Veterans' Homes testing protocol. This failure to clearly communicate testing policy and protocols to staff further amplifies the serious risk that testing will be conducted improperly, or not at all.

Our investigation also identified multiple and troubling delays in testing residents who exhibited COVID symptoms. For example, a Paramus resident with cold symptoms and a moist cough was not tested for four days, even though the facility was in the midst of a COVID outbreak. In another case, a Menlo Park resident displayed ongoing COVID symptoms after her roommate was diagnosed with COVID. Nevertheless, after she was administered a rapid test that read negative, she did not receive a PCR test for nearly four weeks. That test confirmed that she had COVID, and she died the following day.

Furthermore, even with testing, key COVID-related data was not readily available to nursing leadership and staff at either facility in 2021 and 2022. The director of nursing for Paramus reported that "it was difficult" for her to track positive cases among the staff. And at Menlo Park, there was no systematic process for employees to be made aware of new positive cases in the facility. As a result, unit managers would not be able to track COVID exposures in their units and employ the necessary protocols for contact tracing and expanded PPE usage. Exposed residents would not be isolated or subjected to enhanced monitoring, and housekeeping staff would be unaware of which rooms needed different and more extensive cleaning. Together, these failures to employ adequate testing and implement responsive infection control measures contribute to the spread of COVID in both facilities.

### **c. Both Facilities Use Inconsistent and Ineffective Contact Tracing**

In addition to testing, contact tracing<sup>28</sup> remains another critical tool for identifying COVID, isolating infected individuals, and stopping the spread of the virus. Effective contact tracing allows facilities to identify exposed staff and residents, administer necessary COVID tests to exposed individuals, and quarantine or isolate staff and residents. Both CDC guidelines and the Veterans Homes' policies require the facilities to perform contact tracing to identify staff and residents who may have had close contact with COVID-positive individuals. Contact tracing during outbreaks

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<sup>28</sup> Contact tracing involves interviewing COVID-positive individuals to determine what, if any, close contacts they have had starting two days before they began experiencing symptoms of COVID or received a positive test result, whichever occurs first.



at both facilities is inconsistent, ineffective, and likely leads to the spread of COVID. Both facilities have continuously failed to implement these infection control measures properly.

In Paramus, the director of nursing told DOJ personnel that, after identifying the first positive case during a new outbreak of the virus in December of 2021 involving an employee who reported COVID symptoms four days before testing positive, the facility only conducted contact tracing from the date of the positive test. Although the employee worked across multiple units and had recently attended a holiday event with residents, Paramus only quarantined the unit where the employee worked the day before his test.

In Menlo Park, multiple staff members who tested positive for COVID in late December 2021 and early January 2022 reported that no one from the facility conducted contact tracing to ask them when their symptoms started or to identify their contacts while at work. The failure to conduct basic contact tracing meant that the facility was unable to test those whom the staff members may have been in contact with and isolate residents accordingly. CMS highlighted similar deficiencies during its own survey of Menlo Park in August and September of 2022, finding that the facility failed to conduct immediate and thorough contact tracing or ensure that exposed staff were tested prior to returning to work.

#### **d. Both Facilities Fail to Properly Cohort, Isolate, and Monitor Residents**

The Veterans Homes' early difficulties with cohorting infected and exposed residents have continued. Cohorting and isolation remain critical to containing the spread of COVID in group settings such as long-term care facilities. As a result, the CDC has long advised facilities to cohort COVID-positive residents on a dedicated floor, unit, or wing in the facility. *See* Section IV.A.3. Generally accepted standards required that these transmission-based precautions remain in place for symptomatic residents for at least ten days from the onset of symptoms, twenty-four hours from the last fever, and until symptoms have improved.

Both the Paramus and Menlo Park facilities are consistently deficient in cohorting, isolating, and monitoring of residents with COVID. During site visits in 2022, we found glaringly improper isolation of COVID-positive residents. In Paramus, we observed several open resident doors in the COVID unit, contrary to prevailing standards. And in Menlo Park, we identified several instances of delays in isolating infected residents from their roommates. In each case, the roommate subsequently tested positive for COVID.

In addition, we found that some COVID-positive residents were taken out of isolation before their symptoms had substantially improved. In Menlo Park, a resident was returned to his home unit with a moist cough and pneumonia, when CDC guidelines require improvement of symptoms to leave isolation. In Paramus, a resident was transferred out of the COVID unit with a cough and two days later was admitted to the hospital due to shortness of breath, hypoxia, and pneumonia.

Finally, the CDC has provided specific protocols for the treatment of unvaccinated residents during a COVID outbreak. Specifically, even if they have tested negative, CDC guidelines state that the facility should restrict unvaccinated residents to their rooms, prohibit these residents from participating in group activities, and have staff caring for them wear N95 masks, eye protection, gloves, and gowns. But unvaccinated Veterans Home residents were permitted to

leave their rooms and interact with other residents, and no special precautions were taken with respect to PPE. As a result, unvaccinated residents were left vulnerable to more severe illness and hospitalization from COVID.

**e. Both Facilities Fail to Disinfect Surfaces or Ensure Proper Handwashing**

The Veterans Homes systematically fail to implement two basic infection control procedures that should have been regular practice long before COVID: hand washing and disinfecting surfaces. These practices became critical during the COVID pandemic and were a problem early on. During its visit to the homes in the spring of 2020, U.S. Veterans Affairs identified “critical deficiencies” in these practices at both facilities. These failures continued during DOJ’s visits to the Veterans Homes in 2021 and 2022.

During our February 2022 site visit to Menlo Park, we observed widespread failures in hand hygiene. Housekeeping, nurse aides, food delivery staff, and other personnel moved between resident rooms without changing gloves or washing hands in several units, including those under quarantine. In a COVID-positive unit, we observed two CNAs going in and out of resident rooms without wearing gloves or washing hands. In addition, a resident room in that unit lacked hand sanitizer. We also found dirty hand sanitizer dispensers and handrails throughout the facility.

During our December 2021 site visit to Paramus, there was grime and build up on handrails in a quarantined unit and dirt and residue in the bathroom of a resident infected with *C. difficile*. In addition, staff appeared confused about the facilities’ disinfection protocol, indicating a lack of training. As with other failures we observed in the facilities, this breakdown in fundamental infection control protocols increases the risk of infection to the residents.

**f. The State’s Reported Improvements to Disease Prevention are Inadequate**

In response to our concerns in this area, DMAVA advises that it has taken additional steps to improve physical safety and disease prevention in the Veterans Homes. As part of this initiative, DMAVA describes increased availability of hand sanitizing stations throughout the facilities, electronic screening for all visitors and staff, as well as routine rapid tests for all entrants. The Veterans Homes will also purportedly subject themselves to an additional State-administered review to evaluate safety issues including respiratory protection and air quality among other topics. These are positive steps, but even if fully and faithfully implemented, are not enough to address the widespread infection control issues discussed above.

**C. Ongoing Conditions: The Veterans Homes Systematically Fail to Provide Adequate Clinical Care, Exposing Residents to a Substantial Risk of Harm**

The Veterans Homes’ ongoing failures to keep their residents safe extend beyond infection control. The clinical care currently provided by the Veterans Homes is inadequate in multiple areas, including monitoring residents for changes in condition, care planning, implementing a falls program, administering medication, providing wound care, and ensuring basic care competencies. This harms residents and places residents at a substantial risk of harm.

Many of these failures arise from the fragmented structure of clinical care in the Veterans Homes. Prior to 2018, each facility had a full-time medical director and physician's assistant who were reportedly well-equipped to oversee and coordinate clinical care. Since the latter half of 2018, however, the Veterans Homes have used outside clinicians for this purpose. While the use of outside clinicians can be a viable option, it places a greater responsibility on Veterans Homes' administrators to ensure that the medical directors are fulfilling their roles to assure resident health and safety by overseeing care. Unfortunately, the Veterans Homes have failed to meet this responsibility. And DMAVA has failed to ensure that they do so.

### **1. The Veterans Homes' Ongoing Failures to Adequately Monitor for Changes in Condition Expose Veterans Homes Residents to a Substantial Risk of Harm**

When providing care for a population that needs 24-hour skilled nursing, the ability to identify and respond to acute changes in condition is crucial. A change in condition may signal, among other things, an infection or underlying health issue that, left unaddressed, could lead to a serious decline in a resident's condition. A failure to identify or assess a change in condition is a failure in care. Both Veterans Homes fail to consistently monitor and respond to acute changes in residents' conditions. In particular, both facilities have systematically failed to monitor residents for changes in condition during COVID outbreaks, risking the spread of the virus and creating additional health risks for those already infected.

The Veterans Homes ostensibly require staff to monitor every resident for signs and symptoms of COVID during every shift. The facilities claim to do so using a standardized COVID monitoring sheet; according to DMAVA leadership, staff members will complete the sheet, which asks staff to record vital signs as well as the presence or absence of standard COVID symptoms, each shift. But neither facility consistently implemented this basic practice. During active COVID outbreaks, DOJ experts regularly observed resident charts with missing or incomplete monitoring sheets. These failures occurred even after direct exposures, such as a roommate who tested positive for the virus. The accuracy of the sheets that do exist is uncertain; there were discrepancies between the information recorded on the monitoring sheet and the nurse's notes for the same dates and times. In one instance, when a unit in Menlo Park experienced an active outbreak in early 2022, there were no monitoring sheets for a resident for the days after her husband—who was also her roommate—tested positive. She eventually tested positive as well.

There were similar failures in monitoring for other medical conditions. In Paramus, one of the facility's most medically complicated residents, a man with a tracheostomy tube,<sup>29</sup> had a serious, readily detectable, change in condition that the facility failed to identify. For tracheostomy residents, regular monitoring and suctioning to keep the tube clear are critical. The facility had no system in place to adequately monitor this resident and provide care accordingly. In late December 2021, the resident's blood oxygen level dropped substantially. A visiting family member, not the nursing staff, observed the change. Later that day, the resident was transferred to the emergency room. When he arrived at the hospital, doctors identified a plug in his airway, which indicates a failure to adequately suction his tracheostomy tube. Indeed, there was no documentation that

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<sup>29</sup> A tracheostomy tube is a tube inserted into a hole in an individual's trachea to create an alternative airway.

nurses at the facility regularly suctioned the resident's tracheostomy tube from December 1 to December 20, 2021, the day he went to the hospital.

## **2. The Veterans Homes' Ongoing Failures to Create and Adhere to Individualized Care Plans Expose Veterans Homes Residents to a Substantial Risk of Harm**

To respond to acute changes in condition and otherwise ensure that each resident's medical needs are met, the facilities are required to create and periodically update care plans for each resident. A care plan is a written reference that guides staff members of all disciplines, from nurses to social workers to dieticians, when interacting with a particular resident. Federal regulations govern care plans. CMS requires them to be comprehensive: to "meet a resident's medical, nursing, and mental and psychosocial needs."<sup>30</sup> An interdisciplinary team will create a resident care plan; facilities are then obligated to provide services in accordance with that plan.<sup>31</sup> CMS regulations contemplate "person-centered" care plans, meaning that the services and care provided must respond to each individual resident's condition, goals and needs and "[c]onsider each resident as a whole."<sup>32</sup> A typical care plan, for instance, might include individualized interventions to care for pressure injuries, mitigate fall risks, and address weight loss. Care plans for two residents with a history of falls, for example, should differ. An effective care plan would consider the specific reasons for each resident's history of falls—one may be related to medication, another to toileting needs—and prescribe care with specific, non-generalized interventions.

In a large, long-term care facility with multiple caregivers who work across multiple resident units, it is crucial that care plans are comprehensive and functional—that they provide all staff members with a straightforward reference to understand how to care for a particular resident. Even when residents have multiple issues that require a number of interventions, their care plans must be a document that a caregiver can read to understand relatively quickly the care required.

Care plans in the Veterans Homes are not coherent, functional documents that clinical caregivers can implement. Instead, they are generalized, with haphazardly added global interventions that are not specific to individual resident needs. Nor do they reflect meaningful, systematic updates in response to incidents or changes in condition. As a result, nurses, who commonly float among multiple units, cannot reference the care plans in a meaningful way or provide guidance for nurse's aides, who are responsible for implementing many aspects of a care plan. Indeed, at both facilities, there were alarming indications that caregivers did not regularly use or refer to resident care plans. On multiple occasions, nurses and other caregivers were unable to easily locate a resident care plan, raising the concern that plans do not regularly guide resident care. In another instance, the care plan maintained on the facility's computer system differed from the hard copy in the resident chart for use by facility staff.

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<sup>30</sup> 42 C.F.R. § 483.21 (b)(1).

<sup>31</sup> 42 C.F.R. § 483.21(b).

<sup>32</sup> See 42 C.F.R. § 483.21(b); Centers for Medicare & Medicaid Services (CMS) State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities, Note of Intent, 42 C.F.R. § 483.21(b), at 246-47, [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/SOM107ap\\_pp\\_Guidelines\\_ltcf.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/SOM107ap_pp_Guidelines_ltcf.pdf); CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (CMS RAI Manual), Version 1.17.1 (Oct. 2019), Sec. 4-2, [https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1\\_october\\_2019.pdf](https://downloads.cms.gov/files/mds-3.0-rai-manual-v1.17.1_october_2019.pdf).

This ongoing failure to create and maintain functional, individualized care plans poses serious risks to the health of the Veterans Homes' residents. The care planning deficiencies were particularly acute for residents at risk for falls. According to CMS, falls pose a serious risk to the population of long-term care facilities and are, therefore, a "top priority for care planning."<sup>33</sup> Like all care plan interventions, steps taken to avoid falls must be individualized: facilities must work to identify the circumstances and patterns that precede a fall and create interventions that address those individual circumstances. Neither facility regularly created care plans for residents at risk of falling that met this standard. Likewise, failures in care plan creation and implementation created significant risks for residents experiencing substantial weight loss, grief, and choking.

One senior nursing staff member at Menlo Park observed that facility staff "really need to be educated" on how to create care plans. Care plans at Menlo Park were not functional, comprehensive references that could meaningfully guide caregivers; the same senior staff member described them as "siloe" documents that would stack up for a given resident. Throughout Menlo Park, DOJ experts observed serious failures to update care plans in response to falls and other significant changes in condition and failures to implement the measures contained in the care plans.

When a resident falls, Menlo Park's policy requires staff members to identify the probable or actual cause of the fall, and to update the care plan accordingly. On multiple occasions, the facility failed to adhere to its own policy:

- One Menlo Park resident, whom the facility had identified as a fall risk, fell multiple times in 2021. In January 2021, a fall in her room resulted in a hip fracture that required surgery. The same resident fell at least six more times that year. One fall caused head trauma; two of the falls resulted in facial or head lacerations. Her care plan did not materially change after any of those falls.
- Another resident, identified upon admission as a fall risk, fell multiple times in 2021 and early 2022. The care plan interventions were broad and unrealistic for the resident's abilities: although a May 24, 2021 assessment observed that she "was at risk for decline in self care related to forgetfulness, weakness," a care plan entry on the very same day reads "remind [resident] to call for assistance."

Menlo Park also fails to revise care plans promptly and appropriately. To keep residents safe, the facility should revise a resident's care plan within twenty-four hours of a serious fall. One Menlo Park resident, identified as a fall risk, suffered a serious fall in October 2021. Seven days later, the facility added one intervention to address future falls: non-skid socks. It is not clear how this particular intervention addressed the circumstances of the fall, which occurred when he tried to reach under his bed.

In another instance, CMS surveyors found that Menlo Park staff failed to implement the straightforward anti-weight loss measures contained in a resident care plan. Those surveyors evaluated a resident with substantial weight loss. The resident's care plan required staff to

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<sup>33</sup> CMS RAI Manual at J-27, J-31.

administer nutritional supplements twice a day. The facility failed to do so. During the same survey, CMS surveyors found that the facility had failed to take accurate or timely weights of a resident with substantial weight loss and, alarmingly, had inaccurately set the rate of that resident's feeding tube for two consecutive days, placing the resident at risk for aspiration pneumonia.

Like Menlo Park, the Paramus facility systematically fails to create adequate care plans. Two particularly concerning examples illustrate Paramus' failures in connection with resident falls:

- One Paramus resident fell twenty-two times between January 2020 and July 2022. Several of those falls resulted in head trauma. One resulted in hospitalization. But, each time, the resident's care plan was not meaningfully updated to prevent future falls. Instead, there were generalized interventions, such as the instruction after a February 2022 fall to "provide assistance when needed," without any apparent effort to determine the causes of the falls, to specify when the resident might in fact need assistance, or to provide caregivers with actionable guidance. The results were serious: approximately six weeks later, the resident was found in his room in the middle of the day with a fifteen-centimeter laceration on his head, the result of another fall.
- Another Paramus resident fell twenty-seven times between January 2020 and June 2021. A January 3, 2020, fall resulted in a head injury. The resident was sent to the emergency room, returned to the facility, and fell twice the next day. After each fall, the facility failed to revise the resident's care plan with meaningful steps that would account for the cause of the most recent fall and seek to avoid future falls. For instance, multiple care plan revisions instructed staff members to encourage the resident, who had dementia and an impaired mental status, to call for help. The falls continued. The same resident fell twice on March 31, 2021. An intervention listed after the day's first fall required staff to serve the resident his meals in front of the nurses' station for his safety. He fell approximately four hours later, while he sat in front of the nurses' station in his wheelchair and tried to move to the bathroom by himself.

Paramus' deficient care plans extend to other care issues. Care plans fail to provide meaningful help to residents who are dealing with grief, experiencing substantial weight loss, or were at risk of choking while eating. Unaddressed weight loss creates serious health risks including decreased immunity, inhibited movement, decreased activity, and a risk of pressure sores. Substantial and unaddressed weight loss also contributes to an overall decline in independence. An inadequate care plan for residents with difficulty swallowing poses the risk of choking, aspiration pneumonia, and other respiratory infection.

Care planning for COVID is also deficient in both facilities. During site visits to the facilities during an active COVID outbreak, DOJ experts found many missing or non-individualized care plans for active COVID cases. The failure to update care plans for residents

with COVID risks demonstrates grossly inadequate care for a population at risk of becoming seriously ill with a COVID infection, including the risk that the facility will not identify and respond to serious changes in condition.

### **3. The Veterans Homes' Ongoing and Systematic Failures to Implement Fall Prevention Measures Expose Veterans Homes Residents to a Substantial Risk of Harm**

In addition to the failures in care planning, the Veterans Homes' inability to implement facility-wide fall prevention measures compounds the fall risks faced by their residents. Falls are "a leading cause of morbidity and mortality among nursing home residents"<sup>34</sup> and in all adults over the age of sixty-five, often result in serious injuries, lead to a decrease in an individual's mobility, and contribute to an overall decline in independence. Falls may also indicate other serious health issues, such as an adverse medication reaction, dehydration, or infection. Long-term care facilities generally have "falls programs"—a set of systematic practices that address and respond to resident falls and provide a framework for facility staff to respond to resident fall risks in an individualized way. The Veterans Homes and DMAVA have failed to implement a consistent program to adopt and deploy fall prevention tools and programs. An inconsistently administered and inadequate falls program—coupled with a systemic failure to provide adequate care plans for residents at a high risk of falls—poses serious risks to the Veterans Homes' residents.

Both facilities' fall policies recognize that the purpose of a falls program is to "identify Residents at risk for falls and develop an individualized care plan" to "prevent and reduce falls, which would prevent harm to Resident." In both facilities, DOJ's expert observed anti-fall measures taken inconsistently or not at all, which defeats these critical purposes of a falls program. Neither facility consistently engages in what experts refer to as "eyes on monitoring" of high fall risk residents. This type of monitoring involves grouping high-risk residents in an area when staff may supervise them and, crucially, keep them engaged.

According to Menlo Park's falls program, residents at a high risk for falls should be identified by a uniform symbol—a picture of a falling star—on their door to permit any staff member to identify them as at risk for falls and provide care accordingly. The facility is unable to implement this simple measure in a consistent way. During DOJ's visits to Menlo Park, only some units appeared to participate in the program. Staff expressed differing understandings of the program's status: one thought the facility had abandoned it, another thought the stars were on back order and was using a different symbol in her unit—which floating staff likely would be unfamiliar with—in the meantime. One nurse explained that, even if door symbols were unavailable, staff could identify at-risk residents through a wristband system that used a yellow dot to identify an individual at risk of falling. The wristband was not visible under long-sleeved clothing, the dot indicating fall risk was tiny, and the indicator would not be easily visible to staff.

Physical therapy and restorative care, the latter of which maintains progress made in physical therapy, are critical to maintaining mobility and avoiding falls. But in Menlo Park, restorative care and physical therapy staff are excluded from the daily meetings in which other staff members reviewed resident falls. This violates Menlo Park's own falls program, which

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<sup>34</sup> CMS RAI Manual at J-32.

requires their presence. Menlo Park nursing leadership lack engagement with and an understanding of the facility's falls program. When DOJ was at the facility in October 2021, for example, the then-director of nursing was unsure if the facility generated any type of monthly fall update or maintained fall committee meeting minutes.

In 2022, CMS surveyors found that Menlo Park failed to provide required follow-up medical care after a resident fall. On July 12, 2022, a resident fell in their room and was sent to the hospital. An x-ray report of the resident's wrist noted a possible fracture and recommended follow-up imaging. The facility did not see that recommendation, and the resident did not receive the recommended follow-up care for nearly two weeks, when a fracture was indeed confirmed. As of September 1, 2022, the nurse who had not followed up on the recommendation received no education regarding the incident. Regarding the same incident, the facility again failed to involve the physical therapy team; the facility failed to refer the resident for physical therapy for two weeks after the July 12 fall.

Paramus's implementation of its program to prevent and respond to resident falls is similarly deficient and leads to serious adverse medical consequences. The facility's policy, like Menlo Park's, contemplates the use of a uniform symbol—in Paramus, falling leaves—on the doors of residents at a high risk for falls. But, like Menlo Park's, Paramus' program is not consistently implemented.

Paramus's falls policy also requires close supervision of residents who are at risk for falls. But the facility fails to implement this policy consistently, resulting in resident falls. For instance, one resident fell in a common area when the staff member assigned to watch him left the room. The same resident, who fell over a dozen times in his room in the middle of the day, continued to be left unsupervised in his room in the middle of the day.

Like the program in Menlo Park, the falls program in Paramus contemplates the involvement of physical therapy to mitigate fall risk. But a Paramus physical therapy contractor expressed concern that staff responsible for maintaining resident mobility through restorative care are frequently pulled from their care of residents to perform non-restorative duties, leading to a decline in the condition of the residents who did not receive restorative care. One Paramus resident told visiting DOJ team members that he had wanted to continue with physical therapy during a COVID lock down but "there was nobody to ask for it." The resident feared he would lose his ability to stand up.

#### **4. The Veterans Homes' Ongoing and Systematic Errors in Medication Administration Expose Veterans Homes Residents to a Substantial Risk of Harm**

Administering medications is an integral part of the care provided in long-term care facilities. As senior nursing staff at both Veterans Homes acknowledged in interviews with DOJ personnel, generally accepted professional standards of care dictate that medications generally should be administered within one hour of the time prescribed. Failure to meet this standard exposes residents to harm because some medications require administration within a narrow time window to ensure resident safety or achieve a therapeutic effect.



Neither facility has reliable mechanisms to ensure that this standard is met. And over repeated visits to the facilities, we have regularly observed medications being administered late. Further, multiple nursing staff members at both facilities confirmed that medications are routinely administered late. For example, in October 2021, at close to 11 a.m., DOJ's expert observed a licensed practical nurse administering medications scheduled for 9 a.m. that day. The expert determined that the nurse still needed to administer medications to about one-third of the nurse's assigned residents and had charted the administration of medications that he had not yet given. Senior Menlo Park nursing personnel, including the director of nursing, acknowledged that nurses had raised the issue of the timeliness of medication administration in the facility but left it to the facility's contracted pharmacy provider to audit the process.

The Paramus director of nursing also acknowledged that there are “always issues” with medication administration—specifically, that they “won't be on time.” The Paramus assistant director of nursing indicated that the facility was struggling with medication administration because “we have so much medication. . . . Routine medications are nine [per resident], spaced out three times a day. It's a lot because the more residents we receive, the more diagnoses and the more complications.” Separately, a Paramus nurse reported that medication administration is “heavy”—referring to the high number of medications administered—and “often late.” Multiple nurses confirmed to DOJ personnel that it was almost impossible to administer medications in the required window.

The facilities lack a reliable system to detect whether medication administration occurs on schedule and appear to rely on their nurse educators, who lack sufficient resources to oversee medication administration. Menlo Park's medication administration audit samples only three facility residents and does not assess the time frame in which all medications are administered. The Paramus nurse educator acknowledged that she is the only staff person conducting medication administration audits. As of the time of our October 2021 interview, the Paramus nurse educator told us she had detected zero medication administration errors—which would include any medication administered outside the two-hour window—that month, despite multiple staff members, including nursing leadership, reporting an inability to regularly administer medication on a timely basis.

The facilities have also struggled with alarming medication errors. For example, a Paramus resident was prescribed Torsemide, a diuretic, every other day, but the drug was administered daily, except for January 23, between January 15 and 24, 2022. At the same time, the resident's sodium and creatine levels dropped precipitously, and his kidney function changed dramatically. These changes are all signs of significant dehydration, likely caused by the Torsemide overdose. The resident was subsequently hospitalized and died shortly thereafter. CMS investigators in Menlo Park in August and September 2022 also identified multiple errors in medication administration.

## **5. Wound Care at the Veterans Homes Exposes Veterans Homes Residents to a Substantial Risk of Harm**

Decubitus ulcers, also known as bed sores or pressure injuries, are wounds to the skin or underlying tissue, typically caused by prolonged pressure on the skin. The risk of pressure injuries increases for people who cannot easily move or reposition themselves, are incontinent, are nutritionally compromised, or have health problems limiting blood flow, such as diabetes or vascular disease. The Veterans Homes fail to provide adequate care for pressure injuries, which harms their residents and creates a risk of harm.

If untreated or inadequately treated, pressure injuries can expand into muscle and bone. Even an early-stage pressure injury can be painful. For these reasons, in any population of elderly, infirm, non-ambulatory people, pressure injuries are a chronic risk that must be guarded against carefully and treated appropriately. This includes performing timely assessments on newly arriving residents, maintaining adequate nutrition and hydration, performing skin assessments, detecting redness or other signs of skin breakdown, assisting with repositioning as needed at least every two hours, and providing appropriate treatment of wounds, including pain management, to promote healing and prevent further regression.

Typically, a medical director coordinates and oversees wound care programs, which would include the establishment of uniform policies and procedures regarding pressure injury care, and is otherwise knowledgeable about the facility's wound programs, statistics, and trends. The facility's nursing leadership, including the director of nursing, should also be knowledgeable about the facility's wound programs, policies and procedures, and about its wound statistics and trends. Both the medical director and director of nursing should know how wound rounds—the weekly assessment and treatment of residents with wounds—are conducted by occasionally observing those rounds. This knowledge is necessary for the medical director and director of nursing to assess the competency of their staff, to respond to trends on an informed basis, and to prevent the facility's residents from suffering from avoidable wounds.

The Veterans Homes do not adhere to these standards. As a result, some wounds are not timely identified, correctly staged, or appropriately addressed. These deficiencies harm residents and place residents at risk of harm. The wound care provided also causes avoidable pain for multiple residents due to a failure to administer pain medication before treatment.

In particular, the Veterans' Homes have delegated wound care to outside wound specialists without ensuring that the aspects of wound care beyond those specialists' purview are properly implemented. At neither facility has the medical director or director of nursing been involved in overseeing wound care. The nurse educator at one facility was unfamiliar with the current wound repositioning standards and had been training that facility's nurses on wound care using outdated guidelines. Further, nurses at both facilities do not receive regular training on classifying, or "staging," the severity of wounds, and are not expected to stage wounds.

For example, nurses at the Veterans Homes do not regularly perform skin assessments of residents on admission. Consequently, a skin assessment can be delayed, as would any necessary treatment of undetected pressure injuries, exposing residents to potential harm from untreated and worsening injuries. When we asked Paramus's then-medical director about that practice, he

indicated he was unaware of it, and that it would be unacceptable. He also agreed that it was important to have an accurate skin assessment performed on admission.

Separate from an assessment done on admission, one of the basic elements of wound care is regularly checking residents' skin for possible redness or other signs of breakdown. This is not happening at the Veterans Homes. The most reliable way to perform skin checks is during bathing or showering, when the resident's entire body can be clearly examined. And, generally, a resident with skin sensitivity and incontinence should be showered or bathed at least twice a week, in part because decubitus ulcers can worsen in even a few days. However, the Veterans Homes' stated practice is that residents receive showers once a week, not twice. Our check of four Paramus residents indicated that on their assigned shower day, one had received a sponge bath, one declined a shower, and two others had not received a shower. More troublingly, a Paramus nurse flatly reported that "skin checks by a wing nurse when someone is showering isn't happening on my unit." The State has indicated that it has retrained clinical staff on topics including skin/heel checks, but such training is insufficient without oversight to ensure that checks are actually occurring.

Infrequent, inconsistent, and unreliable skin checks of residents expose them to serious harm. From among only those residents with previously detected wounds, our expert identified a resident at each Veterans Home, during wound rounds, with an additional undetected wound, one of which was at least a stage 2.<sup>35</sup> This fact, coupled with the weaknesses described above in the Veterans Homes' ability to look for and identify pressure injuries, strongly suggests that other residents are at risk from pressure injuries that are undetected or that have worsened without appropriate response.

The ongoing inability of each facility to assume sufficient ownership over wound care is demonstrated in their failure, as of the time of our visits, to give residents pain medication before they underwent painful debridement treatments, in which skin around the wound is cut away with a scalpel.<sup>36</sup> We observed multiple residents in pain during these procedures. Independent of whether the Veterans Homes' outside wound specialists provide clinically sound treatment, the Veterans Homes have a duty to give residents appropriate palliative care for procedures that were obviously painful. Failure to do so is a form of neglect.

## **6. The Veterans Homes' Ongoing Failure to Ensure Basic Medical Care Competency Among Staff Exposes Veterans Homes Residents to a Substantial Risk of Harm**

The ongoing failures to ensure adequate training and basic competency, discussed above at Section IV.B.1, extend to medical care. For instance, one Paramus resident's external, part-time health aide reported serious deficiencies in basic care. The aide recounted a time when the resident was covered in feces when she arrived; when she inquired with facility staff, they suggested that

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<sup>35</sup> Decubitus ulcers, also called bed sores, are commonly categorized in four stages, from least to most severe. A stage 2 wound involves partial skin loss, a shallow open ulcer, and a red or pink wound bed. It may also appear as an intact or ruptured blister.

<sup>36</sup> After our expert raised the issue with nursing staff, orders for pretreatment pain medications were sometimes added to resident care plans at both facilities.

the aide address the issue. In addition, the aide reported that facility staff fails to feed the resident when the aide is not there.

A non-clinical Menlo Park staff member recounted a similar incident in which the facility failed to provide basic care. During a COVID outbreak, the staff member observed a resident with a high fever screaming and ripping out his oxygen tube. When she reported the incident to another nurse on the unit, the nurse responded that she should mind her own business because the nurse was finishing her shift.

At Menlo Park, CMS investigators surveying the facility in 2022 observed a serious failure to ensure nursing competency. A registered nurse removing a resident's Foley catheter improperly used scissors to cut the catheter, causing the remaining catheter to retract into the bladder and sending the resident to the hospital. CMS surveyors found that the nurse had never removed a catheter before, and that the facility had no written policy on how to do so and had never provided competency training on the topic. The director of nursing did not interview the nurse who made the error or implement any corrective action. The facility's failures in connection with this resident continued: upon the resident's return to the facility, the staff failed to read the hospital's after-visit summary and thus failed to administer a prescribed antibiotic for fifteen days. The resident then required extended antibiotic treatment for additional bacterial infections, including the methicillin-resistant *Staphylococcus aureus* bacteria, commonly known as MRSA.

#### **D. Ongoing Conditions: DMAVA's Failure to Adequately Oversee Care in its Veterans Homes Exposes Residents to a Substantial Risk of Harm**

Broad failures in leadership and management are a significant factor in the harms identified in the Veterans Homes. As described above, the initial wave of the COVID pandemic exposed key breakdowns in infection control, policy implementation, and management. As far back as June 2020, the U.S. Department of Veterans Affairs highlighted a critical need for improved leadership at the Veterans Homes to ensure accountability, use staff expertise, and improve communication. Today, management deficiencies persist in these and other key areas. The facilities' inability to communicate and implement crucial clinical care policies—and DMAVA's failure to ensure that this happens—harms residents and places them at risk of harm.

##### **1. DMAVA Fails to Ensure Appropriate Oversight and Accountability**

The problems at the Veterans Homes arise from their delegation of responsibilities without sufficient support and substantive oversight to ensure that they are adequately implemented. This approach fosters a lack of accountability and has often resulted in regulatory compliance on paper but not in practice. These failures expose residents to harm, including: the creation of non-responsive, unworkable care plans, *see* Section IV.C.2; the delegation of important duties to consultants with insufficient oversight, *see* Section IV.C.5; and an inability to adhere to basic infection control protocols, *see* Section IV.B. The failures also undercut staff morale, *see* Section IV.D.2.

In important respects, DMAVA has treated the Veterans Homes as freestanding entities and assumes little responsibility for the care provided. When asked who has ultimate responsibility for ensuring that facility staff provide adequate care, the Director of Veteran Health Services, who

oversees the facility CEOs, was nonresponsive, stating, “We have policies in place,” without pointing to measures to ensure that those policies are implemented. By contrast, facility staff suggested to us that DMAVA controls the facilities and that facility CEOs lack authority to make major decisions. This lack of ownership over outcomes—including clinical care outcomes—undercuts accountability, facilitates dysfunction, and places residents at risk of harm.

Although DMAVA quality assurance staff review facility reports, provide guidance on regulatory requirements, and have engaged with the facilities in an effort to prevent avoidable falls, these efforts have been insufficient to address falls and other deficiencies, and are dependent upon the facilities’ self-reporting of data, which itself has been ad hoc and unvalidated. And DMAVA’s fall-prevention efforts have been limited in scope—focusing on time and attendance issues—and unduly punitive, thus exacerbating ongoing dysfunction and distrust among the facilities’ staff. *See* Section IV.D.2.

We did not see material evidence, apart from inadequate attempts at fall prevention, of DMAVA’s active engagement with the facilities to address health outcomes for residents in a substantive way. Crucially, it was not apparent that DMAVA has sought to validate facility performance data, a critical first step of oversight and accountability, which in turn ensure resident safety. This was true even when the data were questionable on its face. For example, as noted in Section IV.C.4, we found repeated examples that medications are administered beyond prescribed time windows, and both facilities’ clinical staff acknowledged chronic delays in medication administration. Each instance of delay is a “medication variance” that should be reported and addressed, but we saw no evidence that this was happening. DOJ experts noted that the facilities reported questionably low medication variance rates. Until DMAVA ensures the facilities’ data are valid and reliable, DMAVA cannot exercise meaningful oversight by relying only upon that data.

The State has indicated that DMAVA has taken steps to address these deficiencies, such as procuring software to identify important clinical information and report trends to DMAVA’s central office. The State also has instructed each facility’s chief executive officer and assistant chief executive officer to walk the facility’s halls each day, to look for issues requiring immediate attention or correction. These initiatives, while constructive, will not rectify the facilities’ longstanding problems.

DMAVA’s practice of delegation without effective oversight is replicated within the facilities themselves. Facility leaders give unit supervisors responsibility but little support. Both facilities suffer from a lack of capable, consistent clinical leadership. Menlo Park’s CEO and director of nursing were replaced during our investigation, and both facilities’ medical directors resigned. Paramus lacked an infection control nurse and nurse educator during the initial COVID outbreak, and subsequently hired then replaced another infection control nurse. Paramus’s assistant chief executive officer for clinical services—second in command to the facility CEO, the top official in the facility with a clinical background, and the person responsible for supervising the director of nursing—worked off-site for several months in 2021 and 2022 without participating in regular meetings or otherwise appearing to perform her normal duties. The Veterans Homes also appear to delegate staff training to their nurse educators and infection control nurses without sufficient resources or oversight to ensure that the training is accurate and effective.

To a striking extent, staff with clinical expertise do not have a leadership role in overseeing policy implementation, actively managing and supporting staff, and responding to significant

health outcomes. Before 2018, each facility had a full-time doctor and nurse practitioners on staff, whom current and former staff praised for their availability and clinical care. As a cost-saving measure, DMAVA replaced them with a consultant medical director, assisted by nurse practitioner. Thereafter, multiple Paramus staff and resident families repeatedly raised concerns regarding the consultant Paramus medical director's availability, responsiveness to residents' health needs, and billing practices. Those concerns went unaddressed by the facility's leadership and DMAVA, which failed even to verify that the medical director, who served as the primary care physician for the majority of the facility's residents, remained credentialed and licensed.<sup>37</sup> It also did not require him to accept health insurance commonly used by Paramus residents, exposing them and their families to significant medical expenses. Further, the facility made no effort to involve the medical director in coordinated care decisions. In essence, rather than ensuring that the medical directors are accountable for providing appropriate medical care and positioned to do so in a cost-effective manner to residents, the facilities have left their medical directors to their own devices, to the detriment of facility residents.

Menlo Park's medical director in early 2022, who has since resigned, reported no regular contact with the facility's director of nursing outside of set committee meetings and stated that he was not involved in coordinating the facility's current response to COVID, including the care of COVID-positive residents. The delegation of wound care to an outside consultant, without ensuring that facility staff maintain responsibility for assessing and staging wounds, have knowledge of current wound interventions, and are appropriately attentive to the status of wounds and residents' wound pain management needs, as discussed in Section IV.C.5, also illustrates an inappropriate relinquishment of responsibility that increases the risk that resident care needs go unaddressed. In a recent update to the Department of Justice, the State represents that it has retained a new Medical Director. But the State's description of the Medical Director's duties reflects a fundamental misunderstanding of a Medical Director's role: to oversee and coordinate clinical care provided by the facilities in a meaningful way, not simply address individual resident concerns.

DMAVA has expressed little interest in examining the deficiencies in its initial COVID response or its ongoing inability to adhere to standard infection prevention guidelines. The agency does not appear to have charged the facility CEOs with identifying and correcting those issues to keep residents and staff safe. The current Director of Veterans Healthcare Services reports that she has spent no time examining the facilities' initial COVID response and was unaware of any specific lessons learned. When asked what changes the facilities had made to their emergency preparedness policies since 2020, the Director of Veterans Healthcare Services stated that she was unaware and that she would not review those changes.

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<sup>37</sup> While we were on site, the Paramus staff responsible for tracking and maintaining the credentialing and licensing of medical personnel could not produce the consultant medical director's current credentialing; the certificate on file had expired. The Paramus staff person reported that she had asked the consultant's medical staff to provide their licensing and credentialing and they had not done so.

Without any targeted or comprehensive efforts by DMAVA to address these systemic failures, in September 2022, the Menlo Park facility was placed in “Immediate Jeopardy”<sup>38</sup> status by CMS. CMS thereafter withheld payments for new admissions to the facility due to ongoing quality concerns. In response, on November 30, 2022, Governor Murphy directed DMAVA to hire a qualified outside vendor to improve and manage operations, review and revise policies, and train leadership, among other initiatives. DMAVA thereafter removed Menlo Park’s CEO and hired an interim CEO along with a nurse practitioner to serve as the new director of nursing and senior infection preventionist. Although it has since removed the facility from “Immediate Jeopardy” status, CMS is still seeking payments of a civil money penalty because of the quality concerns.

## **2. DMAVA and Veterans Home Leadership Contribute to an Adversarial Culture and Low Morale**

Staff morale, low in the early days of COVID, has not substantially improved. The leadership in the Veterans Homes continues to create an environment that is needlessly adversarial toward their employees, the individuals directly responsible for resident care. Staff believe that their concerns are ignored and fear reprisal. In addition, some staff members were alarmed by widespread discipline related to time and attendance issued in November 2021, shortly after DOJ’s first site visit to the facilities. More than ninety employees across both Veterans Homes received discipline ranging from written warnings to multi-week suspensions without pay. Employees who had worked under challenging conditions during the early days of the pandemic now faced being sanctioned for being as little as a few minutes late to work. And social workers and other staff not assigned to direct resident care were penalized for using flex time even when such arrangements were approved by their immediate supervisor.

When asked about the basis for the discipline, DMAVA responded that the discipline was the result of a longstanding time and attendance audit that began in July 2021. Later, DMAVA leadership added that the audit arose out of regularly collected data, which showed an increase in falls on a particular Paramus shift due to late staff arrivals. Notably, the facilities took these steps while failing to implement the medically appropriate measures in care plan updates and facility fall programs. Moreover, it was unclear from DMAVA’s written response and the accounts of senior DMAVA officials why the audit extended to Menlo Park, or whether it included the Vineland facility.

Overall, we found widespread dissatisfaction and low morale among the staff in both Veterans Homes. Employees reported that concerns about resident care, poor communication, and inadequate mental health support were not appropriately addressed by management. These concerns echoed the critical deficiencies in communication and leadership found by the U.S. Veterans Affairs during their emergency deployment to the Veterans Homes in 2020. The systematic failure to address employee concerns around resident care creates a risk of harm to the residents of the Veterans Homes.

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<sup>38</sup> Immediate Jeopardy represents a situation in which an entity’s noncompliance has placed the health and safety of individuals in its care at risk for serious injury, serious harm, serious impairment, or death. *See* [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_q\\_immedjeopardy.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf) at 2.

### **3. DMAVA's Self-Reported Efforts**

In June 2023, the State submitted to DOJ a summary of its efforts to address the ongoing deficiencies at the Veterans Homes. These efforts related to staffing, training, oversight, safety, disease prevention, and communication. Many of the measures described are welcome but are insufficient to improve outcomes for the residents of the Veterans Homes in a systematic or sustainable way. The State's recent efforts seem to do little to address the dynamic underpinning much of the dysfunction at the Veterans Homes: a lack of ownership over policy implementation and clinical care outcomes, and a lack of validated data to track those outcomes. For instance, while the report lists numerous outside consultants, many of whom will likely share valuable information with Veterans Homes staff, there is no indication of who, if anyone, has ultimate responsibility for implementing the reforms those consultants might suggest, and over the resulting outcomes.

The State represents that it instituted most of the described reforms between January and June 2022 but is silent about what, if any, improvements have resulted. To the contrary, the recent report acknowledges a need for outside leadership. The State recently awarded two contracts to outside vendors to assume certain management responsibilities for the Veterans Homes on a consulting basis. It does not appear as though those outside vendors have begun their work. While we commend the State for recognizing the need for outside help, the decision underscores the lack of internal capacity for change.

The past several years indicate that the Veterans Homes, even with the assistance of paid, outside consultants, cannot implement systematic changes to end the ongoing violations of the constitutional rights of the individuals in their care without external accountability. The Veterans Homes did not meaningfully reform their practices after an immediate jeopardy finding by CMS in Paramus in April 2020, after detailed and concrete recommendations from U.S. Veterans Affairs in June 2020, after hiring a consultant infection control specialist in late 2021 and 2022, or after settling private litigations related to the initial COVID response for over \$68 million in 2021 and 2022. In September 2022—nearly two years after DOJ announced its investigation—CMS found clinical care in Menlo Park so unsafe that the agency issued an immediate jeopardy finding.

### **4. DMAVA's Inadequate Cooperation Impeded DOJ's Investigation**

DMAVA's posture toward DOJ's investigation also raises questions about the agency's ability and willingness to accept oversight directly related to substantive concerns around resident care.

During the site visits in connection with this investigation, DOJ personnel observed DMAVA staff attorneys and facility management following DOJ staff around the facility far beyond what was necessary to provide direction, standing nearby as DOJ staff spoke to witnesses, and knocking on the doors of offices and rooms where witnesses were being interviewed. Witnesses reported that supervisors and managers inquired about what questions DOJ personnel had asked and specifically discouraged staff members from speaking with DOJ. For example, after the first site visit, the current CEO of the Paramus facility told department heads that DOJ could shut down the facility. Similarly, another supervisor said words to the effect of: "DOJ can shut us down, staff should be mindful of what they say." As a result, staff expressed concern about being seen speaking to us and feared they would face retaliation for doing so.



Around the time of DOJ’s initial site visit, two Paramus employees were instructed by management and DMAVA central office personnel not to put concerns about a resident in email because those emails could be used in litigation.

DMAVA’s response to DOJ’s subpoena and additional requests for information, including documents directly related to infection control and clinical care, was also troubling. Responses were delayed, incomplete, contained numerous wholly non-responsive documents, and regularly consisted of thousands of documents with little to no organization and in no discernible order. Resident medical records were particularly disorganized, with documents regularly out of order. Some charts contained records related to other residents. These production problems caused substantial delays and impeded the Department’s ability to effectively and expeditiously investigate potential CRIPA violations.

### **E. The Veterans Homes Continue to Have High Mortality Rates**

Given the foregoing deficiencies, and to account for the novelty of the original COVID outbreak and assess whether the Veterans Homes had appreciably improved outcomes in response to subsequent outbreaks, we reviewed mortalities at the Veterans Homes during the first months of the COVID Omicron variant outbreak from December 2021 through March 2022. It is not possible to make precise comparisons across nursing facilities by cause of death because of variability in reporting of COVID deaths, but comparisons based on overall mortalities are possible. The acuity level—or level of medical needs—of a particular facility’s population may, at times, explain a higher overall mortality rate. This is not the case for the Veterans Homes. While many residents require substantial assistance, they do not, based on data regularly provided to CMS, have a higher acuity level compared to other long-term care facilities within the State.

During the first months of the Omicron outbreak in 2021 and 2022, the Veterans Homes’ residents died at a rate that placed the facilities in the eighty-ninth percentile or higher among all long-term care facilities within the State. In other words, only eleven percent of all 346 long-term care facilities in the State of New Jersey had a higher all-cause death rate during the early months of the Omicron wave.

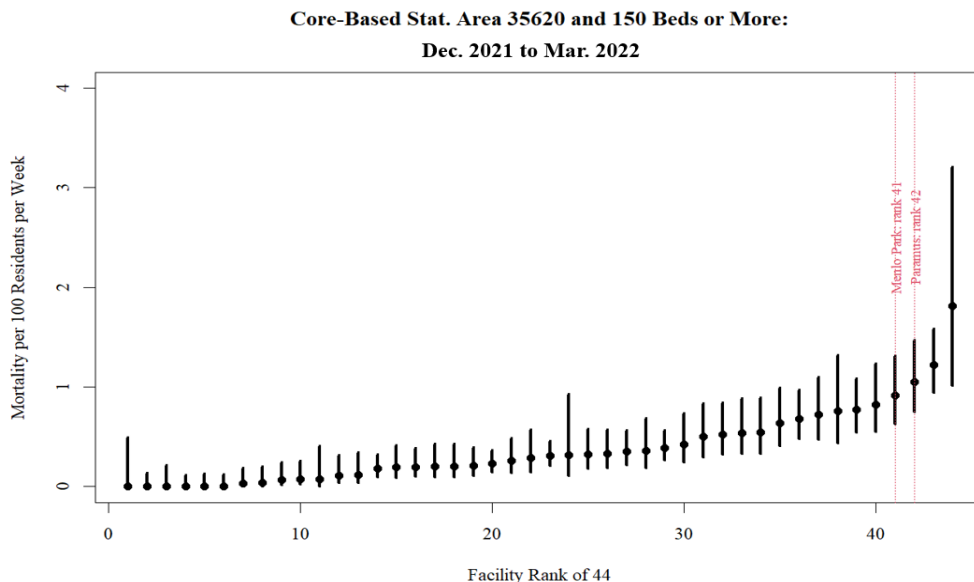
According to current research, location and number of beds are the most reliable predictors of COVID’s prevalence in a particular long-term care facility.<sup>39</sup> We therefore evaluated mortalities of all causes at long-term care facilities of similar size to the Veterans Homes—over one hundred and fifty occupied beds for at least one week during the relevant time period—in the same geographical region,<sup>40</sup> during the early months of Omicron wave. The Veterans Homes

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<sup>39</sup> R. Tamara Konetzka, Elizabeth M. White, Alexander Pralea, David C. Grabowski, Vincent Mor, *A systematic review of long-term care facility characteristics associated with COVID-19 outcomes*, J. of the Am. Geriatrics Soc’y 2766 (2021), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8631348/pdf/JGS-69-2766.pdf>.

<sup>40</sup> DOJ’s expert biostatistician used the core-based statistical area, a U.S. Census Bureau regional designation, to conduct this analysis. In areas with higher population density, a core-based statistical area has at least one urbanized area with a population of at least 50,000 or more, plus “adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties.” Both Veterans Homes are in the New York-Newark-Jersey City, NY-NJ-PA core-based statistical area, which includes the following New Jersey counties: Bergen County, Essex County, Hudson County, Hunterdon County, Middlesex County, Monmouth County, Morris County, Ocean County, Passaic County, Somerset County, Sussex County, and Union County.

continued to have substantially worse outcomes than similar facilities—the facilities had the third and fourth most mortalities out of the forty-four comparable facilities in the region:



These mortality rates indicate that the Veterans Homes have continued to experience significant difficulties in implementing adequate infection control measures.

## V. RECOMMENDED REMEDIAL MEASURES

The State should promptly implement measures to remedy the deficiencies discussed above. These remedial measures should include the following:

- **Infection control.** Provide infection prevention, detection, and control practices consistent with generally accepted professional standards of care, including maintaining and implementing clear and written infection control policies that are consistent with prevailing guidelines, ensuring timely and comprehensive training of staff, having a reliable system to ensure competency and compliance, and ensuring accountability over infection prevention, detection, and control practices;
- **General medical and physical health care.** Systematically provide general medical and physical health care consistent with generally accepted professional standards of care, including maintaining sufficient and available clinical expertise, staffing, medical records, and oversight mechanisms to timely detect and appropriately address changes in health status, prevent or mitigate health risks (e.g., falls, wounds, weight loss), ensure accountability over clinical care outcomes, and otherwise provide appropriate clinical and nursing care;
- **Quality management.** Maintain valid and reliable data within the facilities and at DMAVA sufficient to identify health outcomes, trends, and status changes at the individual, unit, and facility level; and identify and address the root cause of those trends to prevent or mitigate

the occurrence of harmful outcomes and trends, and to maximize positive outcomes and trends; and

- Oversight and accountability. Implement oversight and accountability mechanisms within the facilities and at DMAVA sufficient to ensure that policies and practices embodying current, generally accepted professional standards of care are reliably implemented, that the Veterans Homes maintain an adequate level of emergency preparedness, staff are properly trained and supported to complete assigned responsibilities in a consistent and competent manner, and that remedial and corrective actions foster an engaged and effective workforce.

## **VI. CONCLUSION**

The Department has reasonable cause to believe that New Jersey violates the constitutional rights of the residents of its Veterans Memorial Homes at Menlo Park and Paramus by failing to implement infection control protocols and failing to provide adequate medical care. We look forward to working cooperatively with the State to reach agreement on the remedies for these violations.

We are obligated to advise you that forty-nine days after issuance of this report, the Attorney General may initiate a lawsuit under CRIPA to correct the deficiencies identified in this report if State officials have not satisfactorily addressed our concerns. 42 U.S.C. § 1997b(a)(1). The Attorney General may also move to intervene in related private suits fifteen days after issuance of this report. 42 U.S.C. § 1997c(b)(1)(A). Please also note that this report is a public document. It will be posted on the Civil Rights Division's website.