



OFFICE OF THE INSPECTOR GENERAL
COMMONWEALTH OF MASSACHUSETTS

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INSPECTOR GENERAL

**Holyoke Soldiers' Home,
May 2016 to February 2020**

APRIL 29, 2022

A LETTER FROM THE INSPECTOR GENERAL

Thank you for reading *Holyoke Soldiers' Home, May 2016 to February 2020*. I would like to take this opportunity to provide you with more information about this report, as well as additional related work that the Office of the Inspector General for the Commonwealth of Massachusetts (Office) has undertaken to address issues at both the Holyoke and Chelsea Soldiers' Homes (Soldiers' Homes).

As many of you know, the mission of the Office is to promote good government by preventing and detecting the misuse of public funds and public property. The Massachusetts Legislature established the Office in response to the 1980 report by the Special Commission Concerning State and County Buildings (better known today as the Ward Commission). The Ward Commission found widespread corruption in the awarding of state contracts. As a result, the Legislature created the Office, the first statewide inspector general's office in the nation, with the mandate to prevent and detect fraud, waste and abuse in the expenditure of public funds.¹

Holyoke Soldiers' Home, May 2016 to February 2020, emanated from the Office's investigation into a complaint it received in November 2019. The complaint focused primarily on the leadership of Superintendent Bennett Walsh at the Holyoke Soldiers' Home (Home) until September 2019 and included allegations of payroll fraud, misuse of state funds, misuse of employee resources and retaliatory behavior against the Home's employees. The Office conducted an initial investigation of these allegations. Based on this initial investigation, the Office determined that the allegations in the complaint pointed to issues concerning oversight and management.

Accordingly, during this investigation I directed the Office to undertake a deliberate and thoughtful review of the Home during Superintendent Walsh's tenure. The Office adjusted its scope of work to include the oversight, governance and management structure of the Home, as well as the hiring and supervision of the superintendent, between May 2016 and the end of February 2020. We identified critical issues with management and oversight and created a comprehensive blueprint for lasting improvements. To that end, this report includes a detailed set of recommendations that seek to ensure our veterans live in a well-managed home.

Consistent with the Office's mandate and mission, *Holyoke Soldiers' Home, May 2016 to February 2020*, focuses on leadership and oversight during the four years before the outbreak of the COVID-19 pandemic at the Home. As the devastating impacts of the pandemic on the Home in March 2020 became clear, the Massachusetts Office of the Attorney General and the United States Attorney's Office for the District of Massachusetts announced investigations into the events related to COVID-19. The Office did not conduct its own investigation into these events; such an investigation would have fallen outside of the Office's mandate and expertise.

¹ M.G.L. c. 12A, § 7.

The publication of *Holyoke Soldiers' Home, May 2016 to February 2020*, is only one piece of a larger effort by the Office to address issues related to both Soldiers' Homes. Our investigation found fundamental flaws in the infrastructure for the Soldiers' Homes, many of which are within the Legislature's power to fix. Accordingly, the Office has made outreach to the Legislature a priority. Within our report, you will find the Office's extensive recommendations to the Legislature (see appendix C). The Office has provided these recommendations to the Legislature as it drafted bills to reform the structure of both Soldiers' Homes. For example, the Office recommended critical changes to the governance structure and management practices, including the addition of clinical oversight, of the Soldiers' Homes. In addition, to create channels for communication, the Office has recommended the creation of an ombudsperson and hotline to receive and address complaints about the Soldiers' Homes. In its pending legislation, the Legislature has adopted many of the Office's recommendations.

During the past year, the Office has also been working to address new concerns from the Soldiers' Homes. Throughout 2021 and 2022, the Office has received numerous additional complaints regarding both Soldiers' Homes. The complaints involved clinical issues, such as concerns about infection control, as well as significant management issues in both Homes.

The Office took careful steps to address the complaints that involved infection control as expeditiously as possible. Because these complaints fell outside of the Office's statutory authority and required clinical expertise, the Office notified the Department of Public Health (DPH). While protecting the confidentiality of the complainants, the Office provided DPH with detailed information about the complaints and requested that DPH work with staff at the Soldiers' Homes on their infection control and other related clinical practices. DPH agreed to respond, even though there is no statutory mandate for DPH to provide clinical oversight to the Soldiers' Homes. Moreover, the Office has recommended that the Legislature provide a new mandate to DPH and appropriate funding to create ongoing clinical oversight and support for the Soldiers' Homes.

Monitoring the Soldiers' Homes' implementation of long-standing recommendations from outside consultants and past studies is also an important part of the Office's current work. For example, since at least 2015, consultants and studies have recommended that both Homes implement an electronic medical records management (EMR) system. The Executive Office of Health and Human Services (EHS) and the Department of Veterans' Services (DVS) have not made EMR a priority for the Homes. Our Office has also highlighted this issue in multiple letters to the Legislature over the past year. The Office has recommended that the Legislature take an active role in monitoring EMR implementation.

Finally, the Office has reviewed specific aspects of the fiscal structure and management of the Holyoke Soldiers' Home, including internal controls and segregation of duties. Through its investigation, the Office found that in addition to managing state allocations of approximately \$26 million, the Home's staff also managed an account of donations of over one million dollars. Both the staff at the Home and its Board of Trustees (Board) considered these donations to be Board funds. As appointed trustees of the Home, the Board has a responsibility to be careful, diligent and thoughtful in its management and use of the funds. However, the Office's investigation revealed that the Board did not exercise the appropriate

degree of care by, for example, establishing specific rules for how to invest or expend the Board funds. Nor did the Home or the Board have specific statutory authorization to accept, invest or expend these funds.²

In addition, the Office learned that the Home maintains several financial accounts that do not comply with the fiscal requirements for state agencies. During the Office's investigation, the Home's staff reported that the Home does not use a state-approved bank, provide reports to any state oversight entity, or use best fiscal practices to manage and expend these funds. Moreover, the Home did not have specific statutory authorization to hold or expend these funds. The Office will report on the Board's and Home's management of accounts and the overall fiscal management of the Home, including the lack of controls and segregation of duties, in a future publication.

Holyoke Soldiers' Home, May 2016 to February 2020, illustrates how vital it is to maintain oversight and sound management practices for the Soldiers' Homes and all state agencies and programs. I expect EHS and DVS will implement our recommendations to strengthen their oversight and supervision of agencies and programs, as part of an essential effort to improve quality and integrity in government. The Soldiers' Homes also must implement our recommendations and improve their management practices so that the staff can provide the care that our veterans need and deserve.

Thank you.

Sincerely,



Glenn A. Cunha

² Under state law, state agencies may not retain any donated funds unless the law specifically authorizes an agency to do so. See M.G.L. c. 29, § 2.

TABLE OF CONTENTS

Executive Summary.....	1
I. The Soldiers’ Home in Holyoke.	1
II. Former Superintendent Bennett Walsh.....	2
III. The Office’s Investigation.....	3
IV. Summary of the Office’s Findings and Recommendations.	4
Investigative Findings.....	7
I. EHS Secretary Sudders and Governor Baker made the final selection of Bennett Walsh to lead the Soldiers’ Home.	7
II. Superintendent Walsh did not have and did not develop the leadership capacity or temperament for the role of superintendent.....	11
III. EHS and DVS staff knew that Superintendent Walsh had leadership and management problems, but they did not take appropriate action to address those problems.	19
IV. EHS and DVS bolstered Superintendent Walsh in his role and perpetuated the leadership and management problems at the Home.	34
V. Secretary Ureña and the Board of Trustees were aware of Superintendent Walsh’s leadership failings and management issues but did not take timely and adequate steps to address them.	42
Conclusion and Recommendations	48
I. Recommendations for the Legislature.....	49
II. Recommendations for the Department of Veterans’ Services (DVS) and the Soldiers’ Homes.....	52
III. Recommendations for the Executive Office of Health and Human Services (EHS).	54
Appendix A: Executive Branch Organization Chart.....	57
Appendix B: List of People Included in This Report, by Agency.....	59
Appendix C: Letters to the Legislature	62

EXECUTIVE SUMMARY

The Office of the Inspector General for the Commonwealth of Massachusetts (Office) is an independent state agency charged with preventing and detecting fraud, waste and abuse in the use of public funds and public property.³ By statute, the Office has broad authority to oversee the use of state, local and federal funds by state and local governments, as well as by those who receive government funds or use public property. This includes state agencies, counties, cities, towns, quasi-governmental authorities and districts, as well as individuals, corporations and not-for-profit organizations that do business with the government.

To fulfill its broad mandate, the Office investigates allegations of fraud, waste and abuse at all levels of government and reviews programs and practices to identify vulnerabilities and opportunities for improvement. It also conducts investigations into companies and other organizations, such as vendors that contract with state and local governments to provide goods and services. Moreover, the Office's Bureau of Program Integrity (Bureau) conducts oversight of the agencies and programs within the Executive Office of Health and Human Services (EHS).⁴ The Bureau monitors the quality, efficiency and integrity of programs administered by EHS agencies and seeks to prevent, detect and correct fraud, waste and abuse.

When conducting an investigation or review, the Office has the authority to subpoena records, interview witnesses and take testimony under oath. At the completion of an investigation, review or other project, the Office may issue a letter or report detailing findings and outlining recommendations to prevent future fraud, waste and abuse.

I. The Soldiers' Home in Holyoke.

The Soldiers' Home in Holyoke (Home) has provided state-funded care for veterans in western Massachusetts since 1956. The Home is one of two Soldiers' Homes in the Commonwealth; the second is in Chelsea. The Home provides veterans with long-term care, hospice care, full-time residential accommodations, an on-site dental clinic, a veterans' assistance center and an outpatient department. It has beds for up to 247 veterans in its long-term care facility.⁵ Its operating budget for fiscal year 2022 is \$26.9 million.

As of the date of this report, the Legislature is actively working on statutory changes to how the Home operates.⁶ The current statute creates a seven-member volunteer Board of Trustees (Board) with

³ M.G.L. c. 12A, § 7.

⁴ M.G.L. c. 6A, § 16V.

⁵ The Home also had a dormitory that housed 30 veterans; it closed in early 2022.

⁶ H. 4441, 192nd Gen. Court, Reg. Sess. (Mass. 2022); S. 2761, 192nd Gen. Court, Reg. Sess. (Mass. 2022).

the authority to manage and control the Home.⁷ The governor appoints the seven members of the Board, which must include residents from Berkshire, Franklin, Hampden and Hampshire counties in western Massachusetts.⁸ Besides the statutory residency requirement, the law does not require that the trustees have any specific qualifications, such as veteran status or a background in healthcare or finance. The trustees serve seven-year terms. Massachusetts law vests in the Board the power to appoint the superintendent, who is responsible for the day-to-day operations of the Home.⁹

Under the current statutory structure, the superintendent of the Home reports to the secretary of the Department of Veterans' Services (DVS). DVS is the agency within EHS that is responsible for advocating for veterans, providing support services and directing an emergency financial assistance program for veterans in need of aid.¹⁰

II. Former Superintendent Bennett Walsh.

Bennett Walsh became the superintendent of the Home in May 2016. Before coming to the Home, he had served in the United States Marine Corps since 1992; his resume lists his positions as field and company grade infantry officer, recruiting officer, operations officer/program manager, executive officer, safety officer, faculty instructor and the executive officer for Parris Island, South Carolina. His duties included overseeing large groups of military personnel. His resume does not include any direct or supervisory experience in a healthcare setting or skilled nursing facility. During the superintendent's tenure, DVS Secretary Francisco Ureña was his direct supervisor; Secretary Ureña reported to the EHS secretary, Marylou Sudders.

On March 30, 2020, EHS leadership placed Superintendent Walsh on paid administrative leave pending an investigation into a major COVID-19 outbreak at the Home. Ultimately, that outbreak resulted in the death of at least 76 residents and widespread illness among staff. A day after the June 23, 2020, publication of the report the governor commissioned to investigate the COVID-19 outbreak at the Home, Secretary Sudders sent Superintendent Walsh a termination letter. A court later found this termination letter to be void because the Board, not the EHS secretary, was the proper body through which the governor could have exercised any authority to remove him. A month after the court's decision, on October 13, 2020, the Board accepted Superintendent Walsh's resignation.

⁷ M.G.L. c. 6, § 71.

⁸ M.G.L. c. 6, § 70.

⁹ M.G.L. c. 6, § 71.

¹⁰ Section 16 of Chapter 6A of the Massachusetts General Laws places the Home within the Department of Veterans' Services (DVS). DVS, in turn, resides within EHS, the largest secretariat in the Executive Branch, which oversees 12 human services agencies, the MassHealth program, and the Holyoke and Chelsea Soldiers' Homes. The governor appoints the EHS Secretary, who is responsible for the administration, management and operation of the departments, boards and agencies within EHS. See appendix A for an organization chart.

III. The Office's Investigation.

In 2019, the Office began an investigation after it received an anonymous complaint from staff from the Home. The Office conducted an initial investigation into the allegations in the complaint. Based on this initial investigation, the Office determined that the allegations in the complaint pointed to broader issues related to oversight and management. Accordingly, the Office adjusted its scope of work to examine these issues.

Consistent with the Office's mandate and mission, the Office focused on leadership and oversight during the four years before the outbreak of the COVID-19 pandemic at the Home, between Superintendent Walsh's appointment in May 2016 and the end of February 2020. As the devastating impacts of the pandemic on the Home in March 2020 became clear, the Massachusetts Office of the Attorney General and the United States Attorney's Office for the District of Massachusetts announced investigations into the events related to COVID-19. The Office did not conduct its own investigation into these events; such an investigation would have fallen outside of the Office's mandate and expertise.

The Office's investigation included more than two dozen witness interviews, many under oath, and the review of over 100,000 paper and electronic records from numerous individuals and agencies, including the Home, Board, DVS and EHS.¹¹ These records included:

1. Records from the Home, including internal and external communications, time and attendance documents, policies and procedures, and other related documents.
2. Records from EHS, including personnel records, investigation materials and reports, and internal and external communications.
3. Records from the Board, including meeting minutes and materials, financial records and reports.
4. Records from other state agencies and outside entities related to the Home.

The Home, Board, DVS and EHS did not always keep complete records and could not locate some records that the Office requested.

The Office devoted substantial time and resources to interviewing witnesses and reviewing these materials as part of this investigation. This report does not include detailed findings related to every allegation that the Office investigated; instead, the Office focused this report on management and oversight of the Home.

¹¹ The Office did not interview Bennett Walsh. Counsel for Superintendent Walsh informed the Office that his client would decline to respond to any questions and would instead invoke his Fifth Amendment right against self-incrimination.

IV. Summary of the Office's Findings and Recommendations.

The Office found extensive mismanagement and oversight failures at the Home. First, the current location of the Home within EHS and DVS does not create a clear structure for oversight. Second, senior leaders at EHS and DVS ineffectively supervised the superintendent and the Home, oftentimes in a sporadic and disjointed manner in reaction to complaints or events. Third, Superintendent Walsh did not have the managerial skills or temperament to properly oversee the Home's operations. Specifically, the Office found:

1. The governor, EHS and the Board failed to follow the required statutory framework for hiring a new superintendent for the Home. The EHS secretary met only with Superintendent Walsh and the governor appointed him. After deferring to the governor on Superintendent Walsh's hiring, the Board regularly deferred to the superintendent throughout his tenure.
2. Superintendent Walsh did not have and did not develop the leadership capacity or temperament for the role of superintendent, during his nearly four years on the job. He created a negative work environment, engaged in retaliatory behavior, demonstrated a lack of engagement in the Home's operations, circumvented the chain of command and bristled against supervision.
3. EHS and DVS failed to adequately address complaints from the Home's senior managers and other employees about Superintendent Walsh's leadership and the management of the Home. EHS and DVS staff did not recognize that multiple similar complaints about Superintendent Walsh pointed to serious leadership and management issues at the Home. EHS did not have an organized, systematic method for addressing, documenting or investigating employee complaints. When EHS conducted investigations into the complaints, the investigations were limited, flawed and biased. In addition, EHS's human resources managers hampered an investigation by the Commonwealth's Investigations Center of Expertise into the superintendent.
4. EHS leadership spent time and public resources attempting to improve Superintendent Walsh's management skills. However, EHS failed to regularly document, coordinate or review the efficacy of these efforts. Although Superintendent Walsh was not improving, EHS and DVS leadership did not coordinate with each other or with the Board to evaluate whether he should remain in his role.

Based on its findings, the Office developed a detailed set of recommendations for meaningful and long-lasting improvements. The recommendations focus on fixing longstanding structural problems, addressing fundamental flaws related to oversight, streamlining management and promoting accountability at the Home and its counterpart in Chelsea (together, the Soldiers' Homes).

Many of the problems this report identifies occurred because of gaps in supervision and oversight. To set the foundation for the provision of high-quality long-term care at the Soldiers' Homes, one person must be responsible for the oversight and management of the superintendents: one person must have the authority and responsibility to appoint, supervise, discipline and remove the superintendent. This report also highlights the importance of effective processes to evaluate and respond to employees' concerns. Finally, when creating a new governance structure for the Soldiers' Homes, serving the healthcare needs of the veterans should remain the highest priority.

To that end, the Office sets out detailed recommendations to the Legislature, DVS and EHS at the conclusion of this report. The following is a brief overview of these recommendations.

Legislative Reform. The Office recommends the Legislature consider the following steps to strengthen the governance and clinical oversight of the Soldiers' Homes:

1. Vest the DVS secretary with the responsibility and authority necessary to ensure the superintendents properly manage the Soldiers' Homes. This would include elevating the DVS secretary to the governor's cabinet, and providing the DVS secretary with the authority to appoint, supervise and remove the superintendent of each of the Soldiers' Homes.
2. Create specific requirements for the superintendents, including that all future superintendents be licensed nursing home administrators and have extensive management experience.
3. Remove management responsibilities from the Boards of Trustees for the Soldiers' Homes (Boards); if the Legislature keeps the Boards, reconstitute them as advisory bodies whose members have experience with veterans' issues, healthcare, nursing, fiscal management and labor relations.
4. Establish and fully fund an ombudsperson and hotline to allow confidential reporting by residents, relatives, staff and concerned citizens.
5. Vest the Department of Public Health (DPH) with the authority to provide independent and ongoing clinical oversight and support for the Soldiers' Homes.

DVS Oversight and Management. To improve the management oversight of the Soldiers' Homes, the Office recommends that DVS:

1. Create clear standards, procedures and controls for oversight of the Homes' superintendents.
2. Implement thorough and effective policies and training about the standards and expectations for a professional work culture at the Soldiers' Homes, and hold the superintendents accountable for maintaining a professional and responsive work environment.

3. Work in partnership with DPH to maintain best clinical practices at the Homes.

EHS Oversight and Management. Even if the Legislature removes DVS from EHS, EHS will remain the state's largest secretariat, accounting for approximately one-third of the state's annual budget. To improve EHS's oversight and management practices, the Office recommends that EHS:

1. Improve its oversight of each EHS agency. This includes creating and maintaining a clear reporting structure and chain of command for each of its agencies, and regularly evaluating the performance of agency heads through mandatory, structured performance evaluations.
2. Improve the quality and the integrity of its human resources investigations by employing professionally trained investigators, implementing clear policies and procedures, and conducting fair, objective and thorough investigations.

INVESTIGATIVE FINDINGS

I. EHS Secretary Sudders and Governor Baker made the final selection of Bennett Walsh to lead the Soldiers' Home.

As set forth above, state law vests the Home's Board with the authority to manage and control the Home as well as to appoint its superintendent.¹² None of the laws pertaining to the Home require the superintendent to have specific licenses or qualifications, such as experience running a long-term care facility. Moreover, none of the laws provide any role in the selection process for the DVS secretary, to whom the superintendent reports.

Additionally, neither the governor nor the EHS secretary has the statutory authority to appoint the superintendent. When it came time to hire a new superintendent in 2015, however, Governor Baker advised the Board that he would appoint the superintendent. EHS staff directed the selection process, working with the Board to draft the job posting and providing the Board with a hiring timeline and interview questions. Although the statute gives the all-volunteer Board the authority to hire the superintendent, the Board did not have the staff, resources or expertise to conduct a competitive hiring process. Rather than actively working with EHS, DVS or an outside staffing agency to support the Board's own hiring process, the Board allowed the governor and EHS staff to manage the process and appoint the new superintendent.

Early in the process, EHS staff indicated that Secretary Sudders and the governor would interview all the Board's final candidates. The Board identified three finalists for the position, and Secretary Ureña sent all three names to Secretary Sudders. Despite receiving the names of the three finalists from the Board through Secretary Ureña, Secretary Sudders interviewed only one candidate: Bennett Walsh.

A. EHS staff oversaw and managed the hiring process that resulted in Superintendent Walsh's appointment.

On December 15, 2015, the Home's superintendent and deputy superintendent, Paul Barabani and John Paradis, announced their resignations. On December 21, Governor Baker sent a letter to the Board stating that he would appoint the new superintendent. In his letter, the governor stated that the Board chair should appoint a committee to conduct a search and recommend candidates for appointment.

During a Board meeting on December 23, 2015, the Board chair read Governor Baker's letter aloud. The trustees discussed the interview process and all the trustees volunteered to participate on the search committee. The Board disagreed with the governor about who had the authority to appoint the

¹² M.G.L. c. 6, § 71. The Legislature has proposed changes to this statute, but as of the date of this report, those changes have not become law.

superintendent, but the Board ceded its authority to the EHS attorney at the meeting who supported the governor's interpretation of the appointment process.

On January 6, 2016, the Board chair sent the other trustees the job posting that he developed with DVS and EHS after reviewing the posting from the previous superintendent search. The new posting required at least six years of full-time or equivalent part-time supervisory or managerial experience in business administration, business management or public administration, with at least four years in a managerial capacity. It had no other minimum requirements, such as veteran status, healthcare licensure or experience managing a long-term care facility. The posting was consistent with the Board's desire to find a strong manager. The qualifications in the posting were also consistent with those of past superintendents, who had not had experience running a veterans' home or a nursing home before coming to work at the Home.

In response to the proposed posting, one trustee suggested that the superintendent be a licensed nursing home administrator, "[s]omeone who by education, experience and certification has proven the understanding and competence of running a long [sic] term care facility." The trustee expressed surprise that this was not a requirement and wrote that "at a minimum the person needs to have a few years [sic] experience in running a healthcare facility." Despite this suggestion, the job posting remained unchanged, and the advertisement for the superintendent position appeared in five publications, including on the Massachusetts state website.

At the next Board meeting, the chair told the other trustees that someone from EHS would determine which applicants met the minimum requirements in the posting but that the trustees would receive copies of all applications. The trustees decided that the Home's medical director, director of nursing and one member each of the family and veterans' advocate councils would participate on the search committee.¹³

In February 2016, staff from EHS's human resources (HR) department compiled a list of the 21 applicants who they felt met the minimum requirements in the posting. At the Board meeting on February 17, an EHS representative briefly described the hiring process, and the trustees discussed the screening tool, the interview questions and the following hiring timeline:

¹³ The trustees later agreed that they would allow the family and veterans' advocate councils to submit proposed interview questions and list desirable qualifications for the superintendent. However, representatives from these councils, the medical director and the director of nursing did not participate in the interviews.

Date	Milestone(s)
February 22	Trustees individually review resumes and notify Board chair which candidates they would like to interview.
February 26	Trustees meet in executive session to review lists of candidates and determine which candidates should receive interviews.
February 29	Selected candidates contacted for scheduling.
March 11	Trustees conduct “preliminary screening interviews” and narrow the pool to between two and four candidates.
March 14	Final two-to-four candidates submit background check paperwork to the Governor’s Office.
March 18	Trustees interview the final two-to-four candidates.
March 21-25	Final candidates “meet/interview with Secretary of EOHHS and Governor.”
March 28	Background check “and other required steps” completed. Governor extends offer letter to the final candidate.

Figure 1: Proposed EHS hiring timeline for 2016.

At the Board’s next meeting on February 26, 2016, the trustees reviewed resumes and voted on which of the 21 candidates to interview; the Board included Mr. Walsh among the seven candidates to interview.¹⁴

The trustees met three times in March 2016 to interview the seven candidates. Secretary Ureña, Interim Superintendent Cheryl Lussier Poppe, a member of EHS’s labor relations team and an administrative assistant from the Home attended each of the interviews.¹⁵

Secretary Ureña and the seven trustees gave each candidate a score of one to five on each of twelve questions. The scores for each candidate were added together to reach a cumulative interview score; the highest possible score from all eight interviewers would have totaled 480 points. Mr. Walsh received the highest cumulative interview score (449.5) among all the candidates; the next highest scoring candidates’ interview scores were close behind at 444 and 431.

Mr. Walsh’s resume showed years of military leadership and management experience that were consistent with the job posting requirements. The other two candidates had extensive experience

¹⁴ Secretary Ureña wanted the Board to interview an eighth candidate, John Crotty. Mr. Crotty had run a Veterans’ Administration nursing home, and Secretary Ureña thought that he looked like a strong candidate. The Board did not interview Mr. Crotty because he was out of town during the week of interviews. The trustees felt that they had to fill the leadership vacuum at the Home and keep to the EHS timeline. Superintendent Walsh later hired Mr. Crotty to serve as the Home’s deputy superintendent.

¹⁵ At the time, Cheryl Lussier Poppe was the superintendent at the Soldiers’ Home in Chelsea and the interim superintendent at the Soldiers’ Home in Holyoke. She is now the DVS secretary. Neither EHS nor the trustees documented the role of Interim Superintendent Poppe or the EHS labor relations staff at the interviews.

operating healthcare facilities, and both were licensed nursing home administrators. One applicant had worked in administrative roles in skilled nursing facilities since 1994; the other applicant had worked in skilled nursing administration since 2006, having started as an assistant food service director at a skilled nursing facility in 1990. Neither of these two candidates was a veteran.

One trustee believed that Mr. Walsh had to be in the final slate of candidates. This trustee also had the impression that the governor did not want the Board to send him candidates of whom he would not approve. The trustee's overall sense was that Mr. Walsh was considered a top candidate by the administration and that the administration had predetermined the decision to appoint Mr. Walsh. The trustee also believed that the Board could not have changed the decision or made the process go in a different direction. Other trustees did not share this trustee's impressions and beliefs.

B. Secretary Sudders met with only one of the three finalists: Bennett Walsh, and Governor Baker made the actual appointment.

After the trustees had interviewed and ranked the candidates, they discussed what information to transmit to the governor. The trustees voted unanimously to recommend to the governor that he consider only the top three candidates. The Board did not document whether it ranked the three candidates in order of preference.

On March 21, 2016, Secretary Ureña emailed Secretary Sudders the resumes of the three final candidates that the Board selected "in order of precedence." The email placed Mr. Walsh as the first candidate, followed by the two candidates who had scored just below him. In his email, Secretary Ureña also asked for Secretary Sudders' approval to request background checks on the three candidates so that they could proceed to the next steps.

The Office requested from EHS copies of all application forms completed by candidates for the superintendent position. This application form includes a section where candidates authorize Commonwealth agencies to conduct background checks. Although six other candidates interviewed with the Board, EHS produced only Mr. Walsh's form. He signed the application form on March 8, several days before his interview with the Board. EHS did not provide the Office with completed background check forms for any of the six other candidates, including the two other finalists for the position that Secretary Ureña mentioned in his email to Secretary Sudders.

The timeline that EHS had prepared for the hiring process indicated that Secretary Sudders and Governor Baker would meet with the Board's "[f]inalist candidates." Nevertheless, Secretary Sudders met only with Mr. Walsh. Governor Baker met with Mr. Walsh and signed his appointment letter, dated May 26, 2016.

In summary, although the law requires that the Board appoint the Home's superintendent, EHS staff led much of the hiring process, Secretary Sudders met with only one of the three top candidates, and Governor Baker made the actual appointment. This both supplanted the Board's role and did not comply

with state law. The Board allowed this process to move forward even though the trustees recognized their authority to appoint the superintendent.

II. Superintendent Walsh did not have and did not develop the leadership capacity or temperament for the role of superintendent.

Superintendent Walsh did not have and did not develop the leadership capacity or temperament required for his role. He was hostile and retaliatory, particularly when staff raised concerns or participated in human resources (HR) investigations about his behavior.¹⁶ He failed to comply with directives from those in authority and bristled against supervision. He clashed with DVS Secretary Ureña, DVS Chief of Staff Paul Moran and some of the Board's trustees. He seemed to enjoy spending time with veterans at the Home but otherwise demonstrated a lack of engagement and investment in the Home's operations. He received a disciplinary letter for failing to respect veterans' privacy and may have violated state ethics laws.

A. Superintendent Walsh did not have the temperament required to lead the Home.

Superintendent Walsh did not have the temperament to lead his management team or oversee the clinical, administrative and support staff at the Home. He was quick to anger and intimidated Home employees. He retaliated against individuals who angered him or whom he viewed as disloyal. He prohibited certain members of his staff from talking with EHS, DVS and the Board. He became upset when Secretary Ureña or DVS Chief of Staff Paul Moran tried to supervise him, and he did not follow EHS and DVS policies regarding media interactions.

First, Superintendent Walsh, by his own description, had a short temper.¹⁷ He became visibly angry with employees, yelled at them and stated publicly that he wanted to "hit" and "belt" one particular employee; he also said that he wanted to hurt a veteran who had spoken out against him. He would tell staff that they were "dead" to him. He interpreted staff comments and concerns as disloyalty or personal attacks on him. For instance, he became visibly angry with an employee during a meeting because she said that she had to leave at a specific time. He berated her in front of her colleagues to the point where she became visibly upset.

Second, Superintendent Walsh retaliated against members of his management team when he believed that they did not support him. His primary form of retaliation was to "freeze out" management staff by no longer inviting them to meetings, giving them the "cold shoulder," and making decisions without consulting them on issues that were within their job responsibilities.

¹⁶ See section III of the investigative findings for more information about these investigations.

¹⁷ He acknowledged that he had a temper and that he could "simmer" and "explode."

For instance, after one investigation into his behavior, Superintendent Walsh met with several members of his management team in early 2019.¹⁸ He told them that he had received a copy of the investigative report and that the investigator had told him that he had a “mole” on his team. After that meeting, he started interacting with people differently based on his perception of whether they supported him during the investigation or whether he thought they were the mole. He began alienating himself from key members of his leadership team: Jessica Powers, the HR liaison; Alice Pizzi, the general counsel; Erin Spaulding, the chief financial officer; and John Crotty, the deputy superintendent.

Similarly, in April 2019, after Superintendent Walsh learned that Lori Beswick, his administrative assistant, had spoken with a trustee about a change in her job, the superintendent punished Ms. Beswick by changing her work hours. Ms. Beswick, who had worked for the Home for approximately 25 years, resigned three days later, citing Superintendent Walsh’s “inexplicable personal animosity” towards her and a “hostile work environment” as reasons for leaving. This was the last in a series of events between Ms. Beswick and the superintendent; both acknowledged that their working relationship began to break down a year into his tenure, although their descriptions of the reasons for their difficulties differed significantly.¹⁹

The superintendent also tried to limit communication among his staff, and between his staff and EHS, DVS and the Board. For example, he told Ms. Beswick that she had to go through him any time she needed information. He also instructed his staff not to speak directly with the trustees or staff from EHS or DVS. Likewise, he told DVS managers to reach out to him, not his staff, if they had any questions. He asked trustees to come to him with their questions, rather than ask any of the Home’s staff. He also became upset when he learned that trustees were talking with staff from EHS and DVS when he was not present.

Finally, Superintendent Walsh disregarded directives from leadership, and he bristled against being supervised. He frequently complained about Secretary Ureña and his chief of staff and did not recognize the DVS secretary’s authority. On several occasions, when the DVS chief of staff reminded Superintendent Walsh to comply with rules and policies, the superintendent failed to comply. In addition, when the chair of the Board wanted to better understand the Board’s finances, Superintendent Walsh objected to the additional scrutiny and created a rift between trustees.

B. Superintendent Walsh failed to manage the Home’s staffing issues effectively.

The Home had significant staffing difficulties that began well before the superintendent’s tenure. As a result, he inherited challenging, complex staffing issues. When he began his work at the Home, Interim Superintendent Poppe gave him detailed six-page transition memorandum. In that memorandum, she noted the need for an electronic medical records system and identified two major staffing concerns:

¹⁸ See section III(D) of the investigative findings for more details about the Morin investigation.

¹⁹ Broadly stated, Ms. Beswick attributed the difficulties to the superintendent’s temperament. Superintendent Walsh attributed the difficulties to Ms. Beswick’s job performance.

nursing vacancies (the result of an early retirement program) and staffing patterns.²⁰ Because the Home is a 24/7 direct care facility that is responsible for veterans with complex medical needs, staffing should have been a priority for Superintendent Walsh. As a result, the Home needed stability in its direct care staffing as well as in its operations management. Superintendent Walsh did not make these goals his top priority and missed opportunities to improve stability in the Home.

The Home's primary staffing issue was the lack of a permanent schedule that would allow the direct care staff to know in advance what days and times they were working. During Superintendent Walsh's tenure, several staffing studies recommended that the Home should make it a priority to put a permanent schedule in place that matched the level of care that the veterans required. The staffing studies indicated that a permanent schedule would have provided continuity of care and stability, increased staff morale and decreased staff absences.²¹

However, Superintendent Walsh was not engaged in the staffing problems and did not prioritize or work to resolve the Home's ongoing staffing issues. For example, on Sunday, February 5, 2017, the New England Patriots played the Atlanta Falcons in Super Bowl LI. A few days before the game, Superintendent Walsh sent an email to the direct care staff suggesting that sports fans who wanted to watch the game submit requests for time off that Sunday or the following Monday. One of the direct care staff members tried to explain to him that the Home was short-staffed; there were not enough staff members to cover individual requests for vacation time submitted months in advance, let alone widespread requests submitted days in advance. This example demonstrates Superintendent Walsh's lack of understanding about the direct care staffing issues at the Home.

EHS sponsored a staffing study with Suffolk University in 2018 (the Suffolk study). EHS had to repeatedly remind the superintendent to provide data and other information to the researchers. They ultimately suggested that he create a timeline to "ensure that this project is completed on time and with the level of analysis needed." At the end of the Suffolk study, the lead researcher recommended that the Home continuously monitor overtime, implement a permanent schedule for direct care staff, maximize

²⁰ Interim Superintendent Poppe's memorandum also recommended conducting a cost benefit analysis of the Home's outpatient clinic, better aligning the Home's budget to address staffing costs, addressing outstanding pharmacy bills, standardizing the use of Board funds, evaluating canteen operations, creating joint legal, policy and operational reviews with the Chelsea Soldiers' Home, changing the dress code, controlling involvement with the motorcycle run, outsourcing laboratory services, finding an alternate use for the adult healthcare space, working union relationships, examining medical staffing and compensation, becoming a Medicare provider, and refining the admissions process.

²¹ Interim Superintendent Poppe initiated an in-house staffing study in 2016 and noted that the Board had approved funding for a staffing study by Pathways Healthcare Consultants. Also in 2016, the Public Consulting Group issued a report on both Soldiers' Homes, recommending that the Holyoke Soldiers' Home conduct a full analysis of staffing patterns to avoid "constantly scrambling to cover 8 hour shifts when only 2 to 3 hours of those shifts require additional staff[.]" In 2017, Secretary Sudders sent Secretary Alice Bonner of Elder Affairs to conduct a review of the Home; Secretary Bonner recommended an analysis of the staffing models and development of a comprehensive staffing plan. In 2018, EHS engaged Suffolk University to conduct a staffing study.

available staff, ensure that the staffing meets the acuity of veterans, retain direct care staff, and improve morale by establishing mutual respect and open communication.

Superintendent Walsh was responsible for implementing these recommendations when he received the final Suffolk study report in August 2019, but he did not make them a priority. Implementing a permanent schedule involved a complex process; for example, the unions that represented the Home's direct care staff had to agree to the schedule. He did not reach an agreement with EHS and DVS on a timeline to implement these recommendations until February 2020. EHS and DVS staff had to remind him repeatedly to stay on track with collecting overtime data and preparing model schedules to present to the unions. EHS management felt that the implementation of study results was not moving quickly enough and an EHS manager had to repeatedly follow up with the superintendent.²²

Notably, in 2019, Superintendent Walsh failed to recognize the importance of hiring a deputy superintendent to maintain stability in the operations, management and clinical leadership of the Home. The deputy superintendent was historically the person who managed the day-to-day operations of the Home. It is noteworthy that when Governor Baker appointed Superintendent Walsh, both Secretaries Sudders and Ureña emphasized the need for the Home to have a deputy with strong healthcare experience because Superintendent Walsh did not have any. In July 2018, the Home's deputy superintendent submitted his resignation but remained in his position until June 2019. Superintendent Walsh failed to manage the hiring process for the deputy's successor effectively. Even after the deputy superintendent departed in June 2019, Superintendent Walsh did not focus on hiring someone with healthcare experience and did not coordinate effectively with EHS HR and DVS. It ultimately took more than a year to fill this role, leaving a gap in the healthcare expertise on the Home's leadership team until March 2020, when EHS HR fast-tracked the hiring of a deputy. However, the individual hired for that role resigned just weeks after assuming it.

C. Superintendent Walsh demonstrated a lack of engagement in the Home's operations.

When Superintendent Walsh began working at the Home, he inherited ongoing staffing issues, tension with the unions representing the Home's employees and vacancies in several key leadership positions, including the deputy superintendent. Even with these management challenges, the Office found that Superintendent Walsh was not engaged in the broad range of leadership duties required to manage the Home. Instead, he perceived his role as "external;" he showed little interest in learning the details of how the Home operated, preferring to leave the day-to-day work to Deputy Superintendent John Crotty. For example, one employee told a manager at EHS that the superintendent developed "a 'blank stare' when discussing operational issues related to various aspects of running the home."

The superintendent was often away from the Home during regular business hours. When he was absent, his staff reported that they did not always know where he was. The staff described him as difficult

²² At the same time, he had to wait for feedback from EHS and DVS staff on the proposed schedules before updating the unions, which further delayed the implementation of staffing changes.

to reach. He would not share his calendar, and he was often unavailable for meetings. Members of the EHS and DVS management teams also had trouble reaching him and scheduling meetings.

Superintendent Walsh's absences became significant enough that in the summer of 2018, Secretary Ureña told him that he needed to spend more time onsite at the Home. At Secretary Ureña's request, Superintendent Poppe also talked to Superintendent Walsh about reducing his outside activities, advising him that her approach was to limit external activities to one activity per week and that the activities should be related to the Home and the local community. Starting in June 2018, DVS staff required Superintendent Walsh to share his Outlook calendar with the DVS chief of staff and provide DVS and EHS with weekly activity reports outlining the outside activities he planned to attend.

1. Superintendent Walsh was frequently away from the Home during business hours, prioritizing his external role over managing the Home.

The Office reviewed Superintendent Walsh's outside activities from January 2017 through December 2019.²³ The Office found that Superintendent Walsh focused on external activities and – during certain months – spent a significant number of business days engaged in activities outside the Home. Given how much time the superintendent invested in outside activities, the Office determined that staff concerns about his absence were valid.

The amount of time that Superintendent Walsh participated in outside activities, both related and unrelated to the Home, varied by month and year. The chart below depicts the number of days per month between July 2017 and December 2019 that Superintendent Walsh spent all or part of a regular business day at one or more outside activity.²⁴ Overall, the amount of time that the superintendent spent at outside activities decreased over time. In the months when he was offsite most frequently – August 2017 and November 2017 – he attended outside activities on 65% of business days. In the months when he was offsite less frequently, such as January 2018, he attended outside activities on 24% of business days. Notably, moreover, in August, September and November 2019, Superintendent Walsh maintained a robust level of outside activities, when there was no deputy superintendent at the Home to manage day-to-day operations.

²³ The Office examined the superintendent's activities that occurred between 9:30 a.m. and 4:00 p.m.

²⁴ The Office reviewed the activities that Superintendent Walsh attended between January 2017 and June 2017 but did not include them in this chart. These were the superintendent's first six months in the role and drawing all inferences in his favor, the Office considered them a transition period.

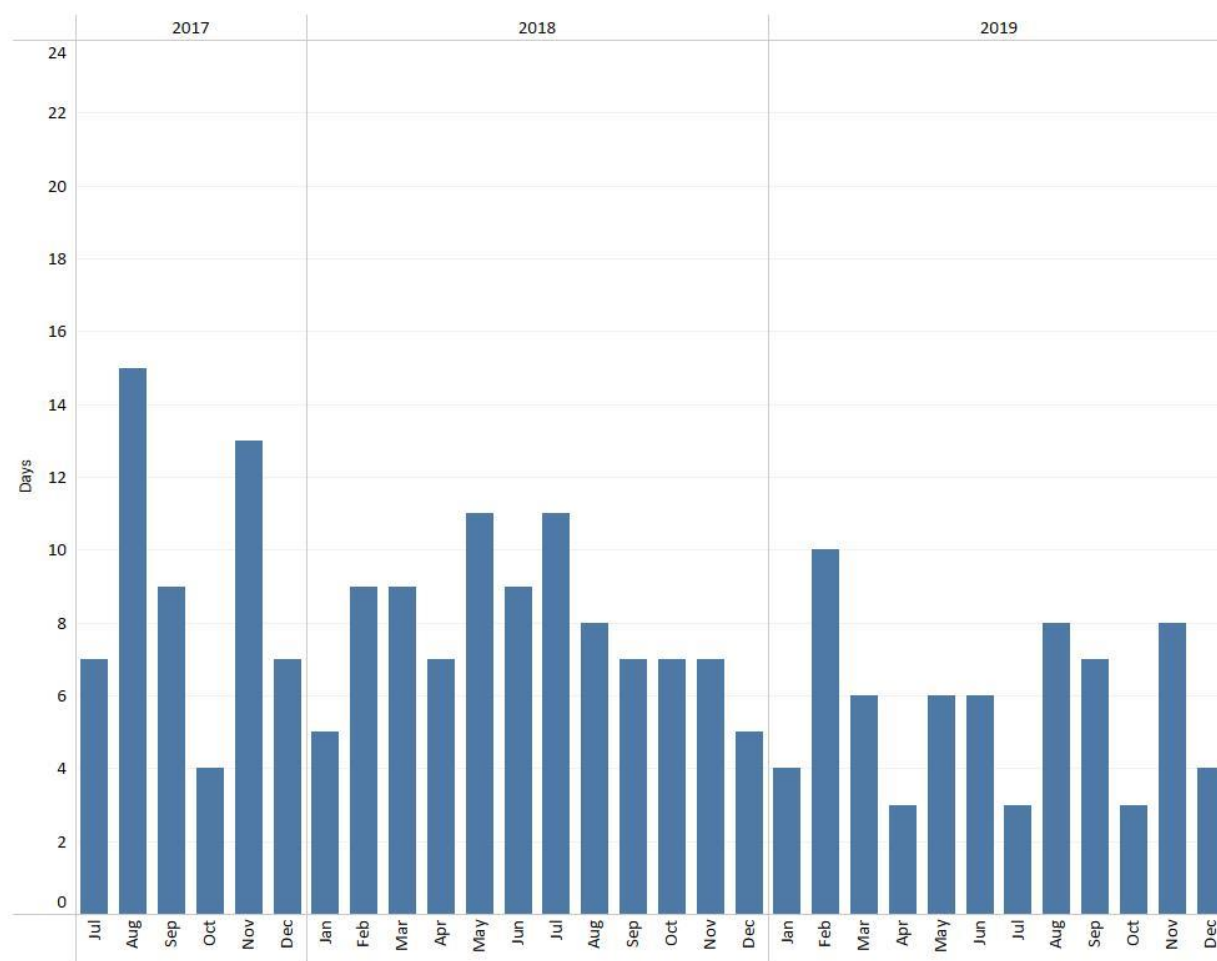


Figure 2: Number of days per month that Superintendent Walsh participated in outside activities between July 2017 and December 2019.

The Office also examined the purpose of the activities, that is whether they were related to his role as superintendent. In conducting this review, the Office drew all inferences in favor of the superintendent. For instance, the Office determined that Superintendent Walsh’s involvement with a March 2018 St. Patrick’s Day parade and luncheon was related to the Home because it was a community event and veterans from the Home participated in the parade.

Among Superintendent Walsh’s outside activities, most were generally related to the Home or veterans. Some offsite activities related to the Home required Superintendent Walsh’s attendance. For example, he had to travel to meetings and events with his superiors at EHS or DVS or with the federal Veterans’ Administration. In addition, he spent a few weeks per year traveling to out-of-state conferences, such as the summer and winter conferences for the National Association of State Veterans’ Homes. Moreover, on some days the superintendent attended both relevant activities and activities unrelated to his job. Finally, Superintendent Walsh did not explain some activities, putting only cryptic references in his calendar.

However, the Office also found that the superintendent participated in numerous activities that appear to be unrelated to his job or the Home. For example, in April 2017, the superintendent attended a “Google Insider Breakfast” in Worcester – an event that focused on big data and marketing. Two other examples of unrelated activities stood out, as they occurred in the summer of 2018 just as DVS and employees of the Home raised concerns about the superintendent’s outside activities:

1. In June 2018, the superintendent attended an event in Boston called the “Statewide Drone Summit.” This event, hosted by the Aeronautics Division of the state’s Department of Transportation, occurred in Boston and provided information about using drones. Superintendent Walsh recognized that the Drone Summit was not related to veterans or the Home. He attended even though Deputy Superintendent Crotty had an appointment that afternoon, and there was a risk that neither of the Home’s leaders would be available to the staff.
2. In July 2018, after the DVS chief of staff raised concerns about Superintendent Walsh’s outside activities, he attended an event at Fenway Park, “The Life Safety Seminar.” This event ended with a “meet-and-greet” with former Red Sox player David Ortiz. The superintendent missed the seminar but arrived at Fenway Park in the late afternoon with his father in time to meet Mr. Ortiz. Because the superintendent did not attend the seminar itself, the Home’s chief financial officer raised concerns about the superintendent’s request for mileage reimbursement. The superintendent eventually withdrew the request.

Thus, Superintendent Walsh’s staff and supervisors’ perception that he was away from the Home on a regular basis was accurate. Although representing the Home at meetings and events was part of the superintendent’s role, he spent a significant amount of his work time on outside activities, and he was absent from the Home frequently throughout his tenure. In addition, he chose to participate in many activities that were unnecessary or wholly unrelated to his role or the Home. Instead of focusing on ongoing staffing issues and vacancies in several key leadership positions, Superintendent Walsh prioritized his outside activities.

D. Superintendent Walsh did not recognize his obligation to protect veterans’ privacy.

Federal law prohibits a healthcare provider from publishing photographs and other personal information about patients without their written permission.²⁵ Despite these prohibitions, Superintendent Walsh posted photographs of veterans from the Chelsea Soldiers’ Homes on his personal social media page without first obtaining their permission. The DVS chief of staff warned him several times that he could not use photographs of veterans without their consent.

²⁵ See 45 C.F.R. § 164.502(a); 45 C.F.R. § 164.514(b)(2)(i)(Q).

Moreover, EHS and DVS provided Superintendent Walsh with rules, policies and protocols that prohibited his participation in any media interviews, prohibited media access to the Home and prohibited video recordings of veterans without prior approval from EHS and DVS. Even after EHS and DVS had instructed him to obtain permission first, the superintendent tried to allow media to come to the Home with cameras without first obtaining the veterans' permission for such publicity. Ultimately, in December 2019, Secretary Ureña placed a disciplinary letter in Superintendent Walsh's personnel file for engaging in a media interview and allowing press with cameras into the Home without first obtaining permission from EHS, DVS or the veterans involved. This was the only disciplinary letter that EHS or DVS leadership put in Superintendent Walsh's personnel file.

E. Superintendent Walsh engaged in behaviors that raise questions about his compliance with state ethics laws.

Superintendent Walsh engaged in several practices that raise questions about his compliance with the state ethics law, Chapter 268A of the Massachusetts General Laws, including his use of state resources for personal business and political activities. The Office's statutory mission, among other charges, is to detect abuse of state funds. The use of state resources for personal activities constitutes an improper use of those resources.

State ethics laws prohibit state employees from using their public position to obtain privileges that are not available to people who are not state employees.²⁶ Similarly, state ethics laws prohibit an agency head like Superintendent Walsh from directing his administrative assistant to assist him with personal matters. The State Ethics Commission, the state agency that administers and enforces the ethics laws, provides the example of a state employee writing a novel using her office computer and having her administrative assistant proofread a draft as a violation of state law.²⁷

Nevertheless, Superintendent Walsh directed staff to perform personal tasks for him and he made this a priority. For example, he had Lori Beswick, his administrative assistant, and other administrative staff communicate with his healthcare providers about his medical appointments and prescriptions. In addition, he tasked Ms. Beswick with helping him figure out how to obtain a copy of his military identification card.

With limited exceptions, state ethics law also prohibits public employees from engaging in political activities while working or with the use of public resources.²⁸ Superintendent Walsh directed Ms. Beswick to place political events on his state calendar. At least one of these events occurred during the business day and others were after hours and on weekends. Superintendent Walsh's decision to have Ms. Beswick schedule political activities for him – as well as his attendance at political events during work hours – may have run afoul of laws that govern state employees' participation in political activities.

²⁶ See M.G.L. c. 268A, § 23(b)(2)(ii).

²⁷ [Misuse of Public Position- Conflict of Interest Law, Section 23\(b\)\(2\)ii | Mass.gov.](#)

²⁸ <https://www.mass.gov/advisory/state-ethics-commission-advisory-11-1-public-employee-political-activity>.

III. EHS and DVS staff knew that Superintendent Walsh had leadership and management problems, but they did not take appropriate action to address those problems.

By mid-2017, EHS leadership, managers and staff began to learn that Superintendent Walsh was not performing his job effectively. They received numerous, similar complaints from employees about him throughout his tenure. By themselves, the complaints should have been red flags that Superintendent Walsh was not addressing staff concerns about the management of the Home. The complaints alone therefore merited a serious response by EHS.

Nevertheless, EHS leadership and staff did not respond appropriately to these complaints. Most notably, EHS leadership and staff addressed each new complaint as if it were the first. They did not investigate the complaints adequately or evaluate them holistically to identify patterns of the superintendent's behavior. Nor did EHS leadership take steps to reevaluate whether he should remain in his role at the Home.

A. In the summer of 2017, the Home's employees raised concerns to Superintendent Walsh, Governor Baker, Secretary Ureña, the Board and the media about leadership, staffing and quality of care.

In June 2017, 175 employees sent a letter to Superintendent Walsh stating that they wanted to improve both the quality of care provided to veterans and the treatment of staff by the Home's administration. The employees expressed concern about an "ongoing lack of mutual respect being exhibited by management," and an "overall disrespectful, retaliatory attitude and behavior of Administration." The employees indicated that understaffing and mandatory overtime contributed to declining staff morale.

On July 26, 2017, a group of the Home's employees sent a letter to Governor Baker, Secretary Ureña, the Home's Board, Superintendent Walsh, two state representatives and a state senator. These employees raised problems with staffing, forced overtime and an increase in serious incidents with veterans' care. The employees stated that the number of falls at the Home had increased, resulting in three major events, including two hip fractures. The employees also wrote that the leadership team did not value staff input and that Superintendent Walsh was often absent from the Home. The letter described the staff's fear of retaliation by management.²⁹

Superintendent Walsh and his managers worked on a reply to the employees' letter with Jesse Caplan, the EHS general counsel; Elizabeth Tierney, the EHS director of HR; and DVS staff. On August 21, Superintendent Walsh sent a reply to the email account that the employees, who had submitted the letter anonymously, had designated for communication. He devoted the majority of the reply to asking for the

²⁹ Superintendent Walsh sent this letter to Secretary Ureña on July 29, 2017, and to Secretary Sudders on September 18.

names of employees with direct knowledge of the issues in the complaint and the identity of the 175 concerned employees, even though they had described a fear of retaliation. The superintendent wrote that the employees should provide their names to Deputy Superintendent Crotty so that he could investigate the issues that they had raised.

Also in August 2017, a reporter from a local newspaper, *The Springfield Republican*, spoke with employees and residents of the Home. They alleged that the superintendent was frequently absent from the Home, was using his position as a steppingstone for another state job or a job in Boston and was hostile to staff. Residents and staff also told the reporter that the Home was providing inadequate medical care to veterans and that staff were allowed to berate residents. They complained that the Home was understaffed, with direct care staff frequently having to remain at the Home after their shift because there were insufficient staff on the next shift.

In September 2017, the superintendent agreed to an interview with the reporter. However, DVS cancelled the interview, choosing instead to provide comments to the reporter by email. The reporter then published his story about the Home. The story reported concerns from eight employees and one resident; three of the employees and the resident allowed the reporter to use their names.³⁰ The employees told the reporter that the number of veteran falls had increased because there were not enough staff available to help veterans walk to the bathroom and around the Home. They reported pressure to distribute medications quickly, which they described as unkind to the residents and increasing the risk of mistakes. One employee described rude treatment from management, employees' inability to plan for vacations and time off because of the lack of a permanent staffing schedule, and the difficulty of always "walking on eggshells" because of the fear of retaliation. The reporter noted that the staff sent a list of issues to Superintendent Walsh, who had held town hall meetings with different shifts on August 24 to give staff an opportunity to speak directly with him about their complaints.

Two weeks later, Secretary Sudders sent a team to conduct a high-level clinical and management quality review of the Home. The team, led by Secretary of Elder Affairs Alice Bonner, reviewed state and national surveys, clinical data, staffing trends and staff grievances. The team also met with the Home's management, nursing staff and clinical staff.

Secretary Bonner's team identified numerous areas where the Home needed improvement: communication and transparency, teamwork, quality assurance, complaint processing and family engagement. In December 2017, EHS staff compiled a PowerPoint presentation outlining 31 recommendations from Secretary Bonner's review. Among other things, Secretary Bonner recommended that Superintendent Walsh and his executive team:

1. Analyze current staffing and forecast models to develop a comprehensive staffing and hiring plan and broaden statewide recruitment strategies.

³⁰ Mike Plaisance, *Concerns raised about Soldiers' Home*, *The Republican* (Springfield, MA) (Sept. 10, 2017).

2. Hire and work with a consultant to support management in implementing a systematic, comprehensive and data-driven approach to maintaining and improving patient safety and quality.
3. Use data to track clinical staff response times to veterans' requests for assistance, conduct audits and improve processes related to preventing falls and promoting mobility, and review falls protocols with a falls expert to ensure a comprehensive and systematic approach to falls prevention.
4. Develop a new process to file complaints, concerns and suggestions, log and maintain all comments and respond with proposed corrective action to the author with an identified point of contact.
5. Explore implementing an electronic medical record system and electronic medication administration records.
6. Improve communication with staff, veterans and families.
7. Work with the unions to address high rates of employee absenteeism.
8. Collaborate with EHS HR to improve and expedite the hiring process for the Home's staff.
9. Administer a survey to all staff to understand their view of the Home's work environment and inform strategies to target areas of concern.
10. Ask veterans and families to submit complaints through the Home's suggestion box, with the Home logging and maintaining all comments and responding to the author within 10 days and with subsequent follow-up.
11. Attend family and veteran advocacy meetings.
12. Improve training opportunities for leadership, management and staff.

Secretary Sudders reviewed and approved the PowerPoint presentation outlining Secretary Bonner's recommendations.

Noting that some of the recommendations were already in progress, the PowerPoint presentation tasked Superintendent Walsh and his management team with working collaboratively with staff to implement the recommendations over the following 12 months. It did not include any benchmarks for progress.

At Secretary Bonner's suggestion, Superintendent Walsh hired a consulting firm to help with some of these recommendations. Members of Secretary Sudders' staff monitored the consultant's work from the beginning of the engagement. However, based on records from EHS and DVS, neither agency required Superintendent Walsh to document his progress, and neither agency provided oversight to ensure that Superintendent Walsh was making progress on the recommendations.

B. EHS received information that Superintendent Walsh said that he wanted to hit an employee.

On March 28, 2018, EHS received an allegation that Superintendent Walsh had become extremely upset during a leadership meeting. The complaint alleged that his face turned “beet red,” he clenched his fists and the veins in his neck pulsed. In the meeting, the superintendent allegedly said that he was so furious that he could hit Scott Zacharie, the Home’s director of admissions. When Superintendent Walsh left the meeting, he said, in front of Lori Beswick, his administrative assistant, that he was “going to belt” Mr. Zacharie.

Two days after documenting the allegations, Jay Talbot, an EHS labor relations specialist, followed up with Ms. Beswick. According to the notes from that conversation, Ms. Beswick confirmed what Superintendent Walsh had said about Mr. Zacharie. She also recounted numerous other issues with Superintendent Walsh. She said he had a temper, reporting that once she had received a call from a maintenance employee asking if the superintendent could move his car. When she relayed the employee’s request, she said that the superintendent immediately became visibly angry and verbally lashed out at her. Ms. Beswick also said that Superintendent Walsh distanced himself from, and created anxiety among, the staff. She further alleged that he restricted her access to other managers and was rude to her. She said she told Superintendent Walsh that she did not like the way he treated her, but he did not change his behavior.

During its investigation, the Office looked for information about how EHS responded to complaints against Superintendent Walsh. For the March 2018 allegations, the Office found no information indicating that EHS management staff spoke with any other employees – including Mr. Zacharie – or fully investigated these allegations. Nor did EHS provide information indicating that its managers informed Secretary Ureña, Superintendent Walsh’s supervisor, that he had threatened one of his staff. Similarly, EHS provided no information indicating that anyone from its management staff took disciplinary action against the superintendent. Finally, EHS provided no information indicating that its staff offered any kind of support for Mr. Zacharie, Ms. Beswick or their coworkers.

Following this incident, however, Secretary Sudders engaged a management coach for Superintendent Walsh.

1. EHS engaged Bruce Cedar, a management coach, to work with Superintendent Walsh.

In the wake of the complaints described above, Secretary Sudders asked Bruce Cedar, a clinical psychologist and president of CMG Associates, to work with Superintendent Walsh. EHS had already contracted with CMG Associates to provide EHS’s employee assistance programs (EAP) as well as leadership coaching and training. At the time, CMG Associates charged \$175 per hour for coaching and training.

Elizabeth Tierney, the EHS director of human resources, contacted Dr. Cedar in May 2018 to request leadership coaching for Superintendent Walsh. Ms. Tierney told Dr. Cedar that Secretary Sudders

was concerned about Superintendent Walsh's behavior, that he was angry and difficult to work with, and that his staff felt he had created an unprofessional work environment. She told Dr. Cedar about Superintendent Walsh's angry outburst when Ms. Beswick asked him to move his car. She also told Dr. Cedar about Superintendent Walsh's angry outburst towards Mr. Zacharie.

Dr. Cedar started working with Superintendent Walsh in May 2018. Secretary Sudders initially asked Dr. Cedar to meet with Superintendent Walsh twice a month for approximately five months. Secretary Sudders later extended the engagement, which continued through the end of February 2020. All told, the superintendent received almost two years of one-on-one management coaching.

Although Secretary Ureña was Superintendent Walsh's direct supervisor, Secretary Sudders became the "sponsoring manager" and oversaw Dr. Cedar's work with the superintendent. On May 4, 2018, she met with Superintendent Walsh and Secretary Ureña to explain Dr. Cedar's role. She briefly mentioned that EHS had received a complaint about the superintendent. Secretary Sudders told Superintendent Walsh that she wanted to make an investment in him and provide a coach to help him develop some of his skills. At the end of the meeting, Secretary Sudders warned Superintendent Walsh not to try to find out who had filed the complaint about him.

Recognizing Secretary Sudders' role as the sponsoring manager, Dr. Cedar sent communications regarding Superintendent Walsh's progress to her. Over the next year and nine months, Secretary Sudders met with the superintendent and Dr. Cedar many times, both with and without Secretary Ureña. Section IV(A) of the investigative findings discusses Superintendent Walsh's engagement with Dr. Cedar in more detail.

C. In late 2018, the Home's staff raised additional complaints about understaffing and poor leadership at the Home.

On July 12, 2018, a union representative sent an email to Secretary Ureña alleging that care for veterans at the Home had deteriorated due "to constant and chronic understaffing." The union representative complained about a "constant lack of leadership and direction" at the Home. He alleged that management retaliated against staff and that management "has consistently ignored and downplayed" one supervisor's bullying and harassment. Secretary Sudders obtained a copy of the complaint on July 16, 2018, after a reporter for *The Springfield Republican* requested comment.³¹

Internal email correspondence shows that EHS's human resources (HR) staff downplayed these complaints, telling its press office that the union representative "has raised many of the issues he lists below on a number of occasions to a number of people. Each time they've been proven to be unfounded." The press office passed along this assessment to Secretary Sudders.

On October 16, the Home's staff wrote a letter of no confidence in the Home's administration. The staff sent the letter to show their "dissatisfaction and as a vote of no confidence with management,

³¹ Secretary Sudders forwarded the union representative's email to Secretary Ureña, writing that she "would have thought that [he] would have mentioned this to me[.]"

including the Director of Nursing and the Assistant Director of Nursing.” The letter mentioned the ongoing staffing problems, including mandatory overtime, disparate treatment, excessive discipline and “rampant” retaliation and bullying at the Home. That same day, Secretary Sudders requested a meeting with Catherine Mick, the EHS undersecretary; Catherine Starr, the EHS HR officer; Leslie Darcy, the EHS chief of staff; Secretary Ureña; Paul Moran, the DVS chief of staff; and Superintendent Walsh.

Ms. Darcy created the agenda for this meeting, which included mandated overtime, short staffing, nursing staff feeling intimidated on the weekends, length of the union grievance process, staff not feeling heard, and intimidation and bullying by nursing supervisors. Ms. Darcy sent Ms. Mick a significant amount of background on the Home, including the current number of staff working at the Home, Secretary Bonner’s PowerPoint presentation from her review of the Home, talking points from past union meetings, lists of mandatory overtime and sick logs, the Home’s response to a 2017 audit by the State Auditor and a review of media requests for information from July 2017. Five days after the meeting, Ms. Mick and EHS HR staff traveled to the Home to meet with the superintendent, the Home’s director and assistant director of nursing. The focus of this meeting was to develop concrete and short-term strategies to address mandatory overtime and scheduling issues.

On October 29, Ms. Mick indicated that EHS intended to initiate a staffing study with Suffolk University for the Home.³²

D. In October 2018, EHS received another complaint about Superintendent Walsh’s temper and his treatment of staff.

In October 2018, EHS received an anonymous complaint that Superintendent Walsh was retaliating against one employee, and that he had lost his temper and publicly berated another employee. Catherine Starr, the EHS HR officer, asked Donna Morin, a director of one of EHS’s labor relations units, to investigate. Two weeks after EHS received the complaint, Secretary Sudders extended Dr. Cedar’s engagement by six more months.

1. EHS assigned Donna Morin to investigate the complaint, which alleged that the superintendent had retaliated against and berated members of his staff.

The complainant alleged that Ms. Beswick, a longtime employee who was the superintendent’s administrative assistant, was upset because she believed Superintendent Walsh was “trying to get rid of her.” Ms. Beswick had also heard that the superintendent blamed her for the March 2018 complaints to EHS about his threat against Mr. Zacharie.

The complainant also reported that Superintendent Walsh became visibly angry when Jessica Powers, a member of his leadership team, announced at the beginning of a morning meeting that she had a “hard stop” at 10:00 a.m. According to the complainant, Superintendent Walsh:

³² See section II(B) of the investigative findings.

[B]ecame upset and began addressing Ms. Powers in front of the others in an angry manner. He said that his meetings never go past 10 am [sic]. He continued to berate her in front of the other staff to the point where she became visibly upset. Ms. Powers did not say anything for the rest of the meeting. Other staff commented that it was an inappropriate situation and expressed concern about the Superintendent's conduct.

As the director of an EHS labor relations unit, Ms. Morin was responsible for overseeing employee and labor issues for six EHS agencies. Ms. Morin's work included resolving labor issues, disciplining employees, assessing union grievances and guiding contract negotiations for collective bargaining agreements.

Ms. Morin's role required her to conduct a handful of investigations every year. Her training was limited to occasional educational seminars. She had not attended an investigative training session in several years. At the time, EHS's human resources department did not employ any full-time investigators. Ms. Starr gave Ms. Morin a document describing the March 2018 allegations regarding Superintendent Walsh's angry outbursts. She told Ms. Morin that EHS had already addressed those allegations and that she should only investigate the new allegations.³³

2. Ms. Morin conducted a flawed investigation in a manner that favored Superintendent Walsh.

Ms. Morin interviewed eight people. She conducted all the interviews at the Home, even though Ms. Pizzi, the Home's general counsel, asked her to meet with employees offsite because they feared the superintendent would retaliate if they cooperated in the investigation. However, Ms. Morin continued to meet with witnesses onsite even after they expressed those same concerns about retaliation to her.

As directed, Ms. Morin limited her investigation to the summer and fall of 2018. As Ms. Morin later documented in her report, the witnesses confirmed the incident involving Ms. Powers. They also raised additional, serious allegations about Superintendent Walsh. These included allegations about workplace violence, his frequent absences from the Home, fiscal mismanagement, time fraud, retaliation and poor treatment of his staff. Ms. Morin decided that some of these issues – including allegations of workplace violence and fiscal mismanagement – were outside the scope of her investigation. She did not, however, refer these allegations to any other person or entity for review.

In addition to the document provided by Ms. Starr from March 2018, Ms. Morin requested and reviewed documents from Superintendent Walsh regarding his complaints about Ms. Beswick. She did not review emails, memoranda or time records that would have substantiated certain allegations or contradicted Superintendent Walsh's version of events.

³³ Ms. Morin knew that Superintendent Walsh was working with Dr. Cedar as the result of concerns from the Home's staff.

For example, several staff members reported to Ms. Morin that Superintendent Walsh seemed to be absent from the Home during business hours. She did nothing to verify how often and for how long he was at the Home. Superintendent Walsh told Ms. Morin that he kept a log of the time he spent at the Home that would show his work hours. Ms. Morin did not ask for a copy of his log and accepted his statement that he worked “most days,” often more than 7.5 hours in a day. He also said that he adjusted his schedule to ensure that he was available to staff on different shifts and on weekends. However, Ms. Morin did not look at his computer calendar, which could have revealed information to her about his day-to-day schedule, because she believed that reviewing his calendar would have been outside the scope of her investigation.

He also told Ms. Morin that he had worked nearly every holiday and had only taken one week’s vacation since he started at the Home. Ms. Morin noted that Superintendent Walsh had documented 26 days of compensatory time.³⁴ However, she reminded him that as a department head he was not entitled to earn compensatory time for working on holidays.³⁵

Ms. Morin also ignored the similarities between the October and March complaints about the superintendent’s abusive behavior toward his staff.

In general, Ms. Morin accepted Superintendent Walsh’s version of events, disregarding witnesses who contradicted him. For example, he told Ms. Morin that he did not yell in the workplace. Ms. Morin credited his statement over numerous other witnesses who reported that he had inappropriately raised his voice at his staff on multiple occasions. Likewise, she believed his statement that his staff could access his schedule, even though several staff members said they could not. As part of her investigation into Superintendent Walsh, she decided to include the superintendent’s complaints about Ms. Beswick, looking at alleged incidents dating back to October 2017.

At the conclusion of her investigation, Ms. Morin told Superintendent Walsh that a person on his team was trying to get him fired. She also gave Superintendent Walsh an unredacted copy of her report, which included the names of the employees she interviewed.

Ultimately, Ms. Morin’s ill-advised decisions resulted in an investigation that favored Superintendent Walsh.

3. Ms. Morin’s final report was flawed, and its recommendations were not meaningful.

Ms. Morin’s final report, provided to Secretary Sudders on December 6, 2018, minimized Superintendent Walsh’s behavior. Its recommendations focused on helping Superintendent Walsh rather than addressing staff concerns and ensuring that the Home was operating effectively. Despite her

³⁴ Compensatory time provides employees with time off instead of overtime pay.

³⁵ State law provides that the superintendents of the two Soldiers’ Homes are not eligible to earn compensatory time when they work on a holiday. M.G.L. c. 30, § 24A. Nevertheless, Superintendent Walsh gave himself compensatory time when he worked on a holiday. During the investigation, the superintendent told Ms. Morin that he was not aware that he could not earn compensatory time.

assignment to investigate Superintendent Walsh's actions, Ms. Morin devoted half of her report to Superintendent Walsh's complaints about Ms. Beswick.

First, Ms. Morin left the most serious allegations out of the report. For example, witnesses told EHS that the superintendent had continued to berate Ms. Powers in front of other staff in the October 11, 2018, meeting to the point where she became visibly upset. Ms. Morin omitted this information from her report. Ms. Morin also failed to include an allegation that the superintendent retaliated against Ms. Beswick because he believed that she told EHS about the March 2018 incident. In addition, Ms. Beswick told Ms. Morin that "[o]n one instance, Bennett [Walsh] took the phone out of my hand and hung up." In Ms. Morin's typed interview notes, this sentence is circled, highlighted and starred; however, Ms. Morin did not mention it in her final report.³⁶

Ms. Morin also minimized the evidence against Superintendent Walsh. In her report, she found that "[i]t is likely that Superintendent Walsh has difficulty hiding his emotions when he is unhappy or frustrated[.]" However, her interview notes paint a more serious picture of his demeanor; one witness stated that they had "witnessed inappropriate events, dozens have occurred" and that Superintendent Walsh "holds grudges." Another witness said the superintendent was "very verbal if someone does him wrong," that he did not "take criticism well," and that he often took feedback personally and focused on that instead of the issues at hand. A witness said the superintendent's moods escalated and deescalated in "seconds." Another witness reported that Superintendent Walsh had said that he wanted to punch a different employee; the witness was concerned that someone would eventually get hurt. Another witness said Superintendent Walsh was "emotionally driven and reactive" and that it was a "world of chaos" when he was in the building. One witness told Ms. Morin that one employee had described the Home as a hostile work environment.

Despite these witnesses' accounts, Ms. Morin omitted this information, concluding that the superintendent had not "instituted a systemic sense of fear in his Executive Team" and that "most of his team expressed a certain level of comfort with confronting him when they think he's made a mistake or behaved inappropriately." Ms. Morin noted that the superintendent should "continue to be mindful of his demeanor and continue working on improving his reactions so as to ensure no one is felt [sic] uncomfortable in his presence." She did not, however, include anything specific in her recommendations about Superintendent Walsh making changes to his demeanor.

Similarly, Ms. Morin reported that several individuals complained that the superintendent was not interested in the Home's business operations. However, she did not provide details, including allegations that he was not meeting with his management staff one-on-one, providing them with formal performance evaluations or engaging in strategic planning. Her report also failed to note that at least three witnesses reported that they did not believe Superintendent Walsh worked full-time.

³⁶ Five months later, in April 2019, Ms. Beswick filed a complaint about this incident with the Commonwealth's Investigations Center of Expertise. See section IV(E) of the investigative findings.

Finally, the report's recommendations were ineffectual, primarily focused on providing more supports for Superintendent Walsh and addressing his complaints about Ms. Beswick. Ms. Morin's recommendations did not reflect the seriousness of the misconduct she was investigating. Moreover, the recommendations did not address his abusive behavior toward his staff, including how he had treated Ms. Powers, or suggest disciplinary action against Superintendent Walsh in connection with his outburst at the leadership meeting. Ms. Morin provided seven recommendations at the end of her report:

1. Continue Superintendent Walsh's work with Bruce Cedar.
 2. Expand Bruce Cedar's work (or find another consultant) to include the Home's entire Executive Team.
 3. Appoint an executive level mentor to Superintendent Walsh (the Superintendent at the Chelsea Soldiers' Home or other appropriate mentor) to help Superintendent Walsh grow as a leader in this environment.
 4. Reassign Lori Beswick to another role within the Home.
 5. Hire an executive assistant at an appropriate position level and skillset for Superintendent Walsh.
 6. Reinstitute labor/management meetings and provide Superintendent Walsh coaching in this area by having a senior labor relations manager present and available at all meetings.
 7. Discuss how to address Superintendent's "earned" holiday compensatory time.
- 4. Ms. Morin demonstrated a bias toward Superintendent Walsh.**

The Office found that Ms. Morin demonstrated a bias toward Superintendent Walsh. As set forth above, she conducted the investigation and drafted the report in ways that favored the superintendent and omitted relevant information she had received from the Home's staff. In addition, at the conclusion of the investigation, Ms. Morin requested and received permission to discuss her recommendations with Superintendent Walsh, and she gave him an unredacted version of the report.³⁷ She had lunch with him and accepted several commemorative pins for family members who had served in the armed forces.

Ms. Morin's report detailed allegations and witness statements, which Superintendent Walsh could have connected to specific individuals. By providing him with an unredacted version of the report, she put individuals who had expressed concerns about retaliation by Superintendent Walsh at risk.

³⁷ Typically, human resources investigative reports would redact witnesses' names to protect their confidentiality, particularly when witnesses have expressed concerns about retaliation by the subject of the investigation.

E. In April 2019, an EHS manager learned that Ms. Beswick had filed a complaint against Superintendent Walsh regarding workplace violence and retaliation.

In April 2019, Marianne Dill, EHS's director of labor relations, learned that Ms. Beswick had filed a complaint with the Commonwealth's Investigations Center of Expertise (COE).³⁸ In her complaint, Ms. Beswick alleged that Superintendent Walsh had engaged in violent and retaliatory behavior in the workplace. Specifically, Ms. Beswick alleged that Superintendent Walsh had taken her telephone out of her hand – the same allegation that Ms. Morin heard about during her investigation but ignored. Ms. Beswick also alleged that Superintendent Walsh had retaliated against her for participating in the Morin investigation.³⁹ Ms. Dill first tried to stop the investigation and then delayed providing information to the investigator.

EHS's response to the COE's investigation is discussed further in section IV(E) of the investigative findings.

F. After conducting an exit interview with the Home's chief financial officer in May 2019, the director of the EHS Office of Diversity and Civil Rights expressed concern about Superintendent Walsh's treatment of women.

In the spring of 2019, Erin Spaulding, the Home's chief financial officer, resigned after working at the Home for three years. Superintendent Walsh had hired her. On May 16, Sonia Bryan, the director of EHS's Office of Diversity and Civil Rights, conducted Ms. Spaulding's exit interview.⁴⁰

Ms. Spaulding said she had not filled out an exit interview form at the Home because she feared retaliation from Superintendent Walsh. She told Ms. Bryan that Superintendent Walsh had created a culture of hostility at the Home. Ms. Spaulding said she had previously shared these concerns with multiple EHS employees. She told Ms. Bryan that Superintendent Walsh retaliated against several members of the team who had participated in Ms. Morin's investigation. Ms. Spaulding also told Ms. Bryan that Superintendent Walsh treated her, Ms. Powers and Ms. Pizzi "far worse" than Deputy Superintendent Crotty.

After the interview, Ms. Bryan sent an email to Catherine Starr, who was her supervisor and the EHS human resources (HR) officer, and Lisa Gallup, an EHS HR manager, indicating that she had concerns regarding Ms. Spaulding's "repeated allegation of a difference in treatment based on her gender." The Office found no information indicating that Ms. Starr or Ms. Gallup took action in response to Ms. Bryan's email.

³⁸ The Executive Branch created the COE in 2019 to investigate allegations of workplace violence and retaliation for bringing a complaint of workplace violence, among other workplace issues.

³⁹ Superintendent Walsh reported that he had wanted to change Ms. Beswick's job since at least September 2018, but she had refused to switch positions. It was not until the conclusion of Ms. Morin's investigation that Superintendent Walsh, with Ms. Morin's assistance, completed the move.

⁴⁰ EHS now refers to that office as the Office of Diversity, Equity and Inclusion.

G. In September 2019, Secretary Sudders received a 93-page complaint against Superintendent Walsh, including allegations about aggressive and retaliatory behavior, time fraud and misuse of state resources.

In September 2019, Secretary Sudders received another complaint against Superintendent Walsh, which she asked her HR staff to investigate. Again, the EHS investigation was cursory and its findings were not reliable.

1. The staff who sent this complaint to EHS included photographs, memoranda, time sheets and other documents to support their allegations against Superintendent Walsh.

On September 18, 2019, EHS received a 93-page anonymous complaint about Superintendent Walsh. A group identifying itself as “Soldiers Home Staff” sent the complaint to Secretary Sudders. It contained five distinct allegations: payroll fraud, misuse of state funds, misuse of public resources, misuse of Board funds, and retaliatory and aggressive behavior by Superintendent Walsh. These allegations varied in seriousness.

The complaint listed nine employees who allegedly had experienced the superintendent’s “personal attacks and retaliation” as the result of “offering a different view point [sic] or questioning him for clarification.” The complaint also listed four members of the executive staff who had left the Home since January 2019.

The complainants attached copies of photographs from surveillance cameras, contemporaneous memoranda to file, time sheets and other information to support every allegation, including the following documents:

1. Several memoranda from employees regarding Superintendent Walsh’s demeanor and outbursts between August 2017 and June 2019.
2. One employee’s resignation letter and another employee’s exit evaluation, both indicating that they had resigned because of the superintendent.
3. Dated and timed-stamped photographs from a surveillance camera showing the superintendent and three other employees arriving at and leaving the Home on certain days, indicating that they had not worked full days. The complaint included these same employees’ timesheets for those days, showing that the employees had claimed to work full days.
4. Documentation of the purchase of 355 gift cards for \$35 each in 2018, a sign-in sheet demonstrating that Superintendent Walsh had distributed only 317 of the cards, and emails from Erin Spaulding, the Home’s chief financial officer, asking Superintendent Walsh to return the remaining 38 gift cards.

One EHS HR manager noted that it was unusual for EHS to receive a complaint with this amount of detail and supporting documentation.

When Secretary Sudders received the complaint, she directed her human resources staff to conduct an investigation. Catherine Starr, EHS's human resources officer, assigned the complaint to Erica Crystal, an EHS deputy general counsel for labor.⁴¹ In previous jobs, Ms. Crystal had conducted many investigations into unfair labor practices, served as a hearing officer and worked in a law firm where she conducted investigations for cities and towns. Ms. Crystal also had conducted a handful of investigations while working at EHS.

2. Ms. Crystal interviewed only Superintendent Walsh and reviewed limited documents beyond those included with the complaint.

Ms. Crystal's investigation was cursory. In total, she reviewed the complaint, read the report from Ms. Morin's investigation, spoke with a colleague about state finance issues, discussed time reporting with another colleague and met with Superintendent Walsh.

3. In her report, Ms. Crystal credited Superintendent Walsh's version of events and summarily dispensed with the allegations about aggression and retaliation.

Ms. Crystal completed a written report of her investigation on October 29, 2019, finding that the allegations in the complaint did not have merit. She concluded that "Superintendent Walsh did not engage in a deliberate misuse of funds and though he made mistakes, they were minor." Her recommendations did not mention any of the complaints relating to the superintendent's temperament; she primarily suggested training Superintendent Walsh about time-and-attendance rules. She also recommended that the Board revise its rules and regulations to prohibit purchasing gift cards for employees.

To reach her conclusions, Ms. Crystal accepted Superintendent Walsh's version of events, even when the documentation accompanying the complaint contradicted his account. She summarily dismissed the allegations regarding Superintendent Walsh's aggressive and retaliatory behavior even while noting that the newer allegations appeared to be similar or identical to the prior allegations.

In her report, Ms. Crystal grouped the allegations into four categories: (1) claims that Superintendent Walsh created a hostile work environment and engaged in retaliatory behavior; (2) payroll fraud by four managers, including Superintendent Walsh; (3) the superintendent's mishandling of gift cards; and (4) state funds and staff time spent on a private charity event. The following sections discuss each of these categories.

⁴¹ Other senior managers at EHS also knew about the complaint. Ms. Crystal sent a summary of the complaint to Sharon Boyle, EHS's general counsel, and Alda Rego, EHS's assistant secretary of administration and finance. Ms. Crystal also discussed the complaint with Marianne Dill, EHS's director of labor relations, and Stephanie Kahn, an EHS deputy general counsel.

a. Ms. Crystal dismissed the allegations regarding Superintendent Walsh's aggressive and retaliatory behavior.

As discussed above, the complaint named nine current and former employees who allegedly had been the subject of Superintendent Walsh's anger, aggression or retaliation. The complaint also provided seven examples of Superintendent Walsh's behavior:

1. In August 2017, the superintendent stated that he wanted to "hurt" a veteran who told a reporter that Governor Baker and Superintendent Walsh had killed a resident who had died of natural causes while living at the Home.
2. Also in August 2017, he became visibly upset with the director of admissions and in front of several members of his management team and stated that he wanted to "deck" him. The complaint stated that this incident was reported to DVS and EHS.
3. In March 2019, Superintendent Walsh again became upset with the director of admissions for having "bolded" two veterans' names on an admissions sheet, which Superintendent Walsh took as a direct insult to him.
4. Also in March 2019, he instructed his human resources liaison to change the director of admissions' job in retaliation for having bolded the two names on the admission lists.
5. Also in March 2019, he told the human resources liaison to cancel Lori Beswick's previously agreed upon flexible schedule because she had talked with a trustee about her job reassignment.
6. In April 2019, he expressed his visible frustration with a member of his executive team by slapping his own elbow with a closed fist.
7. In June 2019, he referred back to the August 2017 incident with a veteran listed above, stating that "All I know is he was wrong and that is enough to be fighting words to an Irishman."

Ms. Crystal recognized the similarity between the allegations here and those from past complaints. However, rather than identify a pattern of behavior occurring over several years, she considered the similarities as a reason to take no action. Ms. Crystal wrote that "[f]or the most part" the allegations were "already investigated." This could not be true as many of these allegations arose after the Morin report. Further, she dismissed the newer allegations because they "appear to be the same as the old allegations just with a different and more current date." Ultimately, she made no recommendations concerning the allegations about Superintendent Walsh's aggression and retaliatory behavior.

b. Ms. Crystal did not thoroughly investigate the other allegations in the complaint.

The complaint included documentation indicating that four employees, including Superintendent Walsh, had committed time fraud by claiming to have worked when they had not. To resolve these allegations, Ms. Crystal interviewed only Superintendent Walsh and accepted his explanations with little additional inquiry or investigation.

For example, the complaint supported allegations that Superintendent Walsh had worked less than a full day on two holidays by including timed photographs of his car entering and leaving the Home's parking lot. However, Ms. Crystal accepted his statement that he worked a full day (7.5 hours) on both days. Ms. Crystal failed to pursue time fraud allegations against Randy Stone, the former director of nursing, because there was a "lack of direct evidence" against him and he no longer worked for the Commonwealth. In addition, she accepted Superintendent Walsh's claim that he had approved an early departure for two employees, Deb Foley and Jeremiah LaPlante, because they worked extra hours at a Board meeting on May 14, 2019. She did not investigate whether the superintendent's explanation was accurate.⁴²

The complaint also alleged that Superintendent Walsh had mishandled 355 gift cards, each valued at \$35 from the Big Y grocery store. When he met with Ms. Crystal, the superintendent showed her a stack of gift cards, telling her there were 38 cards in the stack. He also showed her a log that allegedly documented the distribution of the other 317 cards. Ms. Crystal accepted Superintendent Walsh's account in its entirety, concluding that he had accounted for all the gift cards. In her report, Ms. Crystal recommended that the Home's trustees revise their rules to preclude the purchase of gift cards as gifts for employees. The Office could not confirm, based on the information it received, whether Ms. Crystal transmitted this recommendation to the Board or whether this revision ever happened.

Finally, Ms. Crystal dismissed allegations that Superintendent Walsh had inappropriately used state funds and employees for a non-profit organization's fundraising event. Specifically, Superintendent Walsh had approved the purchase of soda with state funds, as well as use of the Home's staff to transport the soda to the event in the Home's vehicles.⁴³ Ms. Crystal stated that Superintendent Walsh was "sloppy" in using the wrong account to pay for the soda. She concluded that someone had used Board funds to reimburse the money to the Home's account, but she did not verify whether this actually occurred.⁴⁴ Further, Ms. Crystal found that the Home's employees should not have worked overtime to transport the soda, noting that this was "poor management." Ms. Crystal recommended that Superintendent Walsh receive instruction "on what employees can and cannot do as volunteers."

⁴² The Board's minutes from the May 14, 2019, meeting state that it lasted for less than an hour; the superintendent claimed he approved four hours of compensatory time for Ms. Foley, who appeared as an attendee in the minutes. It was unclear from the complaint how much time he approved for Mr. LaPlante; the minutes did not list him as an attendee the May meeting.

⁴³ One of the Home's staff members reportedly earned overtime to deliver the soda.

⁴⁴ Because she failed to investigate, Ms. Crystal was unaware that no transfer of funds occurred.

After Ms. Crystal finished her report, she reviewed her findings with EHS leadership, including Secretary Sudders and Ms. Starr.

H. EHS and DVS failed to appreciate the cumulative effects of the superintendent's actions or recognize that he was not effectively managing the Home.

Starting in 2017, EHS and DVS management knew of mounting complaints against Superintendent Walsh – including problems with Superintendent Walsh's performance, lack of leadership and his frequent absences from the Home. The complaints also raised concerns about the superintendent's temper, the Home's staffing and the quality of care the veterans were receiving.

Nevertheless, EHS's leadership seemed to view each complaint in a vacuum, rather than examining all the complaints and performance problems as a whole to determine whether Superintendent Walsh was suited to lead the Home. EHS's management team did not identify patterns or themes in the complaints that consistently pointed to problems with Superintendent Walsh's demeanor, management and lack of experience. These complaints should have raised red flags about how he was running the Home; the fact that EHS managers did not focus on the consistency and number of complaints was a significant failure of leadership. As a steward of the Home, EHS leadership had an obligation to take steps to reevaluate Superintendent Walsh's tenure at the Home.

IV. EHS and DVS bolstered Superintendent Walsh in his role and perpetuated the leadership and management problems at the Home.

Aware of concerns about Superintendent Walsh's management failings, EHS staff provided him with a variety of resources. However, EHS management did not coordinate these resources or track any progress that he made. Rather than reassessing whether it was in the best interests of the Home, EHS management focused on bolstering Superintendent Walsh as the superintendent.

For example, EHS human resources (HR) and labor relations staff assigned attorneys and other senior managers to help the superintendent manage the unions. The EHS labor relations staff frequently worked onsite at the Home, planning and participating in meetings and assisting with grievances. In addition, senior managers from EHS HR visited the Home on a regular basis – particularly in 2019 – providing onsite assistance with HR issues and advising the superintendent on how to navigate his relationship with Secretary Ureña. It was unusual for EHS to provide this level of support to a senior manager.

As discussed in section IV(A) of the investigative findings, the most significant support that EHS gave to Superintendent Walsh was ongoing one-on-one management coaching from psychologist Bruce Cedar from May 2018 through February 2020. Secretary Sudders and EHS HR leaders hired Dr. Cedar but did not oversee his work with Superintendent Walsh. Dr. Cedar set several goals for the coaching, but Superintendent Walsh did not meet them. Rather, while Dr. Cedar was coaching him, Superintendent Walsh circumvented his chain of command and deflected blame on others for his behavior. However,

neither EHS nor Dr. Cedar recognized this conduct as an indicator that the coaching was not effective. In October 2018, EHS extended Dr. Cedar's coaching without reevaluating the goals or setting deadlines for meeting them.

At the same time, the EHS management team failed to lead Superintendent Walsh and the Home towards improvement in several other significant ways. As discussed further below, EHS and DVS management teams narrowly focused on supporting Superintendent Walsh instead of prioritizing the needs of the Home and the veterans. Staff from EHS and the Home who worked with the superintendent noticed his lack of accountability. These staff members had the perception that EHS leadership would not recommend removal of Superintendent Walsh from his position, that there was no appetite to remove him and that their "marching orders" were to support the superintendent in being the superintendent.

A. EHS HR management staff oversaw the engagement with Dr. Cedar poorly.

As discussed in section III(B)(1) of the investigative findings, in May 2018, Secretary Sudders instructed her director of HR to ask Bruce Cedar, a clinical psychologist and the president of CMG Associates, to provide management coaching to the superintendent. She wanted him to address Superintendent Walsh's angry outbursts towards staff and concerns that he was creating an unprofessional work environment at the Home. Dr. Cedar initially anticipated that he would coach Superintendent Walsh for about five months, meeting twice a month. EHS received additional complaints about Superintendent Walsh in October 2018. On October 31, Secretary Sudders extended the engagement, which ultimately continued through the end of February 2020. In the end, Dr. Cedar coached the superintendent for almost two years of Superintendent Walsh's four-year tenure. As discussed below, EHS did not effectively oversee the coaching engagement. Moreover, EHS did not intervene, change or terminate the engagement when Dr. Cedar did not make meaningful progress towards the goals that he set out at the beginning of his work with Superintendent Walsh.

To start the engagement, Elizabeth Tierney, the EHS director of human resources, informed Dr. Cedar that Secretary Sudders was concerned about Superintendent Walsh's behavior, that he was angry and difficult to work with, and that his staff felt he was creating an unprofessional work environment. Ms. Tierney also informed Dr. Cedar about specific incidents that employees of the Home had reported to EHS before May 2018. Without specifying why, Ms. Tierney and Dr. Cedar agreed that a male coach would be the best fit for the superintendent. Secretary Sudders became the sponsoring manager for the engagement until June 2019, when Secretary Ureña became the sponsoring manager.⁴⁵

After his first meeting with the superintendent in May 2018, Dr. Cedar set out eight goals for their work together:

1. Transition leadership skills from military to public sector.

⁴⁵ The sponsoring manager oversaw the management coaching and was the contact person for Dr. Cedar. Secretary Sudders was not the sponsoring manager for other EHS managers whom Dr. Cedar had coached.

2. Understand natural tendencies as a leader.
3. Build on strengths.
4. Temper frustration and be respectful when interacting with staff.
5. Slow down interactions to listen and be less reactive.
6. Reflect on feedback.
7. Work on verbal and written communication skills.
8. Focus on “excellence and results[.]”

Although Secretary Sudders and the EHS HR staff arranged for Superintendent Walsh to receive coaching, they managed the engagement poorly. First, EHS never set any specific metrics to assess Superintendent Walsh’s progress towards these goals. As the initial sponsoring manager, Secretary Sudders attended periodic meetings with Dr. Cedar and the superintendent, but she did not take appropriate steps to evaluate whether the coaching was worthwhile.

Second, EHS staff did not keep Dr. Cedar informed as he coached Superintendent Walsh. After providing some initial information about the March 2018 complaint, no one from EHS briefed Dr. Cedar regarding the details of the complaints that led to the Morin and Crystal investigations or their investigative findings. Dr. Cedar needed this information to further assess and address Superintendent Walsh’s behavior as a manager.

Third, EHS did not fully support the recommendations that Dr. Cedar made. For example, in May 2019, Dr. Cedar told EHS HR staff that he would like to do a “360” performance review of Superintendent Walsh to better understand how people saw him and his skills, and to provide a roadmap for Dr. Cedar’s work. A 360 review affords supervisors, colleagues and subordinates an opportunity to provide information about a particular employee’s performance. In this case, it would have given Dr. Cedar insight into how the staff at the Home and Secretary Ureña experienced working with Superintendent Walsh. EHS HR staff informed Dr. Cedar it would be “tough” to do a 360 performance review. Ultimately, Dr. Cedar did not speak with staff at the Home about the superintendent’s temperament or management.

Fourth, when it was clear that Superintendent Walsh was not changing his behavior, developing appropriate management skills or creating an appropriate work environment, EHS did not reevaluate Dr. Cedar’s performance as a coach. Rather, EHS extended Dr. Cedar’s contract. Furthermore, throughout the engagement, Superintendent Walsh complained repeatedly about others without taking responsibility for his own mistakes and inappropriate behavior. Dr. Cedar did not identify or address this as a red flag that Superintendent Walsh was not improving or meeting the goals that he had set with Dr. Cedar.

For example, by August 2018, Superintendent Walsh made clear to Dr. Cedar that he had difficulties with Secretary Ureña and the DVS chief of staff. Despite that knowledge, Dr. Cedar did not discuss the chain of command with anyone from EHS. Instead, he communicated solely with Secretary

Sudders as the initial sponsoring manager and acquiesced in the exclusion of Secretary Ureña from meetings with Secretary Sudders. On at least two occasions, Dr. Cedar and Superintendent Walsh met with Secretary Sudders without Secretary Ureña.

In addition, like the EHS investigators, Dr. Cedar accepted Superintendent Walsh's version of events without question. For example, while describing the Morin investigation (discussed in section II(D) of the investigative findings) to Dr. Cedar, Superintendent Walsh minimized the significance of that investigation, telling Dr. Cedar that it revealed some inexperience and loyalty issues with members of his management team. This reaction to the investigation – focusing on his staff's lack of loyalty – raised another red flag that Superintendent Walsh was not examining his own behavior and that he viewed staff who disagreed with him as disloyal. It also demonstrated that Superintendent Walsh was not meeting the goal of reflecting on feedback. Even after hearing the superintendent's reaction to the investigation, Dr. Cedar did not pursue more information from EHS about the investigations.

In summary, EHS staff hired an outside consultant to coach Superintendent Walsh on improving his temperament and management style. However, EHS staff did not set any timelines or goals for Dr. Cedar's work, did not monitor the work to determine its efficacy and missed opportunities to provide valuable information to Dr. Cedar. During the coaching, Superintendent Walsh failed to improve, and his poor behavior continued to have an impact on the Home.

B. Secretary Sudders and the EHS human resources team failed to adhere to the chain of command for Superintendent Walsh and marginalized Secretary Ureña's role.

As discussed in other sections of this report, according to the management infrastructure, Superintendent Walsh was supposed to report to Secretary Ureña. Nevertheless, Secretary Sudders and EHS human resources (HR) staff often marginalized Secretary Ureña's role as supervisor and engaged in sporadic interventions with Superintendent Walsh. Moreover, Superintendent Walsh perceived that he reported to many different supervisors, including Secretary Sudders and Secretary Ureña, as well as the Home's Board. This haphazard supervisory structure contributed to the gaps in oversight for the superintendent and the Home.

Secretary Sudders and EHS HR management limited Secretary Ureña's access to pertinent information, which hindered his ability to provide oversight and guidance to Superintendent Walsh or the Home's staff. For example, as discussed earlier, Secretary Sudders did not include Secretary Ureña in planning the engagement with Dr. Cedar. She was the initial sponsoring manager, rather than Secretary Ureña. Dr. Cedar's first joint meeting with Secretary Ureña and Superintendent Walsh occurred approximately four months into the initial six-month engagement. When Secretary Sudders and EHS HR management extended Dr. Cedar's engagement, moreover, they did not include Secretary Ureña in the decision.

In addition, EHS HR management provided limited information to Secretary Ureña about the complaints regarding Superintendent Walsh's behavior. The secretary knew that there were complaints

and that investigations had occurred, but the Office found contradictory information about his knowledge of the details of the complaints, and the findings and recommendations from the investigations.

Finally, Superintendent Walsh went directly to Secretary Sudders and EHS HR staff when he was unhappy with Secretary Ureña or DVS staff. Secretary Sudders and the EHS HR staff did not discourage this practice. For example, in May 2018, when Secretary Ureña stopped by the Home, Superintendent Walsh complained to Secretary Sudders that Secretary Ureña had not told him he was coming to the Home. Rather than support Secretary Ureña's authority to visit one of the Homes for which he was responsible, she told Superintendent Walsh she would "speak with [Ureña]."

Similarly, in March 2019, Superintendent Walsh emailed Marianne Dill, the EHS director of labor relations, with complaints about Secretary Ureña and DVS. The superintendent informed Ms. Dill that he felt that DVS staff had treated him unprofessionally and unfairly. When he offered to send her a list of his issues, Ms. Dill responded that he should:

[P]rovide any information you feel is helpful but trust we understand the issues. I don't want you feeling you need to put a lot of time into building a case to convince us. I know how problematic and unnecessary this whole experience has been for you.

Superintendent Walsh responded by telling Ms. Dill that he felt "completely supported" dealing with her and Ms. Starr. These examples demonstrate that the blurred supervisory structure, combined with the messages that EHS leadership and HR staff provided to the superintendent, undermined the chain of command.

C. As the EHS human resources officer, Catherine Starr set an inappropriate tone at the top for how to address Superintendent Walsh's management issues and behavior.

In September 2018, Catherine Starr became EHS's human resources (HR) officer. As the head of EHS's HR department, she set the tone for EHS's response to the complaints against the superintendent and led efforts to address his management issues. Her obligation was to work with the Home's management and staff to create and maintain professional working relationships. Ms. Starr favored Superintendent Walsh and held a negative opinion about the Home's employees and management team, particularly those who complained about the superintendent. Ms. Starr's opinion compromised her leadership, her decisions and the direction that she provided to her team. Further, Ms. Starr shared her opinion regarding the Home's staff with Secretary Sudders and Secretary Ureña.

Ms. Starr did not take a neutral view of the complaints about Superintendent Walsh. Instead of taking steps to verify, investigate and address complaints in an objective manner, Ms. Starr and some members of the EHS management team relied on their negative feelings about the complainants to guide their actions. Ms. Starr believed that the Home's staff had an ulterior motive for complaining about the superintendent – to remove him from his job. When Superintendent Walsh's staff brought complaints

about him to EHS, Ms. Starr did not take the complainants seriously and viewed the complainants as the problem.

EHS HR focused on supporting Superintendent Walsh instead of conducting thorough investigations and objectively evaluating the evidence. Ms. Starr supervised Ms. Morin and Ms. Crystal. Ms. Morin's report and recommendations favored Superintendent Walsh and did not fully address serious allegations about his behavior that she had learned during witness interviews. Similarly, Ms. Crystal did not thoroughly investigate the myriad of complaints in the September 2019 letter to Secretary Sudders.

In contrast, when Superintendent Walsh repeatedly complained to Ms. Starr about Secretary Ureña or DVS Chief of Staff Paul Moran, she accepted the superintendent's complaints and concerns as valid. She did not attribute an ulterior motive to him. Moreover, even though Secretary Ureña had supervisory authority over Superintendent Walsh, Ms. Starr did not question whether the superintendent was trying to circumvent his chain of command. Instead, she focused on Superintendent Walsh and Secretary Ureña's communication issues, and she overlooked the superintendent's resistance to Secretary Ureña's supervision.

A further example of the impact of Ms. Starr's leadership arose after Ms. Spaulding's exit interview. Ms. Spaulding was the Home's outgoing chief financial officer who resigned in May 2019. Ms. Bryan, the EHS HR employee who conducted the exit interview, emailed a summary of it to Ms. Starr and Ms. Gallup, another EHS HR manager. In the summary, Ms. Bryan described Ms. Spaulding's belief that Superintendent Walsh retaliated against employees who had participated in the Morin investigation. Ms. Bryan also described Ms. Spaulding's statement that the superintendent treated women on his team poorly. At the end of her summary, Ms. Bryan expressed her own concern that Superintendent Walsh treated employees differently based on gender. Based on information from EHS HR, neither Ms. Starr nor Ms. Gallup took steps to follow up on Ms. Bryan's concerns.

D. EHS personnel did not follow up on the recommendations from the investigations into Superintendent Walsh.

The recommendations from the Morin and Crystal investigations were incomplete because they failed to address the complaints regarding Superintendent Walsh's temperament and leadership issues. Even though the recommendations were inadequate, EHS staff should have taken steps to implement the recommendations provided. EHS staff did not do so. As a result, EHS management missed multiple opportunities to improve Superintendent Walsh's leadership of the Home.

For example, Ms. Morin recommended that EHS assign Superintendent Walsh a peer mentor. With more than a dozen agency heads within EHS, one of them could have provided mentoring to the superintendent. No one from EHS assigned him a mentor.⁴⁶

⁴⁶ Then-Superintendent Poppe spoke informally with Superintendent Walsh but did not have a formal mentoring relationship with him.

In addition, Ms. Morin recommended that EHS provide Superintendent Walsh with coaching on how to work with the unions. EHS HR assigned attorneys and other senior managers to assist the superintendent with labor relations, but they were not directed to specifically coach Superintendent Walsh.

The following chart illustrates how EHS approached the implementation of the recommendations from the Morin report:

Morin report recommendations	Actions taken
Continue Superintendent Walsh's work with Dr. Cedar.	Superintendent Walsh continued to work with Dr. Cedar.
Expand Dr. Cedar's work (or find another consultant) to include the Home's entire executive team.	None.
Appoint an executive-level mentor to Superintendent Walsh (the Superintendent at the Chelsea Soldiers' Home or other appropriate mentor) to help Superintendent Walsh grow as a leader in this environment.	None.
Reassign Lori Beswick to another role within the Home.	Ms. Morin worked with Superintendent Walsh to reassign Ms. Beswick as the volunteer coordinator.
Hire an executive assistant at an appropriate position level and skillset for Superintendent Walsh.	Superintendent Walsh replaced Ms. Beswick with a different executive assistant.
Reinstitute labor/management meetings and provide Superintendent Walsh coaching in this area by having a senior labor relations manager present and available at all meetings.	Superintendent Walsh received labor management guidance from a labor relations manager at EHS and began attending labor/management meetings.
Discuss how to address Superintendent's "earned" holiday compensatory time.	Ms. Morin directed an EHS staff member to delete all of Superintendent Walsh's holiday compensatory time.

Figure 3: Recommendations from the Morin report and the actions taken in response.

E. EHS HR managers hampered the Commonwealth's independent investigation into a complaint of workplace violence and retaliation against Superintendent Walsh.

As discussed in section III(D) of the investigative findings, in November 2018, Ms. Morin interviewed Superintendent Walsh's administrative assistant, Lori Beswick. During this interview, Ms. Morin and her colleague noted that Ms. Beswick alleged that Superintendent Walsh had taken her

telephone out of her hand and hung it up. However, Ms. Morin did not investigate this event or include it in her report.

On April 16, 2019, Ms. Beswick, filed a complaint with the Commonwealth's Investigations Center of Expertise (COE). Located in the state's Human Resources Division (HRD), the COE investigates complaints related to discrimination, sexual harassment, domestic violence, sexual assault, stalking, workplace violence and retaliation across all executive branch agencies.

Ms. Beswick alleged that when she was working for Superintendent Walsh, he took a telephone out of her hand and hung it up. Ms. Beswick also told the COE investigator that the superintendent had moved her workstation and reassigned her to a different job in retaliation for her cooperation with Ms. Morin's investigation.

When Marianne Dill, EHS's director of labor relations, learned of Ms. Beswick's complaint, she tried to stop the COE investigation. Ms. Dill and others in EHS HR also delayed providing information to COE's investigator and gave incomplete information to the COE.

1. From the beginning of the COE investigation, Ms. Dill tried to convince the COE to screen out the complaint and delayed providing the Morin report to the COE investigator.

On April 16, 2019, the COE sent Superintendent Walsh an email notifying him about Ms. Beswick's complaint. Superintendent Walsh reached out to Ms. Dill and forwarded her the email. From that point forward, EHS staff – and Ms. Dill in particular – tried to stop the investigation. Although Ms. Dill worked in labor relations, she stepped outside of that role to serve as the primary point of contact for the COE on behalf of both the Home and EHS.

The day after learning of the complaint, Ms. Dill emailed Susanna Murphy, the director of investigations at HRD, and questioned whether the complaint was within the COE's purview, even though the COE's purpose is to investigate claims of workplace violence and retaliation. Ms. Dill also pressed the COE staff to reject the complaint, inaccurately stating that Ms. Morin had already investigated the allegation.

In the same email, Ms. Dill expressed concern that the COE investigator, Alexis Demirjian, had described Superintendent Walsh as the "target" of the complaint. According to Ms. Dill, it was inappropriate for Ms. Demirjian to have used the term "target" to refer to Superintendent Walsh in an email to her contact at the Home because the email recipient was the superintendent's employee.

Less than two hours after Ms. Dill emailed the COE, she emailed Superintendent Walsh to inform him that she was trying to get the COE to reevaluate whether the complaint fell within its scope.

Despite Ms. Dill's objections to the COE's jurisdiction, Ms. Demirjian began her investigation. On or about April 22, 2019, Ms. Demirjian asked Ms. Morin for a copy of her report. Ms. Demirjian needed the report to understand the scope of Ms. Morin's investigation, including the allegation that she had investigated whether Superintendent Walsh had taken Ms. Beswick's telephone out of her hand. Ms.

Demirjian also needed the report to review the findings and recommendations to determine who decided to reassign Ms. Beswick.

Ms. Morin forwarded the request to Ms. Dill. Instead of providing the report, Ms. Dill again attempted to discuss the COE's jurisdiction with Ms. Demirjian. Ms. Demirjian explained that the allegation was that Superintendent Walsh had "physically grabbed" a telephone out of Ms. Beswick's hand; if that had occurred, it would "potentially violate the workplace violence policy." Ms. Demirjian also explained that retaliation for making such a complaint would be within the COE's scope.

To evaluate the complaint, Ms. Demirjian continued to request information about the Morin investigation. Rather than send Ms. Demirjian her full report, in May 2019 Ms. Morin prepared a two-page document summarizing only the parts of her report regarding Ms. Beswick's conduct. Specifically, Ms. Morin indicated that Ms. Beswick's job performance was poor, that Ms. Beswick delegated her work and that Ms. Beswick used her cellphone for personal business during work hours. She also described one incident when Ms. Beswick became upset in public. Ms. Morin provided only the recommendations from her report relating to reassigning Ms. Beswick and hiring a new administrative assistant, redacting those that related to Superintendent Walsh. After reviewing this summary, Ms. Demirjian determined that she needed to review the full investigative report.

Over the next six months, Ms. Demirjian made multiple requests to Ms. Dill in emails and telephone conversations for a copy of the full investigative report. Ms. Demirjian did not receive the full investigative report until December 2019, when Ms. Dill's supervisor, Ms. Crystal, agreed to send it.

Specifically, on December 3, 2019, Ms. Demirjian emailed Ms. Crystal, who is an attorney within EHS HR, explaining the investigation into possible retaliation. She also noted that both Superintendent Walsh and Ms. Morin "maintain that the recommendation to move [Ms. Beswick] was Morin's." Ms. Demirjian stated that she had not been able to conduct a formal interview with Ms. Morin and had not been able to obtain the full Morin report. Later that day, Ms. Crystal sent the complete report to Ms. Demirjian, which she had first requested in April, eight months earlier.

Although Ms. Crystal ultimately provided Ms. Morin's full investigative report, no one from EHS made Ms. Morin available for a formal interview in response to Ms. Demirjian's request to speak with her. Ms. Dill told Ms. Demirjian that she wanted to keep EHS's labor staff out of the COE investigation.

On December 20, 2019, Ms. Demirjian completed her report. She concluded that Superintendent Walsh did not retaliate against Ms. Beswick for her participation in the Morin investigation.

V. Secretary Ureña and the Board of Trustees were aware of Superintendent Walsh's leadership failings and management issues but did not take timely and adequate steps to address them.

Secretary Ureña and the Home's Board of Trustees (Board) had responsibilities to supervise and oversee Superintendent Walsh, but they failed to fulfill those responsibilities.

Secretary Ureña was Superintendent Walsh's direct supervisor. As such, he met with the superintendent on a regular basis and completed his yearly performance evaluations. As discussed in section IV of the investigative findings, Secretary Sudders and the EHS management team did not communicate effectively with Secretary Ureña, and they marginalized his supervisory role. However, Secretary Ureña knew that the Home's staff had lodged complaints about Superintendent Walsh and that Secretary Sudders had hired a management coach for the superintendent. He also knew that Superintendent Walsh was not performing well in his role. Further, Secretary Ureña understood that Superintendent Walsh resented his supervision and tried to circumvent him.

Even though Secretary Ureña knew that Superintendent Walsh had leadership problems and that he resisted supervision, Secretary Ureña did not take timely and adequate steps to intervene as a supervisor. For example, when EHS made him the sponsoring manager for the management coaching, he did not take an active role in overseeing Dr. Cedar's work with the superintendent. When he conducted annual performance evaluations, he did not evaluate the superintendent's performance in a purposeful, effective manner.

Similarly, the Board had broad statutory authority to oversee the Home and the superintendent.⁴⁷ As discussed in section I of the investigative findings, the Board did not exercise its full authority during the hiring process for Superintendent Walsh. Throughout Superintendent Walsh's tenure, the Board did not take a proactive role in overseeing the superintendent. Some trustees knew about the complaints about Superintendent Walsh and the tension with Secretary Ureña. However, the Board showed deference to Superintendent Walsh and took a narrow approach to its role.

A. Secretary Ureña did not address Superintendent Walsh's management problems in a timely and consistent manner.

Although EHS leadership did not communicate effectively with Secretary Ureña, he knew about Superintendent Walsh's failings as a leader and manager. For example, throughout 2018, Home employees, including the chief financial officer and the general counsel, complained directly to DVS staff about the superintendent's behavior and management practices. By 2018, Secretary Ureña knew that the superintendent did not take direction well and resented being supervised. By the summer of 2019, Secretary Ureña also knew that several key managers at the Home had resigned.

Superintendent Walsh chafed at being supervised by Secretary Ureña and his chief of staff, Paul Moran. In the summer of 2018, as Secretary Ureña took informal steps to address the superintendent's absence from the Home, Mr. Moran requested access to the superintendent's Outlook calendar of work events and activities. Superintendent Walsh delayed providing this access for months. During this time period, Mr. Moran set other expectations, requiring the superintendent to communicate about his schedule, his contact with political figures and his involvement with fundraising activities for the Home.

⁴⁷ The Board's statute states that it "shall manage and control" the Home. M.G.L. c. 6, § 71.

The superintendent resented this supervision and Mr. Moran's role in implementing it. He complained to Dr. Cedar, Ms. Starr and Ms. Dill about Secretary Ureña and Mr. Moran.

Further, Secretary Ureña did not take an active interest in the superintendent's management coaching. For example, after Secretary Ureña became the sponsoring manager for the Cedar engagement in June 2019, he did not respond to Dr. Cedar's repeated requests for meetings. As a result, Secretary Ureña missed the opportunity to discuss the goals and objectives for the coaching engagement, as well as to provide his perspective on the superintendent's management of the Home.

Secretary Ureña issued a written reprimand only once during Superintendent Walsh's tenure. As discussed in section II of the investigative findings, Secretary Ureña issued the reprimand on December 4, 2019, for the superintendent's violation of DVS and EHS instructions, policies and protocols regarding limitations on media presence at the Home and the resulting intrusion on the veterans' privacy.

1. Secretary Ureña did not use annual performance evaluations to document and address Superintendent Walsh's performance issues.

Secretary Ureña did not use the annual performance evaluation process effectively. The Commonwealth's executive branch used a performance evaluation system called the Achievement and Competency Enhancement System (ACES). Secretary Ureña completed three evaluations of Superintendent Walsh; the evaluations were notable for the absence of relevant information. Two of the evaluations occurred after Secretary Ureña was aware of serious concerns raised by Home and DVS staff. Secretary Ureña failed to use these two evaluations to document the superintendent's shortcomings or to create a performance improvement plan.

For example, in the evaluation for the period October 2016 through October 2017, Secretary Ureña rated Superintendent Walsh as "highly effective" overall. He also rated the superintendent as "highly effective" in two categories: (1) working collaboratively with DVS and the Soldiers' Home in Chelsea; and (2) ensuring that the Home was managed in a fiscally responsible manner, meeting with senior leaders and the Board to prioritize the Home's needs.

However, Secretary Ureña was aware of the following issues, set forth in section III of the investigative findings, that arose at the Home during this review period:

1. A petition and a letter in which 175 employees alleged disrespectful and retaliatory behavior by management.
2. A letter to the Board, Secretary Ureña and elected officials alleging problems with staffing and forced overtime, and an increase in serious incidents with veterans' care.
3. An article in a local newspaper that included the issues raised in the letter discussed in number two above, and alleged that the Home was providing inadequate medical care to veterans, was understaffed, had dysfunctional staffing patterns, allowed staff to berate veterans and had "hostile" management.

Secretary Ureña did not mention any of these issues in his evaluation. He did not identify goals aimed at improving Superintendent Walsh's performance with respect to any of the concerns identified, such as staffing, morale or hostile management.

In the evaluation that Secretary Ureña conducted for the superintendent that covered the period June 2018 through June 2019, he again rated the superintendent as "highly effective." Secretary Ureña rated Superintendent Walsh as "exceptional" in these areas: (1) working collaboratively with DVS and the Soldiers' Home in Chelsea to share and create best practices to promote independence and resiliency; (2) providing direction and developing strategies to increase awareness and access to veterans' benefits and services; and (3) ensuring that the Home was managed in a fiscally responsible manner by meeting with senior leaders and the Board. In his final comments about Superintendent Walsh, Secretary Ureña wrote:

Superintendent Walsh has had a highly effective evaluation period as he continues to work collaboratively with the Department of Veterans Services and the Soldiers' Home in Chelsea to share and create best practices in order to promote independence and resiliency for all veterans. He provides direction and has developed strategies to increase the quality of life for Veteran residents of the Soldiers Home. A great deal of emphasis has been successfully placed in the development of positive culture to the staff members of the Soldiers' Home in Holyoke. . . .

However, at the time of this evaluation, Secretary Ureña knew about the following issues, set forth in section III of the investigative findings, that occurred between June 2018 and June 2019:

1. The Home's general counsel, chief financial officer and deputy superintendent all submitted their resignations.
2. Superintendent Walsh consistently sparred with DVS Chief of Staff Paul Moran.
3. Secretary Sudders extended the superintendent's engagement with Dr. Cedar.
4. A union representative raised concerns with Secretary Ureña about the Home's leadership, including allegations of bullying and retaliation.
5. Paul Moran and Secretary Ureña received complaints about the superintendent's conduct.

Again, Secretary Ureña failed to mention any of these important events and issues in this evaluation. Once again, he did not identify any goals aimed at improving Superintendent Walsh's performance with respect to any of the concerns identified, such as maintaining a stable management team and creating a positive work environment.

In addition, as discussed above, Secretary Ureña was concerned about the superintendent's lack of presence at the Home in the summer of 2018. Secretary Ureña, however, did not include these concerns in his evaluation.

Secretary Ureña did not hold Superintendent Walsh accountable for his continual management issues through the performance evaluation process. He did not include the challenges he and his staff faced with the superintendent. Finally, he did not document concerns about Superintendent Walsh's frequent absences from the Home. Secretary Ureña exercised poor judgment when he failed to use the performance evaluation process to accurately portray the superintendent's management of the Home. In addition, he failed to use the evaluations to set goals for improvement or to hold the superintendent accountable when he did not improve.

B. The Home's Board played a minor role in supervising Superintendent Walsh and overseeing the Home.

By law, the Board is responsible for the financial and management oversight of the Holyoke Soldiers' Home.⁴⁸ However, for the majority of Superintendent Walsh's tenure, it took few actions in its oversight capacity.

Superintendent Walsh attended monthly Board meetings and presented a "Superintendent's Report" each month. These reports, in the form of a PowerPoint presentation, provided high-level updates on the Home's events and projects. The presentations were routine and redundant, and the Board provided little response to them. The Home's chief financial officer and medical director also updated the Board about the Home's finances and clinical care. Again, the Board asked few questions and made few comments, deferring to the Home's employees.

In addition, the Board has a fund (the Board fund) of over one million dollars in donations to the Home. The Board had no rules about how to spend or invest these funds. During Superintendent Walsh's tenure, the trustees approved numerous expenditures from the Board fund. Some of these expenditures benefitted the veterans, such as the purchase of wheelchairs or the payment of funeral expenses. Other expenditures benefitted the Home's staff and volunteers, such as scholarships for children of the Home's employees, travel and other expenses for employees to attend conferences, and appreciation gifts for employees and volunteers. Yet other expenditures provided capital improvements, such as paving the circular driveway in front of the Home. The Board did not conduct regular audits of the Board fund; as discussed below, the first review of the fund in recent years occurred in December 2019.⁴⁹

Similarly, the Board did not exercise its responsibility to oversee Superintendent Walsh. The superintendent shared information with Board members that should have raised concerns about his performance, but the Board did not follow up. For example, he told certain trustees about the ongoing investigations into his conduct and stated that the investigators had cleared him of any wrongdoing. He also shared with these trustees that he had a difficult relationship with Secretary Ureña and DVS Chief of Staff, Paul Moran. He also told these trustees that he felt Secretary Ureña and Mr. Moran did not support

⁴⁸ M.G.L. c. 6, § 71 (the Board "shall manage and control" the Home and its property).

⁴⁹ The Office will address the Board fund and the overall fiscal management of the Home, including the lack of internal controls and segregation of duties, in a future publication.

him, undermined him and were not letting him do his job. The trustees did not take any actions to better understand the investigations into the superintendent's conduct or his relationships with DVS staff.

The dynamics of the Board shifted when Governor Baker appointed a new chair, Kevin Jourdain. The governor appointed Mr. Jourdain to the Board in the fall of 2018 and elevated him to chair in November 2019. During his tenure as chair, Mr. Jourdain became actively involved and asked Superintendent Walsh for financial information. The superintendent did not respond well to Mr. Jourdain's requests for information and attempted to undermine him – and to discredit his requests – with other Board members and the Home's chief financial officer.

In the spring of 2019, Mr. Jourdain began to examine the Board's finances. He learned that the Board had not had a finance committee meeting in over five years. He and several other trustees began asking questions about various expenditures from the Board fund. Mr. Jourdain noted that the Board did not have regular audits of its accounts and set the process in motion to engage an accounting firm for a review of the Board fund. Superintendent Walsh and his chief financial officer resisted this oversight and interfered with the review of the fund's expenditures.

Other than the review of the Board fund towards the end of Superintendent Walsh's tenure, the Board conducted little oversight of the Home, its superintendent or the funds that it held on behalf of the Home. The Board therefore failed to carry out its statutory mandate to "manage and control" the Home.

CONCLUSION AND RECOMMENDATIONS

Governor Baker met with and appointed Bennett Walsh as the superintendent of the Holyoke Soldiers' Home (Home) in 2016. The selection process for the superintendent role was inherently flawed. Although the Home's Board of Trustees (Board) had the authority to hire superintendents, Secretary Sudders of the Executive Office of Health and Human Services (EHS) met with only Mr. Walsh after the Board recommended three candidates. He had no experience in healthcare management and did not develop the skills necessary for his role. As superintendent, he was hostile towards certain employees, had a bad temper, created an unacceptable work environment and was a poor manager. He also demonstrated a lack of engagement in the operations of the Home, and he did not prioritize key initiatives and hiring needs.

Between 2017 and 2019, senior managers and employees at the Home reported complaints and concerns to the leadership teams at EHS and Department of Veterans' Services (DVS) on numerous occasions regarding Superintendent Walsh's leadership, management practices and behavior. EHS did not have an organized, systematic method for addressing, documenting or investigating employee complaints. EHS leaders also did not recognize that the repeated complaints revealed a pattern of mismanagement, unhealthy work culture and inappropriate conduct at the Home. In response to complaints, EHS HR conducted biased and flawed investigations. The EHS investigators minimized allegations from employees regarding Superintendent Walsh and deferred to the superintendent's perception of the issues and employees.

EHS leadership provided numerous resources to support Superintendent Walsh as a leader and manager, including professional development training and assistance with labor relations. In addition, for two years starting in March 2018, Secretary Sudders and her HR team provided a management coach for Superintendent Walsh. EHS and DVS did not manage the engagement well; when Superintendent Walsh did not improve, EHS and DVS leaders did not change course and consider whether the superintendent should remain in his role. Instead, EHS leaders bolstered him in his role and interfered when the Commonwealth's Investigations Center of Expertise investigated a complaint of workplace violence and retaliation against the superintendent.

The chain of command for the Home broke down at multiple levels. At the top, EHS leadership failed to provide appropriate oversight for DVS or the Home. While Secretary Ureña was Superintendent Walsh's director supervisor, Secretary Sudders marginalized Secretary Ureña's role. She and other EHS leaders sometimes directly supervised the superintendent, but they did not consistently inform Secretary Ureña about what they were doing and why. For his own part, Secretary Ureña failed to address and hold the superintendent accountable for his many failings. Superintendent Walsh did not follow the chain of command and avoided dealing with Secretary Ureña as his supervisor. Additionally, the Board had broad

statutory authority to oversee Superintendent Walsh and intervene when the superintendent failed as a leader; nevertheless, they chose to play a minimal oversight role.⁵⁰

Recommendations

The Office of the Inspector General (Office) is charged with preventing and detecting fraud, waste and abuse in the use of public funds and public property. By statute, the Office has broad authority to oversee the use of state, local and federal funds by state agencies and municipalities.⁵¹ Moreover, the Office's Bureau of Program Integrity (Bureau) conducts oversight of EHS agencies and programs. The Bureau has its own statutory mandate to monitor the quality, efficiency and integrity of programs that EHS agencies administer and seek to prevent, detect and correct fraud, waste and abuse.⁵²

Consistent with these mandates, the Office has made recommendations over the years regarding agency and municipality management practices that have led to significant reforms. In keeping with this practice and with the findings in this report, the Office makes the following recommendations for all parts of state government that have a role in the structure and management of the Home: the Legislature, the DVS secretary and the Home's current management, and the EHS secretary.

I. Recommendations for the Legislature.

A. Enact legislative reforms to strengthen the oversight of, and assure accountability for, the superintendents of the Holyoke and Chelsea Soldiers' Homes.

For more than a year, the Legislature has been working to reform the statutory structure of the Holyoke and Chelsea Soldiers' Homes (together, the Soldiers' Homes). The Office has reviewed the various legislative proposals, recommended specific reforms, commented on proposed legislation and produced three public advisory letters outlining specific recommendations for reform. See appendix C.

The Office has recommended the following reforms to the Legislature regarding oversight and accountability:

1. Vest the DVS Secretary with the responsibility and authority necessary to ensure that the superintendents properly manage the Soldiers' Homes.
 - a. Elevate the DVS Secretary to the Governor's Cabinet.
 - b. Provide the DVS Secretary with the authority to appoint and remove the superintendents.

⁵⁰ The Office will issue separate findings, conclusions and recommendations regarding the Home's and Board's fiscal practices.

⁵¹ M.G.L. c. 12A, § 7.

⁵² M.G.L. c. 6A, § 16Vs.

- c. Require the DVS Secretary to directly supervise the superintendents.
 - d. Ensure that no other person or entity – including the executive director of the Office of Veterans’ Homes and Housing, the board of trustees, a statewide council or local stewardship body – has authority to hire, supervise, evaluate or terminate the superintendents.
- 2. Create specific principles to guide the DVS Secretary in the selection and management of the superintendents.
 - a. Require the superintendents to be licensed nursing home administrators pursuant to Section 109 of Chapter 112 of the Massachusetts General Laws or have experience managing a skilled nursing facility.
 - b. Require the superintendents to have experience in fiscal management practices and labor relations.
 - c. Remove superintendents expeditiously when they do not meet performance goals or do not comply with performance improvement plans.
- 3. Allocate resources for DVS to support oversight of the Soldiers’ Homes.

B. Designate any statutory boards or councils as advisory in nature.

Advisory boards have an important role in state government; their members can add valuable perspectives and expertise. However, a board whose members are volunteers should not be in the chain of command for a state agency. In light of the need for a clear chain of command and effective oversight of the Soldiers’ Homes, the Office supports legislative reform to eliminate both Soldiers’ Homes’ boards of trustees. If the Legislature decides to keep a board, council or any other body in place, the Office strongly recommends against vesting any such entity with any authority to operate, manage or control the Soldiers’ Homes or the superintendents.

The Office has recommended that the Legislature:

- 1. Limit any board, council or other body to serve in advisory capacity only.
- 2. Require the participants to have experience in the following areas: veterans’ issues, healthcare, nursing, fiscal management and labor relations.
- 3. Require the participants in any advisory board to complete training on fiscal, ethical and fiduciary responsibilities.

C. Create effective, confidential ways for people to report problems and concerns with the Soldiers’ Homes.

Complaints and concerns – from employees, veterans, families and other stakeholders – are important sources of information about the Soldiers’ Homes; they can provide critical insights that lead

to timely and necessary improvements for the Soldiers' Homes. The Office has recommended that the Legislature establish an ombudsperson and a hotline at the secretariat level for DVS. Establishing the role at the secretariat level will enable the ombudsperson to function independently while having full access to the Soldiers' Homes to fulfill their role. The hotline will fill the current reporting gap for complex and time-sensitive complaints about the two Soldiers' Homes.

The Office has recommended that the Legislature:

1. Establish an ombudsperson and staff, reporting to the DVS secretary, to provide independent problem-solving on behalf of employees, veterans, families and other stakeholders.
2. Establish a hotline for complaints and concerns about the Soldiers' Homes, administered by the ombudsperson.
3. Require that investigators follow specific procedures and standards for investigations involving superintendents.
4. Enact protections for complainants and veterans:
 - a. Create whistleblower protections for employees who raise concerns and complaints.
 - b. Maintain all complainant information in strict confidence unless disclosure is necessary to make a referral to another agency or law enforcement.
 - c. Prohibit termination, discipline or other retaliation against employees for reporting concerns.
 - d. Enact confidentiality protections for veterans' records and files held by the ombudsperson and hotline staff.
5. Provide sufficient funding to ensure that the ombudsperson and hotline function effectively as a continuous resource and internal control.

D. Create a new role for the Department of Public Health (DPH) to provide independent clinical oversight for the Soldiers' Homes to ensure that they not only comply with appropriate standards for quality of care, but also maintain clinical best practices.

Clinical oversight and clinical expertise in healthcare and, in particular, long-term care, should be at the center – not on the periphery – of governing the Soldiers' Homes. The Office's investigation noted numerous staff concerns regarding clinical care, but DPH is the state agency with the expertise required to address those concerns. However, DPH does not currently have a statutory mandate or the authority to oversee the clinical care in the Soldiers' Homes. Moving forward, DPH should play a vital role in providing independent oversight of and supporting the quality of care at the Soldiers' Homes. Conducting regular inspections as well as other reviews, DPH should review clinical practices, identify vulnerabilities

and assist with implementing corrective action and improvements. To provide such clinical expertise and oversight, DPH needs the appropriate authority and resources.

The Office has recommended that the Legislature:

1. Expand the resources for DPH to conduct and follow-up on inspections, as well as to provide consultation and advice to DVS on the clinical oversight of the Soldiers' Homes.
2. Mandate that the Soldiers' Homes maintain certification from the Centers for Medicare and Medicaid Services at a five-star rating.
3. Mandate that the Soldiers' Homes meet the same certification standards for private long-term care facilities set forth in 105 CMR 150.
4. Require DPH to conduct independent inspections to ensure that the Soldiers' Homes meet both sets of standards.
5. Require DPH to report noncompliance or other vulnerabilities to DVS, monitor and track corrective action, and conduct follow-up inspections as necessary.
6. Require DPH to address any failure to implement corrective action with the same enforcement actions that it implements for private nursing homes.
7. Direct DPH to help address clinical or staffing vulnerabilities and to assist the Soldiers' Homes in developing and implementing clinical best practices and supporting quality of care.
8. Require DPH to conduct inspections or reviews to evaluate clinical practices and provide recommendations for continuous improvement.

II. Recommendations for the Department of Veterans' Services (DVS) and the Soldiers' Homes.

A. Create a stable and sustainable infrastructure for oversight of the superintendents, under the leadership of the DVS Secretary.

As set forth in the recommendations to the Legislature above, the Office supports elevating DVS to the Governor's Cabinet and requiring the superintendents of the Soldiers' Homes to report directly to the DVS secretary. This will prevent confusion about reporting relationships and create accountability for the DVS Secretary and the superintendents. To conduct appropriate oversight of and provide ongoing support to the Soldiers' Homes, DVS should create standards, procedures and controls for superintendents to govern the Soldiers' Homes; maintain stable management, clinical leadership and direct service staffing at the Soldiers' Homes; and work in partnership with DPH to maintain clinical best practices. DVS should work in partnership with other oversight entities while maintaining a clear reporting

structure. Finally, DVS should operate transparently and hold itself and other oversight partners accountable for providing the optimal quality of care for veterans.

The Office recommends that the DVS Secretary:

1. Hold the DVS leadership team accountable for prioritizing the needs of the Soldiers' Homes and veterans, fulfilling their oversight responsibilities, and promoting and adhering to chain of command.
2. Work with the superintendents to document governance standards, policies, procedures and internal controls for the Soldiers' Homes.
3. Establish clear leadership goals for superintendents.
4. Hold superintendents accountable for improving their performance as managers and leaders, as well as for continuously improving the operation of the Soldiers' Homes.
5. Ensure full and transparent access for DPH and work in partnership with DPH to implement clinical best practices at the Soldiers' Homes.
6. Work with the superintendents to document and implement a contingency plan for the stability of leadership, operations and clinical care at the Soldiers' Homes in the event of the removal of the superintendent, deputy superintendent or other key leaders of the Soldiers' Homes' management teams.
7. Enact mandates to expedite hiring processes and fill management, clinical management and direct care positions within a prescribed time.
8. Provide resources to support the Soldiers' Homes' hiring processes.
9. Implement thorough and effective performance evaluations for superintendents.
 - a. Track superintendents' progress toward implementing oversight recommendations and key initiatives.
 - b. Incorporate feedback from staff, information from complaints and concerns, and findings and recommendations from reports, reviews, surveys and audits into the process of evaluating the performance of superintendents.
 - c. Periodically review goals and recommendations from performance evaluations to ensure that superintendents are on track to meet those benchmarks.
10. If DVS becomes a stand-alone secretariat, create and implement procedures for investigating complaints and standards of conduct to ensure their quality and integrity.

B. Foster a professional and responsive work environment.

The Soldiers' Homes have a critical and challenging mission. Their employees need support to provide the best care possible to the veterans who reside at the Soldiers' Homes. At a minimum, the leadership at the Soldiers' Homes must recognize and respect the employees of the Soldiers' Homes. Leadership also needs to ensure that the Soldiers' Homes' managers and clinical leaders maintain a professional work culture. Managers and clinical leaders must set an appropriate tone at the top; leaders who engage in hostile, threatening or intimidating conduct should not remain in their roles.

In its oversight capacity, DVS should implement policies and training about the standards and expectations for the work culture at the Soldiers' Homes; moreover, DVS should identify and address leadership and management issues expeditiously. Failure to create and maintain a professional work environment comes with significant costs to the Commonwealth in decreased productivity, high staff turnover and the expense of training new employees.

The Office recommends that the DVS Secretary and Soldiers' Homes' leadership:

1. Create and maintain a professional tone at the top to demonstrate and reinforce appropriate management practices.
2. Provide management training to support an appropriate work environment for all employees.
3. Enforce a policy of zero tolerance for hostile, threatening or intimidating conduct by superintendents and management teams.
4. Maintain active channels for employees to communicate concerns about the work culture and the behavior of their supervisors and managers.
5. Address management failures expeditiously and thoroughly, documenting concerns, supports, improvement plans, deadlines and expectations.
6. Remove managers and supervisors who engage in hostile, threatening or intimidating conduct.
7. Recognize the importance of the Commonwealth's Investigations Center of Expertise, and respect and support its mission to promote a professional work environment.

III. Recommendations for the Executive Office of Health and Human Services (EHS).

A. Expand and coordinate EHS's management resources.

EHS is the Commonwealth's largest secretariat, accounting for approximately one-third of the Commonwealth's annual budget. EHS has a broad jurisdiction over a complex matrix of health and human services agencies and programs. Despite EHS's size – or perhaps because of it – there is a lack of oversight, supervision and coordination both within EHS and between EHS and its agencies. Many of the issues

discussed in this report stem from EHS's lack of coordination, communication and resources, all of which made it difficult for EHS staff to provide proper oversight to the Home. At times, moreover, EHS delegated its oversight responsibilities to consultants to fill gaps in its resources or expertise. However, EHS did not have the infrastructure and staff to follow up on and implement the consultants' recommendations.

The Office recommends that EHS:

1. Maintain a clear reporting structure and chain of command with sufficient staff to provide oversight and guidance to EHS agencies. Create structured plans to implement key initiatives and recommendations for improvement.
 - a. Make specific people responsible for carrying out initiatives and recommendations.
 - b. Follow specific milestones for the implementation of initiatives and recommendations.
2. Improve management resources by including additional administrative supports and structures for all of EHS's agencies.
3. Continuously evaluate the performance of agency heads through mandatory, structured performance evaluations.
4. Improve communication within EHS and between EHS and its agencies.

B. Improve the quality and integrity of EHS human resources (HR) investigations.

Regardless of whether EHS HR retains authority for investigations related to DVS and the Soldiers' Homes, EHS leadership must improve its HR investigations.⁵³ As one of EHS HR's critical functions, EHS must appropriately address employee complaints and concerns across the secretariat, including conducting effective investigations. However, the infrastructure for EHS HR investigations is inadequate, its approach to investigations is *ad hoc* and the investigative practices are flawed.

The Office recommends that EHS:

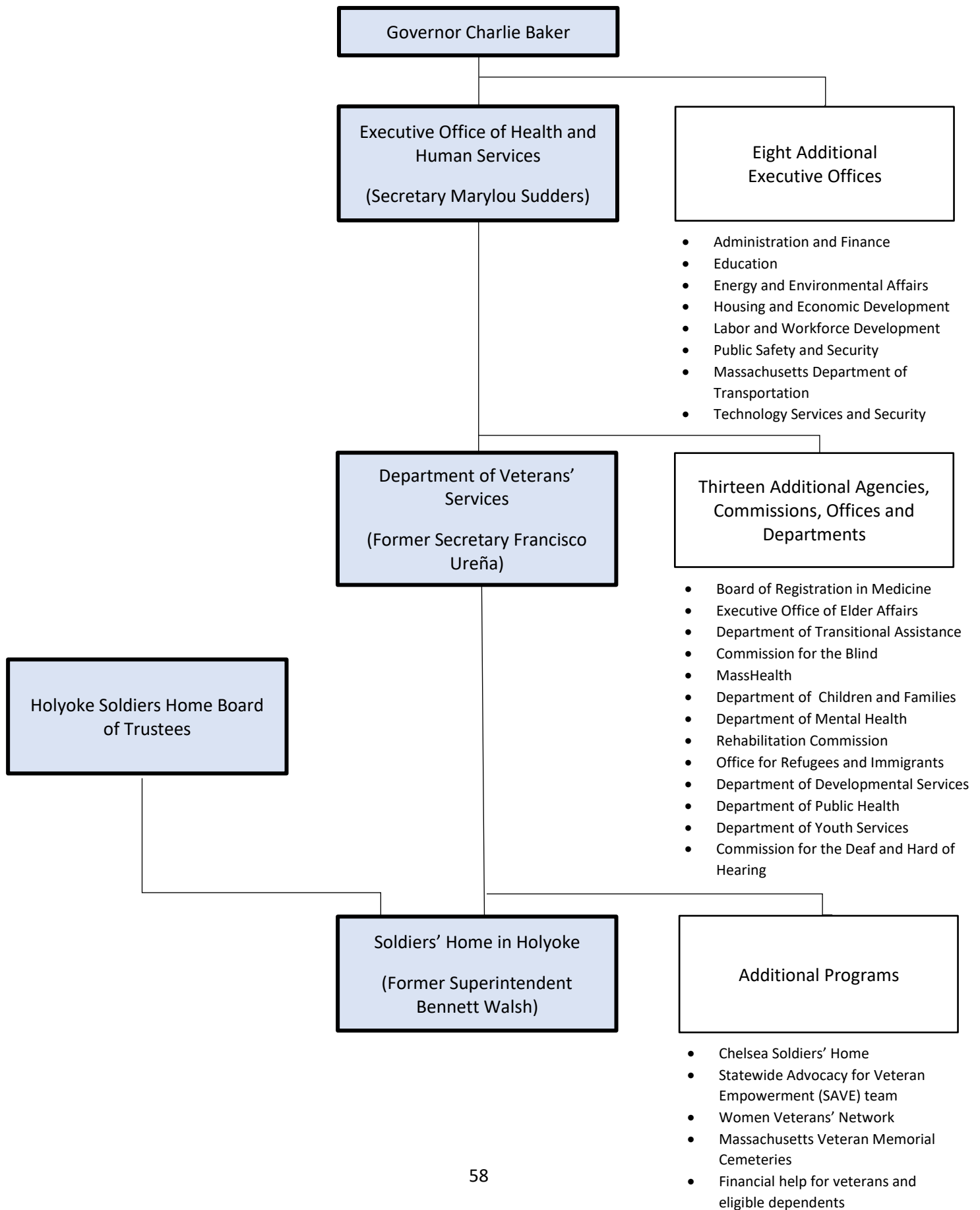
1. Conduct investigations impartially using an objective and evidence-based approach.
2. Use investigators who are professionally trained to conduct HR investigations, and in particular, those who have training in relevant laws and proper investigation techniques for HR complaints.
3. Create policies and procedures for investigations, including – at a minimum – protocols for timelines, witness protection against retaliation, handling new allegations from

⁵³ EHS recently advertised for a "senior manager / lead investigator" for a new investigation unit within the EHS labor relations department. The Office recommends that EHS implement these recommendations as it forms this new unit.

witnesses, witness selection, collection and review of comprehensive evidence, documentation of investigative steps, and accurate maintenance of records.

4. Establish controls to validate findings and recommendations, and ensure that investigations are conducted without bias or threats of retaliation, intimidation or coercion.
5. Document and implement specific policies and procedures for investigations that involve agency heads, focused on ensuring independent and complete fact-finding without deference to the position.
6. Recognize and respect the confidentiality and privacy of witnesses.
7. Provide investigators with access to information regarding related complaints and investigations, whether past or ongoing, to provide context for a new investigation and opportunities for coordination.
8. Respond appropriately to new allegations that come to light during an investigation.
9. Maintain clear records for investigations, findings and recommendations.
10. Respect and fully cooperate with other state agencies that are conducting investigations by facilitating timely access to information and support for their investigations.
11. At the conclusion of an investigation, create a monitoring plan and assign someone to track implementation of recommendations.

APPENDIX A: EXECUTIVE BRANCH ORGANIZATION CHART



APPENDIX B: LIST OF PEOPLE INCLUDED IN THIS REPORT, BY AGENCY

Holyoke Soldiers' Home

Employee name	Title	Dates of employment
Lori Beswick	Typist, administrative assistant	July 1994 – April 2019
John Crotty	Deputy superintendent	January 2017 – June 2019
Stephen Giordano	Accountant	March 2016 – April 2022
Norman Gousy	Chief financial officer	November 2019 – January 2021
Carol Laflamme	Treasurer	February 2004 – present
Alice Pizzi	General counsel	March 2016 – January 2019
Jessica Powers	Human resources liaison	August 2017 – present
Carolyn Rogers	Administrative assistant, admissions coordinator	December 1997 – present
Erin Spaulding	Chief financial officer	March 2016 – May 2019
Scott Zacharie	Admissions coordinator, program coordinator	December 2000 – present

Figure 4: Titles and dates of employment for Holyoke Soldiers' Home employees mentioned in this report.

Executive Office of Health and Human Services (EHS)

The current EHS secretary is Marylou Sudders. During the time covered by this report, her management staff included the following people:

1. Sharon Boyle, general counsel (reported to Secretary Sudders)
2. Leslie Darcy, chief of staff (reported to Secretary Sudders)
3. Catherine Mick, former undersecretary, former chief operating officer (reported to Secretary Sudders)
4. Alda Rego, assistant secretary for administration and finance (reported to Secretary Sudders)

During the time covered by this report, Secretary Sudders' human resources and labor relations staff included the following people:

1. Erica Crystal, deputy general counsel and director of labor relations (reported to Catherine Starr)
2. Marianne Dill, labor relations director (reported to Catherine Starr)
3. Lisa Gallup, senior business partner, HR director (reported to Catherine Starr and Elizabeth Tierney)

4. Donna Morin, director of labor relations for a group of EHS agencies (reported to Erica Crystal)
5. Joel Posner, labor relations specialist (reported to Lisa Gallup and Marianne Dill)
6. Catherine Starr, human resources officer (reported to Secretary Sudders and Alda Rego)
7. Jay Talbot, labor relations specialist (reported to Joel Posner)
8. Elizabeth Tierney, director of human resources (reported to Leslie Darcy and Alda Rego)

Department of Veterans' Services (DVS)

The DVS Secretary was Francisco Ureña during the time covered by this report. His management staff included the following people, both of whom reported to him:

1. Paul Moran, chief of staff
2. Cheryl Lussier Poppe is the current DVS secretary.

APPENDIX C: LETTERS TO THE LEGISLATURE



GLENN A. CUNHA
INSPECTOR GENERAL

The Commonwealth of Massachusetts

Office of the Inspector General

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January 12, 2022

Via Email

The Honorable Cindy F. Friedman, Chair
Joint Committee on Health Care Financing
State House, Room 313
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Cindy.Friedman@masenate.gov

The Honorable John J. Lawn, Chair
Joint Committee on Health Care Financing
State House, Room 236
Boston, MA 02133
John.Lawn@mahouse.gov

**Re: House 4298 An Act Relative to the Governance, Structure and Care of
Veterans at the Commonwealth's Veterans' Homes**

Dear Chair Friedman and Chair Lawn:

As you consider legislation reforming the Commonwealth's Veterans' Homes (Homes), I urge the Committee to strengthen House 4298 to promote effective management of the Homes and enhance the superintendents' direct accountability. The Office of the Inspector General (Office) is an independent state agency charged with preventing and detecting fraud, waste and abuse in the use of public funds and public property. Pursuant to the Office's mandate, I am offering recommendations to support the Legislature's efforts to create a holistic and comprehensive set of reforms. Following the release of the Special Joint Committee on the Soldiers' Home in Holyoke COVID-19 Outbreak (Special Joint Committee) Report, my Office shared some of these recommendations with the chairs of the committee. I respectfully request the opportunity to meet and discuss these recommendations with you.

Structural Overview

The Office has set forth detailed recommendations below. As you will see, the Office finds that the current and proposed structure for the governance and oversight of the Homes are flawed. The Office recommends that the supervision and oversight of the Homes include the following:

- Department of Veterans' Services (DVS) Secretary reporting to the Governor
- Superintendents, Executive Director of the Office of Veterans' Homes and Housing (OVHH) and Ombudsperson reporting to the DVS Secretary
- Independent Office of Veterans Advocate with a hotline reporting to the Governor and Legislature
- Department of Public Health providing reports to DVS Secretary, OVA, Executive Director of OVHH and superintendents
- Council or Boards serving in an advisory capacity

This would create the necessary structure and accountability for the Homes and allow for the provision of high-quality, appropriate long-term care.

Governance Structure

The Office opposes the new governance structure for the Homes. In particular, the Office opposes the creation and mandate of the Veterans' Homes Council (Council) and the modifications to the Boards of Trustees (Boards). If the Legislature does not intend to amend Section 16 of Chapter 6A of the Massachusetts General Laws, this bill adds an additional and unnecessary layer of management and control of the Homes. Currently:

- The Governor oversees the EOHHS Secretary.
- The EOHHS Secretary oversees the DVS Secretary.
- The DVS Secretary oversees the Executive Director of OVHH.
- The Executive Director of OVHH coordinates and oversees the implementation and enforcement of laws, regulations and policies relative to the Homes and meets with the Boards but does not control either the Boards or the day-to-day operations of the Homes.
- Either the DVS Secretary or the Executive Director of OVHH oversees the superintendents of the Homes, but it is unclear from the current statutes who has this responsibility.
- The current statutes provides that the Holyoke Soldiers' Home Board manages and controls that Home and appoints its superintendent; the Chelsea Soldiers' Home Board also manages and controls its Home but the EOHHS Secretary, with the approval of the Governor, appoints that superintendent.¹

In addition to this structure, House 4298 would add the Council and shift the Boards' responsibility to manage and control the Homes to the Council. The Council would also adopt rules and regulations to govern outpatient treatment and admission to the Homes, develop bylaws about operational issues such as admissions, procurement, per diem rates and staffing levels, create a system for reviewing complaints and consider models and guidelines for the delivery of healthcare to the veterans. The addition of this Council would create confusion about roles and responsibilities. This is also far too much management and control for a volunteer council over a state facility.

¹ M.G.L. c. 6, §§ 40, 71.

The Special Joint Committee recognized the need for a clear statutory reporting structure for the superintendents and recommended the establishment of a clear chain of command and communication channels for the Homes. The Office agrees with the Special Joint Committee that the current statute does not provide a clear reporting structure for the Homes. However, inserting the Council as an additional layer of reporting between the Homes and the DVS Secretary creates a risk of gaps in reporting and knowledge, and increases the likelihood of poor oversight and management.

This bill attempts to address the current reporting confusion by having the superintendents report to the Executive Director of OVHH even though by statute the Executive Director has no control over the day-to-day operations of the Homes. Instead, the Office recommends that the Legislature adopt a structure that maximizes the superintendents' direct accountability to the DVS Secretary. The Office maintains that one person must be accountable for the superintendents – the DVS Secretary. The DVS Secretary should be responsible for managing, conducting regular performance evaluations for and disciplining the superintendents. Unless and until the Legislature streamlines and clarifies the existing statutes to make the reporting structure clear, there will be no direct accountability for the superintendents' performance.

House 4298 also revises the role of the local Boards, limiting their statutory duties to only nominating to the Council a candidate for superintendent and participating in trainings. The Council would adopt any rules, regulations, by-laws, roles and responsibilities for the Boards. The Office recommends that the Legislature eliminate the Boards as they add yet another layer of supervision of the Homes and, as modified by House 4298, depend on the Council to define their roles.

The Office also recommends that if the Legislature creates a Council and retains the Boards, the Council and Boards should act in an advisory capacity only. The Council and Boards should have experience in the following areas: veterans' issues, fiscal management, labor relations, healthcare, and nursing. Further, families and other stakeholders should have representation on the Council and Boards. While the Council and Boards could make recommendations and provide advice, they should not be in the chain of command for the superintendents or have any responsibility for the operational decisions involving the Homes. Neither the Council nor the Boards should be involved in hiring, supervision, evaluation or removal decisions for the superintendents.

Hiring and Removal

With regard to the appointment and removal of the Homes' superintendents, the structure for both processes in House 4298 is unclear. The bill provides that the Board for each Home would nominate superintendent candidates to the Council. The Council would then "approve" the superintendents. It is unclear who would then appoint the superintendents.

For the superintendents' removal, House 4298 allows the Boards or the Governor to recommend to the Council for "review" the removal of a superintendent but does not specifically authorize the removal of a superintendent or indicate who has the power of removal.

The Office recommends that the legislation clearly state who is responsible for hiring, appointing, supervising, evaluating and removing the superintendent. As discussed above, one person must be accountable for the superintendents; the person who is responsible for the supervision and evaluation of the superintendents should have the power to decide on an appropriate person to fill the role and, if necessary, whether to remove that person. If the Homes remain within DVS, the Office recommends that the DVS Secretary be responsible for the superintendents' hiring, removal, supervision and evaluation. The Office recommends that no other person or entity – including the Executive Director of OVHH, the Council or Boards – play a role in this process. There is no room for confusion or ambiguity about who hires, supervises, evaluates and, if necessary, removes the superintendent.

Relatedly, the Office endorses the Special Joint Committee's recommendation that the Legislature elevate the DVS Secretary to the Governor's Cabinet. This shift would ensure that the DVS Secretary has access to the Governor to discuss veterans' issues and that the Secretary is directly accountable to the Governor for the performance of the Homes.

Qualifications for the Superintendent

The Office supports the requirements that a superintendent must (1) be licensed as a nursing home administrator pursuant to Section 109 of Chapter 112 of the Massachusetts General Laws and (2) be a veteran or have experience managing the health care of veterans in a nursing home setting.

The Special Joint Committee correctly identified that a superintendent must possess a unique blend of experience and skills to be effective in this role. The Office agrees that experience in nursing home management is an essential qualification to provide appropriate leadership in a clinical care setting. Moreover, a superintendent must also have experience with fiscal management practices, executive management, and how unions operate and how to navigate labor relations issues. The Office recommends an amendment to this bill to include experience in these areas as additional required qualifications for the role of Superintendent.

Channels for Communication and Problem-solving

The Office supports the creation of an independent ombudsperson at each of the Veterans' Homes to focus on concerns regarding veterans' health, safety, welfare and rights. However, an ombudsperson must have independence from the management structure; to ensure this independence the ombudsperson should report to the DVS Secretary and not the Executive Director of Veterans' Homes and Housing. Another way of protecting the ombudsperson's independence is to make them a DVS employee rather than an employee of a Home.

Moreover, the Legislature should create a hotline, which is an important internal control and is often an impetus for problem-solving. The Office supported the creation of the hotline in House 4195 and recommends that the current bill include this important reporting mechanism. The hotline should receive complaints and concerns from residents, staff, families and others, and have a process for qualified investigators to evaluate these reports of problems at the Homes. The Legislature should clearly delineate the types of complaints the hotline would handle in a way that complements those of the ombudsperson. The Office recommends that the hotline handle complaints relating to day-to-day management, personnel, staffing and operational issues.

Further, the hotline staff must have the appropriate authority to conduct investigations and make recommendations. The hotline staff also needs independence from the management structure; to ensure this independence, the hotline staff should report to the DVS Secretary as the supervisor of the Homes. In the alternative, the Office of the Veteran Advocate proposed in House 4298 could run the hotline.

To fulfill their important responsibilities, the ombudsperson and the hotline staff should receive extensive training and guidance. The bill's provision that the ombudsperson "make every effort to ensure the confidentiality of those who submit complaints" does not provide enough clarity or assurance that the ombudsperson will keep a complainant's identity confidential upon request. To encourage complainants to share concerns, the ombudsperson and hotline staff must be able to offer strong statutory protections. To this end, the Office recommends requiring that the ombudsperson and hotline staff maintain all information in strict confidence unless disclosure is necessary to make a referral to another agency or law enforcement. In addition, because the entities have distinct but potentially overlapping roles, the ombudsperson and hotline staff should each have the ability to refer a matter to the other when necessary. The ombudsperson and hotline staff should share information only to the extent necessary to complete the referral.

Both the ombudsperson and the hotline staff should submit an annual report to the Legislature with summaries of their caseloads and activities to create transparency and accountability. In addition, the Legislature should be clear about whether the ombudsperson and hotline staff must refer certain complaints to agencies or entities already charged with investigating specific types of issues.² The Legislature should also mandate that both the ombudsperson and hotline staff address concerns and complaints in a timely, meaningful way, which will enhance confidence in the process. Perhaps most importantly, the Legislature must commit sufficient funding to ensure both programs develop appropriately, function effectively and serve as a continuous resource and internal control.

² For example, if the hotline receives a complaint alleging abuse or neglect of a disabled person, the legislation should state whether the hotline staff must refer that complaint to the Disabled Persons Protection Commission. Similarly, the legislation should articulate whether the hotline should refer a complaint to the Commonwealth's Human Resources Division Center of Expertise if the complaint alleges a violation of a Commonwealth-wide policy involving sexual harassment, discrimination, workplace violence, domestic violence/sexual assault/stalking or retaliation related to those policies.

Moreover, the Office endorses House 4298's strong whistleblower protections for any person who files a complaint with a Home's ombudsperson. However, the Office encourages the Legislature to include similar protections for any individual who reports an issue to a hotline or another entity or person responsible for management or oversight of the Homes.

Office of the Veteran Advocate

House 4298 creates the Office of the Veteran Advocate (OVA), an independent agency charged with ensuring veterans receive timely, safe and effective services. The Office endorses the creation of this oversight agency; however, the Legislature must clearly define the roles of the OVA, the ombudsperson and the Executive Director of OVHH to avoid duplication of efforts or confusion about roles that involve oversight and accountability for the Homes. As noted above, the OVA could run the hotline, much like the Office of the Child Advocate operates its own complaint line to receive concerns about children receiving state services.

Inspections by the Department of Public Health

Given the Homes' critical role in providing health care to veterans, the Office supports the proposal that the Department of Public Health (DPH) inspect the Homes. The Office recognizes the role that DPH currently plays in supporting the quality of care in different healthcare settings and the vital role that it could play in providing clinical support and independent oversight to the Homes.

The Office respectfully suggests that House 4298 provide more structure and specific guidance about the role of DPH and the inspections. For example, the legislation should clarify the purpose and scope of the inspections and delineate how they will differ from other reviews, surveys and inspections by oversight entities. The Office recommends that DPH focus on promoting continuous improvement and evaluating the quality of care at each Home.

The Office also respectfully suggests that the scope of the inspections address concerns related to each home as reflected in issues and findings by other oversight entities, as well as in complaints raised by veterans, families, employees and other complainants. The Legislature should specify that the Homes must provide DPH with a corrective action plan in response to the findings from the inspections and DPH must monitor the Homes' implementation of corrective action. Finally, DPH must have the authority and a clear mandate to take enforcement actions that may be necessary if the Homes fail to implement necessary changes.

To provide inspections and clinical oversight to the Homes, DPH needs adequate resources. The Office recommends that the Legislature create and support a dedicated unit within DPH to support clinical oversight at the Homes.

Reporting Requirements

The bill also includes several reporting requirements, including an annual report from the Executive Director of OVHH on the status of the Homes, an annual report from the Veterans' Advocate on the activities of that office, an annual review by the superintendents and the Executive Director of OVHH on the Homes' health record system, and at least twice each year DPH inspection reports and corrections of violation reports. The Office also recommends that the Legislature require the Ombudsperson and the hotline to submit annual reports documenting their activities. These proposed reports would provide important information about the status of, and recommendations to improve, the Homes. Without coordination, there is a risk that there may not be efficient or effective implementation of these recommendations. The Legislature should designate the DVS Secretary as responsible for integrating, coordinating and implementing these recommendations.

To promote accountability and transparency, the Legislature should require the DVS Secretary to provide monthly updates on the status of the implementation of the electronic medical record system (EMR). Both Homes still operate with paper medical records because there is no EMR at either Home. This is unacceptable and compromises veterans' care. As a result, the Office does not support the annual review by the superintendents and the Executive Director of OVHH on the Homes' health record system proposed in the bill because annual reporting for this critical system is simply not enough. DVS and the Homes have discussed procuring such a system since at least 2016, but there has been a lack of commitment to and funding for the project. Attorney Mark Pearlstein identified this as a long-standing, significant problem in his report to the Governor, *The COVID-19 Outbreak at the Soldiers' Home in Holyoke, An Independent Investigation Conducted for the Governor of Massachusetts*, as well as in his subsequent testimony to the Legislature. DVS and the Homes have had years to put this important system in place, and 18 months have passed since Attorney Pearlstein recommended that the administration make EMR a priority for both Homes. The Legislature must now make EMR a high priority.

Oversight and Clinical Expertise

Finally, the Office strongly recommends that the Legislature consider how the various people and entities charged with leadership responsibilities and oversight of the Homes will coordinate and integrate their efforts. As the bill currently stands, leadership and oversight responsibilities fall under the following roles:

- Governor
- EOHHS Secretary
- DVS Secretary
- Office of the Veteran Advocate
- Executive Director of OVHH
- Department of Public Health
- Ombudsperson


- Superintendents
- Council
- Boards

Although these roles involve overlapping responsibilities, the current bill does not designate a person (or people) at DVS who would be responsible for integrating resources, tracking recommendations and coordinating and implementing improvements to the Homes.

It is critical that the Homes have stable and sustainable clinical leadership and oversight. When creating a new governance structure for the Homes, serving the health care needs of the veterans should remain the highest priority. Leaders with expertise in health care and in particular, long-term care, should be at the center – not on the periphery – of governing the Homes.

I am happy to meet with you to discuss these recommendations, the questions that we have proposed for your consideration, or any other questions you may have. Thank you for your attention to this matter.

Sincerely,



Glenn A. Cunha
Inspector General

cc: Honorable Michael F. Rush, Special Joint Oversight Committee on the Soldiers' Home in Holyoke COVID-19 Outbreak
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February 17, 2022

Via Email

The Honorable Michael Rodrigues
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Michael.Rodrigues@masenate.gov

The Honorable Cindy Friedman
Senate Committee on Ways and Means
State House, Room 313
Boston, MA 02133
Cindy.Friedman@masenate.gov

Re: House 4441 An Act Relative to the Governance, Structure and Care of Veterans at the Commonwealth's Veterans' Homes

Dear Chair Rodrigues and Vice Chair Friedman:

As you consider legislation reforming the Commonwealth's Veterans' Homes (Homes), I urge the Committee to strengthen House 4441 and Senate 2582 to promote effective management of the Homes and enhance the superintendents' direct accountability. The Office of the Inspector General (Office) is an independent state agency charged with preventing and detecting fraud, waste and abuse in the use of public funds and public property. Pursuant to the Office's mandate, I am offering recommendations to support the Legislature's efforts to create a holistic and comprehensive set of reforms.

Following the release of the Special Joint Committee on the Soldiers' Home in Holyoke COVID-19 Outbreak (Special Joint Committee) Report, my Office shared some of these recommendations with the chairs of that committee, provided written feedback to the House members who have been working on these issues and on January 12, 2022, summarized the Office's recommendations for the Joint Committee on Health Care Financing. I respectfully request that we meet to discuss these recommendations.

Structural Overview

The Office has set forth detailed recommendations below. As you will see, the Office finds that the current and proposed structure for the governance and oversight of the Homes are flawed. The Special Joint Committee recognized the need for a clear statutory reporting structure for the superintendents and recommended the establishment of a clear chain of command and communication channels for the Homes. The Office agrees with the Special Joint Committee that the current statute does not provide a clear reporting structure for the Homes. The Office therefore recommended to that Committee, and continues to recommend, the following structure for the supervision and oversight of the Homes:

- Department of Veterans' Services (DVS) Secretary reporting to the Governor.¹
- Superintendents, Executive Director of the Office of Veterans' Homes and Housing (OVHH) and Ombudsperson reporting to the DVS Secretary.
- Independent Office of Veterans Advocate (OVA) reporting to the Governor and Legislature.
- Department of Public Health conducting inspections and providing reports to the DVS Secretary, OVA, OVHH Executive Director and superintendents.
- Council or Boards serving in an advisory capacity.

This would create the necessary structure for the Homes and provide for appropriate stakeholder input. This would also create clarity and direct accountability for the Homes by making one person – the DVS Secretary – responsible for their oversight and management. This structure would set the foundation for the provision of high-quality long-term care, which must always remain the focal point for the Homes. Finally, this structure is similar to other executive branch agencies.

Governance Structure

In light of the need for a clear chain of command and oversight of the Homes, the Office strongly opposes the governance structure set forth in House 4441. In particular, the Office opposes both the creation and mandate of the Veterans' Homes Council (Council), as well as the modifications to the Boards of Trustees (Boards). Adding a Council to the chain of command would reinforce the current lack of accountability, further dilute the current chain of command, and create detrimental layers of management of the Homes. Most importantly, this structure fails to make one person ultimately responsible for the proper functioning of the Homes. As proposed:

- The Governor oversees the EOHHS Secretary.
- The EOHHS Secretary oversees the DVS Secretary.
- The DVS Secretary oversees the OVHH Executive Director.

¹ This change would require amendment to Section 17A of Chapter 6 of the Massachusetts General Laws to place the Secretary in the Governor's cabinet as well as to Section 16 of Chapter 6A of the Massachusetts General Laws to move the Department of Veterans' Services out of the Executive Office of Health and Human Services.

- The OVHH Executive Director coordinates and oversees the implementation and enforcement of laws, regulations and policies relative to the Homes but does not control either the Boards or the Council.
- The OVHH Executive Director oversees the superintendents of the Homes but does not control the day-to-day operations of the Homes.
- The 17-member volunteer Council manages and controls both Homes, administers the Homes' trust funds, appoints and removes the superintendents, and adopts rules and regulations governing the day-to-day operations of the Homes.
- The Boards have no substantive statutory power except for nominating one candidate for superintendent and recommending removal of a superintendent.

The proposed structure in House 4441 does not improve on the current situation. Rather, the proposed structure adds overlapping and misplaced responsibilities by making both the OVHH Executive Director and the 17-member Council responsible for the Homes while removing the DVS Secretary from the superintendents' chain of command. Simply put, these layers of management are not necessary for the Homes.

Role of Council. Inserting the Council between the Homes and DVS creates a risk of gaps in reporting and knowledge, and increases the likelihood of poor oversight and management. In addition, the significant operational, fiscal and supervisory responsibilities that House 4441 assigns to the Council are far too much management and control for a volunteer body to have over state long-term care facilities. The Office recommends against the creation of the Council.

Role of Boards. House 4441 revises the role of the local Boards, limiting their statutory duties to nominating to the Council a candidate for superintendent and recommending removal of a superintendent. The Council would be responsible for establishing the rules, regulations, by-laws, roles and responsibilities for the Boards. The Office recommends that the Legislature eliminate the Boards as they add yet another layer of supervision of the Homes and, as modified by House 4441, depend entirely on the Council to define their roles.

Adding to the confusion, House 4441 makes the Board members voting members of the Council, filling 10 of the 17 Council positions. It is unclear why local Boards are necessary if the Board members sit on the Council that governs the Boards and the Homes.

Proposed Advisory Role of Council and Boards. As stated above, the Office does not recommend the creation of the Council or retention of the Boards. However, if the Legislature creates a Council or retains the Boards, they should act in an advisory capacity only. To provide meaningful guidance to the superintendents, the members of the Council and Boards should have experience in the following areas: veterans' issues, fiscal management, labor relations, health care and nursing. Further, families and other stakeholders should have representation on the Council and Boards. While the Council and Boards could make recommendations and provide advice, they should not be responsible for the appointment or removal of the superintendents or have any responsibility for the operational decisions involving the Homes.

Superintendents' Reporting Structure. House 4441 attempts to address the current reporting confusion by having the superintendents report to the OVHH Executive Director even though by statute, the Executive Director has no control over the day-to-day operations of the Homes. As set forth below, the bill also assigns additional responsibilities to the Executive Director but does not grant the authority to enforce or implement those duties. Instead of the reporting structure proposed in House 4441, the Office recommends that the Legislature adopt a structure that maximizes the superintendents' direct accountability to the DVS Secretary.

The Office maintains that one person must be accountable for the superintendents – the DVS Secretary. The DVS Secretary should be responsible for managing, conducting regular performance evaluations for and disciplining the superintendents. Unless and until the Legislature streamlines and clarifies the existing statutes to make the reporting structure clear, there will be no direct accountability for the superintendents' performance.

DVS Secretary: Member of Cabinet. Relatedly, the Office endorses the Special Joint Committee's recommendation that the Legislature elevate the DVS Secretary to the Governor's Cabinet. This shift would ensure that the DVS Secretary has access to the Governor to discuss veterans' issues and that the Secretary is directly accountable to the Governor for the performance of the Homes. House 4441 does not include this important change.

Hiring and Removal

With regard to the appointment and removal of the Homes' superintendents, House 4441 provides that the Board for each Home would nominate one superintendent candidate to the Council. The Council would then appoint the superintendents. Similarly, House 4441 allows the Boards or the Governor to recommend to the Council the removal of a superintendent and authorizes the Council to remove a superintendent. The Office does not support this process.

DVS Secretary Should Be Responsible for Superintendents. Although the Homes fall within DVS, House 4441 does not assign the DVS Secretary any role in either the hiring or removal of the superintendents. And as the Office has consistently recommended, one person must be accountable for the superintendents; the person who is responsible for the supervision and evaluation of the superintendents should have the power to decide on an appropriate person to fill the role and, if necessary, whether to remove that person.

If the Homes remain within DVS, the Office recommends that the Legislature make the DVS Secretary responsible for the superintendents' hiring, supervision, evaluation and, if necessary, removal. The Office further recommends that no other person or entity – including the OVHH Executive Director, Council or Boards – play a role in this process. There is no room for confusion or ambiguity about who hires, supervises and evaluates the superintendents. Moreover, the DVS Secretary must be able to determine if and when removal is necessary, and to implement a decision to remove a superintendent in a timely and thoughtful manner so that the leadership of the Homes remains stable and veterans' care is safeguarded.

Protection for Current Superintendents. For the same reasons discussed in the prior section, the Office recommends against House 4441's provision allowing the current superintendents to continue to serve in their roles "in accordance with the terms of any existing employment contracts" and subject to the proposed removal provisions set forth above.²

Moreover, this provision could delay the removal of a superintendent if a serious issue were to arise before the EOHHS Secretary's appointment of 10 qualified people to the two Boards and the appointment of the Governor's two Council members, the EOHHS Secretary's one Council member, the Speaker of the House's one Council member and the Senate President's one Council member.³ The appointment process alone could take up to a year because House 4441 does not require the Governor, EOHHS Secretary, Speaker of the House or Senate President to make their respective appointments to the Council until February 1, 2023.

Even after the appointment of the 10 Board members and five Council members, the Board or Governor would have to decide whether to recommend removal and then the Council would have to consider and vote on removal. As discussed above, delaying the removal of a superintendent could destabilize leadership, compromise the veterans' care or threaten the working conditions for the staff at one of the Homes, any one of which is unacceptable. For the reasons set forth above, the Office recommends that the DVS Secretary have the power to remove the superintendents.

Qualifications for the Superintendent

The Office supports the requirements that a superintendent must (1) be licensed as a nursing home administrator pursuant to Section 109 of Chapter 112 of the Massachusetts General Laws; and (2) be a veteran or have experience managing the health care of veterans in a nursing home setting.

Additional Required Qualifications. The Special Joint Committee correctly identified that a superintendent must possess a unique blend of experience and skills to be effective in this role. The Office agrees that experience in nursing home management is an essential qualification to provide appropriate leadership in a long-term care setting. Moreover, a superintendent must also have experience with fiscal management practices, executive management, and how unions operate and how to navigate labor relations issues. The Office recommends that any bill include experience in these four areas as additional required qualifications for the role of superintendent.

Channels for Communication and Problem-solving

Protecting the Ombudspersons' Independence. The Office supports the creation of an independent ombudsperson at each of the Homes to focus on concerns regarding veterans' health,

² The Office understands that neither superintendent has an employment contract.

³ The OVHH Executive Director and adjutant general of the Massachusetts National Guard serve as *ex officio* members of the Council.

safety, welfare and rights. House 4441 protects the ombudsperson's independence by making them a DVS employee rather than an employee of the Home.

However, the Office recommends that the ombudsperson report to the DVS Secretary and not the OVHH Executive Director. Having the ombudsperson report to the DVS Secretary would provide the necessary level of authority over and access to the Homes. It would send the message that the ombudsperson has a significant role and that the Homes' leadership must treat the ombudsperson with respect and cooperation.

Ombudspersons' Qualifications. In responding to numerous complaints about the Homes, the Office has found that they may involve a mixture of complex management and clinical concerns. As a result, it is essential that the ombudsperson be qualified in that role. To that end, the Office recommends that the Legislature include a requirement for the ombudspersons to have both clinical and management expertise to enable them to address the issues that are present in both Homes.

Creation of Hotline. The Office urges the Legislature to create a hotline, which is an important internal control and is often an impetus for problem-solving. The Office supported the creation of the hotline in House 4195 and recommends that the Legislature include this important reporting mechanism. The complaints that the Office has received reveal a reporting gap: there is no appropriate resource available under EOHHS or elsewhere within the executive branch to receive and address complex and time-sensitive complaints about the two Homes.

The hotline should receive complaints and concerns from residents, staff, families and others, and have a process for qualified investigators to evaluate these reports of problems at the Homes. The Legislature should clearly delineate the types of complaints the hotline would handle in a way that complements those of the ombudsperson. The Office recommends that the hotline handle complaints relating to day-to-day management, personnel, staffing and operational issues.

Further, the hotline staff must have the appropriate authority to conduct investigations and make recommendations. The hotline staff also needs independence from the management structure; to ensure this independence, the Office suggests that the Department of Veterans' Services manage this hotline.

Ombudsperson and Hotline Confidentiality. The bill's provision that the ombudsperson shall "make best efforts to ensure the confidentiality of complainants" does not provide enough clarity or assurance that the ombudsperson will keep a complainant's identity confidential upon request. To encourage complainants to share concerns, the ombudsperson and hotline staff must be able to offer strong statutory protections. Accordingly, the Office recommends requiring that the ombudsperson and hotline staff maintain strict confidence unless disclosure is necessary to make a referral to another agency or law enforcement. In addition, because each entity may receive complaints that fall within the other's purview, the ombudsperson and hotline staff should each be able to refer a matter to the other when necessary. The ombudsperson and hotline staff should share information only to the extent necessary to complete the referral.

Ombudsperson and Hotline Annual Reports, Training, Referrals, Response Time and Resources. To create transparency and accountability, the Office recommends that both the ombudsperson and the hotline staff submit an annual report to the Legislature with summaries of their caseloads and activities. To fulfill their important responsibilities, the ombudsperson and the hotline staff should receive extensive training and guidance. In addition, the Legislature should be clear about whether the ombudsperson and hotline staff must refer certain complaints to agencies or entities already charged with investigating specific types of issues.⁴ The Legislature should also mandate that both the ombudsperson and hotline staff address concerns and complaints in a timely, meaningful way, which will enhance confidence in both entities. Perhaps most importantly, the Legislature must commit sufficient funding to ensure both programs develop appropriately, function effectively and serve as a continuous resource and internal control.

Whistleblower Protection. The Office endorses House 4441's strong whistleblower protections for any person who files a complaint with a Home's ombudsperson. However, the Office encourages the Legislature to include similar protections for any individual who reports an issue to a hotline or another entity or person responsible for management or oversight of the Homes.

Office of the Veteran Advocate

House 4441 creates the Office of the Veteran Advocate (OVA), an independent agency charged with ensuring that veterans receive timely, safe and effective services. The Office endorses the creation of this oversight agency. The OVA could operate a complaint line, much like the Office of the Child Advocate operates its own complaint line, to receive concerns about children receiving state services.

The Office recommends that in addition to the list of abilities and professional qualifications included in House 4441, the Legislature should also require that the Veteran Advocate have health care experience because many of the issues that the advocate addresses will involve veterans' health issues.

⁴ For example, if the hotline receives a complaint alleging abuse or neglect of a disabled person under 60 years old, the legislation should state whether the hotline staff must refer that complaint to the Disabled Persons Protection Commission. Similarly, the legislation should articulate whether the hotline should refer a complaint to the Commonwealth's Human Resources Division Center of Expertise if the complaint alleges a violation of a Commonwealth-wide policy involving sexual harassment, discrimination, workplace violence, domestic violence/sexual assault/stalking or retaliation related to those policies.

Inspections by the Department of Public Health

Given the Homes' critical role in providing health care to veterans, the Office supports House 4441's proposal that the Department of Public Health (DPH) inspect the Homes. The Office recognizes the role that DPH currently plays in supporting the quality of care in different health care settings and the vital role that it could play in providing clinical support and independent oversight to the Homes. Accordingly, the Office recommends additional provisions to clarify and strengthen DPH's role.

Authorizing DPH to Address Noncompliance. To leverage DPH's expertise in overseeing long-term care facilities, the Office respectfully suggests that the Legislature provide more specific delineation of DPH's role with respect to the Homes. In addition to the inspections that House 4441 and other versions of the legislation have proposed, the Legislature should specify that DPH must monitor the implementation of the Homes' corrective action plans. The Legislature should also empower DPH to act on noncompliance with federal or state long-term care standards. DPH must have the authority and a clear mandate to take enforcement actions if the Homes fail to implement necessary changes. To this end, the Office recommends that the Legislature provide DPH with the statutory authorization to take such actions. As there is no other state agency charged with addressing noncompliance with 105 CMR 150 or subpart B of 42 C.F.R. § 483, DPH is the correct agency to take on this responsibility.

Creating Consequences for Noncompliance. In addition to charging DPH with the responsibility for addressing noncompliance with these regulatory provisions, the Office recommends that the Legislature create remedies if one of the Homes does not comply with federal or state long-term care standards, does not follow through on a plan of correction, or does not implement other DPH recommendations.

Leveraging DPH's Expertise. The Office also respectfully suggests that the Legislature further develop DPH's clinical oversight role and leverage DPH's expertise in long-term care. The Office recommends that the Legislature direct DPH to identify and help address vulnerabilities and to assist the Homes in implementing the best clinical practices to serve veterans. For example, in response to hotline complaints from whistleblowers and other stakeholders, DVS or the OVA should be able to request that DPH review clinical practices and have DPH's assistance with implementing any resulting recommendations. Finally, DPH should continue to set clinical standards for and conduct oversight of infection control at the Homes.

Reciprocal Obligations

Section 46 of House 4441 creates reciprocal obligations for the two Homes so that each Home is responsible for any obligation of the other Home. The Office objects to the inclusion of Section 46; its vague language and unstated purpose raise concerns about its practical effect on the Homes. The Office is unaware of any similar statutory provision making one state agency responsible for the obligations of another agency. Further, Section 46 is not specific as to what obligations this language encompasses or what funds one Home could use to satisfy the other

Home's obligations. For example, it is unclear whether this language could obligate Chelsea to satisfy any judgments that result from pending civil litigation against Holyoke. Moreover, each Home holds millions of dollars in donated funds and it is unclear whether one Home could use – or could be required to use – its donated funds to pay for the other Home's obligations.

The Office also has questions about the fiscal infrastructure of the Homes, including whether they have proper oversight and controls in place. In light of these concerns, Section 46 could make an already complex situation more challenging and could reduce the transparency of how the Homes are using their appropriated and donated funds.

Reporting Requirements

The bill also includes several reporting requirements, including:

- An annual report from the OVHH, in coordination with the Council, on the status of the Homes.
- An annual report from the Veterans' Advocate on the activities of that office.
- An annual review by the superintendents, in coordination with the OVHH Executive Director, on the Homes' health record system.
- At least biannual DPH inspection reports and corrections of violation reports.

The Office also recommends that the Legislature require the ombudsperson and the hotline staff to submit annual reports documenting their activities. These proposed reports would provide important information about the status of, and recommendations to improve, the Homes.

Coordination of Recommendations and Action Plans. House 4441 provides that the OVHH Executive Director would work with the superintendents and Council on two of these reports. The purpose of these reports is not only to provide transparency, but also to create a platform for coordinated recommendations and action plans to move the Homes forward. However, the work lies in the implementation and prioritization of projects to improve the Homes for veterans. To this end, the Office recommends that the Legislature designate the DVS Secretary as responsible for integrating, coordinating and implementing any recommendations and action plans that result from the Homes' reports.

Frequent Status Updates on the Electronic Medical Record System. To promote accountability and transparency, the Legislature should require the DVS Secretary to provide monthly updates on the status of the implementation of the electronic medical record system (EMR). Both Homes still operate with paper medical records because there is no EMR at either Home. This is unacceptable and compromises veterans' care. As a result, the Office does not support the proposed annual review by the superintendents and the OVHH Executive Director on the Homes' health record system because annual reporting for this critical system is simply not enough. DVS and the Homes have discussed procuring such a system since at least 2016, but there has been a lack of commitment to and funding for the project. Attorney Mark Pearlstein identified

this as a long-standing, significant problem in his report to the Governor, *The COVID-19 Outbreak at the Soldiers' Home in Holyoke, An Independent Investigation Conducted for the Governor of Massachusetts*, as well as in his subsequent testimony to the Legislature. DVS and the Homes have had years to put this important system in place, and 18 months have passed since Attorney Pearlstein recommended that the administration make EMR a priority for both Homes. The Legislature must now make EMR a high priority.

Oversight and Clinical Expertise

Finally, the Office strongly recommends that the Legislature consider how the various people and entities charged with leadership responsibilities and oversight of the Homes will coordinate and integrate their efforts. As the bill currently stands, leadership and oversight responsibilities fall under the following roles:

- Governor
- EOHHS Secretary
- DVS Secretary
- Office of the Veteran Advocate
- OVHH Executive Director
- Department of Public Health
- Ombudsperson
- Superintendents
- Council
- Boards

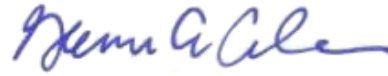
Because these roles involve overlapping responsibilities, the Office recommends that the Legislature designate a person (or people) at DVS who would be responsible for tracking recommendations, setting priorities for implementing these recommendations, and coordinating and integrating resources to support and improve the Homes. House 4441 assigns some of these responsibilities to the OVHH Executive Director, but the legislation does not provide the person in that role with any authority to hold the Homes or superintendents accountable for their actions or inactions.

It is critical that the Homes have stable and sustainable clinical leadership and oversight. When creating a new governance structure for the Homes, serving the health care needs of the veterans should remain the highest priority. Leaders with expertise in health care and in particular, long-term care, should be at the center – not on the periphery – of governing the Homes.

Chair Rodrigues and Vice Chair Friedman
Senate Committee on Ways and Means
February 17, 2022
Page 11 of 11

I would like to meet with you to discuss these recommendations, the questions that we have proposed for your consideration, or any other questions you may have. Thank you for your attention to this matter.

Sincerely,



Glenn A. Cunha
Inspector General

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March 25, 2022

Via Email

The Honorable Michael F. Rush, Chair
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Mike.Rush@masenate.gov

The Honorable Joseph F. Wagner, Chair
State House, Room 234
Boston, MA 02133
Joseph.Wagner@mahouse.gov

Re: An Act Relative to the Governance, Structure and Care of Veterans at the Commonwealth's Veterans' Homes

Dear Chairs Rush and Wagner:

As the Conference Committee considers legislation reforming the Commonwealth's Veterans' Homes (Homes), I write to support many of the proposed changes, which will promote effective management of the Homes, create a clear chain of command and enhance the superintendents' direct accountability.

The Office of the Inspector General (Office) is an independent state agency charged with preventing and detecting fraud, waste and abuse in the use of public funds and public property. Pursuant to the Office's mandate, I have offered recommendations to support the Legislature's efforts to create a holistic and comprehensive set of reforms. Following the release of the Special Joint Committee on the Soldiers' Home in Holyoke COVID-19 Outbreak (Special Joint Committee) Report, my Office shared some of these recommendations with the chairs of that committee. I also provided written feedback to the House and Senate members who have been working on these issues and summarized the Office's recommendations for the Joint Committee on Health Care Financing. Consistent with our previous recommendations, I am now providing comments to the Conference Committee for your consideration.

Oversight of the Homes. The Office supports the elimination of the Homes' boards of trustees. (S2761, § 4.) The Office continues to caution against the retention of the boards of trustees or the creation of new councils because they have the potential to create confusion and misunderstandings about the chain of command. (S2761, § 7; H4441, § 2.) If the Legislature includes these councils in its final legislation, the Office strongly recommends that both councils serve only in an advisory capacity.

DVS Secretary. The Office supports the elevation of the Department of Veterans' Services (DVS) Secretary to the Governor's cabinet and the appointment of the DVS Secretary by the Governor. (S2761, §§ 3, 10.) This will provide the DVS Secretary with direct access to the Governor to discuss veterans' issues and will make the Secretary accountable to the Governor for the performance of the Homes. The Office also supports the creation of a stand-alone DVS, which will create a clearer chain of command for the Homes by removing the Executive Office of Health and Human Services from the reporting structure. (S2761, §§ 8, 9, 12.)

Superintendents. The Office supports the DVS Secretary appointing, supervising and removing the superintendents. (S2761, § 82.) This will eliminate any confusion about to whom the superintendents report and allow the DVS Secretary to have a strong role in the management of the Homes. The Office also supports the requirement that the superintendents have relevant training and work experience. (S2761, § 82.) The Office agrees that the DVS Secretary must conduct annual performance reviews of the superintendents. (S2761, § 82.)

Staffing. The Office supports making the DVS Secretary and the superintendents responsible for filling staffing vacancies within a prescribed time. (S2761, § 82.) This will help to ensure that the Homes have the necessary management and direct care staff to properly care for the veterans.

Ombudsperson. The Office supports the creation of an independent ombudsperson. (H4441, § 35; S2761, § 82.) However, the language proposed by the House would create a lack of clarity about the ombudspersons' reporting structure and could jeopardize their independence. The Office prefers the Senate's placement of the ombudsperson as a DVS employee reporting to the DVS Secretary; this will protect the ombudsperson's independence. This reporting relationship will also provide the necessary level of authority over and access to the Homes. Further, it will send the message that the ombudsperson has a significant role and that the Homes' leadership must cooperate with and respect the ombudsperson.

Hotline. The Office supports the creation of a hotline to channel complaints regarding the Homes to the ombudsperson. (S2761, § 82.) The hotline will fill the current reporting gap for complex and time-sensitive complaints about the two Homes.

Ombudsperson and Hotline Confidentiality. Requiring that the ombudsperson and hotline staff maintain strict confidentiality will create trust and encourage reporting of complaints. (H4441, § 35; S2761, § 82.) The Office prefers the Senate's detailed protections of complainants and confidentiality provisions for complainants and veterans' records and files. (S2761, § 82.)

Ombudsperson and Hotline Training, Annual Reports, Referrals, Response Time and Resources. The Office supports the training requirement for the ombudsperson and the hotline staff. (S2761, § 82.) The Office also supports the requirement that the ombudsperson and hotline staff create an annual report that will be available to the public, DVS Secretary and Legislature. (S2761, § 82.) The Office agrees with the requirement that the ombudsperson or hotline staff report any findings relating to a violation of law to the regulatory agency that is responsible for the enforcement of that law. (S2761, § 82.) The Office supports the requirement that the ombudsperson and hotline staff address concerns and complaints in a timely manner, which will enhance confidence in the system. (H4441, § 35; S2761, § 82.) Finally, the Office continues to recommend that the Legislature commit to providing sufficient funding to ensure both resources develop appropriately, function effectively, and serve as a continuous resource and internal control.

Whistleblower Protection. The Office endorses the strong whistleblower protections for any person who files a complaint with the ombudsperson or hotline staff. (S2761, § 82; H4441, § 35.) The Office supports the Senate language that offers robust protections for those who report issues at either of the Homes. (S2761, § 82.)

Office of the Veteran Advocate. The Office supports the creation of the Office of the Veteran Advocate (OVA), an independent agency charged with ensuring that veterans receive timely, safe and effective services. (H4441, § 36.) The Office endorses the creation of this oversight agency to add a layer of accountability for the caregivers of veterans who reside both in and out of the Homes. However, the Office recommends that the DVS Secretary serve as chair and coordinator for the Veteran Advocate's nominating committee. In addition, the Office recommends that the enabling legislation require the OVA to refer appropriate cases to a law enforcement agency. Finally, the Office recommends that the OVA receive confidentiality protections that are similar to those found in the Senate bill for the ombudsperson and hotline. (S2761, § 82.)

Inspections by the Department of Public Health. The Office supports the requirement that the Department of Public Health (DPH) conduct biannual inspections of the Homes. (S2761, § 27; H4441, § 13.) The Office also supports the requirement that DPH report violations of the applicable rules and regulations to the superintendents and DVS Secretary, and the requirement that the superintendent remedy any violations within 30 days. (S2761, § 27.) The Office agrees that the superintendent must report weekly to DPH on efforts to remediate violations and that DPH must conduct follow-up inspections to verify that the Home has taken the necessary corrective actions. (S2761, § 27.)

The Office continues to strongly recommend that the Legislature authorize DPH to follow up on inspections of the Homes in the same way that it follows up on inspections of private skilled nursing facilities. If one of the Homes fails to implement DPH recommendations or does not follow through on a plan of correction, DPH should have the authority to take remedial steps and enforcement actions as necessary. Without such authority, DPH would conduct inspections without any consequences or impetus for change.

Further, the Office recommends that the Legislature direct DPH to identify and help address clinical or staffing vulnerabilities and to assist the Homes implement the best clinical practices to serve the veterans. Because DPH has the appropriate clinical expertise, DPH should play a vital role in providing independent oversight of and supporting the quality of care at the Homes.

Reporting requirements. The Office supports the reporting requirements for the Office of Veterans' Homes and Housing (S2761, §§ 82; H4441, §§ 34, 35), Ombudsperson and Hotline staff (S2761, § 82), superintendents (S2761, §§ 27, 82; H4441, § 35), Massachusetts Veterans' Homes Advisory Council and Regional Councils (S2761, § 7), DPH (S2761, §§ 27; H4441, § 13) and the Veteran Advocate (H4441, § 36). These reports will create transparency around the organizational plan for emergency response operations, findings of regulatory deficiencies, violations of state or federal law, complaints, caseloads, recommendations for changes to policy or procedures, staffing, monetary donations, and the Homes' census and demographics, among other issues.

Electronic medical records. The Office supports requiring the superintendents to report on the Homes' health record systems, but strongly objects to these reviews occurring only annually. (H4441, § 35.) To promote accountability and transparency, the Legislature should require the DVS Secretary to provide monthly updates on the status of the implementation of the electronic medical record system (EMR). The administration identified the need for an EMR more than five years ago, yet both Homes still operate with paper medical records. DVS and the Homes have discussed procuring such a system since at least 2016, but there has been a lack of commitment to and funding for the project.

Continuing to use paper medical records is unacceptable and compromises veterans' care. Annual reporting for this critical system is simply not enough. Attorney Mark Pearlstein identified this as a long-standing, significant problem in his report to the Governor, *The COVID-19 Outbreak at the Soldiers' Home in Holyoke, An Independent Investigation Conducted for the Governor of Massachusetts*, as well as in his subsequent testimony to the Legislature. DVS and the Homes have had years to put this important system in place, and more than 18 months have passed since Attorney Pearlstein recommended that the administration make EMR a priority for both Homes. The Office therefore recommends that the Legislature make EMR a high priority and require monthly reporting on the Homes' progress with the procurement and implementation of an EMR.

Thank you for your attention to this matter. If you have any questions, please feel free to contact me.

Sincerely,



Glenn A. Cunha
Inspector General

Chairs Rush and Wagner

March 25, 2022

Page 5 of 5

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