The Commonwealth of Massachusetts
Office of the Inspector General

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Via Electronic Mail

Secretary Marylou Sudders
Executive Office of Health and Human Services
One Ashburton Place, 11th floor
Boston, MA 02108
Marylou.Sudders@mass.gov

Re: Chelsea Soldiers' Home

Dear Secretary Sudders:

As you know, the Office of the Inspector General (Office) has received and responded to complaints about the Chelsea Soldiers' Home (Home) since 2021.[1] While responding to these complaints, the Office requested information from the Executive Office of Health and Human Services (EHS) and the Department of Veterans' Services (DVS) pursuant to its statutory authority. On October 14, 2022, the Office requested materials related to any EHS or DVS investigations into the Home and its management, which EHS did not provide until December 22, 2022. The Office has now reviewed seven reports from the EHS Investigations Unit and one report from a member of your leadership team. The Office also requested and received documentation of dozens of complaints from the Commonwealth's Investigations Center for Expertise (COE) into the Home and its management. Together, these reports paint a grim picture of the Home's treatment of the veterans who live there, and a concerning portrait of the superintendent's leadership and the work environment at the Home. Equally troubling is the fact that EHS has been aware of these issues since at least the summer of 2022 but has not taken significant corrective action.

Most importantly, two of these reports described the unacceptable living conditions and clinical care for some of the Home's veterans. A July 12, 2022, report by an EHS employee focused on the conduct of a certified nurse assistant. That report concluded that:

- Veterans at the Home had been found lying "soaked in urine and sitting in feces" or "saturated in urine and double briefed."

[1] Pursuant to Chapter 12A and Section 16V of Chapter 6A of the Massachusetts General Laws, the Office of the Inspector General's (Office) mandates are to monitor the quality, efficiency and integrity of programs administered by the Executive Office of Health and Human Services (EHS) agencies and to prevent, detect and correct fraud, waste and abuse.

- A member of the nursing staff failed to use the proper equipment to move a patient "many times."
- Performance issues on the nursing staff were "going unchecked."

In August 2022, a senior member of your leadership team wrote that at least a dozen rooms in the Domiciliary were in "terrible" condition, with feces, dead rodents, dirt and bugs present. These conditions point to a catastrophic failure of the Home's leadership.[2]

In addition, the reports make it clear that Superintendent Eric Johnson lacks the capacity and integrity to manage the Home. For example, an investigative report from August 2022 provided insight into the employee culture at the Home, stating that:

- It was "reasonable" for one employee to conclude that he was "being targeted for retaliation."
- The Home had a "culture of distrust and tribalism" that "created an environment where some employees feel like their jobs are always in jeopardy and, at any moment, there may be some level of retaliation for just doing one's job."

The senior member of your leadership team reported in their management summary from August 2022 that the superintendent's leadership included "a great deal of turmoil and concerning employee morale issues" and that he imposed "inappropriate discipline" on his staff. They also found that he was not "forthright in his accounts of events and issues." They concluded the management summary by stating that the superintendent "lacks candor, professionalism, judgment and does not seem to possess leadership skills."

Several other reports also found that the superintendent lacked candor and that he did not answer investigators' questions truthfully and completely. For example, investigators found that he was "not believable for multiple reasons" and that his description of events was "not credible." Anything less than complete honesty is simply unacceptable from the head of a Commonwealth agency. It is essential that the superintendent provide accurate information to EHS and the Department of Veterans' Services (DVS) at all times, and especially when there are investigations into inappropriate conduct or potential violations of policy. A superintendent cannot effectively operate a Soldiers' Home while lacking candor, professionalism, judgment and leadership skills.

In addition, some of these reports concluded that the superintendent's actions violated the Commonwealth's or the Home's policies. For example, one report found that it was "more likely than not" that the superintendent and the director of nursing violated the Home's overtime policy and the Commonwealth's telework policy. As leaders of the Home, the superintendent and director of nursing set the tone for the staff; their failure to follow the rules signals to the staff that the rules do not matter.

[2] The Office has copied the Department of Public Health on this letter to ensure that the appropriate agency is aware of the findings regarding the conditions at the Home and the treatment of veterans.

The issues discussed above strongly indicate that the Home is not functioning properly and that the leadership is actively failing. Many of these issues echo those the Office found at the Holyoke Soldiers' Home between 2016 and early 2020. After reviewing the management practices at the Holyoke Soldiers' Home, the Office made numerous, detailed recommendations for the improvement of management practices at both of the Commonwealth's Soldiers' Homes that were designed to prevent many of the issues that are now occurring at the Chelsea Soldiers' Home.

Despite these recommendations and despite your knowledge of the significant ongoing issues at the Home, your administration has not implemented changes to protect the veterans and the Commonwealth's resources. During this time of transition, you must provide a complete, transparent briefing to your successor on these issues. This Office intends to continue to monitor the situation at the Home, to share these concerns with your successor and to make further recommendations as necessary as part of our role in the oversight of Commonwealth resources, all of which fall directly within our statutory mandate and responsibilities.

Sincerely,

Jeffrey S. Shapiro
Inspector General

cc: President of the Senate Karen E. Spilka (Karen.Spilka@masenate.gov)
Speaker of the House Ronald Mariano (Ronald.Mariano@mahouse.gov)
Senator John Velis, Co-Chair of the Joint Committee on Veterans and Federal Affairs (John.Velis@masenate.gov)
Representative Paul McMurtry, Co-Chair of the Joint Committee on Veterans and Federal Affairs (Paul.McMurtry@mahouse.gov)
Kimberly Driscoll, Lieutenant Governor-elect and Chair of the Governor-elect's Transition Committee (by hand-delivery)
Department of Veterans' Services Secretary Cheryl Lussier Poppe (Cheryl.Poppe@mass.gov)
Department of Public Health Commissioner Margret Cooke (Margret.R.Cooke@mass.gov)
Thomas J. Lyons, Chair of Chelsea Soldiers' Home Board of Trustees (by mail)