OFFICE OF THE STATE AUDITOR

DIANA DIZOGLIO

Official Audit Report – Issued January 14, 2026

Veterans Home at Holyoke

For the period July 1, 2020 through June 30, 2023

State House Room 230 ■ Boston, MA 02133 ■ auditor@massauditor.gov ■ www.mass.gov/auditor

OFFICE OF THE STATE AUDITOR

DIANA DIZOGLIO

January 14, 2026

Michael Lazo, Superintendent
Veterans Home at Holyoke
110 Cherry Street
Holyoke, MA 01040

Dear Superintendent Lazo:

Enclosed are the results of the performance audit of the Veterans Home at Holyoke. As is typically the case, this report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, July 1, 2020 through June 30, 2023.

As you know, the Office of the State Auditor helps make government work better. To our disappointment, our requests for information on the COVID-19-related deaths at the Veterans Home at Holyoke (including information related to the Pearlstein report) were rejected. We find this to be troubling, given the importance of this issue, the lack of transparency it shows, and because doing so has undermined the public's faith in government.

I am available to discuss this audit if you or your team has any questions.

Best regards,

Diana DiZoglio
Auditor of the Commonwealth

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LIST OF ABBREVIATIONS

CMR	Code of Massachusetts Regulations
DPH	Department of Public Health
EHR	electronic health record
EOHHS	Executive Office of Health and Human Services
EOP	emergency operation plan
HPPD	hours per patient day
MMARS	Massachusetts Management Accounting and Reporting System
OIG	Office of the Inspector General
VHH	Veterans Home at Holyoke

EXECUTIVE SUMMARY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor has performed an audit of the Veterans Home at Holyoke (VHH) for the period July 1, 2020 through June 30, 2023.

When assessing potential audit objectives related to the tragic losses that occurred at VHH during the COVID-19 pandemic, we examined the Pearlstein report (dated June 2020) and requested the supporting documentation, as we believed it would provide valuable insights for our audit. We attempted to add this as an audit objective, but the refusal of the Office of the Governor to provide us requested information prevented us from examining this matter, dating back to spring 2020.

In this performance audit, we sought to examine the facts and conditions that led to the loss of at least 76 veterans at VHH during the COVID-19 pandemic. This examination included requesting the interviews, interview notes, and other documentary evidence used to complete the Pearlstein Report, in order to better understand the significant management and safety issues at VHH that contributed to these tragic events during the COVID-19 pandemic. These documents were inappropriately withheld from our office. (See Other Matters.) However, we were able to examine other issues related to safety, including the following:

- whether VHH provided safe, effective veteran care and documented rounding in accordance with its Intentional Rounding Policy;
- whether VHH followed its policy on handling of veterans' incidents; and whether the staff members involved in the incidents were properly licensed;
- whether VHH's system for tracking patient records was operating effectively in accordance with Section 150.013 of Title 105 of the Code of Massachusetts Regulations (CMR);
- whether VHH had an emergency operation plan (EOP) in place during the audit period and whether it had been updated to address the risks involved in providing adequate patient care during an emergency in accordance with 105 CMR 150.015(E); and
- whether VHH had controls in place over the receipt, expense, and reporting of COVID-19 funds in accordance with federal requirements.

Below is a summary of our findings, the effects of our findings, and our recommendations, with links to each page listed.

Finding 1 **Page 18**	VHH could not ensure that nurses performed intentional rounding, potentially resulting in an unsafe environment for veterans.
Effect	If intentional rounding is not being completed, then it could increase the risk of veterans having falls or other issues that could adversely contribute to veteran safety and well-being. As already noted (see the "Intentional Rounding" section), intentional rounding reduces falls by an estimated 36%. It is reasonable to conclude that the absence of intentional rounding, as shown here, increased the risk—and likely the number of injuries—while reducing the quality of care, for veterans at VHH.
Recommendations **Page 19**	1. VHH should ensure that timely intentional rounding is performed and documented on Intentional Rounding Logs. 2. VHH should establish monitoring controls to ensure that Intentional Rounding Logs are completed and maintained.
Finding 2a **Page 20**	VHH violated state regulation by not conducting simulated emergency drills for all shifts.
Effect	Without performing simulated emergency drills to test the effectiveness of its EOP, VHH cannot ensure that it has an effective response to disasters and emergencies, thereby jeopardizing the safety of veterans and hospital staff members.
Finding 2b **Page 21**	VHH violated state regulation (105 CMR 150.015(E)(1)) by not posting its EOP throughout the facility.
Effect	Without its EOP posted in conspicuous locations, VHH is unable to ensure an effective response to disasters and emergencies that affect the environment of care and could impede the safety of veterans and hospital staff members.
Finding 2c **Page 23**	VHH violated state regulation (105 CMR 150.015(E)(2)) by its EOP not containing the locations of alarm signals, fire extinguishers, and evacuation routes.
Effect	If VHH's EOP does not contain the location of alarm signals, fire extinguishers, and evacuation routes, then this could affect the timely and safe evacuation of veterans, staff members, and visitors in the event of a disaster.
Recommendations **Page 23**	1. VHH should ensure that it conducts simulated emergency drills for all shifts at least twice a year. 2. VHH should ensure that its EOP is available at all nurses' and attendants' stations and is posted in conspicuous locations throughout the facility. VHH should also make its EOP accessible in digital form from all computer terminals. 3. VHH should add the locations of alarm signals, fire extinguishers, and evacuation routes to its EOP.
Finding 3 **Page 24**	VHH does not use an electronic health record (EHR) system for veterans as required of other, similarly situated healthcare facilities.
Effect	According to Centers for Medicare and Medicaid Services, there are multiple benefits to implementing an EHR system, including improved patient care. For example, an EHR system allows healthcare providers to access medical records in real time to provide accurate and timely care. An EHR system can reduce medical errors and delays in treatment and improve the accuracy and clarity of medical records and improve the security of medical records.
Recommendation **Page 25**	We recommend that VHH implement an EHR system as soon as possible.

As our audit was nearing completion, additional areas of concern that were outside the original scope of our objectives came to our attention. Given the high-risk nature of these areas, we analyzed them while we were still engaged with the auditee. These areas included researching no bid contracts related to conflicts of interest at VHH. We discussed this matter with VHH.

OVERVIEW OF AUDITED ENTITY

The Veterans Home at Holyoke (VHH), established in 1952, is a long-term care facility that provides healthcare services to eligible veterans in the Commonwealth.

VHH's name changed in March 2023 from "Soldiers' Home" to "Veterans Home" to be more inclusive of all branches of the military. Authorized by Chapter 115A of the Massachusetts General Laws, VHH historically operated within the Department of Veterans' Services, which was organized under the Executive Office of Health and Human Services (EOHHS). As of March 2023, VHH is now under the Executive Office of Veterans Services. According to its website, VHH's mission is "to provide the highest quality personal health care services to Massachusetts veterans with dignity, honor, and respect."

VHH operates a healthcare facility that once consisted of two buildings. After the audit period, the domiciliary building was demolished to make way for the construction of a new home. The estimated cost of the new building is $482.7 million, and the estimated completion date is summer 2028. Currently, the main building has 128 long-term care beds. VHH provides services for veteran healthcare, hospice care, on-site dental, and outsourced programs.[1]

VHH's day-to-day operations are overseen by a superintendent who is appointed by the board of trustees. Since March 2023, the superintendent has served as the administrative head of VHH and reports to the Secretary of Veterans Services. The superintendent is tasked with ensuring that facilities, personnel, operations, and finances are well managed and that a high quality of care is maintained. VHH is fully accredited by the Joint Commission, a private organization whose mission is to continuously improve healthcare for the public, and VHH is inspected annually by the US Department of Veterans Affairs.

VHH received $26,858,194, $28,329,371, and $29,734,881 in state budget appropriations for fiscal years 2021, 2022, and 2023, respectively.

COVID-19 at VHH

In spring 2020, at least 76 military veterans who lived at VHH died of COVID-19, the deadliest COVID-19 outbreak at a long-term care facility in the country. These deaths prompted multiple investigations, terminations and resignations, regulatory reforms, and lawsuits. The Commonwealth's Office of the

1. Outsourced programs include audiology, diagnostic imagining, lab services, pharmacy, rehab services, and wound care.

Inspector General (OIG) conducted an investigation for the period May 2016 through February 2020. This investigation was based on a complaint that OIG received about the leadership of the superintendent of VHH who was in charge leading up to and during the initial phases of the COVID-19 outbreak in VHH. OIG conducted an initial investigation and determined that there were issues concerning the oversight and management of VHH. As a result, the Commonwealth's OIG 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. The Office of the Governor also requested that an independent study be conducted that focused on the COVID-19 outbreak that led to the deaths of veterans at VHH. The report, titled "The COVID-19 Outbreak at the Soldiers' Home in Holyoke," dated June 23, 2020, highlighted errors and failures of leadership that likely contributed to the elevated death toll during the outbreak.

The former superintendent was hired to be the superintendent of VHH in 2016. At that time, Section 71 of Chapter 6 of the General Laws stated the following:

> *[The] board of trustees shall have the management and control of said home. . . . In the management of and control of said home as aforesaid, said board of trustees shall (1) adopt, issue and promulgate reasonable rules and regulations governing . . . said home, and (2) appoint a superintendent. The superintendent shall be the administrative head of the home.*

Section 71 of Chapter 6 of the General Laws stated that the board of trustees had the sole authority to appoint the superintendent. The law did not require the superintendent to maintain licenses or have specific qualifications when it came to running a long-term care facility. Additionally, this law did not require the board to cede authority of appointment to the Governor, though the Governor ultimately decided to appoint the former superintendent. As stated in the OIG's "Holyoke Soldiers' Home May 2016 to February 2020" report, dated April 29, 2022,

> *The Board did not have the staff, resources or expertise to conduct a competitive hiring process. Rather than actively working with [EOHHS], [the Department of Veterans Services] or an outside staffing agency to support the Board's own hiring process, the Board allowed the governor and [EOHHS] staff to manage the process and appoint the new superintendent.*

According to OIG's "Holyoke Soldiers' Home May 2016 to February 2020" report and the meeting minutes from the board of trustees meeting held on March 18, 2016, the board conducted interviews. It then sent its top three recommendations for superintendent to the Office of the Governor to interview and appoint the new superintendent. Responsibility was given to the Secretary of EOHHS, and only one candidate was interviewed from the three candidates the VHH board of trustees recommended for consideration.

The law giving the board of trustees the power to appoint the superintendent changed in March 2023, and the board of trustees can now only nominate a candidate for the superintendent position. The final decision to appoint a superintendent rests with the Secretary of Veterans Services. This new law outlines the licenses and qualifications that a candidate needs in order to be appointed superintendent. Section 14(a) of Chapter 115A of the General Laws states,

> *Each state-operated veterans' home shall have: (i) a superintendent as its administrative head, who shall report to the secretary of veterans' services; and (ii) a deputy superintendent, who shall report to the superintendent. The superintendent for each state-operated veterans' home shall be: (i) licensed as a nursing home administrator pursuant to section 109 of chapter 112; and (ii) a veteran or have experience with management of veterans in a nursing home or long-term care facility. The superintendent shall be appointed by the secretary of veterans' services and may be removed by the secretary without cause.*

During the period June 2019 through March 2020, there was no licensed, certified nursing home administrator on staff. The then-superintendent did not have his certified nursing home license, and the deputy superintendent position had been vacant since June 2019. The previous deputy superintendent, hired in January 2017, was a licensed nursing home administrator, but they resigned in June 2019.

The former superintendent was relieved of duty in October 2020. One of the leading contributing factors to his dismissal was his lack of medical and technical expertise. In addition, the absence of a deputy superintendent and the absence of a statutorily mandated executive director of veterans homes and housing within the Department of Veterans Services (now the Executive Office of Veterans Services) were reported to have contributed to the cascading failures at the home. On March 30, 2020, the National Guard was mobilized to help alleviate staffing shortages and assist with VHH's general operations. On the same day, the then-superintendent was placed on administrative leave, and an administrator from a neighboring hospital was appointed by the Secretary of EOHHS to provide oversight of the incident command center[2] and day-to-day leadership/ operations of VHH.

An interim superintendent was appointed in January 2021. At this time, the board of trustees initiated a search through a talent acquisition firm. Two candidates were selected as top choices, and the primary candidate was selected in April 2021. According to the VHH board of trustees' meeting minutes from

2. The incident command center is the area in which senior staff members and emergency personnel meet to coordinate the type of response needed based on the type of emergency, including resources needed and how/to whom to communicate the emergency. The incident command center was not initiated during the COVID-19 pandemic until the National Guard was mobilized on March 30, 2020.

August 10, 2021, this candidate declined the position. The second choice was brought on as administrator. The board of trustees attempted to work with the talent acquisition firm for the next year to hire a permanent superintendent. However, after a lack of promising progress over the year, the board of trustees ended its relationship with the talent acquisition firm and decided to appoint the interim superintendent to the position of superintendent. Additionally, according to the VHH board of trustees' meeting minutes from November 8, 2022,

> *Obviously the governance legislation is changing the appointment authority for the superintendent of the Holyoke Soldiers' Home but that change is not going to happen until March of 2023 so we are sticking with the current statute and the current statute is clear that the board of trustees appoints the superintendent to the Home so it is within the authority of the Holyoke Soldiers' Home Board of Trustees to appoint a superintendent.*

In addition, according to the VHH board of trustees' meeting minutes from November 8, 2022, the vote for appointing the current superintendent was 4-2. During that meeting, two board members expressed that they felt that this was an overextension of the board's powers because the board of trustees was losing the ability to select the superintendent in four months. The rest of the board ceded this fact; however, because the current superintendent received the appropriate license for the position and had been performing in the role successfully, the four board members believed that he had proven his ability to continue performing the job, according to the meeting minutes.

Board of Trustees Members During the Audit Period

Board Members*	2020	2021	2022	2023
Kevin Jourdain	Yes	Yes	Yes	Yes
Christopher Dupont	Part of the year	No	No	No
Cindy Lacoste	Yes	Yes	Part of the year	No
Isaac Mass	Yes	Yes	Yes	Yes
Cesar Lopez	Part of the year	No	No	No
Carmen Ostrander	Yes	Yes	Yes	Yes
Sean Collins	Yes	Yes	Yes	Yes
Gary Keefe**	Yes	Yes	Yes	Yes
Mark Bigda	Yes	Yes	Yes	Yes

* Board members in bold were on the board of trustees for the entire audit period.
** Gary Keefe left the board of trustees after the audit period.

The same six board members highlighted in the table above who served for the entire audit period serve currently, five board members remain in their positions since the COVID-19 outbreak, and all served at some point during the audit period, which started July 1, 2020.

In July 2020, a lawsuit was filed by the families affected by the events of the COVID-19 outbreak, and in May 2022, the state agreed to pay a settlement of $56 million to these families. The settlement was split between the estates of veterans who died before June 23, 2020 and veterans who were ill with COVID-19 but survived. The Office of the Governor and each named defendant sought and retained independent counsel to represent their interests in this matter. Additionally, VHH's board of trustees retained independent legal representation because the Attorney General was already investigating the incidents that occurred in the home. The Attorney General's investigation created a conflict related to the Office of the Attorney General's ability to represent VHH's board of trustees.

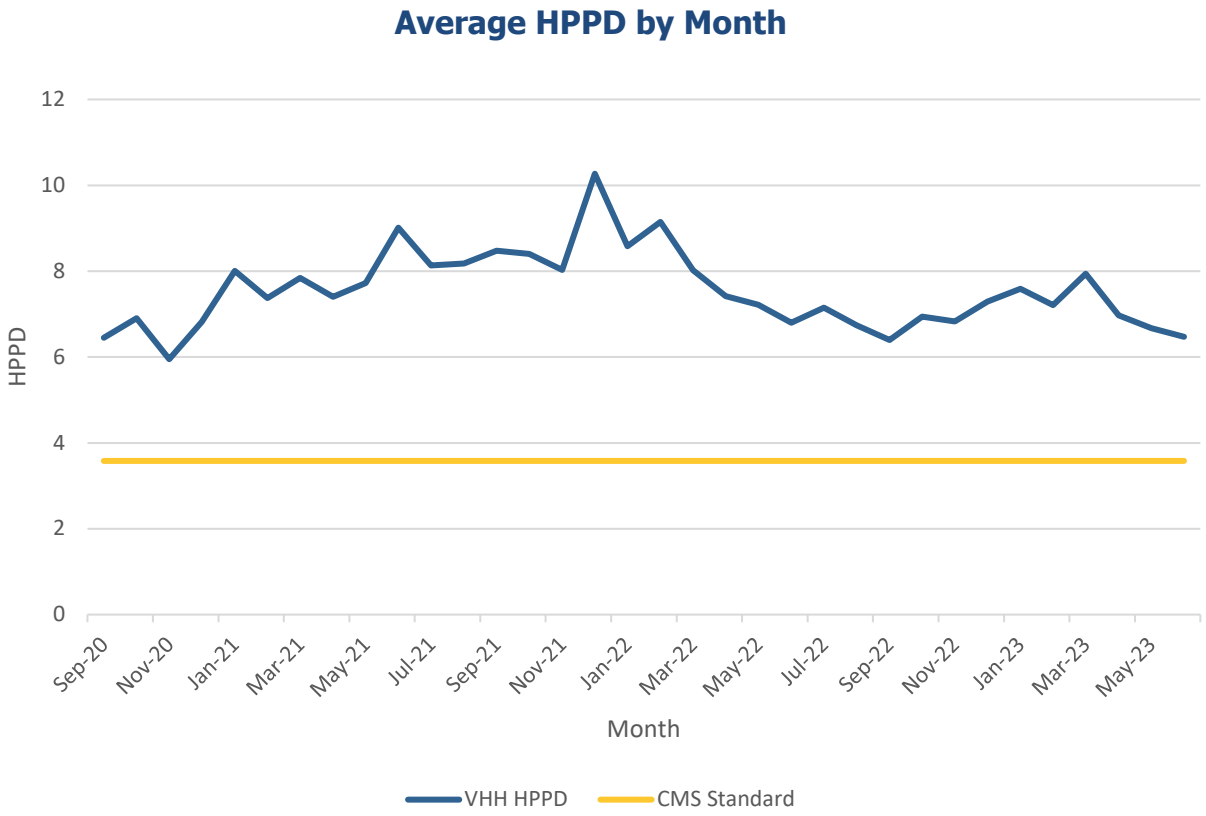
As a result of the events that occurred during the COVID-19 pandemic at VHH, we deemed these significant management and safety failures to be high risk and wanted to highlight for the reader the issues and changes that occurred during this time.

Staffing Ratios

There have been a number of reports including "COVID-19 Outbreak at the Soldiers' Home in Holyoke" from Mark W. Pearlstein; the Commonwealth's OIG's report titled "Holyoke Soldiers Home, May 2016 to February 2020"; and a previous audit (Audit No. 2017-0065-3S), issued December 14, 2017 by the Office of the State Auditor, which all looked into staffing levels at VHH because of multiple complaints of low staffing and concerns about veteran safety. In order to make sure this high-risk concern was addressed, our auditors researched staffing ratios in Massachusetts and other states. In addition, we held several interviews with upper management; nursing staff members; and the director of nursing, who is responsible for scheduling, to understand how VHH staffs each unit and shift. We collected staffing reports, variance reports, and daily rosters for the audit period. After compiling all the documentation, researching regulations, and reviewing past audit reports, we determined that there is a low risk that VHH is not meeting the federal staffing ratios. Below are the average hours per patient day (HPPD)[3] by month

3. Massachusetts requires all long-term care nursing homes to have an overall minimum of 3.58 HPPD, which is higher than the minimum federal level of 2.5 HPPD.

at VHH compared to the Massachusetts requirements of 3.58 HPPD set forth in Section 150.007(B)(2)(d) of Title 105 of the Code of Massachusetts Regulations (CMR).



Intentional Rounding

We looked at intentional rounding to examine staffing levels and veteran safety. Intentional rounding is the practice of professional nursing staff checking on veterans regularly throughout the day and providing necessary care. The Journal of Geriatric Medicine reported that intentional rounding reduces falls in long-term care facilities by 36%. In addition, VHH's NSG-113 Intentional Rounding Policy states the following:

a. *Research supports purposeful, scheduled Veteran rounding as a best practice in providing safe, effective Veteran care as it reduces Veteran falls and decreases hospital acquired pressure ulcers. In addition, research shows that overall Veteran experience improves and call light use decreases as Veteran needs are met in a timely manner.*

b. *Best practice evidence recommends hourly Veteran rounding as an effective process that anticipates Veteran needs and allows those needs to be met in an efficient and timely manner. This proactive approach results in improved Veteran safety and enhances the Veteran experience.*

VHH's NSG-113 Intentional Rounding Policy sets the requirements for the rounding performed by its licensed professional nursing staff members, with the goal of enhancing veteran safety. VHH's policy acknowledges that intentional rounding enhances veterans' experiences and quality of life while simultaneously helping to reduce falls and minimize the need for veterans to call for nurses because their needs are met in a timely manner. Intentional rounding requires licensed professional nursing staff to check on veterans' four Ps, according to VHH's NSG-113 Intentional Rounding Policy, which are listed as follows:

i. *Pain — Does the Veteran have pain?*
ii. *Personal Needs — Do you need to use the bathroom? Recommend taking the Veteran to the bathroom if condition permits.*
iii. *Position — Assist Veteran into a new position that is comfortable.*
iv. *Possessions — Move personal possessions within reach of the Veteran (phone, call light, trash can, water pitcher, over bed table, etc.) and ensure the area is clutter free.*

These checks are scheduled every hour between 6:00 am and 10:00 pm and every two hours between 10:00 pm and 6:00 am, during typical sleep time. Professional nursing staff members can increase rounding depending on the veterans' individual needs. Rounding is documented on VHH's Intentional Rounding Log at the time the rounds occur by the person who performs them. Intentional Rounding Logs are kept on veterans' closet doors for easy access.

Incidents/Occurrences

VHH uses its "Admin-041 Incident/Occurrence Report Policy" to report incidents/occurrences that occur during a work shift. According to this policy, "Incident/Occurrence Reporting is a process in which occurrences that affect any person on the premises, including veterans, employees, physicians, visitors, students, or volunteers and are inconsistent with routine facility operation or veteran care are documented." Some examples of incidents/occurrences include veteran falls, abuse/neglect, medication errors, and missing items.

According to Section I of VHH's "Admin-041 Incident/Occurrence Report Policy," the purpose of an incident/occurrence report is:

PURPOSE: *To provide accurate and timely documentation of all incidents, to:*

a. *Review and evaluate episodes which are inconsistent with the Soldiers' Home in Holyoke (SHH) mission or routine operations, as well as those that jeopardize the safety of veterans;*

b. Improve the safety of veterans and staff;

c. Correct isolated untoward events;

d. Identify trends and patterns;

e. Improve quality of care and Facility operations;

f. Provide channels of communication to the Facility administration for legal and risk management purposes;

g. Comply with Incident/Occurrence Reporting requirements established by regulatory agencies;

h. Review analyze and report sentinel events as required by the Joint Commission (TJC) and the Department of Veteran's Affairs.

All incidents are to be recorded on an incident/occurrence report and then added to an incident log. A veteran care coordinator or supervisor reviews and signs off on the report. The report is then forwarded to the quality manager, who determines any trends or problem areas that need improvement.

Nurse Training

As a requirement of employment at VHH, nurses are required to maintain appropriate licensure through continued education and training. This helps determine that the staff members in charge of caring for veterans have the required training necessary for their line of work and ensure veteran safety. VHH Safety Fairs are one way the home ensures veteran safety. VHH conducts safety fairs on an annual basis to ensure that nursing staff members receive necessary training. These Safety Fairs cover a wide range of topics, for example, infection prevention, veteran rights, safety of veterans, harassment training, workplace injuries, security, and facility emergencies.

Records Management System

VHH currently uses hardcopy medical records for its veterans. In addition, older records are kept in the health information management system office or at an offsite storage facility after four years.

According to 105 CMR 150.013(C), "all facilities shall maintain a separate, complete, accurate and current clinical record in the facility for each resident from the time of admission to the time of discharge. The record shall contain all medical, nursing and other related data."

VHH and the Veterans Home at Chelsea entered into a joint contract with a vendor on March 4, 2022 in an effort to make all medical records electronic. The vendor reported to leadership at VHH that, as of May 2024, it had finished scanning medical records at the Veterans Home at Chelsea and had moved to scanning medical documents at VHH.

Emergency Operation Plan

VHH has an emergency operation plan (EOP) that outlines actions to take in case of a manmade or natural disaster or other emergencies that present imminent danger of death or serious physical harm of a veteran. This plan also helps address the medical and physical needs of its staff members and veterans during an emergency. VHH's EOP establishes the procedures, responses, and infrastructure required to maintain safety for all of VHH's staff members and veterans. The EOP addresses four phases of its management processes, specifically, mitigation, preparedness, response, and recovery. The EOP was developed by the VHH leadership team and the safety committee, which includes medical staff members and local public safety and emergency management teams (e.g., the local fire department). Each staff member is trained on their specific role and responsibilities during an emergency, which helps VHH staff members provide a safe and dignified response to emergencies. Given the recent tragedy that occurred at Gabriel House in Fall River, in which 10 residents of an assisted-living facility perished in a fire, this topic is especially relevant. There are now increased efforts across Massachusetts to ensure that every assisted living residence is prepared to respond to emergencies and protect residents' safety.[4]

COVID-19 Expenditures

In March 2021, the American Rescue Plan Act of 2021 established the Coronavirus State and Local Fiscal Recovery Funds in order to respond to the pandemic and its economic effects. These funds could be used to respond to shortfalls in the budget because of the COVID-19 pandemic. VHH followed spending guidelines from EOHHS. EOHHS had regular check-in meetings with VHH on American Rescue Plan Act funding. Approximately $2.9 million was allocated to VHH and was loaded directly into the Massachusetts Management Accounting and Reporting System. VHH management stated that this funding was spent on standard expenses.

4. For more information related the Commonwealth's response to the events at Gabriel House in Fall River, see this July 22, 2025 article from *The Herald News* and this July 18, 2025 press release from the Office of the Governor.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor has conducted a performance audit of certain activities of the Veterans Home at Holyoke (VHH) for the period July 1, 2020 through June 30, 2023.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Below is a list of our audit objectives, indicating each question we intended our audit to answer; the conclusion we reached regarding each objective; and, if applicable, where each objective is discussed in the audit findings.

Objective	Conclusion
1. Did VHH provide safe, effective veteran care and document rounding in accordance with its NSG-113 Intentional Rounding Policy?	**No; see Finding 1**
2. Did VHH follow its ADMIN-041 Incident/Occurrence Report Policy to handle incidents involving veterans and determine whether the nurses involved in the incidents had professional licenses to provide care to veterans?	**Yes**
3. Did VHH's system for tracking patient records operate effectively in accordance with Section 150.013(c) of Title 105 of the Code of Massachusetts Regulations (CMR)?	**No; see Finding 3**
4. Did VHH have an emergency operation plan (EOP) in place during the audit period and has it been updated to address the risks involved in providing adequate patient care during an emergency in accordance with 105 CMR 150.015(E)?	**No; see Findings 2a, 2b, and 2c**
5. Did VHH expend COVID-19 funds in accordance with requirements established by the American Rescue Plan Act?	**Yes**

To accomplish our audit objectives, we gained an understanding of the VHH internal control environment relevant to our objectives by reviewing VHH's policies and procedures, as well as by conducting inquiries with its staff members and management. We also tested the operating effectiveness of the Finance Department's approval control related to expenditures of COVID-19 funds.

Veteran Safety

To determine whether VHH provided safe, effective veteran care and documented rounding in accordance with NSG-113 Intentional Rounding Policy, we obtained a list of veterans who were at VHH during the audit period. We selected a nonstatistical,[5] random sample of 35 veterans out of a population of 218.

Next, we obtained the medical record for each veteran in our sample and reviewed the Intentional Rounding Logs to determine whether the licensed professional nursing staff members performed rounds every hour between 6:00 am and 10:00 pm and every two hours between 10:00 pm and 6:00 am.

Based on the results of our testing, we determined that VHH did not provide safe, effective veteran care in accordance with its NSG-113 Intentional Rounding Policy. See Finding 1 for more information.

Incident Reporting

To determine whether VHH followed its ADMIN-041 Incident/Occurrence Report Policy to handle incidents involving veterans, we obtained a log of all incidents that occurred during the audit period. We filtered the incident log to only include incidents that directly affected the care of a veteran. These incident types included falls, medical incidents (medication errors or reactions to medication), and veteran care (neglect or abuse). Below is a chart that breaks down the number of each type of incident in our population.

Incident Type	Count
Falls	466 (49%)
Medical	357 (37%)
Veteran Care	131 (14%)
Total	954

We selected a nonstatistical, random sample of 60 incidents out of a population of 954. We reviewed the hardcopy incident reports and any accompanying documents, such as staff member statements, witness statements, veteran care plans, veteran treatment records, and veterans' Medication Administration Records. We determined whether the details of the incident were recorded on the Incident Report form, whether a veteran care coordinator or supervisor reviewed the form, and whether a veteran care

5. Auditors use nonstatistical sampling to select items for audit testing when a population is very small, the population items are not similar enough, or there are specific items in the population that the auditors want to review.

coordinator or supervisor completed the assessment and follow-up sections and signed the form. We also reviewed each veteran's medical record to determine whether there was a reference to the incident in the record describing what occurred and the results of the evaluation and treatment provided.

In addition, we examined the licensing documentation of licensed nursing professionals involved in each incident in the sample to ensure that all nursing professionals were properly licensed.

Based on the results of our testing, we determined that VHH had no significant issues in documenting the incidents according to its policy and that all nursing professionals were properly licensed. Examples of actions VHH has taken for veterans who have fallen include increased rounding, bed rails, bed alarms, and non-slip socks. For medical errors, VHH has provided re-education to clinical staff members and contacted veterans' physicians for new prescription orders. For veteran care incidents, VHH has provided medical care, interviews, and re-education to clinical staff members who were involved.

Medical Records

To determine whether VHH patient record files contained all required information in accordance with 105 CMR 150.013(C), we obtained a list of veterans who were at the home during the audit period. We selected a nonstatistical, random sample of 35 veterans from a population of 218. To complete our testing, we requested the hardcopy medical records for each veteran in our sample. We determined whether the medical records contained the following documentation: the Summary Sheet, referral intake information, admission data, medical evaluation, progress notes, consultation reports, medication and treatment records, nursing care plans, nursing notes, periodic reviews, lab reports, personal effects, and discharge information.

Our testing did not reveal any exceptions with veteran medical records; however, VHH has not implemented an electronic health record system and still relies on paper medical records. See Finding 3 for more information.

EOP

To determine whether VHH had an EOP in place during the audit period and whether it had been updated to address the risks involved in providing adequate patient care during an emergency, in accordance with 105 CMR 150.015(E), we obtained and reviewed a copy of VHH's fiscal year 2022 and fiscal year 2023 EOPs and their attachments from VHH. Next, we performed the following procedures:

- We conducted a tour of VHH to determine whether there was a written plan in place and whether there were copies posted throughout the facility.
- We reviewed the hardcopy EOP contained in the incident command center to determine whether the plan detailed which people should be notified and when; the location of alarm signals, fire extinguishers, and evacuation routes; procedures for evacuation of veterans; and assignment of responsibilities to the personnel of each shift.
- We reviewed the sign-in sheets from the annual Safety Fair to determine whether personnel were trained to perform assigned tasks.
- We reviewed After Action Reports to determine whether staff members conducted a minimum of two drills per year per shift.
- We reviewed After Action Reports to determine whether a reliable means of communication was always available for sending and receiving information from the Department of Public Health.

In addition, we reviewed the sign-in sheets from the annual Safety Fair to determine whether VHH senior leadership received training on the EOP.

Based on the results of our testing, VHH's EOP did not meet the requirements of 105 CMR 150.015(E). See Findings 2a, 2b, and 2c for more information.

COVID-19 Funds

To determine whether VHH expended COVID-19 funds in accordance with requirements established by the American Rescue Plan Act, we obtained a list of expenditures from VHH during the audit period. We then filtered the data to include only expenditures using COVID-19 funds. We selected a nonstatistical, random sample of 40 COVID-19 expenditures (totaling $215,984.49) from a population of 512 (totaling $2,527,263.57) that were appropriated from COVID-19 funds during the audit period. For our sample, we reviewed supporting documentation, including receipts, purchase orders, invoices, bills, and time sheets to determine whether the COVID-19 funds had been used for the following:

- to replace lost public sector revenue;
- to support the COVID-19 public health and economic response;
- to provide premium pay for eligible workers performing essential work; or
- to make necessary investments in water, sewer, and broadband infrastructure.

Based on the results of our testing, we did not identify problems related to VHH's expenditure of COVID-19 funds during the audit period.

We used nonstatistical sampling for all our objectives; therefore, we did not project the results to the populations.

Data Reliability Assessment

In 2022, the Office of the State Auditor performed data reliability assessments of the Massachusetts Management Accounting and Reporting System (MMARS) focused on testing selected system controls (access, security awareness, audit and accountability, configuration management, identification and authentication, as well as personnel security). In addition, as part of our current audit, we tested controls in place over VHH's personnel security. Further, we selected a random sample of 20 invoices from VHH's files and determined whether the information on the invoices matched the data in MMARS. We also selected a random sample of 20 transactions from MMARS and traced the information to physical documentation (invoices).

To determine the reliability of data from the incident log of all incidents involving veterans that occurred at VHH during the audit period, July 1, 2020 through June 30, 2023, we traced a sample of 20 incidents from the incident log to the incident reports and selected 20 incident reports to trace back to the incident log.

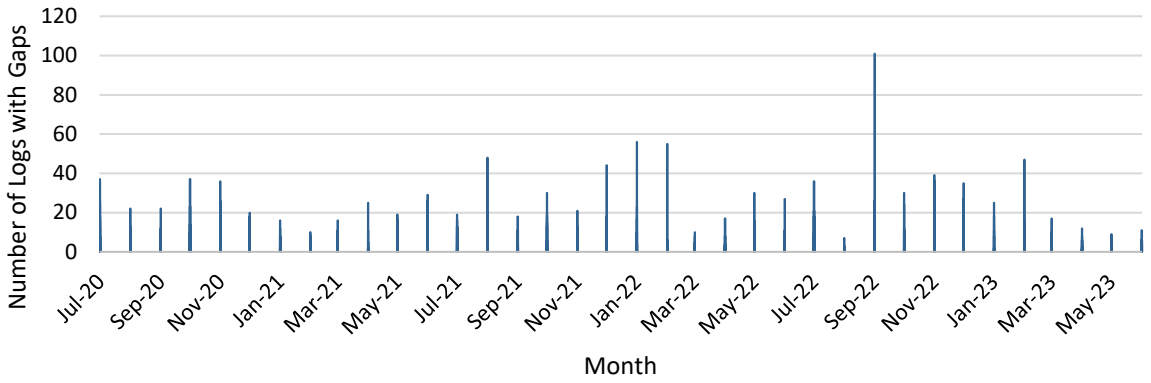
To determine the reliability of the data from the list of all veterans at VHH during the audit period that we obtained from VHH, we traced a sample of 20 veterans from the list to veteran files and selected 20 veteran files that we traced back to the list. In addition, we conducted tests to identify any duplicates to determine the integrity of the information on the list.

Based on the results of the data reliability assessment procedures described above, we determined that all data we obtained during the course of our audit was sufficiently reliable for the purposes of our audit.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. The Veterans Home at Holyoke could not ensure that nurses performed intentional rounding, potentially resulting in an unsafe environment for veterans.

VHH could not provide documentation to prove that nurses performed intentional rounding on all veterans during the audit period. Specifically, 32 out of our sample of 35 (91%) veterans did not have complete intentional rounding logs. The 32 veterans accounted for 384 out of 562 (68.3%) intentional rounding logs that had gaps, indicating that rounding did not occur as required. Below is a chart showing the number of intentional rounding logs that had gaps. Each log accounts for one month of intentional rounding.



If intentional rounding is not being completed, then it could increase the risk of veterans having falls or other issues that could adversely contribute to veteran safety and well-being. As already noted (see the "Intentional Rounding" section), intentional rounding reduces falls by an estimated 36%. It is reasonable to conclude that the absence of intentional rounding, as shown here, increased the risk—and likely the number of injuries—while reducing the quality of care, for veterans at VHH.

Authoritative Guidance

According to Section VI of VHH's NSG-113 Intentional Rounding Policy,

> *VI. Procedure . . .*
>
> *b. Hourly rounding will occur*
>
> *i. Every hour on every Veteran between the hours of 0600 and 2200*
>
> *ii. And reduced to every 2 hours between the hours of 2200-0600 to facilitate sleep.*

iii. Hourly rounding is decreased at night to facilitate sleep for the Veteran. If the Veteran is sleeping, continue to observe and perform detailed rounding when Veteran awakens and/or is aroused for Veteran care activities. Nursing care should be clustered to facilitate Veteran's sleep.

iv. Veteran rounding may need to be increased depending on the condition of the Veteran. . .

f. Documentation

i. Intentional rounds are to be documented at the time they occur by the person completing them.

Reasons for Issue

VHH stated the reason Intentional Rounding Logs were incomplete was either because staff members performed the scheduled room check and forgot to complete the Intentional Rounding Log, or that staff members did not perform those room checks as scheduled. In addition, VHH did not have established monitoring controls to ensure that intentional rounding logs were completed and reviewed.

Recommendations

1. VHH should ensure that timely intentional rounding is performed and documented on Intentional Rounding Logs.
2. VHH should establish monitoring controls to ensure that Intentional Rounding Logs are completed and maintained.

Auditee's Response

At present, the Massachusetts Veteran Home at Holyoke (HLY) has a robust intentional rounding program. HLY and [the Executive Office of Veterans Services (EOVS)] implemented nursing policies which postdated the audit period and include the intentional rounding program. These policies state that each Veteran gets rounded on by a licensed nurse or a Certified Nursing Assistant (CNA) 20 times a day (hourly from 6:00am to 10:00pm and every 2 hours from 10:00pm to 6:00am). The HLY nursing leadership continues to review and support improvement of the intentional rounding program documentation. To address this, a process of re-education for all the clinical staff was accomplished in May 2025 during the annual staff education program. The nursing leadership team also established audits of the intentional rounding program starting in April of 2025. To date, 1,919 audits have been completed with real time follow-ups and education being done on audits that do not meet the policy standards. HLY's senior CNAs have emphasized rounding and documentation with all CNAs.

Auditor's Reply

Based on its response, VHH is taking measures to address our concerns regarding this matter. As part of our post-audit review process, we will follow up on this matter in approximately six months.

2. The Veterans Home at Holyoke's emergency operation plan did not include all the required components, resulting in an unsafe environment for veteran residents.

We identified several issues regarding VHH's access to and understanding of its emergency operation plan (EOP), leading to multiple findings detailed below.

a. The Veterans Home at Holyoke violated state regulation by not conducting simulated emergency drills for all shifts.

VHH did not perform simulated drills of its EOP for all shifts at least twice a year; however, VHH did perform two drills each year for day shift employees during the audit period.

Without performing simulated emergency drills to test the effectiveness of its EOP, VHH cannot ensure that it has an effective response to disasters and emergencies, thereby jeopardizing the safety of veterans and hospital staff members.

Authoritative Guidance

According to Section 150.015(E)(4) of Title 105 of the Code of Massachusetts Regulations (CMR), "Simulated drills testing the effectiveness of the plan shall be conducted for all shifts at least twice a year."

Reasons for the Issue

VHH officials stated that, during the audit period, VHH was not licensed as a long-term care facility or nursing home under the Department of Public Health (DPH), so it operated in accordance with the US Department of Veterans Affairs and the Joint Commission's guidelines instead of DPH's guidelines. However, our office disagrees and believes VHH is subject to 105 CMR 150.

Auditee's Response

During the audit period July 1, 2020, through June 30, 2023, the Veterans Home at Holyoke did not fall under 105 CMR 150 but was subject to life safety requirements in [Section 51.200 of Title 38 of the Code of Federal Regulations]. Pursuant to An Act Relative to the Governance Structure and Care of Veterans at the Commonwealth's Veterans' Homes*, [Chapter 144 of the Acts of 2022], the Veterans Home at Holyoke became a Department of Public Health licensed nursing facility on July 25, 2024. Prior to July 25, 2025, the Veterans Home at Holyoke was compliant with [National Fire Protection Association (NFPA)] 101. NFPA 101 involves many standards related to Life Safety & Fire Safety Standards including Emergency Drills that were conducted for all shifts each quarter. These drills have been under scrutiny of an annual [Veterans Affairs] regulatory survey from which the home did not receive any citation during that period. The Home currently has added its*

emergency operations plan onto every computer desktop throughout the facility. Additionally, staff are trained in the emergency operations plan by the Director of Facilities during new hire orientation and during their annual Safety Fair each March.

Auditor's Reply

We disagree that VHH was not subject to 105 CMR 150 because 105 CMR 150.001 defines a long-term care facility as the following:

> *Any institution whether conducted for charity or profit that is advertised, announced or maintained for the express or implied purpose of providing four or more individuals admitted thereto with long-term resident, nursing, convalescent or rehabilitative care; supervision and care incident to old age for ambulatory persons; or retirement home care for elderly persons. Long-term care facility shall include convalescent or nursing homes, rest homes, infirmaries maintained in towns and charitable homes for the aged. Facility as used in 105 CMR 150.000, shall mean a long-term care facility or unit thereof and units within acute hospitals converted under provisions of [Section 32 of Chapter 23 of the Acts of 1988].*

While VHH does not agree that it was subject to DPH regulations during the audit period, based on its response, VHH is taking measures to address our concerns regarding this matter. As part of our post-audit review process, we will follow up on this matter in approximately six months.

b. The Veterans Home at Holyoke violated state regulation (Section 150.015(E)(1) of Title 105 of the Code of Massachusetts Regulations) by not posting its emergency operation plan throughout the facility.

VHH's EOP was not posted at nurses' and attendants' stations and in conspicuous locations throughout the facility. The staff we spoke to at the nurses' stations we visited did not know where the plan was or how to access the plan online.

Without its EOP posted in conspicuous locations, VHH is unable to ensure an effective response to disasters and emergencies that affect the environment of care and could impede the safety of veterans and hospital staff members.

Authoritative Guidance

According to 105 CMR 150.015(E)(1),

> *Every facility shall have a written plan and procedures to be followed in case of fire, or other emergency, developed with the assistance of local and state fire and safety experts, and posted at all nurses' and attendants' stations and in conspicuous locations throughout the facility.*

Reasons for the Issue

VHH officials stated that, during the audit period, VHH was not licensed as a long-term care facility or nursing home under DPH, so it operated in accordance with the US Department of Veterans Affairs and the Joint Commission's guidelines disregarded DPH's guidelines. However, our office believes VHH is subject to 105 CMR 150.

Auditee's Response

During the audit period July 1, 2020, through June 30, 2023, the Veterans Home at Holyoke did not fall under 105 CMR 150 but was subject to life safety requirements in [Section 51.200 of Title 38 of the Code of Federal Regulations]. Pursuant to An Act Relative to the Governance Structure and Care of Veterans at the Commonwealth's Veterans' Homes*, [Chapter 144 of the Acts of 2022], the Veterans Home at Holyoke became a Department of Public Health licensed nursing facility on July 25, 2024. The Home currently has added its emergency operations plan onto every computer desktop throughout the facility. Additionally, staff have been trained in its emergency operations plan by the Director of Facilities. The Emergency Operations Plan is located on the HLY Shared Drive and in the Incident Command Center.*

Auditor's Reply

We disagree that VHH was not subject to 105 CMR 150 because 105 CMR 150.001 defines a long-term care facility as the following:

> *Any institution whether conducted for charity or profit that is advertised, announced or maintained for the express or implied purpose of providing four or more individuals admitted thereto with long-term resident, nursing, convalescent or rehabilitative care; supervision and care incident to old age for ambulatory persons; or retirement home care for elderly persons. Long-term care facility shall include convalescent or nursing homes, rest homes, infirmaries maintained in towns and charitable homes for the aged. Facility as used in 105 CMR 150.000, shall mean a long-term care facility or unit thereof and units within acute hospitals converted under provisions of [Section 32 of Chapter 23 of the Acts of 1988].*

While VHH does not agree that it was subject to DPH regulations during the audit period, based on its response, VHH is taking measures to address our concerns regarding this matter. As part of our post-audit review process, we will follow up on this matter in approximately six months.

c. The Veterans Home at Holyoke violated state regulation (Section 150.015(E)(2) of Title 105 of the Code of Massachusetts Regulations) by its emergency operation plan not containing the locations of alarm signals, fire extinguishers, and evacuation routes.

VHH's EOP does not contain the location of alarm signals, fire extinguishers, and evacuation routes at VHH.

If VHH's EOP does not contain the location of alarm signals, fire extinguishers, and evacuation routes, then this could affect the timely and safe evacuation of veterans, staff members, and visitors in the event of a disaster.

Authoritative Guidance

According to 105 CMR 150.015(E)(2),

> *The plan shall specify persons to be notified, locations of alarm signals and fire extinguishers, evacuation routes, procedures for evacuating residents, and assignment of specific tasks and responsibilities to the personnel of each shift.*

Reasons for the Issue

VHH officials stated that, during the audit period, VHH was not licensed as a long-term care facility or nursing home under DPH, so it operated in accordance with the US Department of Veterans Affairs and the Joint Commission's guidelines instead of DPH's guidelines. However, our office disagrees and believes VHH is subject to 105 CMR 150.

Recommendations

1. VHH should ensure that it conducts simulated emergency drills for all shifts at least twice a year.
2. VHH should ensure that its EOP is available at all nurses' and attendants' stations and is posted in conspicuous locations throughout the facility. VHH should also make its EOP accessible in digital form from all computer terminals.
3. VHH should add the locations of alarm signals, fire extinguishers, and evacuation routes to its EOP.

Auditee's Response

During the audit period July 1, 2020, through June 30, 2023, the Veterans Home at Holyoke did not fall under 105 CMR 150 but was subject to life safety requirements in [Section 51.200 of Title 38 of the Code of Federal Regulations]. Pursuant to An Act Relative to the Governance Structure and Care of Veterans at the Commonwealth's Veterans' Homes*, [Chapter 144 of the Acts of 2022], the Veterans Home at Holyoke became a Department of Public Health licensed nursing facility on July 25, 2024. In preparation for licensure, the Holyoke Veterans Home engaged Code Red Consultants to guide the*

facility through Fire Safety Evaluation System life safety requirements. Code Red made several recommendations to the facility on April 10, 2024, which were promptly implemented. The Home currently has Evacuation Route signs throughout the building including all Veteran occupied units. These Evacuation Route signs also contain the location of the fire alarm pull stations and fire extinguishers for that area. Copies of the Evacuation Route signs have been added to the Emergency Operations Plan.

Auditor's Reply

We disagree that VHH was not subject to 105 CMR 150 because 105 CMR 150.001 defines a long-term care facility as the following:

Any institution whether conducted for charity or profit that is advertised, announced or maintained for the express or implied purpose of providing four or more individuals admitted thereto with long-term resident, nursing, convalescent or rehabilitative care; supervision and care incident to old age for ambulatory persons; or retirement home care for elderly persons. Long-term care facility shall include convalescent or nursing homes, rest homes, infirmaries maintained in towns and charitable homes for the aged. Facility as used in 105 CMR 150.000, shall mean a long-term care facility or unit thereof and units within acute hospitals converted under provisions of [Section 32 of Chapter 23 of the Acts of 1988].

While VHH does not agree that it was subject to DPH regulations during the audit period, based on its response, VHH is taking measures to address our concerns regarding this matter. As part of our post-audit review process, we will follow up on this matter in approximately six months.

3. The Veterans Home at Holyoke does not use an electronic health record system for veterans as required of other, similarly situated healthcare facilities.

VHH does not currently have an electronic health record (EHR) system to store veterans' medical records. Instead, VHH retains only hardcopy medical records.

According to Centers for Medicare and Medicaid Services, there are multiple benefits to implementing an EHR system, including improved patient care. For example, an EHR system allows healthcare providers to access medical records in real time to provide accurate and timely care. An EHR system can reduce medical errors and delays in treatment and improve the accuracy and clarity of medical records and improve the security of medical records.

Authoritative Guidance

As part of the American Recovery and Reinvestment Act of 2009, qualified medical professionals and hospitals were eligible for financial incentives to use EHR systems. While VHH was not an eligible provider, we consider implementing an EHR system to be a best practice because of the multiple benefits CMS has referenced.

In addition, according to 105 CMR 130.375, DPH requires Massachusetts hospitals and community health centers to implement EHR systems. Specifically, acute care hospitals were required to have implemented an EHR system no later than December 1, 2013; non-acute hospitals were required to implement EHR systems no later than October 1, 2015; and community health centers were required to implement EHR systems no later than October 1, 2016.

Reasons for the Issue

In April 2019, the Department of Veterans Services (now the Executive Office of Veterans Services) posted a bid for an EHR system to COMMBUYS. In May 2019, VHH, along with the Veterans Home at Chelsea, the Department of Veterans Services, and EOHHS, planned to implement an electronic medical records system. However, VHH told us that there were issues with the first vendor, and the original contract was terminated around September 2021. VHH and the Veterans Home at Chelsea entered into a joint contract with a vendor on March 4, 2022 to make all medical records electronic. The vendor has reported to leadership at VHH that, as of May 2024, it had completed scanning medical records at the Veterans Home at Chelsea and has moved to scanning medical documents at VHH.

Recommendation

We recommend that VHH implement an EHR system as soon as possible.

Auditee's Response

> *During the audit period, the Veterans Homes at Holyoke and Chelsea were in the process of procuring an electronic medical record. Both Veterans Homes currently use [an electronic medical record system] for their electronic medical records and as part of the "go live" process, physical medical records were scanned and are now stored electronically. [This system] became operational at [VHH] on September 9, 2024.*

Auditor's Reply

Based on its response, VHH is taking measures to address our concerns regarding this matter. As part of our post-audit review process, we will follow up on this matter in approximately six months.

OTHER MATTERS

The Office of the Governor violated Section 12 of Chapter 11 of the Massachusetts General Laws by withholding supporting documentation from the Pearlstein Report.

As part of the audit, we reviewed the report, "COVID-19 Outbreak at the Soldiers' Home in Holyoke," authored by Mark W. Pearlstein of McDermott Will & Emery LLP (known as the Pearlstein Report). We also believe that the interviews, interview notes, and other documentary evidence used to write the Pearlstein Report may contain valuable information to help us understand the issues we sought to audit, as well as the perspectives and opinions of those who worked at VHH during the audit period.

On August 9, 2024, we requested "any and all records, including, but not limited to, notes, recordings, and transcripts, in connection with the interviews conducted in connection with Pearlstein Report documents" from the Office of the Governor under Section 12 of Chapter 11 of the Massachusetts General Laws, which provides us the statutory authority to access records in connection with the scope of our audit.[6]

In an email response, dated August 12, 2024, counsel for the Office of the Governor denied our request for the records, stating, "Governor Baker's office, in response to several requests, withheld the notes you are seeking as protected by the work product doctrine as well as attorney-client privilege, and that will be our position as well."

We disagree with this reasoning.

The Pearlstein Report was not legal work. In its engagement letter, dated April 1, 2020, to the Office of the Governor, McDermott Will & Emery stated that it "will be conducting an investigation of the events that led to the death of veterans in the Soldier's Home, and the management and organizational oversight of the Covid-19 response in the Soldier's Home." The resulting report was—in large part—a fact-finding and—in part—a management study that made recommendations regarding non-legal matters. The Pearlstein Report itself confirms this, citing that its scope of work was to answer the following three questions:

- *First, what caused and contributed to the COVID-19 outbreak at the Soldiers' Home?*

6. We made similar requests to McDermott Will & Emery LLP and VHH, both of which directed us to the Office of the Governor.

- *Second, did the Soldiers' Home's leadership comply with applicable requirements to provide timely and accurate counts of the number of infected patients and staff, and the number of deaths associated with COVID-19?*
- *Third, what if anything can be done in the future to prevent or reduce the likelihood of a similar outbreak?*

This scope of work does not represent legal work but rather a management study of what occurred at VHH and how a recurrence can be prevented in the future. The Pearlstein Report suggests the contributing factors included "staffing, technology, and physical plant improvements," which are non-legal in nature, further underscoring that the report itself is not legal work that can be withheld as privileged. The underlying records of the Pearlstein Report also cannot be protected on these grounds, as they are not attorney-client work product or protected under attorney-client privilege.

The Pearlstein Report states that the Executive Office of Health and Human Services (EOHHS) withheld 138 documents from the McDermott Will & Emery team, citing attorney-client privilege. This withholding of documentation confirms that Mr. Pearlstein was not serving in the capacity of an attorney for the Office of the Governor, which oversees EOHHS, but rather as a fact-finding investigator against whom EOHHS could assert attorney-client privilege.

We further note that any attorney-client privilege related to the Pearlstein Report was waived when the report was released to the public.

While our office was able to examine other issues related to safety, as detailed more fully in this audit report, we find the withholding of the requested documentation to be troubling. Withholding these records limits VHH's and the public's transparency with regard to the safety issues at VHH. This lack of transparency before the pandemic—including the hiring of an unqualified administrator at VHH, which was not broadly known at the time—directly contributed to the tragedy at VHH during the COVID-19 pandemic. The public deserves even more transparency and accountability now, after the tragedy has occurred. Improperly withholding the backup documentation to this report has denied the public the information, accountability, and transparency they deserve as taxpayers and residents.

Refusal to provide records to us through the improper assertion of attorney work product and attorney-client privileges unnecessarily undermines the public's faith in their government. In this case, the failure to permit appropriate oversight and scrutiny invites criticism and suspicion that the report may not accurately represent what investigators found.

In addition, auditees withholding documents from auditors, who have the legal right to receive them, violates the law and undermines the public's faith in government. This is even more the case when those documents are clearly public records, as they are in this case.

Recommendations

1. Agencies, such as VHH and the Office of the Governor, should only exercise attorney-client privilege when appropriate.

2. The work of vendors, including fact-finding investigators and consultants, should be turned over to the contracting agency and made available to the Office of the State Auditor when conducting an audit, and more widely to the public in accordance with the public records law.

Auditee's Response

In April 2020, the Baker Administration retained McDermott Will & Emery LLP ("McDermott") to investigate the events that led to the deaths of veterans in the Soldier's Home caused by COVID-19. Governor Baker's Chief Legal Counsel executed an engagement letter retaining McDermott as "representation [for] the Office of the Governor" and creating an "attorney-client relationship" between McDermott and the Office of the Governor. EOVS understands that McDermott was retained not only to provide a written report but also to provide legal advice in anticipation of expected litigation. Indeed, a class action lawsuit brought by veterans who contracted COVID-19, and the families of veterans who died during the outbreak, was filed in July 2020 and later settled by the Baker Administration for $56 million.

The Baker Administration determined that McDermott's interview notes and work papers were subject to the attorney client privilege and the work product doctrine and, on that basis, denied numerous requests for the materials. The [Office of the State Auditor's (SAO's)] suggestion to the contrary appears to be based on a misunderstanding of the scope of privilege and work product in the investigatory context. See Att'y Gen. v. Facebook, Inc.*, 487 Mass. 109, 125, 130 (2021) (explaining that the attorney-client privilege "certainly applies to communications between counsel and client made as part of an internal investigation that is undertaken to gather facts for the purposes of providing legal advice," and that the work product doctrine similarly applies to documents prepared with the prospect of litigation in mind even if "primarily prepared for a business or other nonlitigation purpose");* In re Kellogg Brown & Root, Inc.*, 756 F.3d 754, 760 (D.C. Cir. 2014) ("In the context of an organization's internal investigation, if one of the significant purposes of the internal investigation was to obtain or provide legal advice, the privilege will apply.");* Koch v. Specialized Care Servs., Inc.*, 437 F. Supp. 2d 362, 369 (D. Md. 2005) ("[T]he simple fact that attorney-client communications eventually result in a 'public' communication does not rob the preliminary or prior attorney-client communications of their privileged status.").*

Finally, [the Executive Office of Veterans Services] notes that the Pearlstein Report was issued in June 2020, prior to the start of the SAO's audit period. The application of the attorney-client privilege and work product doctrine to the materials sought did not limit the SAO from fully exploring the issues discussed in the report.

Auditor's Reply

We disagree with VHH's assessment that the interviews, interview notes, and other documentary evidence used to write the Pearlstein Report are subject to attorney-client privilege, as any attorney-client privilege related to the Pearlstein Report was waived when the report was released to the public under Massachusetts public records law. In addition, while we agree that the Pearlstein report was issued prior to the audit period, as mentioned in the Executive Summary above, we believe that it contains valuable information to help us understand the issues we sought to audit, as well as the perspectives and opinions of those who worked at VHH during the audit period and witnessed what occurred.

As highlighted in this Other Matters, the Pearlstein Report itself specified a scope of work that was part fact-finding and part management study. These are not eligible for protection under the attorney-client doctrine. It was, and remains inappropriate, that the notes and other documents that led to the development of this report remain outside of public view.

The public requires transparency relative to (1) repeated failures regarding VHH's hiring of an unqualified leader, failure to properly supervise him even after many warnings, etc.—and (2) failures in its response to the COVID-19 pandemic at VHH. The public is then asked, by this current administration, to accept that the Pearlstein Report conducted under the prior administration is complete and accurate—while denying our office the ability to provide independent oversight with respect to these important matters. Independent oversight is a hallmark of good government that is transparent and accountable to the people it serves. The failure to provide transparency, accountability, and the requested documentation does nothing to build the public's faith in its government and, in fact, erodes it.