IN THE UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

Thomas Wilkes, et al.,	)	
On behalf of themselves and	)	Civil No.: 3:20cv594
all other persons similarly	)	
situated,	)	
Plaintiffs,	)	
v.	)	
	)	
Ned Lamont, Governor, et al.,	)	
Defendants.	)	June 8, 2020

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Plaintiffs, on behalf of themselves and a class of all individuals who are patients at Connecticut Valley Hospital and Whiting Forensic Hospital (hereinafter collectively "Plaintiffs"), seek a preliminary injunction to remedy the undue risk of contracting and dying from COVID-19 that exists at these facilities.

Plaintiffs seek relief under the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution, which affords individuals institutionalized in state mental health facilities a right to safety and protection from harm. *Youngberg v. Romeo*, 457 U.S. 307 (1982); *Society for Good Will to Retarded Children v. Cuomo,* 737 F.2d 1239, 1246 (2d Cir. 1984). These rights are violated when, as here, those who run state mental facilities depart substantially from professional standards and thereby jeopardize the health and safety of residents. *Youngberg*, 457 U.S. at 323. Plaintiffs' are entitled to a preliminary injunction to end and correct Defendants' illegal practices.

Plaintiff's request that the Court issue a preliminary injunction ordering the defendants to:

1. Conform their testing protocols to CDC standards,
2. Take steps to ensure that staff consistently wear masks and that Plaintiffs are encouraged and supported in wearing masks including through education,
3. Improve hygiene and decontamination practices,
4. Implement social distancing to the maximum extent possible including by reducing patient census,
5. Undertake a clinical review in order to accelerate discharges, and
6. Grant such other or different relief the Court deems appropriate.

Wherefore, Plaintiffs request that the Court issue a preliminary injunction to enforce their constitutional right to safe conditions of confinement. In support of this motion Plaintiffs submit an accompanying memorandum.

The Plaintiffs

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Certificate of Service

On June 8, 2020 a copy of the foregoing **Motion for Preliminary Injunction** was filed electronically and served by mail on anyone unable to accept electronic filing. Notice of this filing will be sent by email to all parties by operation of the Court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF System.

s/Kirk W. Lowry__________
Kirk W. Lowry

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PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

I. INTRODUCTION

Plaintiffs, on behalf of themselves and a class of all individuals who are patients at Connecticut Valley Hospital and Whiting Forensic Hospital (hereinafter collectively "Plaintiffs"), seek a preliminary injunction to remedy the undue risk of contracting and dying from COVID-19 that exists at these facilities.

Plaintiffs seek relief under the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution, which affords individuals institutionalized in state mental health facilities a right to safety and protection from harm. *Youngberg v. Romeo*, 457 U.S. 307 (1982); *Society for Good Will to Retarded Children v. Cuomo,* 737 F.2d 1239, 1246 (2d Cir. 1984). These rights are violated when, as here, those who run state mental facilities depart substantially from professional standards, including for infection control, and thereby jeopardize the health and safety of residents. *Youngberg*, 457 U.S. at 323. To protect Plaintiffs' safety and health, this Court should issue a preliminary injunction requiring Defendants to conform their actions to professional norms.

II. FACTS

In Connecticut Valley Hospital (CVH) and Whiting Forensic Hospital (WFH), patients and staff live and work in very close quarters. There is an especially high risk that COVID-19 will spread into and through facilities, like CVH and WFH, that congregate residents and staff in confined spaces—and indeed outbreaks have already occurred in both CVH and WFH. These risks have been widely recognized, including in correctional facilities, *see, e.g., Wilson v. Williams*, 2020 WL 2904706 (6th Cir. June 1, 2020) (denying stay of preliminary injunction); *Martinez-Brooks v. Easter*, 2020 WL 2405350 (D. Conn. May 12, 2020) (granting TRO), nursing homes, *see, e.g., McPherson v. Lamont*, 2020 WL 2198279 (D. Conn. May 6, 2020) (nursing home residents at high risk of severe illness from COVID-19), and psychiatric hospitals. *See, e.g., Costa v. Bazron*, 2020 WL 2025701 (D. D.C. May 24, 2020) (issuing preliminary injunction). *See also*, Declaration of Farrin A. Manian, M.D., M.P.H ("Manian Decl.") ¶ 7 (attached to this Memorandum as Exhibit 1) (**"**the risk of transmission of SARS-CoV-2 is much higher wherever people reside or congregate in confined spaces, such as … prisons, and long-term care facilities, including psychiatric hospitals.")

One-third of deaths from COVID-19 in the United States have involved residents or staff of such facilities, "where people live in a confined environment and workers move from room to room, at times unknowingly infecting the residents or getting infected themselves." *Id.* ¶ 8. This "constant close contact, coupled with the presence of risk factors for severe disease . . . among residents, provide the elements for a 'perfect COVID-19 storm' with its attendant complications and mortality." *Id.*

The risks at CVH and WFH are real, and the results have been tragic. Five patients at CVH have died from COVID-19. At CVH and WFH, Defendants have confirmed 73 cases of COVID-19 among patients and 64 cases among staff, since testing began. As of June 8, 2020, at least one unit at CVH remains under quarantine.

Recognizing the health risks that inherently exist in congregate facilities, the Centers for Disease Control and Prevention (CDC) have issued widely accepted guidelines for limiting the spread of COVID-19 in such facilities. These guidelines emphasize testing, the use of personal protective equipment (PPE), social distancing, and isolation of individuals with symptoms or confirmed cases. Centers for Disease Control and Prevention, *How to Protect Yourself and Others*, available at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html (attached to this Memorandum as Exhibit 11).

Defendants were slow to take action to protect Plaintiffs from COVID-19. However, they have adopted some of the measures that national guidelines require. For example, they have adopted a policy requiring staff, and encouraging residents, to wear masks, although the evidence indicates that the policy is not being consistently implemented at CVH and WFH. Affidavit of Vincent Ardizzone (attached to this Memorandum as Exhibit 4) ("Ardizzone Aff.") ¶¶ 18, 32; Affidavit of Gail Litsky (attached to this Memorandum as Exhibit 5) ("Litsky Aff.") ¶¶ 10, 14, 16, 28, 32, 33, and 36. Defendants have also committed to improved hygiene and decontamination practices, which are not being consistently followed. Affidavit of Carson Mueller (attached to this Memorandum as Exhibit 3 ("Mueller Aff.") ¶¶ 29, 38, 39, 42, 45, 47, and 48. Defendants are now conducting weekly testing of staff, but they are not regularly testing patients. Plaintiffs' understanding is that testing of both patients and staff remains voluntary.

The failure to regularly test patients and to ensure that staff consistently wear masks creates health risks that this Court needs to address. What is placing Plaintiffs at greatest risk, however, is Defendants' failure to ensure social distancing within the facilities. Social distancing is an essential strategy for protecting individuals from COVID-19. Manian Decl. at ¶ 12. However, under the circumstances now present at CVH and WFH, Plaintiffs are unable to practice social distancing. *E.g.,* Mueller Aff. ¶¶ 11,12,13, 14, 15, 17, and 21; Ardizzone Aff. ¶¶ 19, 20, 21, and 26.

Defendants contend that Plaintiffs' safety and health can be maintained without social distancing. However, as Plaintiffs' experts explain, Defendants are wrong and the lack of social distancing at CVH and WFH is placing Plaintiffs at great risk. Manian Decl. ¶¶ 12, 23, Declaration of Patrick J. Canavan, Psy.D, and Elizabeth Jones (attached to this Memorandum as Exhibit 2 ("Canavan/Jones Decl.") ¶ 15.

Instead of implementing professional standards and CDC requirements on social distancing, Defendants are instead using a practice they call "unit segregation," which is essentially an attempt to keep units as a whole apart, rather than individuals. But, as Plaintiffs' experts explain, this practice does not provide sufficient protection for Plaintiffs or staff. Manian

Decl. ¶ 23. "As relates to designated units, 'COVID-negative' does not mean 'COVID-impervious.' As long as new cases of COVID-19 are being diagnosed in the community, long-term care facilities remain vulnerable to the importation of the virus from the outside world, particularly through unsuspected infected healthcare providers who live in the community, visitors, or residents who may need to temporarily leave the unit to seek medical care." *Id.*

In order to comply with professional standards and CDC requirements on social distancing at CVH and WFH, the number of patients at the facility would need to be reduced. However, Defendants have taken little action aimed at reducing the patient census at CVH or WFH. While admissions are down, largely through the efforts of courts, which have reduced both civil and criminal commitments, discharges are stagnant.

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has said that, during the pandemic, inpatient psychiatric care should be used only when absolutely necessary to protect the life or safety of the individual. In all other circumstances, outpatient arrangements should be utilized. SAMHSA, Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic (revised May 7, 2020), https://www.samhsa.gov/sites/default/

files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf (attached to this Memorandum as Exhibit 18). Defendants have not heeded this call.

Accordingly, Plaintiffs seek a preliminary injunction requiring, in addition to improved practices within the hospitals, that Defendants change their approach to discharges. As Plaintiffs' experts urge, Defendants should promptly complete a clinical review of every patient at CVH and WFH to determine whether it would be feasible, under present circumstances, to discharge the patient. According to Plaintiffs' experts, "there are individuals who could be discharged without posing significant safety risks." Canavan/Jones Decl. ¶ 21.

The details of the clinical review Plaintiffs seek are more fully explained below. At its core, the clinical review would "identify those who can be discharged, determine what supports would be needed, and implement strategies to effectuate these plans." Canavan/Jones Decl. ¶ 22. In so doing, "DMHAS should apply a different standard than it would in ordinary times and should focus on such basic questions as where the person can live, have access to food and needed medication, and take appropriate COVID precautions, with available assistance, if necessary, without being a danger to self or to others." *Id.* The review should be conducted by professionals with extensive knowledge of the community service system and by staff who could identify family and friends willing to provide the patient housing and other support during the pandemic. Canavan/Jones Decl. ¶¶ 22, 25.

A. The Risks Posed by COVID-19

Plaintiffs, indeed all residents of the State of Connecticut, are facing extraordinary risks caused by the coronavirus pandemic. As of June 8, 2020, there were approximately 1.939 million confirmed cases of COVID-19 and 110,375 deaths in the U.S., with 17,919 new cases and 475 new deaths on June 8 alone. Centers for Disease Control and Prevention, *Cases, Data, Surveillance*, available at https://cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (last visited June 8, 2020). As of June 8, Connecticut has suffered 44,092 infections and 4,084 COVID-19 deaths, including 124 new cases and 13 new deaths occurring on that date. https://portal.ct.gov/Coronavirus/COVID-19-Data-Tracker (last visited June 8, 2020). Despite its small size, Connecticut has incurred more deaths than some significantly more populous states, including Texas, Florida, and Ohio, and even more than some countries. *Id*. (last visited June 6, 2020). On a per capita basis, Connecticut's death rate, 1,231 per 100,000, ranks sixth in the nation. Center for Disease Control and Prevention, *"Death* *rates from coronavirus (COVID-19) in the United States as of June 8, 2020 by state,"* available at https://www.cdc.gov/covid-data-tracker/index.html (last visited June 8, 2020). As discussed above, the risks posed by the pandemic are even higher for Connecticut's citizens in the tightly confined spaces of CVH and WFH. Yet, Defendants have not taken needed steps to protect the safety and health of these individuals.

B. The CDC's Guidelines for Protecting Against Transmission of COVID-19.

The CDC has issued a variety of guidance on limiting the spread of this highly communicable virus. Central to its guidance is the recommendation to practice social distancing, i.e., staying six feet away from others. Frequent hand washing and disinfecting commonly used surfaces on a regular basis are also critical. Centers for Disease Control and Prevention, *How to Protect Yourself and Others*, https://www.cdc.gov/coronavirus/ 2019-ncov/prevent-getting-sick/prevention.html (attached to this Memorandum as Exhibit 11).

The CDC has issued specific guidelines on addressing COVID-19 in nursing homes and other long-term care facilities. *See, e.g.*, *Key Strategies to Prepare for COVID-19 in Long-term Care Facilities*, https://www.cdc.gov/ coronavirus/2019-ncov/hcp/long-term-care-strategies.html (attached to this Memorandum as Exhibit 12) *Preparing for*

COVID-19 in Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html (attached to this Memorandum as Exhibit 13). *Testing Guidance for Nursing Homes*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html (attached to this Memorandum as Exhibit 15). Experts agree that these guidelines should be followed in inpatient psychiatric facilities. Manian Decl. at ¶ 10.

Following these CDC guidelines for COVID-19, which constitute "minimally acceptable professional practice," is "essential" for protecting Plaintiffs' safety and health. Manian Decl. ¶ 10. The CDC guidelines require the following steps once COVID-19 has been identified in a facility *or* achieves widespread community transmission, both of which have been present at CVH and WFH and in Connecticut for months:

1. Enforce social distancing among residents;
2. Cancel all groups activities and communal dining;
3. Ensure all residents wear a cloth face covering whenever they leave their room or are around others;
4. Ensure all staff wear a facemask or cloth face covering while in the facility; and

5. If COVID-19 is identified in the facility, restrict all patients to their rooms and have staff wear all recommended PPE regardless of symptoms on the affected unit.

Centers for Disease Control and Prevention, *Key Strategies to Prepare for COVID-19 in Long-term Care Facilities*, Exh. 12.

In addition, hand washing with soap and water, covering of coughs and sneezes, daily cleaning and disinfecting of frequently touched surfaces, and monitoring of health status must be maintained. Centers for Disease Control and Prevention, *How to Protect Yourself and Others,* Exh. 11. Manian Decl. ¶¶ 15, 17 (residents should have ‘ready access to proper hand hygiene” and facilities “should enforce a schedule for regular cleaning and disinfection of shared equipment, and high-touch surfaces in rooms and common areas”).

The guidelines on *Preparing for COVID-19 in Nursing Homes* also require enforcing social distancing, cancelling group activities, and face masks for staff and face coverings for residents. Centers for Disease Control and Prevention, *Preparing for COVID-19 in Nursing Homes*, Exh. 13. In addition, they call for:

1. A plan for “testing residents and healthcare personnel” with the capacity to perform testing of “all residents and HCP [health care

personnel, i.e. staff],” as well as a “procedure for addressing residents or HCP who decline or are unable to be tested [i.e., isolation and quarantine].

2. Hand hygiene supplies in every resident room; tissues and trash cans in common areas and patient rooms; and environmental cleaning and disinfection of frequently touched surfaces in resident rooms and common areas.

The CDC provided detailed guidance on testing in nursing homes, including: screening staff for fever and COVID-19 symptoms at the start of their shift and testing any who screen positive; screen and test any resident who exhibits fever or symptoms consistent with COVID-19; test all residents if there is a new confirmed case of COVID-19, including during reopening when there is a suspected or confirmed case in any resident or a confirmed case in any HCP; and, test all residents and staff weekly until the testing identifies no new cases of COVID-19 among residents or staff over at least 14 days.

Centers for Disease Control and Prevention, *Testing Guidance for Nursing Homes*, available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html (attached to this Memorandum as Exhibit 15).

C. Applying the CDC Guidelines to CVH and WFH

1. Testing

SARS-CoV-2 can be transmitted by people without symptoms. Manian Decl. ¶ 6. Staff or patients may have the virus for days with no symptoms, yet be infectious. *Id.* This unique property of SARS-CoV-2 makes it easy for the virus to spread through a population. *Id.* On average, two to three people become infected from each individual infected with SARS-CoV-2 and sometimes many more, resulting in persons described as "super-spreaders." *Id.* Since the virus may be spread by infected persons who are asymptomatic, the only way to know whether there is virus in CVH and WFH is to test. Manian Decl. ¶ 17.

According to Dr. Manian, professional standards require that CVH and WFH perform baseline testing of all residents and staff, and test at least once a week all previously negative *residents and staff* until the testing identifies no new cases of COVID-19 for at least 14 days since the most positive result. Manian Decl. ¶ 16.[1] Defendants have just begun weekly testing of staff, but only on a voluntary basis, and have no plan for regular testing of residents.

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[1] Dr. Manian explains, that when it comes to testing, the CDC Guidance for Nursing Homes is the appropriate professional standard. Manian Aff. ¶ 11

Despite the obvious importance of testing in controlling the spread of the virus, as of late May only some 600 of 1,000 staff at CVH and WFH had been tested. *See* DMHAS News Releases for May 26 and May 29, 2020, available at https://portal.ct.gov/DMHAS-COVID-19. Patient testing was very limited until May 13. Litsky Aff. ¶ 36. And as testing has become more available in the past two weeks, the number of confirmed infections has continued to increase, demonstrating that the failure to take comprehensive protections a month ago has contributed to several patients' deaths and an increase in the number of staff and patients becoming infected. See, DMHAS periodic reports at https://portal.ct.gov/DMHAS-COVID-19.

Defendants' practices are contrary to accepted professional norms for fighting COVID-19. *See* Manian Decl. ¶ 16.

2. Personal Protective Equipment

According to Plaintiffs' expert Dr. Farrin Manian, staff in CVH and WFH "should have access to PPE" and "should always wear a face mask while they are in the healthcare facility." Manian Decl. ¶ 14. Residents "should be encouraged to routinely wear a cloth face covering" as appropriate and those with "significant exposure to COVID-19 or suspected of having COVID-19 should wear a face mask when outside their rooms." *Id*. at 15.

Defendants delayed implementing such guidelines and have not ensured that they are practiced consistently or that residents are encouraged to wear masks. Ardizzone Aff. ¶¶ 18, 32; Litsky Aff. ¶ 33. DMHAS mandated the use of masks by staff at CVH and WFH on April 10, 2020, stating that "there is growing evidence of transmission risk from infected persons without symptoms or before the onset of recognized symptoms." DMHAS Protocol for Quarantine and Isolation, "*PPE Use: General Guidelines for Use of Face Masks*," May 17, 2020, available at https://portal.ct.gov/DMHAS-COVID-19. Until April 23, 2020, masks were not even *offered* to patients in either hospital, and to this day they are not required as a matter of practice. Affidavit of Carson Mueller ¶ 34 (May 18, 2020) ("Mueller Aff."); Affidavit of Gail Litsky ¶ 14 (May 18, 2020) ("Litsky Aff."); Affidavit of Vincent Ardizzone ¶ 17 (May 18, 2020) ("Ardizzone Aff."). When patients asked for masks, they were refused. Litsky Aff. ¶ 14.

After April 23, masks were finally made available for patients to wear on a voluntary basis, without regard to the impact on all patients from a failure of some to wear them. On one unit at WFH, Dutcher North 2, staff offered no encouragement to use the masks, nor did they provide any education about the importance of wearing them in light of the COVID-19 crisis. Litsky Aff. ¶¶ 17, 36. Use of masks by both staff and patients remains intermittent and unenforced, resulting in ongoing but avoidable risk of infection to both. Ardizzone Aff. ¶¶ 18, 32; Litsky Aff. ¶ 33.

3. Hygiene and Decontamination

Dr. Manian states that all residents "should have ready access to proper hand hygiene within the facility." Manian Decl. ¶ 15. In addition, facilities should enforce a schedule for regular cleaning and disinfection of shared equipment and high-touch surfaces in rooms and common areas (including shower knobs, curtains, and bathroom surfaces) with an EPA-registered, hospital-grade disinfectant. *Id*. at ¶ 17. "Ready access to proper hand hygiene" requires providing hand sanitizer to patients, with supervision if needed, and that all patients be taught about infection control strategies. Canavan/Jones ¶ 14.

Patient testimony indicates that proper hygiene and decontamination practices are not being consistently followed. Even after patients began to test positive, maintenance staff on did not thoroughly clean Dutcher South 3, where 15 men live there. Mueller Aff. ¶ 39. All of the men on that unit use the same bathroom, with several men using the two showers, sinks, urinals, and toilets at the same time. *Id.*at ¶12. On another unit, Dutcher

North 3, 22 men share a shower room and restroom, Ardizzone Aff. ¶ 15, making it impossible to clean the fixtures and surfaces between each use by individual patients.

On Dutcher North 3 and Dutcher South 3, maintenance staff do not work on the weekend, so soap dispensers in the bathroom are not replaced when they become empty. Ardizzone Aff. ¶ 16; Mueller Aff. ¶ 39. On Dutcher South 3, a patient asked that a stethoscope and pulse oximeter be sanitized before they were used to take his vitals. His request was viewed by staff as “oppositional.” Mueller Aff. ¶ 38. When patients asked for hand sanitizer, the request was denied because the administration considered the risk that patients would ingest the alcohol-based product more serious than the risk of infection or death. Ardizzone Aff. ¶16; *See* Mueller Aff. ¶ 47.

4. Social Distancing

Although it is a critical strategy for reducing the spread of COVID-19 in CVH and WFH, Manian Decl. ¶ 12, social distancing is not part of the protocol at WFH or CVH in any meaningful way. Defendants do not appear to dispute that social distancing, as described by Dr. Manian, is not being practiced at WFH or CVH.

Patient testimony provides examples: using an elevator in which up to 10 people crowd in, walking in a group down a narrow stairwell, patients from several units eating together in a dining room with staff. Mueller Aff. ¶ ¶ 13, 14. When the patients on the Dutcher North 2 unit were quarantined after one of the unit residents tested positive, they were directed to eat on the unit under circumstances in which social distancing could not be observed. Litsky Aff. ¶ 26

On March 15, 2020, Governor Lamont issued an order restricting visits to DMHAS facilities, including CVH and WFH. *See* Exec. Order 7C, His Excellency Ned Lamont, State of Connecticut (March 15, 2020), available at https://portal.ct.gov/Coronavirus/Pages/Emergency-Orders-issued-by-the-Governor-and-State-Agencies. Yet even as efforts were made to reduce visitors, hospital staff were working double shifts on *different* units, including a quarantined unit, *see* Litsky Aff. ¶ 27), increasing the number of individuals going onto units and interacting with patients.

While it may be more challenging to achieve social distancing in congregate facilities compared to the community, it is necessary to protect the Plaintiffs and should be implemented to the maximum extent possible. Manian Decl. ¶ 12. To effectuate social distancing, CVH and WFH should develop a plan to move all patients into single-bed sleeping rooms or into rooms with sufficient space to allow sleeping in beds that are at least six feet apart. Canavan/Jones Decl. ¶ 14. In addition, patients should be taught social distancing and other infection control strategies. Id. at ¶ 13. Meals should be delivered so that all patients could eat in a socially distanced manner. Id at ¶ 10. The number of people using elevators at one time be limited and/or an alternative such as a stairway be permitted. Id at ¶ 11.

CVH and WFH have failed to implement social distancing on units. No education is provided to patients about the importance of social distancing. No accommodations in living areas or adjustments in eating routines are undertaken to promote social distancing. Despite the obvious transmission threat the virus poses, almost all patients on every unit in CVH and WFH live in close contact with 15-20 other patients and 5-10 staff. Amended Compl. ¶ 43. Mueller Aff. ¶ 7. They share bathroom facilities and use those facilities simultaneously. *Id.* Ardizzone Aff. ¶ 15. They eat together, either on the units or in a communal dining room. *Id. See* Ardizzone Aff. ¶¶ 19.20; Mueller Aff. ¶¶ 10,11. Patients sleep in the same room with other patients, and their beds are closer than the required social distance of six feet. Mueller Aff. ¶ 21.

"Facilities should reduce their census as soon as possible to enable social distancing of residents as needed." Manian Decl. at ¶ 14. This is an essential strategy both to allow social distancing and to reduce the risk of infection and death. Census reduction can be done in two basic ways: stopping new admissions and increasing discharges. Manian Decl. ¶¶ 14 and 20.

The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has said that, during the pandemic, inpatient psychiatric care should be used only when absolutely necessary to protect the life or safety of the individual. In all other circumstances, outpatient arrangements should be utilized. SAMHSA, Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic (revised May 7, 2020), https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf (attached to this Memorandum as Exhibit 18). Similarly, CDC Guidelines instruct nursing facilities to "[c]onsider temporarily halting admissions to the facility, at least until the extent of the transmission can be clarified and interventions can be implemented." Centers for Disease Control and Prevention, *Responding to Coronavirus (COVID-19) in Nursing Homes*, at 3, available at https://www.cdc.gov/coronavirus/2019-

ncov/hcp/nursing-homes-responding.html (attached to this Memorandum as Exhibit 14).

Dr. Canavan and Elizabeth Jones concur that distancing is essential and that it can and should be accomplished by limiting admissions and accelerating discharges. They state that admissions should be limited by stopping most civil admissions, discouraging forensic admissions (including individuals admitted for competency restoration or after being found not guilty by reason of insanity) and working closely with the Superior Court to ensure diversion to other settings "while taking into account the current situation and balancing risk." Canavan/Jones Decl. ¶¶ 15-16. They opine that WFH should follow its own policies for maintaining patients on "temporary leaves" in the community during this emergency and return only patients who present the highest level of risk. Further, DMHAS should make use of other hospitals, crisis services, transitional housing and respite services to prevent readmissions of individuals under civil commitment. *Id.* ¶¶ 18-19.

Since admissions have already been reduced, through the actions of courts, the most important strategy for implementing social distancing is accelerating discharges. To accelerate discharges in light of the current crisis, "DMHAS should develop a plan to promptly assess all residents for discharge, identify those who can be discharged, determine what supports would be needed, and implement strategies to effectuate these plans." It should "apply a different standard than it would in ordinary times," focusing on whether the person has a place to live, has access to food and needed medication, and can take appropriate COVID precautions with available assistance in the community without being a danger to self or others. *Id*. ¶ 22. Evaluations "should identify potential community-based supports and wherever possible, recommend discharge." *Id.* ¶ 24. Individuals who may have family and friends who might be able to take them in should be identified and appropriate supports offered, and any available capacity in community programs (including temporary housing) should be considered. *Id.* ¶ 25. To expedite discharge planning, community providers should be included as part of the assessment process and assist in discharge planning." *Id.*

Despite the urgency of taking these actions, Defendants have failed to take even preliminary steps to identify patients who can safely return to the community, or to granting temporary leave or conditional discharges to those patients for whom such actions would be appropriate. Instead, patients at CVH and WFH continue to be unnecessarily and unsafely confined in small spaces, contrary to professional standards.

Beginning in March, temporary leaves have been canceled. Two patients who were already in the community on temporary leaves were brought back to WFH, making the hospital more crowded and increasing the risks to those two patients. Mueller Aff. ¶27.

CVH and WFH continue to admit new patients. While Superior Court and Probate Courts have operated in a limited manner after onset of the pandemic, commitments continue. If no effort is made to increase discharges and temporary leaves for appropriate individuals, the population of the units will continue to grow, making it increasingly difficult to prevent the spread of contagion. Defendants' ongoing failure "to reduce the number of people hospitalized as safely and quickly as possible given the risks of COVID-19 is inconsistent with the exercise of reasonable professional judgment." Canavan/Jones Decl. ¶ 25.

III. LEGAL STANDARD

To obtain a preliminary injunction that results, as here, in the alteration of the status quo, the moving party must show: "(1) irreparable harm and (2) either (a) likelihood of success on the merits or (b) sufficiently serious questions going to the merits to make them fair ground for litigation plus a balance of hardships, tipping decidedly in favor of the moving party." *Oneida Nation of New York v. Cuomo,* 645 F.3d 154, 164 (2d Cir. 2011) (quoting *Monserrate v. N.Y. State Senate,* 599 F.3d 148, 154 (2d Cir. 2010)). In addition, the moving party must show that the preliminary injunction is in the public interest. *Id.* (citing *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 19-20 (2008)).

IV. ARGUMENT

A. Irreparable Harm

In the Second Circuit, a "showing of irreparable harm is the single most important prerequisite in the issuance of a preliminary injunction." *Faiveley Transp. Malmo AB v. Wabtec Corp.,* 559 F.3d 110, 118 (2d Cir. 2009*); Basank v. Decker*, 2020 WL 1481503 at *2 (S.D.N.Y. March 26, 2020). The irreparable harm alleged must not be remote or speculative but must instead be actual and imminent. *Grand River Enter, Six Nations, Ltd. v. Pryor,* 481 F.3d 60, 66 (2d Cir. 2007).

There can be no dispute that Plaintiffs face actual, imminent, and ongoing irreparable harm as a result of Defendants' failure to take necessary actions to protect Plaintiffs from COVID-19. Plaintiffs' risk of being infected by and transmitting the virus is greatly increased by living in the congregate and confined setting of a psychiatric hospital. Manian Decl. at ¶4. CVH and WFH "provide the elements for a 'perfect Covid-19 storm,' with its attendant complications and mortality." *Id.* At least five patients have died, dozens more have been infected, and as expert testimony demonstrates, Plaintiffs are at "imminent risk to their health, safety and lives." *Henrietta D. v. Giuliani*, 119 F.Supp.2d 181, 214 (E.D.N.Y 2000); *Barbecho v. Decker,* 2020 WL 1876328 at *6 (S.D.N.Y. April 15, 2020). "A substantial risk of serious illness or death has been found to constitute irreparable harm." *Martinez-Brooks v. Easter,* 2020 WL 2405350 (D. Conn. May 12, 2020) at 57, *citing Innovative Health Systems, Inc. v. City of White Plains,* 117 F.3d 37, 43-44 (2d Cir. 1997).

Accordingly, Plaintiffs have met their burden of demonstrating irreparable harm.

B. Success on the Merits

Defendants have violated Plaintiffs' rights under the Fourteenth Amendment in their failure to adequately protect Plaintiffs from the risks associated with COVID-19. As explained in more detail below, Defendants' ongoing failure to provide Plaintiffs with reasonably safe conditions constitutes a substantial departure from accepted professional judgment in violation of the Fourteenth Amendment.

1. *Defendants Are Violating Plaintiffs' Fourteenth Amendment Guarantees to Reasonably Safe Conditions of Confinement.*

The Due Process Clause of the Fourteenth Amendment protects the right of Plaintiffs, as persons in a state psychiatric hospital, to be held in safe conditions, free from unreasonable risks of harm. *Youngberg v. Romeo,* 457 U.S. 307 (1982). "If it is cruel and unusual punishment to hold convicted criminals in unsafe conditions, it must be unconstitutional to confine … [those] who may not be punished at all – in unsafe conditions." *Id.* at 315-316. *See also Ingraham v. Wright*, 430 U.S. 651, 673 (1977) (safety is a "historic liberty interest").

The Second Circuit has recognized that *Youngberg's* right to safe conditions extends to both voluntary and involuntary residents of state mental health facilities. *Society for Good Will to Retarded Children v. Cuomo,* 737 F.2d 1239, 1246 (2d Cir. 1984). Voluntary residents, the Second Circuit declared, "are entitled to rights of personal freedom at least as great as those of prison inmates." *Id.* ". . . [Once] it chose to house those voluntary residents, thus making them dependent on the state, it was required to do so in a manner that would not deprive them of constitutional rights." *Id., citing Youngberg,* 457 U.S. at 317; *Perry v. Sindermann*, 408 U.S. 593, 597 (1972); see also, *Helling v. McKinney*, 509 U.S. 25, 33 (1993) (even the criminally convicted may not be subjected to "a condition of confinement that is . . . very likely to cause serious illness and needless suffering.”).

The standard for determining whether Defendants have violated Plaintiffs’ rights under *Youngberg* is whether Defendants’ decisions constitute “such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment.” *Youngberg*, 457 U.S. at 323. Such a departure is demonstrated when the care provided residents is substantially below the standard of care. *Messier v. Southbury Training School*, 562 F. Supp. 2d 294, 301 (D. Conn 2008). Deference is not owed to decisions made by individuals who are not qualified professionals. *Id.* at 300. If CVH and WFH did not have a board-certified infectious disease physician on staff or consulting to make determinations about mitigation strategies, the Court need not give deference to an unqualified administrator or physician. *Id.* As discussed below and shown in the affidavits submitted by Plaintiffs and their experts, Defendants have violated this standard in several key ways.

a. The CDC’s COVID-19 Guidance Constitute Professional Standards that Must Be Met in Psychiatric Hospitals.

The CDC standards constitute the professional standards that apply to combatting COVID-19 in psychiatric hospitals like CVH and WFH. Manian Decl. ¶ 11. Infectious disease specialists and healthcare epidemiologists routinely look to the CDC for guidance. *Id*. ¶ 10. Following the CDC's guidelines is crucial during the current pandemic. With a virus that has never been seen before, "reliance on the wisdom and knowledge in the experts of the field of virology, epidemiology, and disease transmission is essential to minimizing the spread of SARS-CoV-2 in high risk settings." *Id.* The CDC guidelines are "essential to the professional practice of healthcare epidemiology and infection control and prevention" at CVH and WFH. *Id.* Departure from the CDC guidelines at these facilities "places patients and staff—and potentially the community at large—at risk of a preventable disease and death." *Id.*

In rendering his opinions, Dr. Manian relied primarily on CDC guidelines. He also took into account other prominent national guidelines, including those of the American Health Care Association, the National Center for Assisted Living, and the Substance Abuse and Mental Health Services Administration, as well as his own experience as an infection control officer and healthcare epidemiologist for nearly 30 years. *Id*. ¶ 11.

b. Defendants Have Substantially Departed from Professional Standards.

Social Distancing. Social distancing is a key strategy for infection control. “Patients should maintain at least six feet distance from each other and staff. This practice should apply to all aspects of life within the state psychiatric facilities, including interaction with other residents, dining, and distance between sleeping quarters.” Manian Decl. ¶ 13.

Defendants have not implemented social distancing, as described by Dr. Manian, at CVH and WFH. Their alternative practice, which they call “unit segregation,” is not an acceptable alternative without social distancing and census reduction. Manian Decl. ¶ 23 (“Separating activities to occur only within each unit, allowing for COVID-19 and non-COVID-19 units, is not an adequate means of infection control. It is a substantial departure from the basic science of infection control and prevention to not require. . .social distancing in places such as bedrooms, dining rooms, group therapy and day hall. . .”)

All three of Plaintiffs’ experts concur that, if social distancing cannot be consistently and successfully implemented at CVH and WFH, census reduction, including discharges, is imperative and must be pursued. Social distancing could be accomplished if there were fewer people on each unit. Manian Decl. ¶ 14, Canavan/Jones Decl. ¶ 15-25.

Census Reduction. According to Dr. Manian, Dr. Canavan, and Elizabeth Jones, it is imperative, for the safety and health of Plaintiffs, that Defendants aggressively pursue census reduction. Fortunately, admissions to CVH and WFH are being limited by the courts. To reduce census from present levels, discharging patients who could be safely served in the community is required. As Dr. Canavan and Elizabeth Jones stress, the review should apply a different standard than in ordinary times, focusing on basic questions such as whether the person has a place to live, has access to food and needed medication, and can take appropriate COVID precautions with available assistance and live in the community without being a danger to self or others. Canavan/Jones Decl. ¶ 22.

There is no indication that Defendants have identified social distancing or census reduction as necessary to mitigate patient infection and death. Nor do they appear to have considered that some patients at CVH and WFH are elderly or have health conditions that put them at high risk. Manian Decl. ¶ 8. Plaintiff Vincent Ardizzone has Stage IV prostate cancer and is currently undergoing radiation therapy. Ardizzone Aff. ¶ 9. Plaintiff Gail Litsky has asthma, high blood pressure, high cholesterol, pre-diabetes, and is overweight. Litsky Aff. ¶ 8. Plaintiff Barbara Flood is 64 years old and receives weekly dialysis for kidney failure. Gudis Aff. ¶ 14.

According to Plaintiffs' experts, "there are individuals who could be discharged without posing significant safety risks." Canavan/Jones Decl. ¶ 18. One possible candidate is WFH resident Francis Clarke is a 72-year-old honorably discharged veteran who was arrested for driving under the influence and on a suspended license. He was found not competent to stand trial and sent to WFH in November 2019 for restoration to competency on minor charges. He has never been committed or treated for a mental illness until now. As far as Plaintiffs are aware, Defendants are not taking steps to secure his discharge.

Despite actual knowledge that these and other CVH and WFH residents face significant risk from the COVID-19 virus, Defendants have failed to undertake a program of census reduction, including especially by accelerating discharges.

Testing. Defendants' failure to have a plan for testing of residents and to conduct repeat testing of residents following a confirmed case of COVID-19 is a substantial departure from professional standards. As Dr. Manian and the CDC guidelines make clear, professional standards require a plan for testing all residents and staff and the capacity to perform such testing. While Defendants have finally begun testing all staff on a weekly basis, they lack an acceptable plan for testing residents. Professional standards require that Defendants perform baseline testing of all residents and staff, and also test at least once a week all previously negative *residents and staff* until the testing identifies no new cases of COVID-19 for at least 14 days after the most recent positive result. Manian Decl. ¶ 16; *Testing Guidance for Nursing Homes*, Exh. 15.

Such testing of residents is critical to prevent transmission of the virus. Staff or patients may be infectious for days while exhibiting no symptoms, allowing the virus to spread rapidly through these facilities. *Id.* ¶ 6. Defendants have not conducted weekly testing of residents following confirmed cases at CVH and WFH. Even today, although some patients are in quarantine in CVH, residents are not being tested weekly. This is a substantial departure from professional judgment that puts residents at grave risk of harm.

PPE. Defendants' failure to ensure that staff consistently wear face masks and to encourage residents to wear face masks constitutes a substantial departure from professional judgment. Staff in CVH and WFH "should always wear a face mask while they are in the healthcare facility." Manian Decl. ¶ 14. Residents "should be encouraged to routinely wear a cloth face covering" as appropriate and those with "significant exposure to COVID-19 or suspected of having COVID-19 should wear a face mask when outside their rooms." *Id*. at 15. Defendants initially delayed in implementing these guidelines, and did not even offer masks to patients in either hospital until April 23, 2020. Mueller ¶ 34. When patients asked for masks, they were refused. Litsky Aff. ¶ 14.

While staff are now required to wear masks and patients are now offered one mask per week, Defendants still do not ensure that PPE guidelines are practiced consistently or that residents are encouraged to wear masks. Ardizzone Aff. ¶¶ 18, 32; Litsky Aff. ¶ 17, 32, 33, 36. Moreover, staff continues to work on multiple units, as need dictates. Litsky Aff. ¶ 23. Use of masks by both staff and patients remains intermittent and unenforced, resulting in ongoing but avoidable risk of infection to both. Ardizzone Aff. ¶¶ 18, 32; Litsky Aff. ¶ 33. This failure to follow professional standards violates plaintiffs' Fourteenth Amendment rights.

Hygiene and Decontamination. Defendants' failure to ensure that CVH and WFH are appropriately decontaminated and that patients have access to proper hand hygiene during the pandemic is a substantial departure from professional standards.

Professional standards require that all residents "should have ready access to proper hand hygiene within the facility," and that facilities should enforce a schedule for regular cleaning and disinfection of shared equipment and high-touch surfaces in rooms and common areas (including shower knobs, curtains, and bathroom surfaces) with an EPA-registered, hospital-grade disinfectant. Manian Decl. at ¶¶ 15, 17. "Ready access to proper hand hygiene" requires providing hand sanitizer to patients, with supervision if needed, and that all patients be taught about infection control strategies. Canavan/Jones Decl. ¶ 14.

Yet Defendants have failed to ensure that hygiene and decontamination standards are consistently followed. Even after patients began to test positive, maintenance staff did not thoroughly clean Dutcher South 3, where 15 men live and share a bathroom, with several men using the two showers, sinks, urinals, and toilets at the same time. Mueller Aff. ¶¶ 12, 39. On another unit, Dutcher North 3, 22 men share a shower room and restroom, Ardizzone Aff. ¶ 15, making it impossible to clean the fixtures and surfaces between each use by individual patients. On each of those units, soap dispensers sometimes go empty on the weekends, because maintenance staff do not work on weekends. Ardizzone Aff. ¶ 16; Mueller Aff. ¶ 39. On Dutcher South 3, a patient's request that a stethoscope and pulse oximeter be sanitized before they were used to take his vitals was considered "oppositional" and denied. Mueller Aff. ¶ 38. Patients' requests for hand sanitizer have been denied because the administration considered the risk of patients ingesting the alcohol-based product more serious than the risk of infection or death. Ardizzone Aff. ¶16; *See* Mueller Aff. ¶ 47. These failures to ensure basic hygiene and decontamination practices constitute a substantial departure from professional standards in violation of Plaintiffs' Fourteenth Amendment rights.

2. The Defendants Are Violating the Fourteenth Amendment Right to Safe Conditions for Pre-Trial Detainees.

If, as to some Plaintiffs, Defendants' actions are governed by Fourteenth Amendment standards for the treatment of pre-trial detainees rather than state hospital patients, Defendants have violated these standards as well. The Fourteenth Amendment right of pre-trial detainees to safe conditions is violated when they are subjected to conditions that create an unreasonable risk of serious harm, including to physical health, *Darnell v. Pineiro*, 849 F.3d 17, 30 (2d Cir. 2017), amounting a reckless disregard for safety, i*d.* at 32. There is no requirement of subjective intent: ". . .[T]o establish a claim for deliberate indifference to conditions of confinement under the Due Process Clause of the Fourteenth Amendment, the pretrial detainee must prove that the defendant-official acted intentionally to impose the alleged condition, or recklessly failed to act with reasonable care to mitigate the risk that the condition posed to the pretrial detainee even though the defendant-official knew, or should have known, that the condition posed an excessive risk to health or safety. In other words, "deliberate indifference" should be defined objectively." *Darnell*, 849 F.3d at 35.

The same actions and inactions that violate the *Youngberg* rights of patients at CVH and WFH constitute violations of the right to safe conditions held by pre-trial detainees. As described above, Defendants have failed to adequately protect Plaintiffs from the risks of COVID-19.

Recent court decisions confirm the above analysis. For example, in *Basank v. Decker*, 2020 WL 1481503 (S.D.N.Y. March 26, 2020), the court granted a temporary restraining order for the immediate release of immigration detainees in the Hudson, Bergen, and Essex County Correctional Facilities due to the health risks in these facilities. The court noted that the detainees were likely to succeed on the merits because the facilities were exhibiting deliberate indifference by failing to follow professional standards for protecting the detainees. *Id.* at *2.

C. The Balance of Equities Tips Decidedly in Favor of Plaintiffs, and an Injunction Will Serve the Public Interest.

"Where the Government is the opposing party," the final two factors in the analysis—"the balance of the equities and the public interest—merge." *Martinez-Brooks v. Easter*, 2020 WL 2405350 at *27 (D. Conn. May 12, 2020), *quoting Coronel v. Decker*, 2020 WL 1487274, at *7 (S.D.N.Y. Mar. 27, 2020).

Given the evidence that Plaintiffs, psychiatric patients in state hospitals, are at serious risk including of death, there can be no reasonable dispute that the balance of the equities favors them and that an injunction is in the public interest. "[I]t is always in the public interest to prevent the violation of a party's constitutional rights." *G & V Lounge, Inc. v. Michigan Liquor Control Com'n*, 23 F.3d 1071, 1079 (6th Cir. 1994). *See also Coronel*, 2020 WL 1487274, at *7 ("the public interest is best served by ensuring the constitutional rights of persons within the United States are upheld," *quoting Sajous v. Decker*, 2018 WL 2357266, at *13 (S.D.N.Y. 2018)); *Barbecho v. Decker*, 2020 WL 1876328, at *7 (S.D.N.Y. Apr. 15, 2020); *Doe v. University of Connecticut*, 2020 WL 406356, at *6 (D. Conn. Jan. 23, 2020). "Moreover, the … interest in avoiding serious illness or death must weigh heavily on the scales." *Martinez-Brooks*, 2020 WL 2405350 at *28.

In addition, granting Plaintiffs' motion will serve the larger public interest of reducing the risk of transmission of the COVID-19 virus from the hospitals to the community. Fewer COVID-19 cases – even less of a risk of such cases – at CVH and WFH will benefit staff who enter and leave the facilities on a daily basis, reducing the risk to the community at large. Accordingly, it is clear that Plaintiffs meet the final two factors for granting a preliminary injunction.

V. CONCLUSION

For the reasons above, this Court should grant a preliminary injunction.

The preliminary injunction should be granted on a class basis. The Court should certify a class in order to ensure that all patients at CVH and WFH enjoy the benefits of relief granted in a preliminary injunction. The class seeking a preliminary injunction -- all patients at CVH and WFH – meets the requirements for certification under Rule 23 of the Federal Rules of Civil Procedure. The class is so numerous, about 438 in all, that joinder of all members is impracticable. There are questions of law or fact common to the class, including what the Fourteenth Amendment demands of Defendants and whether Defendants' conduct is a substantial departure from professional standards. The claims of the named plaintiffs are typical of the claims of the class as a whole. The named plaintiffs are represented by competent counsel and will fairly and adequately protect the interests of the class. Defendants have acted or refused to act on grounds that apply generally to the class, so that final injunctive relief is appropriate respecting the class as a whole.

Plaintiffs respectfully request that the preliminary injunction direct Defendants to:

1. Conform their testing protocols to CDC standards,
2. Take steps to ensure that staff consistently wear masks and that Plaintiffs are encouraged and supported in wearing masks including through education,
3. Improve hygiene and decontamination practices,
4. Implement social distancing to the maximum extent possible including by reducing patient census,
5. Undertake the clinical review described above in order to accelerate discharges, and
6. Grant such other or different relief the Court deems appropriate.

Respectfully submitted,
The Plaintiffs
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s/Kirk W. Lowry

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Certificate of Service

On June 8, 2020 a copy of the foregoing **Memorandum in Support of Their Motion for Preliminary Injunction** was filed electronically and served by mail on anyone unable to accept electronic filing. Notice of this filing will be sent by email to all parties by operation of the Court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF System.

s/Kirk W. Lowry__________
Kirk W. Lowry

Wilkes v. Lamont

Exhibit List

Exhibit 1 Dr. Manian Declaration

Exhibit 2 Dr. Jones and Dr. Canavan Declaration

Exhibit 3 Mueller Affidavit

Exhibit 4 Ardizzone Affidavit

Exhibit 5 Litsky Affidavit

Exhibit 6 Clarke Affidavit

Exhibit 7 King Affidavit

Exhibit 8 Gudis Affidavit

Exhibit 9 CT DPH Guidance for LTCFs

Exhibit 10 CMS Nursing Home Reopening Recommendations

Exhibit 11 CDC – How to Protect Yourself

Exhibit 12 CDC – Key Strategies to Prepare for COVID-19 in LTCFs

Exhibit 13 CDC – Preparing for COVID-19 in Nursing Homes

Exhibit 14 CDC – Responding to Coronavirus in Nursing Homes

Exhibit 15 CDC – Testing Guidance for Nursing Homes

Exhibit 16 CDC – Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes

Exhibit 17 CDC – Infection Prevention and Control (IPC) Assessment Tool for Nursing Homes Preparing for COVID-19

Exhibit 18 SAMHSA Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic: March 20, 2020; Revised May 7, 2020

Exhibit 1

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

Thomas Wilkes, et al., On behalf of themselves and all other persons similarly situated, Plaintiffs,	)	Civil No.: 3:20cv594
v.	)	
Ned Lamont, Governor, et al., Defendants.	)	June 6, 2020

Declaration of Dr. Farrin A. Manian, MD, MPH

I, Farrin A. Manian, MD, MPH, pursuant to 28 U.S.C. § 1746, make this Declaration in support of Plaintiff's Motion for a Preliminary Injunction, and state as follows:

1. I am a double board-certified physician in infectious disease and internal medicine by the American Board of Internal Medicine. I received my medical degree from the University of Missouri School of Medicine. I completed my residency in internal medicine and fellowship in infectious disease at Vanderbilt University Medical Center. I received a Masters of Science in Public Health-Epidemiology from the University of Missouri-Columbia. I am a fellow in the American College of Physicians, Society of Healthcare Epidemiology of America, and Infectious Diseases Society of America.

2. I am currently a practicing physician and teach at Massachusetts General Hospital in Boston.

3. I have reviewed the Amended Complaint in *Wilkes v. Lamont* and the affidavits of Vincent Ardizzone, Gail Litsky, Carson Mueller, and Attorney Richard Gudis. I have reviewed publicly available reports from Governor Lamont and the Department of Mental Health and Addiction Services (DMHAS), which report numbers of staff and patients who are laboratory confirmed positive for COVID-19. I reviewed the DMHAS Isolation and Quarantine Protocol and the Whiting Forensic Hospital (WFH) Isolation and Quarantine Protocol. I have reviewed WFH's Emergency Plan. I have reviewed publicly available documents describing Connecticut Valley Hospital (CVH) and WFH. I have reviewed the DMHAS website and the websites for CVH and WFH. I have reviewed the Connecticut Department of Public Health guidance on long-term care facilities (LTCF) and the CDC's guidance for LTCF's and nursing facilities.

Background

4. COVID-19 is caused by severe acute respiratory syndrome coronavirus 2, also known as SARS-CoV-2. This is a recently discovered virus the likes of which none of us in the field of infectious diseases has ever seen before, even after years of practice. SARS-CoV-2 is spread

through respiratory droplets when an infected person sneezes, coughs, or even talks or sings. These droplets contain large numbers of virus particles that put anyone within 6 feet at risk of contracting it through the nose or mouth.

5. In addition to droplet transmission, SARS-CoV-2 has the potential for contaminating environmental surfaces when an infected person comes in contact with them. A susceptible person may contract the virus by touching these surfaces and then touching their mouth, nose, or eyes.

6. In contrast to many other respiratory viruses, however, SARS-CoV-2 can be transmitted by people before the onset of their illness, i.e., for days when they have no symptoms. This somewhat unique property of SARS-CoV-2 makes it easy for the virus to spread through the population. In fact, on average, 2 to 3 people become infected from an individual infected with SARS-Co-2, sometimes many more as there is evidence for some infected persons serving as "super-spreaders." Its relative ease of transmission through the respiratory tract coupled with its contagiousness in the absence of symptoms have facilitated the rapid spread of SARS-CoV-2 throughout the world, hence the current pandemic.

7. As might be expected with many respiratory viruses, the risk of transmission of SARS-CoV-2 is much higher wherever people reside or

congregate in confined spaces, such as cruise ships, prisons, and long-term care facilities, including psychiatric hospitals. Unfortunately, in contrast to the typical "cold" virus, which often causes a self-limited infection with the inconvenience of runny nose for a few days, SARS-CoV-2 causes severe disease in a significant number of patients (approximately 20%), in some cases resulting in a fatal outcome.

8. Mortality from COVID-19 is not evenly distributed within the population. Most who die from COVID-19 are older adults and/or have underlying chronic medical conditions. In the United States, about one-third of deaths from COVID-19 have involved residents or workers of chronic care facilities, where people live in a confined environment and workers move from room to room, at times unknowingly infecting the residents or getting infected themselves. Similarly, facilities where limited physical space forces residents to be in close proximity to each other or staff for long periods of time create an environment conducive to ready transmission of SARS-CoV-2. Such constant close contact, coupled with the presence of risk factors for severe disease (e.g. older age and underlying health problems) among residents, provide the elements for a "perfect COVID-19 storm" with its attendant complications and mortality. That's why doing everything possible to prevent and control the spread of

SARS-CoV-2 within healthcare facilities, including psychiatric hospitals housing vulnerable residents, is of paramount importance.

9. As an infectious disease physician with over 25 years of experience in healthcare epidemiology in a variety of settings (including a mental health facility, a nursing home, and a rehabilitation center), I appreciate the importance of sound and timely infection control practices to prevent and stop outbreaks of disease within healthcare facilities. I have dealt with influenza and norovirus outbreaks within long-term care facilities but I have found that, in many respects, they are no match for the current SARS-CoV-2 pandemic virus.

10. Whether it's dealing with outbreaks or tackling endemic infections within a healthcare facility, infectious disease specialists and healthcare epidemiologists routinely look to the Centers for Disease Control and Prevention (CDC) for guidance. Following the CDC's guidelines is even more crucial during these pandemic times, as the world tries to grapple with a novel virus the likes of which it has never seen before. Now more than ever, reliance on the wisdom and knowledge of the experts in the field of virology, epidemiology, and disease transmission is essential to minimizing the spread of SARS-CoV-2 in high risk settings. CDC guidelines aim to prevent infections, serious harm, and death. Deliberate departure from

these guidelines when dealing with COVID-19 in healthcare facilities, including psychiatric hospitals, places patients and staff-- and potentially the community at large -- at risk of a preventable disease and death. For these reasons, I consider the CDC guidelines essential to the professional practice of healthcare epidemiology and infection control and prevention.

11. In the absence of CDC guidelines specifically relating to the management of COVID-19 in psychiatric hospitals, at the minimum, those pertaining to other long-term care facilities, such as nursing homes, should be used, as recommended by the National Council for Behavioral Health. My opinion herein is based on the CDC guidelines for COVID-19 in nursing homes as well as other national guidelines, such as those of the American Health Care Association, National Center for Assisted Living, and Substance Abuse and Mental Health Services Administration for state psychiatric hospitals, as well as my own experience as an infection control officer and healthcare epidemiologist for nearly 30 years.

Below is a select list of major strategies that I believe must be implemented in order to mitigate the spread of SARS-CoV-2 within CVH and WFH and ensure minimum health, safety, and welfare of patients and staff.

12. **Social distancing**. This is an essential strategy for reducing the overall risk of transmission of SARS-CoV-2 in CVH and WFH. It has been a major strategy in the community as well as nursing homes. Patients in

CVH and WFH should maintain at least six feet distance from each other and staff. This practice should apply to all aspects of life within the state psychiatric facilities, including interaction with other residents, dining, and distance between sleeping quarters. It is recognized that complete compliance with the practice of social distancing as described may not be possible in facilities with traditionally high census within a confined and limited space. In such facilities, it is critical that census reduction and discharge be an integral part of the overall strategy.

13. **Census reduction and discharge**. Facilities should reduce their census as soon and as much as possible to enable social distancing of residents. Priority for discharge should be given to those who are at high risk of complications from COVID-19 after contracting SARS-CoV-2 within the facility. These include older adults and those with chronic health conditions, such as pulmonary or cardiac disease, malignancy, or immunocompromised state. Facilities should immediately evaluate all patients for discharge, expedite the review, and triage patients for discharge as soon as possible, utilizing criteria that considers the serious risk of infection to the patient who remains in the facility against the risks to the patient when out in the community.

14. **Personal protective equipment (PPE) for staff**. Protection of staff working in these facilities should be of paramount importance. In addition to meticulous attention to hand hygiene and standard precautions in the care of residents, staff should have access to PPE, including face masks, respirators (if available and the facility has a respiratory protection program with a trained, medically cleared, and fit tested healthcare provider (HCP)), eye protection (face shield or goggles), gowns, and gloves. In addition, as part of source control efforts, HCPs should always wear a face mask while they are in the healthcare facility. Face cloth may be used, but a face mask is preferred as the mask offers both source control and protection for the wearer against exposure to splashes and spray of infectious material from others. HCPs should wear all recommended PPE for the care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes an N-95 or higher-level respirator (or face mask, if a respirator is not available), eye protection, gloves, and gowns. HCPs should be trained on PPE use, including putting it on and taking it off.

15. **Hand hygiene and wearing of face masks by residents.** All residents should have ready access to proper hand hygiene within the facility. In addition, they should be encouraged to routinely wear a cloth

face covering (if tolerated) when social distancing may be compromised during their daily activities outside their rooms. Residents with significant exposure to COVID-19 or suspected of having COVID-19 should wear a face mask when outside their rooms. Those diagnosed with COVID-19 should be masked whenever others are in the room.

16. **Screening and testing**

a. All HCPs should be actively screened for fever and COVID-19 symptoms at the start of their shift, with testing of those who screen positive. Those who screen positive for COVID-19 should stay off of work until test results are known. Those who test positive should be excluded from work until they meet return-to-work criteria.

b. Baseline testing of all residents and HCPs should be performed.

c. Repeat testing of any resident or HCP who subsequently develops fever or symptoms consistent with COVID-19 should be performed.

d. Repeat testing (e.g., at least once a week) should be performed of all previously negative residents until the testing identifies no new cases of COVID-19 among residents or HCPs over at least 14 days since the most recent positive result.

e. Repeat testing (e.g., at least once a week) should be performed of all previously negative HCPs until testing identifies no new cases of COVID-19 among residents or HCPs over at least 14 days since the most recent positive result.

f. Screening and testing should be implemented in addition to the other infection prevention and control practices described herein.

17. **Environmental cleaning and decontamination**. Facilities should enforce a schedule for regular cleaning and disinfection of shared equipment, and high-touch surfaces in rooms and common areas (including shower knobs, curtains, and bathroom surfaces) with an EPA-registered, hospital-grade disinfectant.

18. **Limiting visitors**. Visitors should be strictly limited to the end-of-life situations.

19. **Stopping new admissions**. This strategy should be implemented immediately when there is evidence for ongoing transmission of SARS-CoV-2 within the facility or when adequate staffing levels and PPE to manage COVID-19 positive resident cannot be assured. If an admission is mandated by law, the new admission should be confined to a separate room and monitored for signs of COVID-19 for fourteen days.

20. **Resident cohorting.** Facilities should identify a separate unit for residents with confirmed COVID-19. The unit should be physically separated from other rooms or units housing residents without confirmed COVID-19. Only dedicated HCP should be assigned to work on the COVID-19 care unit. Residents with new-onset suspected or confirmed COVID-19 should be isolated and cared for using all recommended COVID-19 PPE. If possible, each resident should be in a separate room. Residents confirmed to have COVID-9 should be transferred to the designated COVID-19 care unit. Roommates of residents with COVID-19 should be considered exposed and potentially infected and should not share a room with other residents until they test negative or remain asymptomatic for 14 days after their last exposure. Suspected COVID-19 residents should have vital signs, oxygen saturation via pulse oximetry and a respiratory exam three times a day. Residents should be restricted to their rooms as much as possible. Testing should be consistent with paragraph 17 above. (CDC Guidelines for Responding to Coronavirus [COVID-19] in Nursing Homes.)

21. **Overseeing the infection control program**. Facilities should identify and assign one or more individuals with training in infection control

to provide permanent on-site management of the infection prevention and control program for COVID-19 and beyond.

22. **Collaboration with the State of Connecticut Department of Health.** Facilities should seek on-going guidance from the state DPH in developing and implementing appropriate infection control and prevention plans.

During the pandemic, social distancing and other basic infection control and prevention measures should be implemented even in psychiatric care units designated as "non-COVID-19" units

23. Separating activities to occur only within each unit, allowing for COVID-19 and non-COVID-19 units, is not an adequate means of infection control. It is a substantial departure from the basic science of infection control and prevention to not require all residents and staff to follow basic COVID-19 mitigating principles of hand hygiene, social distancing in places such as bedrooms, dining rooms, group therapy and day hall, staff wearing face masks and residents wearing cloth face coverings in "COVID-negative" units for several reasons:

1. As described in paragraph 7, long-term care facilities, including psychiatric hospitals, provide a fertile ground for transmission of respiratory diseases such as COVID-19 by housing residents in congregate within confined spaces.

2. As described in paragraph 12, per CDC, social distancing is a cornerstone of reducing transmission of respiratory diseases such as COVID-19.

3. Key strategies set forth by the CDC to prevent spread of COVID-19 in long-term care facilities include enforcement of social distancing among residents, cancelling all group activities and communal dining, and ensuring that all residents wear a cloth face covering for source control whenever they leave their room or are around others. No distinction is made between "COVID-positive" and "COVID-negative" units during the pandemic as relates to implementation of these mitigating measures when social distancing and wearing proper face cover or facemasks is required of everyone in the community.

4. As relates to designated units, "COVID-negative" does not mean "COVID-impervious." As long as new cases of COVID-19 are being diagnosed in the community, long-term care facilities remain vulnerable to the importation of the virus from the outside world, particularly through unsuspected infected healthcare providers who live in the community,

visitors, or residents who may need to temporarily leave the unit to seek medical care.

5. The risk of importation of the virus into the unit exists as long as there is ongoing transmission of COVID-19 in the community, given the known limitations of screening based on symptoms and signs alone---as many contagious persons have no symptoms or signs of the disease---and known limitations of periodic testing for the virus by nasopharyngeal sampling, as a single negative test can miss 30% or more of infected and potentially contagious cases.

6. Protecting the health of the residents should be of paramount importance in psychiatric hospitals since these long-term care facilities often house older residents and those who have chronic medical conditions that increase their risk of severe disease from COVID-19, including death. Their risk of contracting COVID-19 in these facilities should be mitigated by enforcing social distancing and other basic infection control and prevention measures during the pandemic.

7. Protecting the health of healthcare providers who work in psychiatric hospitals should be of paramount importance since

they may have chronic medical conditions that increase their risk of severe disease from COVID-19, including death. In addition, they may in turn spread the infection from the unit into the community where they live. Their risk of contracting COVID-19 in the facility should be mitigated by adhering to standard infection control and prevention measures and enforcing social distancing, among other measures, among the residents.

8. CMS guidelines (Center for Clinical Standards and Quality/Quality, Safety & Oversight Group) on Nursing Home Reopening for state and local officials (May 18, 2020) retain the practice of social distancing, wearing of face covers or facemasks and proper hand hygiene as a constant throughout the reopening phases. Even under phase 3, the most relaxed reopening phase, the guidelines allow for group activity among asymptomatic or COVID-19-negative residents only when social distancing can be maintained with appropriate hand hygiene and use of cloth face covering or face masks.

9. A single case of a new facility-acquired COVID-19 in a resident on a "COVID-negative" unit will have serious

ramifications and will require prompt outbreak investigation (including extensive testing) and quarantine of all exposed residents, as well as possible furlough of exposed healthcare providers, all of which can result in severe disruption in the everyday operation of the entire unit and threaten the mental and physical health of its residents.

CMS Reopening Guidelines for Nursing Homes should be followed by CVH and WFH

24. As long-term care facilities, CVH and WFH must, at the minimum, follow the May 18, 2020 CMS Guidelines for Nursing Home Reopening for COVID-19. The CMS guidelines outline seven factors that the state must consider before relaxing any of the standards required in this statement. These factors include whether Connecticut is still experiencing community transmission, whether there are any new facility-onset cases in residents or staff, staffing shortages within the facility, access to universal testing and weekly retesting of residents and staff, access to universal source control (i.e., face covering or face mask), access to PPE for staff, and whether Middlesex Hospital has adequate capacity to accept transfers from these facilities. The CMS standard generally requires the facility to stay at least fourteen days behind the state at each

phase of reopening. The facility must spend a minimum of fourteen days in each phase of reopening with no new COVID-19 cases, prior to entering the next phase. If a resident contracts COVID-19 within the facility without a prior hospitalization within the last 14 days, the facility must go back to the highest level of mitigation in the guidelines and start the phases over. Future decisions regarding the timing of the elimination of social distancing and other infection control and prevention practices within these facilities should only be made with guidance and input from the Connecticut State Department of Health.

Potential impact of ongoing disease transmission within a facility on the community at large

25. COVID-19 is a major public health threat with consequences that extend far beyond the four walls of any given healthcare facility. Ongoing spread within a facility not only affects the health and well-being of its patients/residents and its staff but also their families and other contacts within the community. To “flatten the curve” of the current COVID-19 epidemic in this country, we need to stop the transmission of SARS-CoV-2, irrespective of the setting or place where people live. It is imperative for all healthcare facilities, including state psychiatric hospitals, to do their best in protecting the health of the population.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: June 6, 2020

Farrin A. Manian MD, MPH

Harvard Medical School/Harvard School of Dental Medicine

Curriculum Vitae Format

Date Prepared: April, 2020

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Education

1976	Bachelor of Arts	Biology, Magna Cum Laude	University of Missouri-Columbia
1977	Master of Science	Public Health	University of Missouri-Columbia
8/77-5/81	MD	Cum Laude, AOA	University of Missouri-Columbia

Postdoctoral Training

7/81-6/84	Resident	Internal Medicine	Vanderbilt University
7/84-6/86	Fellow	Infectious Diseases	Vanderbilt University

Faculty Academic Appointments

7/08-6/13	Associate Clinical Professor of Medicine	Medicine	University of Missouri-Columbia
7/13-5/18	Visiting Associate	Medicine	Harvard Medical School

6/18-	Professor of Medicine Associate Professor of Medicine	Medicine	Harvard Medical School

Appointments at Hospitals/Affiliated Institutions

7/86-6/13	Physician	Medicine Infectious Diseases Division	Mercy Medical Center St. Louis, Missouri
7/2013 -	Associate Physician	Medicine	Massachusetts General Hospital, Boston, MA

Other Professional Positions

Major Administrative Leadership Positions

Local

7/86-6/13	Chief, Division of Infectious Diseases	Mercy Medical Center, St. Louis, Missouri
1/87-6/13	Hospital Epidemiologist	Mercy Medical Center, St. Louis, Missouri
1/95-6/13	Director, Care for AIDS Patients Fund	Mercy Medical Center, St. Louis, Missouri
4/09-6/13	Director, Research, Department of Medicine	Mercy Medical Center, St. Louis, Missouri
1/94-6/13	President, Infectious Diseases Consultants	Mercy Medical Center, St. Louis, Missouri

Regional

2004-07	President, St. Louis Metropolitan Infectious Disease Society	St. Louis, Missouri

National and International

(None)

Committee Service

Local

1/87-6/13	Chair, Infection Control Committee	Mercy Medical Center, St. Louis
1/90-12/01	Chair, HIV Task Force	Mercy Medical Center, St. Louis
1/90-6/13	Pharmacy and Therapeutics Committee	Mercy Medical Center, St. Louis
1/95-6/13	Chair, Antibiotic Stewardship Committee	Mercy Medical Center, St. Louis
1/01-12/02	Medication Safety Committee	Mercy Medical Center, St. Louis
1/01-12/05	Quality Improvement Council	Mercy Medical Center, St. Louis
1/08-6/13	Performance Improvement Clinical Council	Mercy Medical Center, St. Louis
1/10-6/13	Board Quality Improvement Committee	Mercy Medical Center, St. Louis

2014-	Professional Development Coaching Program	Massachusetts General Hospital, Boston, MA
2015-	Education Committee Hospital Medicine Unit's "Pulse: A Monthly Educational Series".	Massachusetts General Hospital, Boston, MA
2015-2017	Partners Microbiology Specimen Ordering Work Group	Partners Health System, Boston, MA
2019-2020	Harvard Academy, Committee on Scholarly Writing	Harvard Medical School

Regional

1/01-6/13	Executive Board member, St. Louis Metropolitan Infectious Disease Society	St. Louis
1/02-12/03	Executive Board member St. Louis Metropolitan Medical Society	St. Louis
1.04-6/13	State of Missouri Advisory Panel for Hospital-acquired infections	Missouri

National and International

1/95-99	Association of Professionals for Infection Control	
	1/95-12/99	Member, Education Committee
1/01-12/08	Society of Healthcare Epidemiologists of America	
	1/01-12/02	Member, Executive Board of Directors
	1/04-12/06	Member, Membership Committee
	1/05-12/08	Member, Public Health Policy Committee

Professional Societies

1986-current	American College of Physicians
1986-current	Infectious Disease Society of America
1989-current	Society of Healthcare Epidemiologists of America
2017-	Society of Hospital Medicine

Grant Review Activities

2008, 2010, 2012, 2014, 2015, 2016, 2017, 2018	Hong Kong Government, Ad Hoc Reviewer	Studies relating to methicillin-resistant *Staphylococcus aureus,* gram-negative bacilli, antibacterial agents

Editorial Activities

- **Ad hoc Reviewer**

American Journal of Infection Control
Annals of Internal Medicine
Infection Control and Hospital Epidemiology
Clinical Infectious Diseases
Southern Medical Journal
Pediatrics
Archives of Internal Medicine
Journal of American Medical Association
Journal of Infectious Diseases
Kidney International
American Journal of Managed Care
Journal of Hospital Medicine
Microorganisms
BMJ Case Reports
The Joint Commission Journal on Quality and Patient Safety

- **Other Editorial Roles**

1/09-13	Member, Editorial Board	American Journal of Infection Control

Honors and Prizes

1981	Alpha Omega Alpha	University of Missouri-Columbia	Academic/service achievement
1984	Honorable mention	The New Physician	Writing contest
1995	Internal Medicine Teacher of the Year	Mercy Medical Center	Excellence in clinical teaching
1995	Fellow	American College of Physicians	Professional achievement
1999	Grand Prize	Medical Economics Journal	Medical writing
2008	Fellow	Infectious Disease Society	Professional achievement
2009	Fellow	Society of Hospital Epidemiologist of American	Professional achievement
2009	Internal Medicine Teacher of the Year	Mercy Medical Center	Excellence in clinical teaching

2010	Internal Medicine Teacher of the Year	Mercy Medical Center	Excellence in clinical teaching
2010	Best reviewer	Annals of Internal Medicine	Reviewing manuscripts
2013	Top reviewer	Journal of Hospital Medicine	Reviewing manuscripts
2013	Internal Medicine Teacher of the Year	Mercy Medical Center	Excellence in clincal teaching
2014	Alfred Kranes Award (Nominee)	Mass General Hospital	Excellence in clinical teaching
2015	Alfred Kranes Award (Nominee)	Mass General Hospital	Excellence in clinical teaching
2016	Alfred Kranes Award (Nominee)	Mass General Hospital	Excellence in clinical teaching
2016	Swartz Humanitarian Award (Nominee)	Mass General Hospital	Excellence in humanitarian care
2017	Alfred Kranes Award (Nominee)	Mass General Hospital	Excellence in clinical teaching
2017	Partners in Excellence Award	Partners Healthcare	In recognition of efforts and participation as Professional Development Coach in area of Leardership
2018	Practice of Medicine Excellence in Teaching Award	Harvard Medical School Mass General Hospital	In recognition of teaching Harvard medical students
2019	Alfred Kranes Award (Nominee)	Mass General Hospital	Excellence in clinical teaching
2019	Outstanding Reviewer	Annals of Internal Medicine	Excellence in reviewing article

Report of Funded and Unfunded Projects

Current Unfunded Projects

2016- Principle investigator
Study of falls resulting in hospital admission: How often is infection the culprit?

2016- Use of Chemically Actuated Resonance Device (CARD) technology in detecting active tuberculosis

Report of Local Teaching and Training

Teaching of Students in Courses

1995-1998	Respiratory tract infections Respiratory therapy students	Mercy Hospital One hour lecture

Formal Teaching of Residents, Clinical Fellows and Research Fellows (post-docs)

1986- 6/2013	Infectious Diseases topics Medicine residents	Mercy Hosptial 6 x/year One hour lecture
1990- 6/2013	Infectious Diseases in ICU patients ICU/pulmonary fellows and residents	Mercy Hospital 12x/year One hour lecture

Clinical Supervisory and Training Responsibilities

1986-2013	Infectious diseases inpatient consultative service / Mercy Hospital	5 days/week 4-6 months/year
2010-2013	Infectious diseases inpatient consultative service / Mercy Hospital	5 days/week, 4-6 months/year
2013-	General Medicine Ward Attending / Massachusetts General Hospital	5 months/ year
2013-	General Medicine Consultative Service / Massachusetts General Hospital	2 months/ year
2013-2015	Peer clinical collaborator, Hospital Medicine Unit / Massachusetts General Hospital	1-2 months/ year
2014-2018	OSCE Patient Doctor II examiner Harvard Medical School Physician	1-2x/year
2016-2017	Practice of Medicine preceptor-Harvard Medical School	4-6x/year
2017-2018	Medical Student Bedside PE Sessions-Harvard Medical School	6x/year
2017-2018	Practice of Medicine (POM)-1st year Harvard Medical Students	11x/year

Formally Supervised Trainees

2006-2007	Aradhyula, S. Intensivist, Barnes-Jewish Hospital, St. Louis, MO. Published 2 manuscripts
2006-2007	Reuter, M. Hospitalist, Missouri Baptist Hospital, St. Louis, MO. Published 1 manuscript
2007-2008	Gaddam, S., Fellow, Washington U., St. Louis, MO. Secured G I Fellowship

Formal Teaching of Peers (e.g., CME and other continuing education courses)

2006	West Nile Infection St. John's Mercy Hospital Medical Staff Biannual Conference	Single presentation Branson, Missouri
2008	Foot and soft tissue infections in diabetes St. John's Mercy Hospital Medical Staff Biannual Conference	Single presentation Branson, Missouri
2010	Prevention of surgical site infections St. John's Mercy Hospital Medical Staff Biannual Conference	Single presentation Branson, Missouri

Local Invited Presentations

No presentations below were sponsored by outside entities

1986	Adverse effects of antibiotics in renal insufficiency / Grand Rounds Department of Medicine, Mercy Hospital
1988	HIV testing of hospitalized patients / Grand Rounds Department of Medicine, Mercy Hospital
1989	Tick-borne diseases / Grand Rounds Department of Medicine, Mercy Hospital
1991	Hepatitis A / Grand Rounds Department of Medicine, Mercy Hospital
1993	Overview of antibiotics / Grand Rounds Department of Medicine, Mercy Hospital
1994	Vaccinations / Grand Rounds Department of Medicine, Mercy Hospital
1995	Update in infectious diseases / Grand Rounds Department of Medicine, Mercy Hospital
1996	C-reactive protein / Grand Rounds Department of Medicine, Mercy Hospital
1999	Soft tissue infections / Grand Rounds Department of Medicine, Mercy Hospital
2003	Severe acute respiratory syndrome (SARS) / Grand Rounds Department of Medicine, Mercy Hospital
2003	Overwhelming post-splenectomy syndrome / Grand Rounds Department of Medicine, Mercy Hospital
2004	MRSA and *Clostridium difficile* / Grand Rounds Department of Medicine, Mercy Hospital

2004	Bioterrorism / Grand Rounds Department of Medicine, Mercy Hospital
2004	Healthcare-associated infections / Lecture Neuroscience conference, Mercy Hospital
2005	Public reporting of infection rates / Grand Rounds Department of Medicine, Mercy Hospital
2005	Public reporting of infection rates / Lecture Neuroscience conference, Mercy Hospital
2005	Public reporting of hospital infection rates / Lecture Healthcare Infections Conference, Washington University, St. Louis
2006	Adult immunization update / Grand Rounds Department of Medicine, Mercy Hospital
2006	Strategies for prevention of surgical site infections / Grand Rounds Department of OB-GYN, Mercy Hospital
2007	Transverse myelitis / lecture Neuroscience conference, Mercy Hospital
2007	Strategies to prevent healthcare-associated infections / Grand Rounds Mercy Hospital
2007	Herpes zoster / Grand Rounds Department of Medicine, Mercy Hospital
2007	Acinetobacter: essential knowledge / Lecture Nursing conference, Mercy Hospital
2008	Pertussis / Grand Rounds Department of Medicine, Mercy Hospital
2008	Herpes zoster / Grand Rounds Department of Family Practice, Mercy Hospital
2008	Home laundered scrubs. Safe? / Lecture Nursing conference, Mercy Hospital
2008	Acinetobacter: the bug from you know where! / Lecture Nursing conference, Mercy Hospital
2008	Infections in the elderly / Lecture Neuroscience Nursing conference, Mercy Hospital
2008	Clinical Research 101: getting started / Research Conference Mercy Hospital
2009	Infections in diabetes / Grand Rounds Department of Medicine, Mercy Hospital
2010	Foot infections: the bane of diabetics / Grand Rounds Department of Medicine, Mercy Hospital
2010	*Clostridium difficile* infections / Grand Rounds St. Joseph Hospital, St. Louis, MO.
2010	*Clostridium difficile* infections / Grand Rounds Mercy Hospital, Washington, MO
2011	C-reactive protein: commonly used, rarely understood / Grand Rounds Department of Medicine, Mercy Hospital
2012	CNS infections / Grand Rounds Department of Medicine, Mercy Hospital
2013	Travel Medicine / Grand Rounds Department of Family Practice, Mercy Hospital

2013 Diagnosis and treatment of CNS infections: pearls and pitfalls
Lemuel Shattuck Hospital, Boston, MA
2014 Epidural abscess
Department of Medicine, Massachusetts General Hospital
2014 Case Records of Massachusetts General Hospital
Department of Medicine, Massachusetts General Hospital
2015 Risk factors and evidence-based medicine
Noon Conference, Department of Medicine, Massachusetts General Hospital
2015 Urinary tract infections
Noon conference, Department of Medicine, Massachusetts General Hospital
2016 Acute kidney injury, Resident Report, Department of Medicine, MGH
2016 Talking therapeutics: An overview of antibiotics, HMS students, MGH
2016 CRP: How I Teach This series, Core Educator Faculty Conference, MGH
2016 Walking the minefields to save a leg…or life, Frontline series, Division of General Medicine, MGH
2016 Case Records of MGH/NEJM
Department of Medicine, MGH
2017 "Talking Therapeutics", Antibiotics, Core Educator Faculty conference
2017 Postop delirium, Core Educator Faculty conference
2017 17th Annual DOM Faculty Teaching Retreat. Millenium learners: crafting teaching moments for a light speed world. Workshop facilitator. Boston, MA.
2017 "How to give a chalk talk" workshop facilitator, Boston Area Academic Hospitalist Meeting
2017 Rational for selection of antibiotics, Medical Student Conference, Massachusetts General Hospital
2017 Sepsis, Medical Student Conference, Massachusetts General Hospital
2017 "NEJM CPC: A 28 year old woman with headache, fever, and a rash." Department of Medicine Resident Conference, North Shore Medical Center, Salem, MA
2017 "Spinal epidural abscess: Think early, think often!", Department of Medicine Resident Conference, North Shore Medical Center, Salem, MA
2018 "Spinal epidural abscess: Think early, think often!" PULSE lecture series, Hospital Medicine Group, Massachusetts General hospital
2018 Talking Therapeutics: Antibiotics Review, Noon Conference, Department of Medicine, Massachusetts General Hospital
2018 Yes, but can you write? Noon Conference, Department of Medicine, Massachusetts General Hospital
2018 Yes, but can you write? Noon Conference, Department of Medicine, Northshore Medical Center, Salem, MA.
2019 Yes, but can you write for the web? Noon Conference, Department of Medicine, Northshore Medical Center, Salem, MA.
2019 Antibiotics for the generalist. Grand Rounds, Division of General Internal Medicine, Massachusetts General Hospital
2019 Antibiotics for the hospitalist: pearls and pitfalls. PULSE conference for Hospital Medicine Unit, Massachusetts General Hospital
2019 Antibiotics for the hospitalist: pearls and pitfalls. Noon conference, Northshore Hospital, Salem, Massachusetts
2020 Antibiotics for the generalist: PULSE conference for Hospital Medicine Unit, Massachusetts General Hospital

Report of Regional, National and International Invited Teaching and Presentations

Invited Presentations and Courses

Regional

No presentations below were sponsored by outside entities

1990	Updated on Lyme disease Greater Kansas City Infectious Disease Conference, Kansas City
1993	Infections in transplant patients Transplant conference, St. Louis
1995	Microbes and man Association of Practitioners in Infection Control Basic Course, St. Louis
1995	HIV update Greater Kansas City Infectious Diseases Conference, Kansas City
2004	Bioterrorism basics for general practitioners Regional Medical Conference, St. Louis
2006	Bioterrorism Medical Librarians Conference, St. Louis
2007	No, Virginia, you don't have to go to the hospital to get MRSA! Greater Kansas City Infectious Diseases Conference, Kansas City
2007	No, Virginia, you don't have to go to the hospital to get MRSA! Greater St. Louis, Infectious Disease Conference, St. Louis
2010	Striking back at endemic healthcare-associated infections Regional APIC Conference, St. Louis
2011	Striking back at endemic healthcare-associated infections Bi-state Infection Control Conference, St. Louis
2012	Detection and treatment of CNS infections; pearls and pitfalls Greater Kansas City Infectious Diseases Conference, Kansas City
2012	Hospital rankings Medical Librarians Conference, St. Louis
2015	NEJM CPC: a 28 year old woman with headache, fever, and a rash Grand Rounds, Mercy Hospital, St. Louis, Missouri
2015	"Risk factors and evidence-based medicine" Medicine Noon Conference, Mercy Hospital, St. Louis, Missouri
2015	Visiting Clinician Medicine Case Discussion Mercy Hospital, St. Louis, Missouri
2016	Infectious Disease Emergencies: Clinicopathologic Correlation. 27th Infectious Disease Symposium, Research Medical Center, Kansas City, Missouri.

National

1991	*E.coli* susceptibility to ampicillin and ampicillin-sulbactam, 1988-90 Interscience Conference on Antimicrobial Agents and Chemotherapy, Chicago

1997	Surgical site infection surveillance in alternative settings Annual Society of Healthcare Epidemiologists of American Conference, Atlanta
2001	Hospital epidemiology in community hospitals Annual Society of Healthcare Epidemiologists of American Conference, Boston
2002	Surgical site infections caused by MRSA: does postoperative care play a role? Annual Society of Healthcare Epidemiologists of American Conference, Salt Lake City
2004	Predicting *Clostridium difficile* infection among hospitalized patients with diarrhea: a case control study Annual Society of Healthcare Epidemiologists of American Conference, Philadelphia
2005	Compliance with gown and gloving upon entry into rooms of hospitalized patients on contact isolation Annual Society of Healthcare Epidemiologists of America Conference, Los Angeles
2010	Impact of an intensive terminal cleaning and disinfection program involving selected hospital rooms on endemic nosocomial infection rates of common pathogens at a tertiary care medical center. Fifth Decenniel International Conference on Healthcare-Associated Infections, Atlanta.
2012	"Touchless" technology is necessary to control nosocomial pathogens. ID week (joint conference of Infectious Disease Society of America and Society of Healthcare Epidemiologists of America), San Diego

International

2014	" Enhanced environmental cleaning in controlling *Clostridium difficile* infections in the healthcare setting: Does it matter? Webber Training Teleclass, October 9, 2014.
2015	"Sleep quality in adult hospitalized patients with infection: an observational study." Webber Training Teleclass, February 12, 2015.

Report of Clinical Activities and Innovations

Current Licensure and Certification

1984	Tennessee
1986	Missouri
2013	Massachusetts

Practice Activities

1986-2013	Consultative practice in infectious diseases-hospitalized patients	Infectious Diseases Consultants-Mercy Hospital	Daily
1986-2013	Consultative practice in infectious diseases-ambulatory care (including HIV care)	Infectious Diseases Consultants-Mercy Medical Center	4x/week
2013-	Inpatient Clinician Educator/Core Educator	Department of Medicine, Massachusetts General	Daily

	Faculty	Hospital	
2013-2016	Preceptor, second year Harvard medical students	Massachusetts General Hospital	1x/week
2013-2020	Course examiner, first year medical students	Harvard Medical School	2x/year
2017-2018	Preceptor, first year Harvard medical students	Massachusetts General Hospital	1x/month
2019-2020	Preceptor, first year Harvard medical students	Massachusetts General Hospital	1x/month

Clinical Innovations

1989-Development of a monthly questionnaire for surgeons with surgeon specific procedures to facilitate reporting of surgical site infections to infection control departments. Discussed at national meetings, published in peer-reviewed journals and adopted by many centers.

1995- Utility of daily measurement of serum C-reactive protein levels in earlier diagnosis of infections was established in a first of its kind blinded study involving patients with malignany undergoing chemotherapy. A similar practice in the management of patients with malignancy has been adopted in various centers, including in patients with multiple myeloma at the University of Arkansas and University of lowa medical centers.

2013- Healthcare-associated infections are an important cause of death in the US and worldwide, with increasing attention directed toward more thorough cleaning and disinfection of hospital rooms to combat these infections. Dr. Manian was among early pioneers in applying a novel technology (vaporized hydrogen peroxide) in the terminal cleaning and disinfection of patient rooms at high risk of persistent (often for months) contamination with nosocomial pathogens, including multi-drug resistant *Acinetobacter baumannii* complex, methicillin-resistant *Staphylococcus aureus*, and *Clostridium difficile*. In a first of its kind hospital-wide adoption of this technology through implementation of a novel priority scale for daily identification of not only isolation but non-isolation rooms without prior record of decontamination, he was able to demonstrate a nearly 40% drop in the incidence of hospital-associated *C. difficile* infections. Presented at regional and national meetings and published in peer-review journals.

Report of Technological and Other Scientific Innovations

www.pearls4peers.com (June 2015-)	Creator of an educational website dedicated to hospital medicine, providing concise (usually 200 words or less), uptodate and evidence-based answers to clinical questions raised during daily patient rounds. Since its creation, monthly viewership has increased to nearly 3,000/month, involving over 2,000 unique visitors from over 100 countries. With over one-quarter of all posts submitted by MGH Medicine housestaff and HMS students, the site is being used as a means of promoting scholarly web-writing and an important "writing to learn" experience not routinely incorporated in the curriculum of physicians-in-training.

Report of Education of Patients and Service to the Community

Activities

1990	Student Forum, HIV among youth, Union High School, Union, Missouri
1990	AIDS in the community, Call-in Radio show, St. Louis, Missouri
1991	Catholic student forum, St. Louis, Missouri
1991-1998	Served as a member of St. Louis AIDS Foundation Board
1992	Hepatitis A in the community, public forum, St. Louis, Missouri
1992-1993	Served as a member of the Metropolitan Hospital Association HIV/HBV Task Force
1992-1995	Coordinated free confidential HIV testing at a local hospital once a week
1995-2013	Created, raised funds, and managed the "Care for AIDS Patients" fund for HIV-positive patients unable to afford basic needs (e.g. food, transportation, and utilities)
2000	Influenza in the community, Call-in Radio show, St. Louis, Missouri
2002	STD's in the community, Rotary Club, St. Louis Missouri
2003	HIV in youth, High School student forum, St. Joseph Academy, St. Louis, Missouri
2007	Battling healthcare-associated infections, St. Louis Business Coalition for Healthcare
2009	Infections in the community, High School students, St. Joseph Academy, St. Louis
2011	E. Coli 0157 diarrhea outbreak in St. Louis, KSDK TV Morning Show
2012	Tick-borne diseases, KSDK TV News
2012	Infections in the community, Call-in Radio Show, St. Louis, Missouri
2013	Influenza in the community, Call-in Radio Show, Northern Missouri
2015	Unprepared for the end stages of end-stage kidney disease, Podcast, Health Affairs
2015	"Dad's last days weren't easy: effect of kidney disease were an unpleasant surprise even for me, an experienced doctor". Washington Post, September 22, 2015
2015	Coexisting systemic infections and falls. Taped radio interview for broadcast in US at IDWeek, Oct 9, 2015

Educational Material for Patients and the Lay Community

Books, monographs, articles and presentations in other media

2011	Tick borne diseases	Article	*Self* magazine

Educational material or curricula developed for non-professional students

Patient educational material

1988	HIV	Author	Pamphlet for patients and their families

Recognition

2009-13	Listed in St. Louis Magazine "Best Doctors"
2009	Listed in "American's Top Doctors"
2009-2013	Listed in "Best Doctors in America"

Report of Scholarship

Publications

Peer reviewed publications in print or other media

Research investigations

1. Powers JS, Berger C, **Manian FA**, Kuhn K, Lichtenstein MJ, Billings FT. A Teaching Nursing Home: The Vanderbilt Experience. *South Med Journal.* 1986; 79:267-271.
2. **Manian FA**, Alford RH. Ticarcillin plus clavulanic acid activity against ticarcillin-resistant *Pseudomonas aeruginosa:* discrepancies between disk diffusion and broth susceptibility studies. *Antimicrobial Agents and Chemotherapy.* 1986; 30:35-38.
3. Maloney JM, Gregg CR, Stephens DS, **Manian FA**, Rimland R. Infections caused by *Mycobacterium szulgai* in humans. *Rev Infect Dis.* 1987: 9:1120-1126.
4. Stratton CW, Franke JJ, Weeks LS, **Manian FA**. Comparison of the bactericidal activity of ciprofloxacin alone and in combination with selected antipseudomonal beta-lactam agents against clinical isolates of *Pseudomonas aeruginosa. Diag Microbiol Infect Dis.* 1989; 11:41-52.
5. **Manian F**, Rinke D. HIV Antibody Testing in Hospitalized Patients. *South Med J.* 1990; 83: 23-29.
6. **Manian FA**, Meyer L. Comprehensive surveillance of surgical wound infections in outpatient and inpatient surgery. *Infect Control Hosp Epidemiol.* 1990;11:515-520.
7. **Manian, FA.** Hepatitis B vaccination among physicians: a decade later. *Infect Control Hosp Epidemiol.* 1991; 12:576.
8. **Manian FA**, Meyer L. Comparison of patient telephone survey with traditional surveillance and monthly physician questionnaires in monitoring surgical wound infections. *Infect Control Hospital Epidemiol.* 1993; 4:216-218.
9. **Manian FA,** Meyer L, Jenne J. Puncture injuries due to needles removed from intravenous line: should the source patient be routinely tested for blood borne infections? *Infect Control Hospital Epidemiol.* 1993; 14:325-330.
10. **Manian FA**. Simultaneous measurement of antibodies to Epstein-Barr virus, human herpesvirus 6, herpes simplex virus types 1 and 2, and 14 enteroviruses in chronic fatigue syndrome: is there evidence of activation of a nonspecific polyclonal immune response? *Clin Infect Dis* 1994; 19:448-53.
11. **Manian FA**. A prospective study of daily measurement of C-reactive protein in serum of adults with neutropenia. *Clin Infect Dis* 1995;21:114-21.
12. **Manian FA**, McKenzie DS. A prospective study of 2,092 "curbside" questions asked of two infectious disease consultants in private practice in the Midwest. *Clin Infect Dis*1996;22:303-7.
13. **Manian FA**, Meyer L, Jenne J, Owen A, Taff T. Loss of antimicrobial susceptibility in aerobic Gram-negative bacilli repeatedly isolated from patients in intensive-care unit. *Infect Control Hospital Epidemiol* 1996; 17:222-6.
14. Pirwitz S, **Manian F**. Prevalence of use of infection control rituals and outdates practices: education committee survey results. *Am J Infect Control* 1997; 25:28-33.
15. **Manian FA**, Meyer L. Adjunctive use of monthly physician questionnaires for surveillance of surgical site infections after hospital discharge and in ambulatory surgery patients: report of a seven-year experience. *Am J Infect Control* 1997; 25: 390-394.
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Scholarly Clinical Blogs

Hundreds of original evidence-based blogs posted at www.Pearls4Peers.com , "A Learning by Sharing Resource Dedicated to the Curious Clinician in Hospital Medicine" (created June 2015)).

Professional educational materials or reports, in print or other media

1. AIDS video for healthcare workers, Mercy Hospital, 1987
2. Online scholarly contribution of 120 hospital medicine pearls at www.Pearls4Peers.com

Clinical Guidelines and Reports

1999: I was part of the consensus panel (convened by the Association of Practitioners in Infection Control and the Society of Healthcare Epidemiologists of America) that developed the "Requirement for infrastructure and essential activities of infection control and epidemiology in out of hospital settings" intended for both national and international professionals. The panel met several times per year.

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8. **Manian FA**. Scientific writing for the web by medical students and housestaff: Experience at an acatdemic institution. Medical Education Day, Harvard Medical School. October 24, 2017.
9. **Manian FA,** Hsu F, Huang D, Blair A, Mosaria R, Lipartia M. More than just another admission for fall: coexisting systemic infections in patients hospitalized with chief complaint of fall. Society of Hospital Medicine Annual Meeting, March 25, 2019, Abstract #596567.

Exhibit 2

DECLARATION OF DR. PATRICK CANAVAN AND ELIZABETH JONES

We, Patrick J. Canavan, Psy.D, and Elizabeth Jones, declare and state the following:

1. I, Patrick J. Canavan, am a clinical psychologist, licensed in the District of Columbia. I received my doctorate in clinical psychology from the Illinois School of Professional Psychology. I completed my clinical internship and forensic fellowship at St. Elizabeths Hospital in Washington, DC. I have extensive experience in the diagnosis and treatment of serious and persistent mental illness and in working with forensically involved individuals. I have clinically administered forensic units (admissions, evaluation, long-term treatment, women's trauma-informed) for many years. In addition, I have extensive experience in leading recovery-oriented reforms in psychiatric and medical organizations, having served as Chief Executive Officer at St. Elizabeths and Chief Operating Officer of Howard University Hospital. I have conducted reviews of state hospital systems in Georgia, Pennsylvania and Maryland. Recently, I was appointed as an *amicus curiae* expert by a federal district court judge regarding how to address inpatient psychiatric treatment during the COVID 19 pandemic. My resume is attached.

2. I, Elizabeth Jones, have over 35 years of experience in implementing or monitoring federal and state court orders regarding services for individuals with a mental illness and/or developmental disability. I have had administrative responsibility for four institutions including three public psychiatric hospitals for individuals who were admitted with forensic or civil commitment status. These hospitals were located in Massachusetts, Maine and the District of Columbia. In each of these settings, I worked closely with clinical staff to design and effectuate individualized plans so that discharges to the community could occur in a timely and responsible manner. Currently, I am the Independent Reviewer for a Settlement Agreement between the United States Department of Justice and the State of Georgia. In part, this Agreement requires the development of community-based services for adults at risk of hospitalization in a state psychiatric facility or in the process of being discharged from one. My resume is attached.

3. In order to complete this Declaration, we reviewed numerous documents including the May 7, 2020 Amended Class Action Complaint in Wilkes v. Lamont (Civil No.: 3:20cv594); the affidavits of Vincent Ardizzone, Francis Clarke, Gail Litsky, Carson Mueller, Richard Gudis, Rahab King and Farrin A. Manian, MD, MPH; and policies, reports, contracts,

memoranda and plans issued by the Connecticut Department of Mental Health and Addiction Services (DMHAS). A list of these state documents is attached.

4. Based on the information we have reviewed and carefully considered, it is our professional opinion that Connecticut Valley Hospital (CVH) and Whiting Forensic Hospital (WFH) have not taken actions that are critically necessary to ensure that patients are adequately protected from risk of transmission of COVID-19. As a result, patients remain at significant risk of death or serious harm. Indeed, during the course of this review, the sad news of a fifth patient death at the hospitals was reported by DMHAS.

5. Reportedly, the Final Revised WFH Coronavirus Pandemic Incident Action Plan was not finalized until May 26, 2020. This delay exacerbated the already serious risks present at WFH. The Plan outlined in this document should have been implemented at the outbreak of the pandemic, not months later in phase 6. These actions include:

- Review, revise as needed, and activate guidelines for coronavirus prevention and control measures;
- Conduct surveillance and testing for coronavirus as guided by local and state public health agencies;

- Provide training to staff and cross-train staff as appropriate;
- Develop a comprehensive plan for building quarantine resources;
- Screen all incoming patients for the virus;
- Implement a plan for early detection and reporting of WFH personnel with the virus;
- Reinforce infection control procedures to prevent the spread of coronavirus and utilize personal protective equipment appropriately; and
- Increase environmental cleaning efforts, including the living space utilized by patients.

6. We have reviewed the affidavit of Dr. Manian, an expert in infectious disease and internal medicine, with particular attention to what he terms as "major mitigating strategies aimed to reduce the risk of SARS-COV-2 transmission in CVH and WFH." We find that his arguments are compelling. In our opinion, these strategies could and must be implemented at CVH and WFH. The strategies are focused on social distancing, census reduction and discharge, personal protective equipment, hand hygiene, face masks for patients, screening and testing of all patients and staff, environmental cleaning and decontamination, limiting visitors and stopping new admissions. We strongly concur that

these strategies should be part of the two hospitals' response to this pandemic. Efforts to implement these strategies sufficiently are lacking currently and, therefore, place individuals at significant risk.

7. Social distancing requires patients and staff to maintain at least six feet between themselves and others. The patients' affidavits we reviewed are replete with examples of how social distancing is not possible in bedrooms and bathrooms, in elevators and in the dining room. Multiple patients raised concerns about safety in sleeping arrangements, where individuals are housed two to a room with beds less than six feet apart. For instance, Mr. Ardizzone, who resides on the Dutcher North 3 unit in WFH, states: "I sleep in a room with one roommate. Our room is about 10-12 feet square. We both have beds that are about four to five feet apart."

8. Patients' affidavits likewise raise concerns about lack of distancing during meals, in bathrooms, and in elevators. These practices place patients at significant risk. Regarding bathrooms, Mr. Ardizzone states that "22 patients share one bathroom. There are three stalls, two urinals, three sinks and four showers. There are often five or more patients in the bathroom at any one time… usually just a foot apart. Very few patients are wearing masks." These circumstances in congregate situations could

be avoided if there were fewer people on the unit, if there was scheduled use of the bathrooms, if staff reinforced the need for masks while in public areas, and if the bathrooms were consistently cleaned and restocked. As described by Mr. Ardizzone, "Soap runs out sometimes on the weekend because maintenance-cleaning staff do not work on weekends... we cannot have Purell or any hand sanitizer that has any alcohol in it ... Apparently someone has determined that the small risk of someone ingesting hand sanitizer outweighs the risk of contracting a deadly virus in a pandemic."

9. Other affidavits make a similar mention of lack of hand sanitizer, communal use of a single dental floss container, and lack of disinfection between staff's use of pulse oximeters. Patients also mention the lack of cleaning of the two patient phones per unit, used by as many as 20 patients.

10. The Dutcher dining hall is in the basement of the building, a large open room with approximately ten tables. On March 30, 2020, Ms. Litsky, a Dutcher patient with asthma and other health conditions, was so concerned for her safety that she requested permission to take her meals on the unit rather than in the dining room due to an "unreasonable risk of infection because we were all too close together and people were not

wearing masks." Her request was denied by the Medical Director and an internal medicine physician until a unit psychiatrist ordered on unit meals because of the risk of virus given her asthma. As described by Mr. Ardizzone, the tight space in the dining room, sometimes with two units having meals at the same time, requires that patients "stand in line shoulder to shoulder, get our trays, and sit down at tables with no masks and no gloves. Sometimes there are two units all in the dining room at the same time. There is no social distancing." It would be reasonable to have meals delivered to the residential units so that all patients could eat in a socially distanced manner. While this requires dietary staff to adjust their routine and unit staff to supervise dining, in our professional judgment, it is a reasonable accommodation.

11. To access the dining room, six or seven patients use the one elevator in Dutcher, estimated to be four by eight feet in size. Others use the stairwells. Mr. Mueller asked the staff if the stairwells could be kept open so that residents never had to use the elevators, but was told no. Again, if there were socially distant ways of using an elevator, such as limiting the number of people using it at one time, or providing an alternative such as a stairway, patients could be given a choice.

12. Screening and testing of patients and staff to determine COVID-19 status is another tool that the infectious disease expert, Dr. Manian, has identified. His advice is consistent with CDC guidelines. The use of testing in communities across the country is a well-known strategy. However, testing for patients at CVH and WFH did not begin until May 13, 2020, according to patient affidavits.

13. Numerous patients indicated that staff have not consistently worn masks, even though patients were getting sick and testing positive. According to patient affidavits, WFH delayed until April 13, 2020 the mandate that staff wear a mask while in patient areas. Further, it was not until April 22 or 23, 2020 that patients were offered one mask a week upon request. In addition, it appears that there has been inconsistent patient education and reinforcement about the importance of wearing a mask and keeping social distance.

14. We strongly recommend that CVH and WFH develop a plan to move all patients into single bed sleeping rooms, or into rooms with sufficient space to allow sleeping in a bed at a distance of at least six feet from another bed. This may require a reduction of the inpatient census, which could be accomplished through appropriate discharge planning, to address the imminent and ongoing threat of the virus in congregate

settings. We also urge that hand sanitizer be given to patients, with supervision if needed, that there be frequent redirection if social distancing is violated and that teaching on infection control strategies be required for all patients.

15. In addition to the above infection-control procedures, we emphatically concur with Dr. Manian's guidance that social distancing be accomplished through a reduction in the census at CVH and WFH. This should be accomplished by the cessation of most civil admissions, discouraging forensic admissions, and appropriately discharging individuals to community-based settings with supports. Based on our years of experience managing psychiatric hospitals and other facilities, planning for the successful transition of individuals with serious mental illness from state psychiatric hospitals can be accomplished, even under these circumstances, through individualized planning and using all available resources, including natural supports.

16. In a forensic hospital, the courts play a major role in admission to the facility. For competency restoration or NGRI status individuals, WFH staff should work closely with the Superior Court to ensure diversion to other settings, while taking into account the current situation and balancing risk. The courts, aware of the danger posed to individuals in

congregate settings, may benefit from the staff's expertise in risk assessment and in defining a risk hierarchy for admissions: Is the individual charged with a misdemeanor or a felony? Does the charge include claims of violence? Does the individual have a history of danger to self or others? Does the individual have family or strong community ties who, with clinical support or community-based competency restoration from DMHAS, could help the individual remain stable while living in the community?

17. Limiting new admissions to CVH and WFH is an important way of maintaining a lower census. Regretfully, based on the information we have received, it appears that the State of Connecticut actually has returned individuals from temporary leave in community settings to the unsafe environments at WFH. This decision is highly troubling and frankly incomprehensible given the risks in the inpatient setting. The individuals on leave in the community may very well have been able to remain there for at least the foreseeable future. For example, Mr. Mueller recalled that, on March 16, 2020, when a patient was diagnosed with a COVID-like illness, the unit was essentially closed down and that those on "temporary leave (were) called back, and scheduled leaves were

cancelled. There were two patients on temporary leave who were pulled back from their community placement and confined to our unit."

18. WFH has options for maintaining patients on temporary leave in the community. In WFH's "Protocol for the Care of Patients on Temporary Leave (TL)," it states: "If a coronavirus case is discovered at WFH while a patient is on overnight TL, the patient will remain at their current location for up to 7 days, per the patients' Memoranda of Decision (MOD). If longer duration is necessary due to mandated quarantine, the Chief of Forensic Services will be responsible for coordinating plans with the PSRB." During the current pandemic, the hospital should have followed its own policy and only returned patients who are at the highest level of risk, i.e. danger to self or others, during this emergency.

19. For patients under civil commitments, DMHAS should make other hospitals, crisis services, transitional housing and respite services available in lieu of rehospitalization in CVH. Based on the information we have reviewed, there should be further examination of the community resources that could be utilized in lieu of returning a civilly committed individual to COVID 19 involved care settings.

20. CVH and WFH policies relating to discharge are clear that discharge must be contemplated from the moment of admission to the hospital.

The hospitals' own policies regarding treatment planning include a focus on discharge planning. They require that the Treatment Plan must reflect a focus on those who are determined to be ready for discharge. For instance, CVH's "Community Integration and Discharge" policy, dated June 4, 2015, states:

> "When a treatment team determines that an individual no longer needs hospital level of care, the team will chart the person as discharge ready, specify the least restrictive community living arrangement appropriate for that individual, the specific barriers to discharge to that setting, and a schedule for implementing the discharge plan, taking into account the resources available to the State and the needs of others with mental disabilities and the individual's or his/her legal representative's informed choice.

21. It is unclear how many individuals the hospitals consider to be ready for discharge, but it appears from the affidavits that we have reviewed that there are individuals who could be discharged without posing significant safety risks. For example, Mr. Mueller feels that the risk of staying in the hospital is great. He would like an apartment with wrap-around supports and services, as his outpatient treatment team has recommended. According to her conservator Attorney Gudis, Barbara Flood has been determined to be ready for discharge for over a year now and "she is willing to go anywhere upon discharge." Mr. Gudis states that DMHAS has never discussed alternative placements such as hotels, family units, or

supportive housing with him, which would be a failure of minimal professional judgment in the circumstances of a pandemic.

22. In order to accelerate discharges under these extraordinary circumstances, DMHAS should develop a plan to promptly assess all residents for discharge, identify those who can be discharged, determine what supports would be needed, and implement strategies to effectuate these plans. DMHAS should apply a different standard than it would in ordinary times and should focus on such basic questions as whether the person has a place to live, has access to food and needed medication, and can take appropriate COVID precautions with available assistance, and live in the in the community setting to which the person will be released without being a danger to self or to others.

23. Unlike other jurisdictions where efforts to discharge significant numbers of psychiatric hospital residents have been made in order to address COVID-19 risks, Connecticut does not appear to have made such efforts to date at CVH and WFH despite the current and ongoing potential risks at these facilities.

24. Based on the conversations we have had, we are confident that community service providers would be willing to engage with the

hospitals on planning and implementing discharges as part of such an effort at CVH and WFH.

25. It is our professional judgement that the following strategies for accelerating discharges should be implemented:

a. An individualized assessment of each patient should be conducted to determine whether other options exist in lieu of continued placement at CVH or WFH. This assessment should be conducted with input from the patient's treatment team, his/her attorney, and/or significant others of his/her choice. The assessment should identify potential community-based supports and, whenever possible, recommend discharge. Individuals who present low risks should be considered first.

b. Individuals who may have family and friends who might be able to take them in, at least during the pandemic or until other housing can be secured, should be identified and appropriate supports offered, such as food assistance, case management, a stipend to cover the additional costs.

c. Any available capacity in community programs, including the nursing home waiver, respite beds, transitional housing, supported housing, ACT and other services/supports should be utilized or expanded to permit discharge from CVH and WFH. Temporary housing in hotels or other temporary settings should be considered but there should not be any referrals to jails, nursing homes or shelters for the homeless.

d. In order to expedite discharge planning, community providers should be included as a part of the assessment process described above and should assist in planning for specific individuals. Additional funding to enhance community services needs to be considered in order to de-escalate the crisis at CVH and WFH.

25. The ongoing failure of Defendants to implement these or similar strategies designed to reduce the number of people hospitalized as safely and quickly as possible given the risks of COVID-19 is inconsistent with the exercise of reasonable professional judgment.

Pursuant to 18 U.S.C. § 1746, we declare under penalty of perjury that the foregoing is true and correct.

Dated: June 8, 2020	Dated: June 8, 2020
Patrick J. Canavan	Elizabeth Jones

List of State Documents Reviewed

State of Connecticut DMHAS Commissioner's Policy and Implementing Procedures on Community Integration and Discharge from Connecticut Valley Hospital (CVH).

CVH/Whiting Legislative Task Force report by C. Dike, MD, DMHAS Medical Director and V. Carvalho, MD, CVH Medical Director.

CVH and Whiting Forensic Hospital (WFH) Staff Education and Training presentation, November 21, 2019.

CVH Operational Procedural Manual, Community Integration and Discharge, June 11, 2015.

DMHAS Annual Statistical Report, SFY 2019.

DMHAS Commissioner's Policy Statement of DMHAS Client Rights Policy, January 3, 2019.

DMHAS Statewide Services Resource Guide, January 1, 2013.

DMHAS Supportive Housing List, 2013.

"Evolution of Forensic Services in Connecticut," presentation to IRCC Conference, May 14, 2015.

WFH Operational Procedural Manual on Community Integration and Discharge, June 18, 2018.

WFH Task Force presentation by H. Smith, CEO and T. Wasser, MD, CMO, June 17, 2019.

DMHAS Purchase of Service Contract with Middlesex Hospital, March 27, 2017.

DMHAS Contract Amendment with Middlesex Hospital, March 28, 2018.

DMHAS Contract amendment with Middlesex Hospital, September 19, 2019.

WFH Coronavirus Pandemic Incident Action Plan, undated.

DMHAS Commissioner's memorandum announcing "Change in Visitation Policy at DMHAS Facilities," May 14, 2020.

DPH COVID-19 Guidance for Long-Term Care Facilities, March 26, 2020.

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PROFESSIONAL EXPERIENCE

Vice President for Consulting Services, IdeaCrew, Inc. February 2017 – Present

Direct the consultation work of IdeaCrew, Inc. the health care IT leader which built the technology powering the D.C. Health Benefits Exchange. An agile, in the cloud, Serve as IT project leader customizing and deploying this technology to the first partner state, the Commonwealth of Massachusetts. Successfully deployed the technology on time and on budget, offering Massachusetts members an excellent online benefits shopping experience.

Consultation work is focused on hospitals, healthcare systems and other large organizations seeking clinical and operational improvements. Led the assessment of a five-hospital state behavioral health system, making recommendations that impact all aspects of treatment, administration and quality of care issues. Appointed *amici* by U.S. District Court to investigate mental health services

Senior Managing Director, Paladin Healthcare Management June 2015 – January 2017

Served as the Chief Operating Officer (COO) of Howard University Hospital (HUH), under management contract with Paladin. HUH is a 288 licensed bed facility, with an average census of 130 and academic affiliation with Howard University, training more than 200 residents and supporting medical student training. As the COO, was a key member of the Chief Executive Officer's management and advisory staff, and participate in recommending and formulating policies and strategies on business process engineering, information systems technology, budgeting, human resources, procurement, security, facilities management, and property management and provide managerial direction and guidance in support of the operation of the various programs within the hospital.

Key accomplishments include:

- Management lead for all non-Nursing unionized employees (techs, ancillary and support services workers. Negotiated a contract that will greatly expand management rights and a continuation of benefits package that will give management flexibility to modernize clinical practices, respond to changing conditions and lower costs.
- Supervised Patient Experience improvements throughout the hospital using the Press Ganey survey results. Worked with faculty and emergency services leadership to attain coordinated renovation of waiting room and increased ED beds. Increased customer satisfaction ratings in the key categories such as timeliness and the overall patient experience;
- Led the renovation of the Emergency Department clinical, patient, administrative and public areas;
- Initiated top to bottom review of ancillary services with focus on laboratory processes, contracts and equipment; radiology staffing and services; respiratory staffing; sleep center.

Chief Executive Officer, Saint Elizabeths Hospital
D.C. Department of Behavioral Health January 2007 – May 2015

Managed the operation of the public psychiatric inpatient facility for the District of Columbia. With more than 290 licensed beds, and average census near 275 patients, Saint Elizabeths Hospital had both court-ordered and civil patients. Operating budget exceeded $90M with almost 830 approved positions in FY15. Directed all clinical and administrative operations and represented the hospital on key budgetary and resource issues to the Mayor's Office, City Council, and other important constituencies.

Key accomplishments included:

- Successfully managed the U.S. Department of Justice (DOJ) Settlement Agreement by instituting significant improvements across a wide range of clinical practices, including assessments, the day treatment program, infection control, pharmacy and direct care staffing. The hospital fully complied with the 224 requirements under DOJ and the Federal lawsuit was dismissed September 16, 2014.
- Revitalized the professional nursing staff by hiring over 160 new registered nurses in two years to successfully meet a DOJ requirement of 6 hours of nursing care per day for each patient, with a staff mix of 50% registered nurses.
- Planned and oversaw a reduction in expenditures and non-clinical staff to meet mandated budgetary cuts resulting in reduction of staff by over 120 employees since January 2009 resulting in approximately $7,200,000 in annual savings.
- Managed the completion and transition to the new $143M replacement hospital on time and with minimal disruption to individuals in care and staff.
- Created a new "one hospital" culture which emphasized treatment and rehabilitation for both court-ordered and civil individuals in care by eliminating forensic-specific units and treatment and assigning individuals in care to units based on therapeutic need
- Streamlined administrative services and ensured higher levels of staff accountability including a major reorganization of the clinical programs including the creation of a new Therapeutic Learning Center Reinvigorated the Performance Improvement Department resulting in the completion of significant routine audits and reports and a greatly enhanced investigatory capability.
- Implemented a hospital-wide electronic medical records system which included all patient information.
- Improved the quality of life for patients through the initiation of programs such as a Summer Concert series and an Annual Friends and Family Day,

Director, Department of Consumer and Regulatory Affairs
Government of the District of Columbia — January 2005 – January 2007

Leader of the major regulatory agency in the District of Columbia. Supervised 430 full time staff and more than 100 contractors with a budget of $50.4M and revenues of $49M. Major areas of regulation included land use/zoning, construction permitting, business licensing, housing inspection, commercial compliance, administration of boards and commissions, professional licensing, rent control, consumer protection, and commercial investigations.

Key accomplishments included:

- Realigned of the agency to focus on two major business activities: 1) issuing important business and construction documents, and 2) enforcing housing and commerce laws and regulations.
- Created the Office of the Chief Tenant Advocate.
- Restored the Office of Consumer Protection.
- Created the Homeowners Center for small home renovation projects.
- Formed the Illegal Construction Unit to increase safety in construction.
- Reduced the permit application backlog from over 5,200 to less than 400.
- Lowered the vacancy rate by 12% over two years.
- Consolidated 51 stand-alone databases into nine integrated systems.
- Achieved legislative successes including Rent Control reform, the establishment of the Green Building construction code, and expanded Civil Enforcement authority.

Director, Neighborhood Services, Office of the City Administrator
Government of the District of Columbia — July 2000 – January 2005

Created and led this cutting-edge, 16-agency Neighborhood Services program, a community-based, interagency collaborative problem-solving approach to create and sustain clean, safe, healthy, and economically vibrant neighborhoods. Key accomplishments included:

- Successfully implemented an innovative model for achieving positive outcomes in areas formerly plagued with persistent problems such as addressing highly violent neighborhoods with infrastructure and other problems.
- Established interagency, collaborative teams of agency Senior Staff and empowered ward Core Teams to lead, champion, and implement cultural and performance change that mattered to neighborhoods.
- Facilitated systemic change toward performance-based accountability by integrating and linking neighborhood outcomes with agency performance contracts, citywide strategic planning, and budgeting.

Special Assistant, Office of the City Administrator
Government of the District of Columbia — March 1999 – July 2000

- Implemented Mayor's Short-Term Action Team (STAT) activities for the human services cluster to support the public commitments of the Mayor's First 100 Days
- Managed day-to-day interaction between the City Administrator and health and human services agencies with a particular focus on policy and budget issues.
- Managed the complex negotiations regarding the bankruptcy of a hospital in an economically depressed ward with minimum health care options.

Clinical Administrator, D.C. Commission on Mental Health Services
Saint Elizabeths Hospital, John Howard Pavilion — April 1996 – March 1999

- Administered the Forensic Special Treatment Unit and the Forensic Women's Unit.
- Coordinated treatment, evaluations, and facilitated day-to-day operations of units for court-ordered individuals.
- Provided expert testimony in court.
- Supervised psychology trainees in APA accredited training program.

Forensic Psychology Fellow/Psychology Intern, D.C. Commission on Mental Health Services
Saint Elizabeths Hospital, John Howard Pavilion — September 1993 – April 1996

EDUCATION

Doctor of Psychology, Illinois School of Professional Psychology, March 1995.
Master of Education, Counseling & Student Personnel, University of Delaware, June 1986.
Bachelor of Arts, English & Religious Studies, Villanova University, June 1984.

LICENSURE

Licensed Psychologist — District of Columbia

AWARDS

- 2015 Robert L. Sloan Leadership Award, D.C. Hospital Association
- 2015 Meritorious Service Award, Government of the District of Columbia
- 2009 Distinguished Alumnus Award, Argosy University

ASSOCIATIONS

- American Psychological Association

COMMUNITY INVOLVEMENT

- District of Columbia Clemency Board, Member, appointed by Mayor Muriel Bowser, 2020.
- Board of Directors, The Woods at Seaside Homeowners Association, 2015-present.
- Board of Trustees, Capital City Public Charter School: authorized and facilitated the establishment of an Upper School, extending the existing program (Pre K 3 to Grade 8) to include high school, now Pre K 3 to Grade 12 (2009 through 2014).
- Completed seven Century Rides (100-mile bike rides) to raise funds for the Leukemia and Lymphoma Society.

PROFESSIONAL DEVELOPMENT

- Program for Senior Executives in State and Local Government, Harvard University, John F. Kennedy School of Government, February 2000.
- Panelist at the Historical Society of the U.S. District Court of the District of Columbia for the presentation: "Duran and the Evolution of the Insanity Defense."
- Faculty member, Psychiatry Residency Training Program, taught two courses: "Clinical Case Conference" and "Administrative Psychiatry" to third and fourth year residents at Saint Elizabeths Hospital.
- Graduate of the District's first Certified Public Manager program class in 1998.

RESUME

ELIZABETH JONES

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EDUCATION

Bachelor of Arts, English, University of California at Santa Barbara, 1972.

Graduate work (20 credit hours) in Educational Psychology, Georgia State University, Atlanta, GA, 1976-77.

Master of Science, Labor Studies, University of Massachusetts, Amherst, Labor Relations and Research Center, 1982. Thesis focused on the Rhode Island Labor/Management agreement regarding the transfer of public employees from institutional to community-based programs.

Program for Senior Executives in the Commonwealth of Massachusetts, Kennedy School of Government, Cambridge, MA, 1983.

Web-based Certificate Course in Supported Employment, Virginia Commonwealth University, Rehabilitation Research and Training Center on Workplace Supports, Richmond, VA, 2002.

WORK EXPERIENCE

October 28, 2010 to present: **Independent Reviewer**
United States v. State of Georgia

With agreement of the Parties, appointed by the United States District Court to review the State of Georgia's implementation of a Settlement Agreement requiring the development of integrated community-based services and supports as alternatives to institutionalization for individuals with developmental disabilities and/or mental illness.

February 10, 2004 to January 10, 2017: **Court Monitor**
Washington, DC

Appointed as Court Monitor in Federal Court class action litigation, Evans v. Bowser, brought to compel the development of community-based, individualized services/supports for former residents of the District-operated Forest Haven institution (now closed) for children and adults with intellectual and/or developmental disabilities. Responsibilities included oversight of all monitoring activities, management of the Court Monitoring Office, reporting to the Federal Court, and working with the Parties to identify issues/concerns affecting compliance with longstanding court orders and agreements.

November 5, 2003 to December 31, 2004: **Receiver**
Riverview Psychiatric Center/Augusta Mental Health Institute
Augusta, ME

Appointed by the Maine Superior Court in the Bates v. Harvey case, class action litigation brought in 1989 to ensure the provision of mental health treatment to current and former clients of the Augusta Mental Health Institute. Responsibilities included oversight of all Hospital management and operations, preparation and implementation of a work plan that will lead to compliance with the Consent Decree, and monthly reporting to the Court. The Receivership was vacated by the Law Court of Maine in December 2004.

August 1, 2001 to February 10, 2004: **Senior Planner**
District of Columbia
Department of Mental Health
Washington, DC

Within the newly formed Department of Mental Health, responsible for planning systemic initiatives that improve the quality of care/treatment for individuals with serious mental illness. Major responsibility for the Department's evidence-based supported employment initiative, including the Ticket to Work; development of core curriculum for employment specialists; implementation of the Johnson & Johnson-Dartmouth Community Mental Health Program grant award; data analysis of existing employment services; restructuring employment models no longer considered consistent with best practices; and interagency collaboration to expand employment options for adults and youth with serious mental illness/emotional disturbance. Additionally, exercised major responsibility for interagency efforts to improve services/supports for those clients with a dual diagnosis of mental illness/intellectual disability.

June 1, 2000 to August 1, 2001: **Chief Operating Officer**
District of Columbia
Commission on Mental Health Services
Washington, DC

April 1, 2000 to June 1, 2000: **Acting Chief Operating Officer**

Under the direction of the Transitional Receiver, responsible for the day to day operations of the Commission including supervision of all administrative and programmatic functions; working with other government agencies and providers of services/supports to the Commission and its clients; collaborating with consumer groups, advocates, family groups and other interested parties to strengthen the mental health system's responsiveness and effectiveness in meeting its mandates; participating in the design and implementation of systemic reform initiatives; overseeing the investigation and resolution of concerns impeding the delivery of services/supports of the highest possible quality.

February 1998 to April 2000: **Hospital Director**
St. Elizabeths Hospital
Washington, DC

Overall management responsibility for the Acute Care and Continuing Care programs of a public psychiatric hospital then under Federal Court receivership pursuant to orders in the Dixon case, a longstanding class action lawsuit mandating the development of a comprehensive community based mental health system.

Responsibilities included direction and oversight of the provision of active treatment to approximately 375 clients; identification of appropriate community services for individuals no longer requiring stabilization in an inpatient setting; management of personnel and budget; work with advocates, families, legal representatives, community providers, community advocacy groups and public officials. As a member of the senior executive staff, responsible for working with the Receiver and colleagues to design, implement and evaluate strategies for systemic reform. Also responsible for the overall management of the CarePoint Project, an initiative designed to substantially reform and improve the provision of individualized services and supports.

June 1990 to February 1998: **Executive Director**
Disability Rights Maryland
Baltimore, MD.

Disability Rights Maryland, formerly known as the Maryland Disability Law Center, is a public interest law firm funded mainly through federal and state grants and contracts. Pursuant to federal law, it has been designated since 1977 as the Protection and Advocacy System for the State of Maryland. Reporting to an independent Board of Directors, responsibilities as Executive Director included supervision of thirty-six staff, including thirteen attorneys and nine paralegals, and management of a two million dollar budget. Responsibilities also included planning, program implementation, liaison with advocacy groups and state agencies, public relations and playing a key role in the disability and public interest community.

July 1986 to June 1990: **Coordinator**
Dixon Implementation Monitoring Committee
Washington, D.C.

Coordinator for the Dixon Committee, a monitoring group established in 1980 by Federal District Judge Aubrey Robinson in the Dixon lawsuit. The Committee was mandated to receive and analyze defendant's reports and factual investigations; screen and investigate complaints; oversee and report on the progress of the implementation of the Court's decrees. Responsibilities as Coordinator included advising plaintiffs' attorneys at the Mental Health Law Project (now the Bazelon Center for Mental Health Law) and at Covington and Burling on programmatic issues; serving as a liaison between the Committee and its attorneys as necessary; community organizing; conducting site visits; designing public education strategies; extensive public speaking; working with the media; fundraising; and developing and managing student internships with local colleges and universities.

December 1983 to July 1986: **District Manager**
Department of Mental Health
Northampton, Massachusetts

Chief Executive Officer for five mental health and intellectual disability service areas (total population 800,000). Exercised responsibility for an approximately sixty million dollar budget. Overall responsibility for the implementation of the Brewster decree, a landmark Federal Court order governing the use of Northampton State Hospital and the development of community programs for people with mental illness. Responsibility for inpatient services at Northampton State Hospital until reorganization occurred. Extensive experience in working with organized labor, private provider agencies, local and state government officials, consumer and family advocates, the media and a wide spectrum of community groups interested in the mental health system and the implementation of necessary systemic reforms.

Management responsibilities also included planning; program development; program implementation; supervision of senior staff; community relations; dispute settlement; interagency coordination; budget preparation; oversight and monitoring; designation as appointing authority for all area-based state employees.

September 1983 to December 1983: **Director of Planning, Development and Compliance**
Belchertown State School
Belchertown, Massachusetts

Oversaw Belchertown State School's compliance with federal, state and court mandates; coordinated all responses and compliance plans for the court under the Ricci v. Greenblatt decree and for federal Medicaid. Worked with local and state officials and agencies on issues related to the present and future uses of state school property; developed long-range initiatives for the use of state school resources; designed and implemented tools, methods and techniques for monitoring service delivery at the State School; designed and implemented training in quality assurance for staff at all levels of the organization.

August 1982 to September 1983: **Acting Superintendent**
Belchertown State School
Belchertown, Massachusetts

Overall management responsibility for the direction of a large residential facility for individuals with an intellectual disability. Responsibilities included the implementation of a consent decree resulting from a federal class action lawsuit, Ricci v. Greenblatt. Management functions also included personnel authority over 1,400 staff; supervision of senior staff; oversight of budget preparation and spending for direct resources of over twenty eight million dollars in state and federal funds; labor relations; community relations; participation in the planning and implementation of community programs for clients with an intellectual disability in District I; and planning on statewide issues. Initiated the development of self-advocacy programs for the residents of Belchertown State School.

Worked as a primary member of the regional senior management team to plan and ensure the implementation of all necessary reforms in the provision of mental health and intellectual disability services to residents of Western Massachusetts and their families. Worked with senior management colleagues to design, coordinate and evaluate policies and program standards for all components of the systems in Western Massachusetts as mandated by two Federal Court ordered consent decrees.

October 1977 to August 1982: **Director of Employee Services**
Belchertown State School
Belchertown, Massachusetts

Responsible for the direct management and administration of all personnel, staff development and employee assistance programs. Responsible for labor/management activities including participation in state and national initiatives. Regional responsibilities included the development and support of staff development offices and programs. Co-investigator for a federal grant on training and manpower development from 1979-80.

Worked as a member of the regional management team responsible for the design, coordination and evaluation of staff development strategies for mental health and intellectual disability programs in Western Massachusetts as stipulated in two court ordered consent decrees.

April 1977 to October 1977: **Community Residential Services Consultant**
State of Georgia
Division on Mental Health and Mental Retardation
Atlanta, Georgia

Responsible for the statewide planning and monitoring of community residential services for people with an intellectual disability, including those with a dual diagnosis of mental illness, particularly those in transition from institutional settings. Designed specific plans and processes for the placement of five hundred clients from state institutions throughout Georgia.

July 1976 to April 1977: **Advocacy Specialist**
Advocacy Planning Project
Atlanta Association for Retarded Citizens
Atlauta, Georgia

Responsible for the statewide design and implementation of a protection and advocacy system for people with developmental disabilities as specified in Public Law 94-103. Activities included the planning and implementation of public hearings throughout Georgia.

July 1975 to July 1976: **Community Services Consultant**
State of Georgia
Division of Mental Health and Mental Retardation
Atlanta, Georgia

Supervision of community services workers monitoring the placement of people with an intellectual disability who had returned to the Atlanta area from state institutions.

April 1974 to July 1975: **Cottage Life Supervisor**
Georgia Mental Health Institute
Atlanta, Georgia

Supervisor of staff working in a transitional living unit for adults with an intellectual disability, including those with a dual diagnosis of mental illness, previously institutionalized in state facilities.

November 1973 to April 1974: **Assistant Teacher**
Georgia Center for the Multihandicapped
Dekalb County Schools
Atlanta, Georgia

Assisted in the evaluation of school-aged children with multiple disabilities, including deafness and/or blindness. Assisted in the coordination of community-based services for these children in order to support their individual and family needs.

January 1971 to October 1971: **Editorial Assistant**
Department of Anthropology
University of Turin
Turin, Italy

Editing of manuscripts on primate classification. Editing and preparation of journal articles on genetics for the Academic Press, London. Teaching of English to graduate students at the University of Turin.

January 1969 to June 1970: **Board of Education**
Dayton, Ohio

Teacher of remedial class for seventh and eighth grade inner city children bused to suburban school to meet desegregation mandates.

CURRENT CONSULTATION

New York: Expert consultant for the Plaintiffs in Disability Advocates, Inc. v. Paterson, later refiled as O'Toole v. Cuomo, class action litigation brought on behalf of the residents of adult board and care homes in New York (June 2004-present).

Virginia: Expert consultant to the Independent Reviewer for the Settlement Agreement in United States v. Commonwealth of Virginia (July 2012-present).

North Carolina: Expert consultant to the Independent Reviewer for the Settlement Agreement in United States v. North Carolina (March 2015-present).

PAST CONSULTATION

Oregon: Expert consultant to the Independent Reviewer regarding compliance with the provisions of the Oregon Performance Plan (May-June 2018).

Puerto Rico: Assistant to the Court Monitor (January 2016). Under the supervision of the Court Monitor, assisted in the review of an outpatient mental health center previously under Federal Court supervision in Navarro v. Governor.

Maine: Consultant to the Court Master (August 2010 to 2015). Appointed Court Monitor by the Superior Court in order to document the funding for the adult mental health system and describe the impact of that funding on the Defendant's ability to achieve substantial compliance in Bates v. Harvey (August 2008-January 2010).

Consultant to the State Department of Health and Human Services regarding mental health services related to achieving compliance in the Bates v. Harvey case (February-June 2006).

Illinois: Expert consultant to the Court Monitor in Williams v. Quinn, class action case brought on behalf of individuals with mental illness who are confined to intermediate care nursing homes (October-December 2014). Expert witness to the Plaintiffs in Williams v. Quinn (February 2007-September 2010).

Texas: Member of the Monitoring Team reviewing compliance with the Department of Justice Settlement Agreement for Lubbock State Supported Living Center and Austin State Supported Living Center. Designated with expertise in protection from harm (November 2009-January 2013).

Expert consultant for the Plaintiffs in Lelsz v. Kavanagh, a class action lawsuit regarding the rights of individuals with an intellectual disability residing in institutions funded by the State of Texas (1991-1992).

Connecticut: Expert witness for the Plaintiffs in Messier v. Southbury Training School (September 2009-February 2010).

Virginia: Expert consultant to the Virginia Office of Protection and Advocacy regarding the death investigation of an individual confined to a state psychiatric hospital (November 2007-October 2008).

New York: Expert consultant to Touro Law Center in Rothenberg v. State, a case brought on behalf of an individual confined to a state psychiatric hospital (July 2004); Monaco v. Carpinelli regarding involuntary commitment evaluations (August 2006); and Sparks v. Seltzer regarding visitor restrictions on an inpatient ward (December 2006).

Paraguay: Expert consultant to Mental Disability Rights International on the reform of the mental health system in Paraguay. Action was taken pursuant to the Inter-American Commission on Human Rights' decision to grant precautionary measures regarding the Neuro-Psychiatric Hospital in Asuncion (2005-2010).

Kosovo: Expert consultant to Mental Disability Rights International for the development of a plan to assist the government of Kosovo in replacing the Shtime Institution with community based services/supports (November 2006-2007).

Bulgaria: In collaboration with Amnesty International and Mental Disability Rights International, expert consultant for the Bulgaria Helsinki Committee. Visited eight institutions for children and adults with an intellectual disability and/or mental illness in order to provide recommendations for systemic reform. Guest presenter at the Bulgarian Psychiatric Association's annual conference (October 2001-2002).

Massachusetts: Expert witness for the plaintiffs in Rolland v. Celluci. Case involved the right to habilitation for individuals with an intellectual disability/developmental disabilities confined to nursing homes (1999-2004).

Ireland: Guest lecturer to students/faculty at the Center for the Study of Developmental Disabilities, University College of Dublin, on contemporary issues in the field of intellectual disability 1999-2003).

Pennsylvania: Consultant for the Special Master in Halderman v. Pennhurst (May 1996-January 1997).

Romania: Consultant for Mental Disability Rights International on the development of services/supports for people with an intellectual disability (November 1995-1997).

District of Columbia: Expert consultant for the Department of Justice, Plaintiff-Intervenor in Evans v. Bowser, a class action lawsuit filed in Federal Court on behalf of individuals with a developmental disability institutionalized at Forest Haven (February 1995-May 1995).

Massachusetts: Expert consultant for the Defendants regarding the implementation of the consent decrees regarding the state schools (1992).

North Dakota: Consultant for the Protection and Advocacy System regarding systemic issues affecting individuals with mental illness institutionalized in state psychiatric facilities (1992).

Iowa: Expert consultant for the Plaintiffs in O'Connor v. Branstad, a class action lawsuit on behalf of individuals with an intellectual disability residing in two state schools (May 1989 to 1994).

New Mexico: Expert witness in Robbins et al. v. Budke, a class action case concerning access of the Protection and Advocacy System to a state hospital (December 1989).

Michigan: Expert witness in Kope v. Watkins, a class action lawsuit on behalf of individuals with an intellectual disability living in nursing homes (January 1989-1993).

Louisiana: Consultant to the Special Master in the Gary W. case in the New Orleans region (Spring 1986).

England and Wales: Consultant on the development of intellectual disability services for the Sheffield Health Authority, Manchester Health Authority and NINROD of Cardiff, Wales (October 1984).

PRIOR WORK IN OTHER LITIGATION

In Monaco v. Carpinelli, Sparks v. Seltzer, and Williams v. Quinn, I was deposed.

In Rolland v. Celluci, DAI v. Paterson and Messier v. Southbury Training School, I provided deposition and trial testimony. In Williams v. Quinn and O'Toole v. Cuomo, I testified at the Fairness Hearings.

In Robbins et al. v. Budke, I provided trial testimony.

Exhibit 3

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

Thomas Wilkes, et al.,	)	
On behalf of themselves and	)	Civil No.: 3:20cv594
all other persons similarly	)	
situated,	)	
Plaintiffs,	)	
v.	)	
	)	
Ned Lamont, Governor, et al.,	)	
Defendants.	)	May 24, 2020

Affidavit of Carson Mueller

I, Carson Mueller, being of lawful age and understanding the obligation of an oath to tell the truth, after being so sworn, and upon personal knowledge, state and allege as follows:

1. I am a 45-year-old man and was committed to the jurisdiction of the Psychiatric Security Review Board (PSRB) on June 25, 2009.

2. I have been committed to Whiting Forensic Hospital (WFH) for almost 11 years.

3. I was born in San Rafael, California. A few years later my family moved to Washington State. Since then I have traveled as far north as Anchorage, Alaska and as far south as Melbourne, Australia.

4. In my early twenties I studied classical, renaissance, and modern drawing, painting and sculpture at the Lyme Academy of Fine Arts. I also

studied classical guitar with a professional instructor. I have auto didactically studied philosophy. I have also worked as a carpenter for a remodeler, a waiter in a fine restaurant, a medical courier, and an art teacher.

5. I have two daughters, Anna and Niomi.

6. I reside on Dutcher Hall South 3 (DS3). I am a full Level 4 with six pass times on campus. My mental health condition is stable, and I voluntarily comply with treatment, individual therapy and some group therapy. I do not have a conservator. My treatment team has told me that my mental health condition is in complete remission, and I do not need or take psychiatric medication because I do not have any symptoms. My treatment team closely monitors me for mental health symptoms. In my ten years of commitment to WFH, I have never had a relapse or been violent.

7. I was admitted to Whiting Max on June 25, 2009 and resided there until October 21, 2014, when I transferred to DS3. I have resided on DS3 from October 21, 2014 to the present.

8. I was approved for temporary leave by my DS3 treatment team, the Forensic Review Committee, the Consulting Forensic Psychiatrist, and the PSRB on March 19, 2019 and started temporary leaves in Torrington with Western Connecticut Mental Health System in April, 2019. Temporary

leaves permit patients to leave the hospital and engage in treatment and reside in the community for anywhere from one to seven nights each week.

9. After doing well with my temporary leaves to Torrington for almost six months, the transportation arrangements changed. WFH added another patient's temporary leave to Waterbury with my transportation. This change doubled my drive time to almost four hours each trip and caused me to be late to my check-in at Torrington at times. After numerous discussions about these problems with my treatment team, I decided to suspend by temporary leaves until the transportation problems could get resolved.

10. Most patients on DS3 have a legal status of acquittee committed to the PSRB. There are approximately 20 patients on DS3, including about 15 men and five women. There is a female bedroom wing, a male bedroom wing, staff offices, two bathrooms, a laundry room, a day room, the treatment team meeting room, the nurses room, a TV room, and a small meeting room.

11. It is impossible to keep social distancing of six feet from other patients on the unit. Some patients sneeze or cough without covering their mouth and nose and without wearing a mask. Some patients struggle with more significant symptoms of their mental health condition.

12. My day starts at 7 a.m. I get up and use the men's restroom. The room is relatively small for a unit of 15 men. There are two showers in a separate room, two sinks, two urinals and two toilets. At 7 a.m. and throughout the day there are always many other people in the bathroom. It is impossible to keep a social distance of at least six feet. Patients are coughing, sneezing, talking, and blowing their noses. No one wears a mask in the bathroom.

13. We line up to go to breakfast in the dining room, which is three floors down in the basement of Dutcher Hall. Some patients use the elevator and some use the stairs. I take the stairs because the elevator is too small and I am afraid of excessive virus risk in such a small enclosed space with five to ten people in it, shoulder to shoulder and without masks.

14. Once in the dining hall, we line up again to get our trays. We are shoulder to shoulder. There are three to five staff present, and most wear masks. Very few patients wear masks. Many times, other units' patients and staff mix with our unit during breakfast. The dining room has about 10-12 tables. We all sit next to each other and eat breakfast.

15. After breakfast, I go back to DS3, again using the stairs and again in close proximity to other patients also using the stairs. Sometimes

staff require us to use the elevator. Once on the unit I use the bathroom again.

16. At 9 a.m. I have an hour pass where I get out, walk, exercise, read, and meditate on grounds close to Dutcher. I have to check back in with the unit at 9:55 a.m. and then go back out for another pass at 10 a.m.

17. At 11:40 a.m. I am back on the unit, go to my room, use the bathroom, and get ready for lunch. The unit's residents go back to the dining room for lunch at 11:45 a.m. The situation at lunch regarding lack of social distancing and use of masks is similar to what I describe above regarding breakfast. Residents are in close proximity as they take the elevator or stairs to get to the dining room, stand in line, and then sit at tables while eating.

18. I usually do not have any treatment, group therapy, or individual therapy in the morning.

19. After lunch I am back on the unit until 1 p.m., when I go back outside for another pass. I come back in at 1:55 p.m. and then go out for another pass at 2 p.m. until 2:45 p.m. Second shift starts at 3 p.m. and residents have to be back on the unit from 3 p.m. to 6 p.m. for shift change and dinner.

20. My final pass time, only available in late spring, summer and fall, is from 6 p.m. to 7 p.m.

21. I come back in for the day at 6:55 p.m., read in my room, and then go to bed about 9 p.m. I have a roommate. Our beds are approximately five feet apart.

22. I do attend a group called forensic group. I do not take psychiatric medication. The most helpful treatment I receive is one hour a week of individual therapy with Dr. Papapietro, a psychologist. I have been in individual treatment with him for ten years. He is a good therapist and has helped me work through my index incident, the antecedents to the incident, the reasons for it, the consequences to others as a result of what I did, and how I can come to terms with it and move on, take responsibility, and never commit another act of violence on another person again.

23. I have participated in individual therapy and group psychotherapy with several different psychologists for about ten years. Up until the last year I attended dialectical behavior therapy (DBT) group, Start Now group, and many occupational therapy groups. I benefitted greatly by the groups in Torrington when I was out on temporary leave.

24. During my temporary leaves away from WFH, which occurred from approximately April 1, 2019 to October 1, 2019, I attended groups at

Western Connecticut Mental Health Network (WCMHN) in Torrington. It was such a wonderful experience to finally be out of the psychiatric hospital away from the same staff, same patients, and same routine, day after day, year after year.

25. The staff with Western Connecticut Mental Health Network (WCMHN) in Torrington treated me with respect and warmth. I started feeling better about myself and life, and by contrast, realized how dehumanizing treatment at Whiting Forensic Hospital can be at times. The treatment team at WCMHN was ready to move me into an apartment program with wrap-around supports and services.

26. In February 2020, I became concerned about my health, safety, and welfare from being locked on a confined unit with 20 other patients with the start of the coronavirus outbreak and pandemic.

27. On March 16, 2020, a patient on our unit was diagnosed with pneumonia and sent to Middlesex Hospital. Our unit was essentially closed off. All pass time was cancelled. We were quarantined and confined to the unit. No visitors were allowed. Everyone on temporary leave was called back, and scheduled leaves were cancelled. There were two patients on temporary leave who were pulled back from their community placement and confined to our unit. We told staff that we were willing to clean the unit

with disinfecting wipes and asked to be given wipes for use in our rooms and in the bathrooms. We were denied. We asked for Purell, but we were denied because it has alcohol in it.

28. On March 17, 2020, we were told that the patient taken to the hospital tested negative for the virus, and our quarantine ended. The unit director told me that the DMHAS medical director was considering revoking all pass time at Connecticut Valley Hospital (CVH) and WFH. On March 19, 2020, staff told me that if anyone in the hospital tested positive, the administration will take away all pass times for all patients. Fortunately, once positive tests started being discovered, pass time was not revoked. This was distressing, both in the message and the tone of its delivery.

29. As of March 25, 2020, as the pandemic was heating up and patients were testing positive in Woodward Hall in CVH, maintenance staff came on the unit once a day in the morning and cleaned for approximately 60-90 minutes. Everyone on temporary leave was pulled back on the units except for patients who had Phase 2 temporary leave with full seven-day overnights in place. Dr. Papapietro, my clinician, was self-quarantining, so my only hour of therapy each week stopped. My individual therapy resumed a few weeks later but was conducted over the phone.

30. On March 30, 2020, WFH administration restricted patients' ability to move about the campus and allowed us to go no farther than the front of Dutcher Hall. We had been able to go into Page Hall and the walking track and chapel which are only a few hundred yards away on campus. Those areas were all restricted. If people went past the allowable boundary they were punished, labelled as an AWOL, their privilege level was revoked, and they were confined to the unit.

31. On April 2, 2020, WFH administration told us that anyone testing positive for COVID-19 would be sent back to the gym in Whiting Max, which had been turned into a quarantine unit. This frightened me and many other patients because most of us have experienced abuse by other patients and staff in WFH Max.

32. On April 18, 2020, the Connecticut Legal Rights Project (CLRP) wrote a letter to the Governor and the Attorney General requesting that immediate action be taken to protect us from the coronavirus by stopping admissions, discharging as many patients as possible who can move safely to the community, and testing and providing us with safe conditions of confinement.

33. On April 22, 2020, CLRP wrote to the WFH administration requesting that masks be made available to patients.

34. On April 23, 2020, we were all offered masks for the first time. A MHA had created homemade masks for us and wanted to offer them to us. WFH administration refused to let her offer patients the homemade masks, asserting that it might scare some of the patients.

35. On or about April 23, 2020, I asked that residents be allowed to open windows. I also asked that action be taken to reduce crowding on the elevator, that the bathrooms be cleaned at least once every shift, and that soap dispensers be kept full. Staff told me that I should not worry and that I was in the safest place right now.

36. On May 6, 2020, I asked staff if the stairwell could be kept open so that residents never had to use the elevator. I was told no. I asked for wipes and was told no. WFH administration refused to make even minor modifications to their rules and procedures, even in the face of a pandemic.

37. On or about May 8, 2020, a staff person told me that another MHA was working at a nursing home on her own time and then coming to work at Dutcher Hall.

38. On or about May 9, 2020, WFH nursing staff started to take residents' pulses and O2 saturation with a pulse oximeter. I thought this was great until I saw patient after patient being fitted with the finger pulse oximeter without it being cleaned between each use. I asked for the pulse

oximeter to be wiped clean between uses, but the nurse was dismissive. The nurse sought to take my vitals with a stethoscope, and I asked for it to be cleaned too. She refused, so I declined to have my vitals taken. The nurse then told me that she was going to have to report me "for being so oppositional that you won't even let me take your pulse." All I wanted was clean instruments during a pandemic. Shortly thereafter, when I declined to consent to my vitals being taken with unsanitized equipment, the nursed asked, "Do I have to have the team diagnose you with OCD?"

39. On Sunday, May 10, 2020, when I went to the bathroom, the soap dispenser was empty. Housekeeping staff only work Monday through Friday. So if, as happened on May 10, the soap runs out by Sunday, we cannot properly wash our hands until the housekeeping staff returns. MHA's are reluctant to change the soap because it is not their job.

40. Another day, when I went to the dining hall for breakfast, the residents of Dutcher North 2 (DN2) were also using the dining hall. We are supposed to be separated and not mix with other units due to the virus. We were forced to eat with DN2 residents who had only been off quarantine for two days. There were now residents of three different units crowded into the dining room, many sitting or standing shoulder to

shoulder, in violation of my understanding of the protocols designed to stop the spread of the virus.

41. On May 13, 2020, I talked to a staff person from another unit, who told me that WFH administration should be asking staff about outside employment because some staff were working at nursing homes that have residents with COVID-19 and then coming to work at Dutcher Hall.

42. There are only two phones on my unit for 20 patients. The phones are in the day room. The phones are heavily used throughout the day. Some days, the phones are not cleaned at all. At most, phones may be cleaned once or twice a week. Other days, they are cleaned once a day by maintenance staff. Residents are not allowed to have disinfectant wipes to clean them.

43. DN2 had a patient get really sick, and he was taken by ambulance to Middlesex Hospital. He tested positive for the virus, so DN2 residents were quarantined for 14 days. While DN2 was quarantined, staff from DN2 was mandated for overtime and floated to other units.

44. On May 14, 2020, I went down to lunch at 11:45 a.m. Another unit came down at the same time. I told staff that I thought that the units were supposed to be kept apart and staff told me, "We are doing the best we can."

45. On May 19, 2020, the soap dispenser in the bathroom rant out of soap again.

46. All twenty patients share one communal dental floss container that is handed out individually to each patient upon request. It is never cleaned and staff do not wash their hands before giving it to patients.

47. Patients are not allowed to use alcohol-based hand sanitizer.

48. One communal pen is used by all patients when signing out on pass each hour. I have never seen the pen cleaned.

49. Sometimes nurses do not wash their hands before dispensing medication or between dispensing medication to different patients.

50. The risk of infection and death from COVID-19 is significant at this time and for the foreseeable future until a vaccine can be developed and administered. I have recovered from my mental health condition and it is currently in remission. I have not been a danger to myself or others for over ten years. I already have been approved for and attended six months of temporary leave. I should be given a discharge or a conditional discharge because I am no longer mentally ill, am not a danger to myself or others, and discharges and reduction of census at WFH and in Dutcher Hall will mitigate the risk of infection and death of those who may need to stay in the hospital.

Carson Mueller

State of Connecticut)
) ss: at Middletown
County of Middlesex)

Subscribed and sworn to before me on this 24th day of May, 2020.

Commissioner of the Superior Court

Exhibit 4

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

Thomas Wilkes, et al., On behalf of themselves and all other persons similarly situated, Plaintiffs,	)	Civil No.: 3:20cv594
v.	)	
Ned Lamont, Governor, et al., Defendants.	)	May 23, 2020

Affidavit of Vincent Ardizzone

I, Vincent Ardizzone, being of lawful age and understanding the obligation of an oath to tell the truth, after being so sworn, and upon personal knowledge, state and allege as follows:

1. I am a 58-year-old man and was committed to the jurisdiction of the Psychiatric Security Review Board on March 5, 1993.

2. I have been committed to Whiting Forensic Hospital (WFH) for 27 years.

3. Before I was committed to WFH, I was married, had a daughter, and owned two of my own businesses.

4. I reside on Dutcher North 3 (DN3). My status is "limited Level 4," and I receive pass times that allow me to leave DN3 at certain times. My

mental health condition is stable, and I voluntarily comply with treatment. I do not have a conservator. I work on campus in the dining room.

5. My master treatment plan, dated April 14, 2020, states that "Mr. Ardizzone has been compliant with medications and has been free of psychotic symptoms for 15 years."

6. On March 3, 2020, Dr. Marc Hillibrand, a psychologist who worked at WFH for 26 years and treated me, testified under oath that he recommended that Mr. Ardizzone be discharged from the hospital because he did not pose any danger to himself or others. (Transcript attached as A.)

7. Dr. Rossina Bandanza, my treating psychiatrist for several years, testified under oath on March 3, 2020 that I was stable psychiatrically, had problems following small rules that had nothing to do with my mental health, and that I was consistently not a danger to myself or others while she treated me. (Transcript attached as B.)

8. Dr. Gregory Peterson, a psychiatrist at WFH who treated me as my attending psychiatrist for two years and has known me for almost 20 years at the hospital, testified under oath on March 3, 2020 that I am not a danger to myself or others and not gravely disabled. Dr. Peterson also testified that, "I think [his continued hospitalization] is a cruel and unusual

punishment. I think it violates the Eighth Amendment." (Transcript attached as C.)

9. On November 5, 2019, Dr. Edward G. Meyer, a physician with Middlesex Urology, diagnosed me with Stage IV prostate cancer. I started radiation treatment on May 11, 2020. (Dr. Myer's April 22, 2020 letter attached as D.)

10. Dr. Meyer stated that I am at increased risk of COVID-19 because I live in a group setting, have a long smoking history, and a history of emphysema.

11. DN3 is an inpatient unit with 21 other patients, all of whom are male.

12. DN3, to my knowledge, has not had a patient who has tested positive for COVID-19. Dutcher North 2 and Dutcher South 2 have both had patients who were symptomatic or tested positive for the virus, resulting in the residents of those units being quarantined.

13. There are three shifts of staff that come on and off DN3. First shift has professional staff, including a psychiatrist, psychologist, social worker, rehabilitation therapist, and two nurses. There are usually four mental health associates, who function as front-line staff. On the second and third shifts, there is a nurse and three or four mental health associates.

14. I sleep in a room with one roommate. Our room is about 10-12 feet square. We both have beds that are about four to five feet apart. I usually sleep from 9 p.m. to 5:30 a.m.

15. I usually get up at approximately 5:30 a.m. I go to the bathroom. All 22 patients share one bathroom. There are three stalls, two urinals, three sinks, and four showers. There are often five or more patients in the bathroom at any one time from 5:30 a.m. to 8:30 a.m. Patients are almost always closer together than six feet apart, usually just a foot apart. Very few patients are wearing masks.

16. There are three soap dispensers in the bathroom. Soap runs out sometimes on the weekend because maintenance-cleaning staff do not work on the weekends. Hospital administration have determined that we cannot have Purell or any hand sanitizer that has any alcohol in it. Apparently someone has determined that the small risk of someone ingesting hand sanitizer outweighs the risk of contracting a deadly virus in a pandemic.

17. WFH did not provide any masks to patients until the Connecticut Legal Rights Project asked for masks for all patients on April 22, 2020. Masks were provided the next day, on April 23, 2020.

18. Wearing masks is encouraged but not enforced. Most staff, but not all, wear masks regularly. Many patients are not wearing masks.

19. DN3 goes to breakfast as a whole unit, all 22 of us at one time. The dining hall is in the basement of Dutcher Hall, four floors down. There is one elevator in the building. The elevator is about four feet wide by eight feet long. Every day, some pack into the elevator shoulder to shoulder and head down for breakfast. Some patients line up at the stairwell and are escorted down the stairs and we are close together. I take the stairs down and the elevator up.

20. The Dutcher dining hall is in the basement. It is a large open room with about 10 tables. We stand in line shoulder to shoulder, get our trays, and sit down at tables with no masks and no gloves. Sometimes there are two units all in the dining room at the same time. There is no social distancing. We all eat close to other people, within six feet. We have thirty minutes to eat breakfast from 8 a.m. to 8:30 a.m.

21. After breakfast on Wednesday we have a unit community meeting, where unit residents gather in close proximity in the day room. Having been in Whiting Forensic Hospital for twenty-seven years with my mental health condition in full remission, I rarely attend.

22. The first pass time is at 9 a.m. Pass time is allowed for people who have worked their way through the system of behavioral control and clinical stability to have a status of Level 4 with pass time. Level 1 is confined to the unit. Level 4 is the highest level. A full Level 4 gets pass time out of the building for one hour at a time without direct staff supervision. There are cameras all over campus and an entire unit of DMHAS Police on grounds.

23. Currently I am escorted to my radiation therapy for Stage IV prostate cancer every morning. The radiologist's office is in Middletown. I go every day from 9:30 a.m. to 11 a.m. I will have radiation treatment for nine weeks.

24. I am currently a limited level four with two pass times, 10 a.m. to 11 a.m. and 11 a.m. to 11:30 a.m. I use the pass times to walk and socialize.

25. When I am on the unit, I play cards on the unit with other patients and staff.

26. At noon we go to lunch to eat. I take the stairs down to the dining room and the elevator up. There are six or seven people in the elevator when we go up. Lunch is from noon to 12:30 p.m.

27. In the afternoon I play cards, watch TV, or go on walks with staff on campus.

28. I have PSRB group on Tuesdays from 2:45 p.m. to 3:30 p.m. I have individual therapy on the phone with Dr. Conover on Thursdays from 10 a.m. to 11 a.m., though the exact time may vary. I work in the dining room on Tuesdays and Fridays from 3:45 p.m. until finished with dinner.

29. Dinner is from 4:45 to 5:15 p.m.

30. In the evening the last pass is 6 p.m. to 7 p.m. This is only in the spring, summer and fall. I play cards with staff or watch TV until bed. Again, social distancing is not enforced.

31. Bedtime is about 8:30 p.m. to 9 p.m. for me.

32. My highest risk of getting infected is from staff from one of the three shifts. We often have staff that are mandated to work a double shift from another unit. Staff do not always wear their mask. I don't feel safe with staff working doubles onto our unit back-to-back.

Vincent Ardizzone

Vincent Ardizzone

State of Connecticut)
) ss: at Middletown
County of Middlesex)

Subscribed and sworn before me on this 23rd day of May, 2020.

Commissioner of the Superior Court

NO. AAN-CR91-09294-T	:	SUPERIOR COURT
STATE OF CONNECTICUT	:	JUDICIAL DISTRICT OF ANSONIA/MILFORD
v.	:	AT MILFORD, CONNECTICUT
VINCENT ARDIZZONE	:	MARCH 3, 2020

HEARING

BEFORE: THE HONORABLE PETER BROWN, JUDGE

A P P E A R A N C E S:

Representing the State of Connecticut:

ATTORNEY MARGARET KELLEY
State's Attorney
14 West River Street
Milford, Connecticut 06460

Representing the Defendant:

ATTORNEY PETER MANKO
Law Office of Peter Manko
141 Durham Road, Suite 18
Madison, Connecticut 06443

Recorded By:
Lisa Feiler

Transcribed By:
Lisa Feiler
Court Recording Monitor
14 West River Street
Milford, Connecticut 06460

EXHIBIT
A

DR. MARC HILLIBRAND, CALLED AS A WITNESS ON BEHALF OF THE DEFENDANT, HAVING BEEN DULY SWORN BY THE CLERK OF THE COURT, WAS EXAMINED AND TESTIFIED AS FOLLOWS

THE CLERK: Please state your name and address, your work address, for the record and spell your last name, please?

THE WITNESS: Marc, with a C, last name is H-I-L-L-I-B-R-A-N-D. The address is 11 South Main Street in Middletown, 06457.

THE CLERK: Thank you.

THE COURT: Please be seated, doctor. Good afternoon.

THE WITNESS: Good afternoon.

THE COURT: Attorney Manko.

ATTY. MANKO: Thank you, Your Honor.

DIRECT EXAMINATION BY ATTORNEY MANKO:

Q Good afternoon, Doctor Hillibrand.

A Good afternoon.

Q If you could please state your educational background?

A Yes. I have a PhD from Kent State University in Clinical Psychology. I did a postdoctoral training at the Whiting Forensic Institute in Connecticut and then worked there for another 26 years and became a Director of Psychology until I retired. And then I moved to full-time private practice which is what I do now, including forensic assessments.

Q And how long did you say you were at CVH?
A A total of 26 years, most of them at Whiting.
Q And what were your responsibilities there?
A Well, I started off as a unit psychologist at the Whiting maximum security building, and that's actually where I originally met Mr. Ardizzone in the 90's. And my duties involved the treatment of insanity equities and then also preparing forensic reports on them and testifying to the courts, including the Psychiatric Security Review Board.
Q You mentioned -- When did you first meet Mr. Ardizzone?
A In the mid 90's. He resided on several units at Whiting and our paths crossed, I think, twice in the 50 years or so that our tenures overlapped.
Q Since you've been in private practice, how did you come to meet or be associated with Mr. Ardizzone?
A So in 2017 you requested that I conduct a psychological evaluation and a forensic evaluation of Mr. Ardizzone, which I did, and I then, in 2017, prepared a report based on that evaluation. And I have updated my assessment of him once last year in preparation for a court hearing and again last month I met with him a few times to find out from him what the developments had been since the original evaluation in 2017.
Q And, so, if you could just articulate for the Court what exactly you did in the last interviews and evaluation?
A So initially I gave him a full battery of

psychological tests. I reviewed the existing records, both legal and medical records. I interviewed him. And more recently I read the current medical records and legal documents, such as the memoranda from the Psychiatric Security Review Board and reports by CVH to the Board.

Q When you first testified on behalf of Mr. Ardizzone, you recommended discharge, correct?

A That is correct.

Q And has anything changed?

A No, this continues to be my opinion that he should be discharged.

Q If you could reflect on your reasons for reaching that conclusion.

A So that conclusion is based on my assessment of him as an individual who, first of all, has intact intellectual resources; he functions in the low average to average range. He suffers from a type of schizophrenia that it is his good luck, responds to medication. He had one psychotic episode at the time of the incident offense, which is when he committed that offense that he was later found not guilty by reason of mental disease or defect. And once treated with medication he remitted very promptly and has really remained free of psychotic symptoms for the vast majority of the last two plus decades. He had one brief flare-up of symptoms in the 90's, the one time he stopped taking medication which is more than 20 years ago. And then around 2006 there was -- he was under various stressors and he started showing some symptoms. He has shown no symptoms of psychosis for the -- more than ten years.

I also see in him a commitment to take medication, to follow the advice of his treaters, in all areas but one and it's one that's very significant in terms of his care, which is that he has historically and continuously shown disregard for rules, the rules of the hospital, the rules imposed on him by the Psychiatric Security Review Board, and I view that as part of his personality, a relatively mutable factor that's very self-defeating because if he had gone along with the rules imposed on him by the board, by the hospital, he probably would have been discharged many, many years ago.

So I think in terms of his -- the stability of his response to medication, the clarity of his diagnosis, his commitment to taking medication and to work with his treaters, I view him as somebody who has not really presented a risk of violent recidivism in more than ten years. This has actually led to the Psychiatric Security Review Board granting him temporary leaves. He was out of the hospital for many, many years, even holding jobs where he was manipulating kitchen knives all day long for a couple of years. So if he had -- He had plenty of opportunities to recidivate and they never occurred. Most of the reasons that have brought him back to the hospital were a violation of rules, such as no female visitors overnight that haven't been approved by the Psychiatric Security Review Board, no lottery tickets, even legal lottery tickets, smoking in places he's not allowed to smoke and that sort of thing. So to me, although those are significant factors, they're not significant with respect to the risk he poses. I think the risk he poses is minimal.

Q You said from your review of the record that he was returned to the hospital four years ago based upon rule violations. From your perspective as a member of the hospital team for many years, what would you imagine the purpose would be to return him to the hospital?

A Well, I think the purpose of returning him to the hospital is the following: the Psychiatric Security Review Board operates within a structure and functions in a matter that basically goes like this. It says we want people to adhere to their treatment. We want them to take medications. We want them to follow psycho-social treatments like therapy, et cetera. Then we want to see some progress in terms of symptoms, see if they improve, if they can become free of symptoms. And then as this is demonstrated over time and they abide by the various rules, whatever they may be, the rules imposed by the Board or the hospital, as a function of that demonstrated "good behavior," the individual, the acquittee, gets awarded more privileges, more freedom, more autonomy, can at some point move to the community and be increasingly involved with all decisions that affect his or her care; that's the model. For most individuals that model works and people respond to treatment, get better, follow the rules, and end up in the community and eventually discharged, and I've witnessed many of those. And for some of these people they were much more symptomatic than Mr. Ardizzone is. But in his case these recurrent rule violations have periodically brought him back and so here we are.

Q And when you say other patients that follow the rules are more symptomatic, what do you mean by that?

A No. What I meant to describe is that some people, a number of people, have been released to the community and eventually discharged from under the Board, from the oversight of the Board, who had more symptoms of psychosis than he does. He has, essentially, been free of psychotic symptoms for certainly ten plus years, of any symptoms.

Q The rules that are promulgated are -- what's the basis for the rules?

A Well, the basis of the rules is in part -- The rules that come from the hospital have to do with the proper running of a hospital. As a hospital you're responsible for the well-being of your folks. There are even state laws about smoking in public places, so therefore the hospital cannot allow smoking on the hospital grounds, for example, so that's the purpose of some of the rules. The other rules, such as those imposed by the Board, are for the safety but in a very broad sense. So, for instance, if the Board wants to approve female visitors, in part to assure that they're not ex-felons and that's one of the things that they check, and whether they think this might be a bad influence on the acquittees.

Q But in Mr. Ardizzone's case, prohibition against gambling, associating with women not approved, is there a therapeutic basis to that?

A I would say it's not a therapeutic basis, it's a risk management basis. So, for instance, with the prohibition against gambling is generic, it applies to all the -- as far as I know applies to all acquittees. They're not allowed to consume alcohol. They're not allowed to gamble and they're not allowed to associate with people who've been convicted of crimes.

Q So in the recent few years you've had contact with Mr. Ardizzone, has he experienced, maybe not traumatic, but events in his life that you've discussed with him?

A Well, I would say the most significant of those is his recent diagnosis of prostate cancer. So that would be a considerable stressor to anybody. I think somebody in his position, anybody with a significant psychiatric illness would be burdened even more by that. And I think the fact that he has been very measured in coping with that, going for treatment and maintaining his good spirits and his collaboration with the team and with his oncology treaters, shows that he's capable of handling a very significant -- what would be a very significant stressor for any of us.

Q So I will ask you again, it's your opinion that if the Court were to grant his application that Mr. Ardizzone would fare well in the community without oversight by the

DR. ROSINA BANDANZA, CALLED AS A WITNESS ON BEHALF OF THE DEFENDANT, HAVING BEEN DULY SWORN BY THE CLERK OF THE COURT, WAS EXAMINED AND TESTIFIED AS FOLLOWS:

THE CLERK: Please state your name and work address for the record and spell your first and last name, please.

THE WITNESS: My name is Rosina Bandanza, R-O-S-I-N-A B-A-N-D-A-N-Z-A. And my address is 915 River Road in Middletown, Connecticut.

THE CLERK: Thank you.

THE COURT: Good afternoon. Attorney Manko.

ATTY. MANKO: Thank you, Your Honor.

DIRECT EXAMINATION BY ATTORNEY MANKO:

EXHIBIT
B

Q Good afternoon, Doctor.
A Good afternoon.
Q Could you please state your educational background and professional experience to the Court?
A Yes. I am a graduate of medical school in the Dominican Republic, The Universidad Nacional Pedro Henriquez Urena. And I came to the U.S. to specialize in psychiatry. I did my four year specialty at St. Vincent's Medical Center of Richmond in Staten Island. After that I did one year of fellowship specializing in psychodynamic psychotherapy at Yale University from 1994 to 95.

I have worked with the State of Connecticut since 1998. The vast majority of my career was with the Department of Mental Health and Addiction Services where I functioned mostly as an outpatient psychiatrist in different locations.

I also have worked at Whiting Forensic Hospital. I worked there from August of 2016 until March of 2019.

Q And where are you currently?

A Currently, I am working at the Solnit Children's Center in Middletown which used to be the Riverview Hospital.

Q And are you familiar with Vincent Ardizzone?

A Yes, I am.

Q And how are you familiar with him?

A I'm familiar with him because he was under my care while I was working at Whiting Forensic Division, Dutcher, and he became my patient, I believe, in December of 2016, and he was under my care until March of 2019.

Q And what can you tell us about Mr. Ardizzone, his diagnosis and his treatment while under your care?

A Well, his diagnosis was schizophrenia and he was treated with antipsychotic medication, injectable formulation that he would get every two weeks. Mr. Ardizzone responded very well to the treatment. When I first started treating Mr. Ardizzone he had been psychiatrically stable for 12 years. No psychotic symptoms in that entire period of time. And I simply continued the medication that he was already on because of his stability. He was always compliant with the medication and didn't report side effects.

Q And you're familiar with his deficiencies, correct?

A Yes.

Q Which are?

A Well, his deficiencies are that he doesn't have too much patience with the system. It seems like at times he doesn't follow the rules, you know, like the hospital rules or the rules that are set forth by the PSRB and things like that. But I think that most of the times when this happens it's really out of his frustration because of the extensive period of time that he finds himself confined, you know, in a maximum security or moderate security facility. I think it's just, kind of, acting out some of that anger and that frustration.

Q And how does he express that anger and frustration?

A Well, he challenges, sometimes, the rules, you know, questions the motivation, you know, behind certain hospital rules. For example, when I started working at Connecticut Valley Hospital patients were able to smoke inside the hospital. And then they were able to smoke not in the hospital but on grounds. And then that was, you know, stopped. So, you know, he often would bring that to the front, like it's really not fair. We don't have too many pleasures available to us here. Why can't we smoke? So that's most of the manifestations, you know, like violating the rule of smoking on campus.

Q Did you find that to affect his psychiatric condition?

A No.

Q So the last time you were his treating physician was, did you say, in 2000?

A 2019.

Q 2019. About a year ago?

A Yes.

Q Have you been in communication with Mr. Ardizzone since?

A Yes. Mr. Ardizzone contacts me at my place of employment every so often, maybe once or twice a month.

Q And what's the subject of those conversations?

A Well, the subject is his pursuit of freedom. You know, his frustration with the fact that he's been stable psychiatrically for so long and he still finds himself confined.

Q And while you were the treating psychiatrist, was there discussion with regard to applications for temporary leave?

A Yes, there were.

Q And what became of those?

A Well, the problem was that because he would break some of the rules, you know, it kind of hindered on our ability to move forward many times. Because, for example, there was a system in Dutcher where you progress in your level of privilege, meaning the amount of freedom that you have, right. And, so, it's usually the norm that in order to start that process of temporary leave applications, the patient has been at the maximum of that level of freedom and autonomy for an extended period of time, which means like a full level four. And, so, Vinnie had trouble maintaining his full level four, not because he was psychiatrically unstable but because he was tempted sometimes to smoke outside. So that was the main reason why it's taken this long.

Q Again, it had nothing to do with his psychosis?

A No.

Q And as his treating psychiatrist, what kind of therapy or what would he receive in the hospital outside of medication?

A Well, when he was in the hospital he received individual psychotherapy with a psychologist. He went to group therapy. He did rehabilitation activities. Mostly that.

Q And while you were his treating physician, did you find him at all times to be not a danger to himself or to others?

A Yes. I consistently found him to be not a danger to himself or to others.

ATTY. MANKO: I have no other questions. Thank you.

THE COURT: Attorney Kelley.

ATTY. KELLEY: Thank you.

CROSS-EXAMINATION BY ATTORNEY KELLEY:

Q Good afternoon, Doctor.

DR. GREGORY PETERSON, CALLED AS A WITNESS ON BEHALF OF THE DEFENDANT, HAVING BEEN DULY SWORN BY THE CLERK OF THE COURT, WAS EXAMINED AND TESTIFIED AS FOLLOWS:

THE CLERK: Please state your name and work address for the record and spell your first and last name.

THE WITNESS: Dr. Gregory Peterson, P-E-T-E-R-S-O-N. Address, 47 Walkley Road, West Hartford, Connecticut.

THE CLERK: Thank you.

THE COURT: Good afternoon, Doctor.

THE WITNESS: Good afternoon.

THE COURT: Attorney Manko.

ATTY. MANKO: Thank you, Your Honor.

EXHIBIT
C

DIRECT EXAMINATION BY ATTORNEY MANKO:

Q Good afternoon, Doctor. If you could let the Court know your educational background and profession experience, please?

A Yes. I've been a board certified psychiatrist for 23 years. I've worked in the State of Connecticut for 23 years and I've worked at Whiting Forensic Hospital for 13 years. I worked at St. Francis Hospital for approximately 8 years and I've also worked for Catholic Charites and the Probate courts here in Connecticut. So I've various experiences with thousands of patients and I've known Vinnie at Whiting Forensic Hospital for 13 years.

Q You're anticipating one of questions. How do you know Mr. Ardizzone?

A I've known him ever since I've been at Whiting, I've known Vinnie. He was on my unit for approximately two years so I was directly involved with his care. But since then I've known him peripherally by doing mental status exams and seeing him in various occasions and case conferences and various meetings.

Q And from your knowledge, just briefly tell the Court, Vinnie's diagnosis?

A His diagnosis has been in the psychotic realm of schizophrenia, that's his diagnosis, primary diagnosis, his only diagnosis and that's my impression.

Q And what is the status of that diagnosis when you were treating him?

A He had an episode at the time of his crime where he became delusional, paranoid, disorganized, psychotic, impulsive, erratic, but since the time that he has taken medications, he has since had no symptoms, since I've known him for the 13 years that I've known him, he's had no symptoms of psychosis. He's had no symptoms of impulsive, erratic, unpredictable behaviors that have caused anyone any harm in any way. He's never been a danger to himself or others and he's never been gravely disabled.

Q You're aware, I'm sure, that he continues to be in the hospital basically for his in ability to follow rules?

A Yes, that's why he's been kept in the hospital. He's been confined because he has broken the sex and the cigarette rules, and the lottery ticket rules which I think is, you know, extremely demoralizing.

Q How do you relate those rules to his diagnosis and his present status as being in remission?

A I don't relate to his diagnosis at all.

Q Do you believe that one has any effect on the other?

A No, I don't. I believe his rule breaking is more of a personality attitude problem. He has a defiant streak in him. He likes to express himself honestly and forcefully to other people regarding his desires, his likes, his interests. And he has a bit of an attitude that can rub people the wrong way.

Q Rubbing people the wrong way, but have you ever seen or been aware of in any kind of aggressive manner?

A He has never been aggressive, never, no gestures, no speech, no behavior, no inappropriate sexual behavior in any manner, shape or form that I've ever seen and I've never seen any documentation of it.

Q So while you were his treating physician, again, I think you said he's not a danger to himself or to others, correct?

A Absolutely not.

Q And he requires medication?

A Yes, he does.

Q And when you were his treating psychiatrist, did he give you any reason to believe that he would discontinue his medication?

before the Court.

Q You feel passionate about Mr. Ardizzone.

A What's that?

Q You feel passionate about Mr. Ardizzone's release?

A Yes, I do.

Q And why is that?

ATTY. KELLEY: Objection, Your Honor.

A I think this is a cruel and unusual punishment. I think it violates the Eighth Amendment. I think it's based on --

THE COURT: There's a --Dr. Peterson --

THE WITNESS: He asked me a question.

THE COURT: You're going to listen to me, okay, sir. You're the witness, I'm the Judge; I'm going to rule on the objection. Okay? Thank you very much.

THE WITNESS: Sorry.

THE COURT: The basis of your objection?

ATTY. KELLEY: Irrelevant. Whether or not Dr. Peterson feels passionate or not, we're not here -- The Court is here to determine facts, his personal feelings don't enter into it.

THE COURT: I understand. So I'll sustain that objection.

THE WITNESS: Uh-huh.

ATTY. MANKO: I have no other questions.

THE COURT: Any other questions?

ATTY. KELLEY: No questions, Your Honor.

MiddlesexUrology

RICHARD O. FRINK, M.D.
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4-22-2020

Kirk W. Lowry
Connecticut Legal Rights Project
P.O. Box 351, Silver Street
Middletown, CT 06457

Re: Vincent Ardizzone
DOB: 08/20/1961

Dear Mr. Lowry,

I see Vincent Ardizzone for Gleason 5+4 = 9 stage IV (T3aN1M1) prostate cancer diagnosed on 11/5/19. He has been on androgen deprivation therapy with Lupron since November, to which he has had an excellent response. Radiation therapy to his prostate, retroperitoneal lymph nodes, and a bony lesion in his spine is planned in May.

Mr. Ardizzone is at increased risk for Covid 19 because he lives in a group setting, has a long smoking history, and a history of emphysema. Neither his currently well-controlled prostate cancer, androgen deprivation therapy, nor radiation therapy will substantially increase that risk.

My greatest concern is that if he is discharged into the community, he will not be compliant with social distancing (he has already expressed a desire to return to work), which will paradoxially increase his risk for acquiring Covid 19. I am also concerned that he will not be compliant with radiation therapy, which requires daily appointments for 8 weeks. Once radiation has been started, a pause in treatment or failure to complete treatment will compromise the efficacy of radiation. If he remains at CVH, his compliance with the treatment protocol, transportation to and from radiation, and management of side effects will be assured.

I hope this has been helpful. Please do not hesitate to call with questions or concerns.

Sincerely,

Edward Myer MD

Edward G. Myer M.D.

EXHIBIT
4

Exhibit 5

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

Thomas Wilkes, et al.,)	
On behalf of themselves and)	Civil No.: 3:20cv594
all other persons similarly)	
situated,)	
Plaintiffs,)	
v.)	
)	
Ned Lamont, Governor, et al.,)	
Defendants.)	May 23, 2020

Affidavit of Gail Litsky

I, Gail Litsky, being of lawful age and understanding the obligation of an oath to tell the truth, after being so sworn, and upon personal knowledge, state and allege as follows:

1. I am a 53-year-old woman and my legal status is committed to the jurisdiction of the Psychiatric Security Review Board (PSRB). I was committed on January 13, 2015.

2. I have been committed to Whiting Forensic Hospital for five years. This is my first admission to Whiting Forensic Hospital for any reason.

3. I am a mother of two children. When my incident occurred in 2014, I was 47 years old and had no prior criminal record. Prior to my commitment I struggled with poverty and homelessness.

4. I resided in Whiting Max Unit 1 for over four years, from January 13, 2015 to September 3, 2019. Although Unit 1 is a competency restoration unit and I am an acquittee, I was assigned there because the general policy is that female acquittees are placed on WFH U1. It was difficult being a female acquittee on Unit 1 because I was a long-term patient and many other women would be admitted and discharged after resolution of their competency restoration. Some were found competent, plea out and be discharged. Some would be found not competent and get civilly committed. It was difficult seeing other women charged with crimes come and go over the years, while I was stuck on the competency unit with mostly competency restoration groups, treatment and education. All the while, I maintained stability without psychiatric medication. I was assaulted five times on WFH U1.

5. I was transferred to Dutcher North 2 (DN2) on September 3, 2019. I am the only female on DN2 due to a conflict with a patient on DS3. The general policy is that female acquittees are placed on DS3.

6. I am currently a Level 4 with six pass times on campus. This means that I may leave the Dutcher building and be outside without direct staff escort within the privilege boundaries of Whiting Forensic Hospital. On pass times I get fresh air, walk the grounds, and socialize.

7. My mental health condition is stable and I do not take psychiatric medication. I do not have a conservator. My treatment team closely monitors me for mental health symptoms. I have not had any assaultive or aggressive behavior in five years at Whiting Forensic Hospital. I have not been secluded or restrained. I have not had any forced intra-muscular psychiatric drug administered for a psychiatric emergency.

8. I have asthma and have an inhaler on order. I have high blood pressure, high cholesterol, pre-diabetic, GERD and overweight. I take medication for high blood pressure.

9. In mid-March 2020, I became aware of the serious nature of the coronavirus outbreak and that Whiting Forensic Hospital patients were at risk because we live in close quarters, cannot social distance, and have three shifts of hundreds of staff moving in and out of the hospital every day.

10. On March 27, 2020, I requested to take my meals on the unit instead of going to the dining room/activity room with the rest of the patients and staff. I thought that picking up my tray in the dining room in a line of people in close quarters and eating in the activity room created an unreasonable risk of infection because we were all too close together and people were not wearing masks. We came in to the dining room food line and were exposed to the 15-20 patients from DS2 while we got our trays.

We (DN2) got our trays in the dining room and went down the hall to the activity room. In the activity room, patients sit together at tables and it is usually impossible to sit more than six feet from others.

11. Dr. Strockbine, a psychiatrist and the Dutcher Medical Director, refused to let me eat on the unit.

12. On March 30, 2020, due to my asthma and other health conditions, I raised my request to eat on the unit (DN2) with Dr. Aberientos, an internal medicine doctor, designated as ambulatory care services (ACS) by WFH. She is the ACS doctor that covers DN2. Dr. Aberientos denied my request. Staff made clear to me that if I wanted to eat, I had to go to the dining room like everyone else. An order was written instructing staff not to bring food to the unit for me to eat.

13. On April 2, 2020, Dr. Kale, the DN2 psychiatrist, ordered that I be allowed to eat on the unit because my asthma created a heightened risk regarding the virus.

14. Throughout April 2020, I became more concerned about the virus and the lack of masks, gloves, and social distancing in Dutcher. From March through April 22, 2020, patients were not given masks, even if we asked for them. Staff had masks, but few had them on their faces for any significant part of the day.

15. On April 9, 2020, the program manager for Dutcher held a community meeting on DN2 and told us that if anyone reported symptoms the whole unit would be quarantined for seven days.

16. On April 13, 2020, Hal Smith, CEO of WFH, finally mandated that staff wear their masks while in patient areas.

17. On April 22, 2020, my attorney with Connecticut Legal Rights Project (CLRP) wrote an email to the Whiting administration. Later that day, the program manager announced to the unit that we would be allowed one mask a week upon request. Administration had previously told us that masks were for staff and only those patients who tested positive for COVID-19, but now they were going to offer masks to all patients.

18. On April 23, 2020, my unit, DN2, had its first very sick patient. He was taken off the unit on a stretcher and taken by ambulance to Middlesex Hospital.

19. On April 24, 2020, the unit was put on quarantine for fourteen days because the patient had tested positive for COVID-19. The program manager met with us and went through the rules for quarantine. She said that masks had been ordered for patients. Mask instructions were posted on the window of the nurses' station.

20. Since I am the only female on the unit, I have a single room and my own bath room. All of the other 19 male patients are doubled up in their rooms and share one main bathroom. The roommate of the patient who was taken to the hospital remained on the unit and was allowed to be out in the common areas with us and ate with the rest of the unit. He was not confined to his room.

21. There is almost no treatment since the virus outbreak. First-shift professional staff, psychiatrist, psychologist, social worker and rehabilitation therapists, are split in two groups, so only about half of them are on the unit at any one time each week.

22. The lead Mental Health Associate (MHA) who took the sick patient to Middlesex Hospital on April 23, 2020, was off work on April 24, 2020, but was back at work on April 25 and 26. I was surprised at this since he was in close contact with the Covid-positive patient but was back at work after one day off.

23. We were told by staff that the patient tested positive for the virus and we would have to stay on quarantine for the full fourteen days.

24. DN2 has two patient phones for 20 patients. The phones are in an open common area. We have two TV rooms, a small room and large room. The phones are not even cleaned once a day.

25. While we were on quarantine, we were only allowed off of the unit for fresh air once a day from 5:30 p.m. to 6:15 p.m.

26. While we were on quarantine after April 23, 2020, we had to take meals on the unit. Patients were eating and were not keeping six feet of social distancing and, of course, were not wearing masks while eating. I started eating in the hall outside my room on the floor.

27. After we were quarantined on April 24, 2020, we were locked down on the unit, but all three shifts of staff continued to come and go on and off the unit. I was very concerned when I learned that staff were being mandated to work double shifts on different units, including our quarantined unit.

28. On April 28, 2020, I got in an argument with one of the staff. Staff retaliated against me by claiming I was a choking risk and so could no longer eat in the hall. I was told I had to eat with the rest of the male patients even though there was no social distancing and masks, and I had asthma and hypertension and was at increased risk for severe respiratory symptoms from the virus. The staff knew that I was very scared about being infected. This felt retaliatory and cruel to me.

29. On April 29, 2020, a nurse showed me the doctor's order prohibiting me from eating in my hallway or room. No other safe eating

arrangements were offered. I called WFH administrators to complain about the retaliation and unsafe conditions of confinement.

30. On April 30, 2020, I learned that a patient in Connecticut Valley Hospital, another building on the campus that includes Whiting Forensic Hospital, had died from the virus. I felt terrified. All of my worst fears were coming to pass.

31. On April 30, 2020, my attorneys at CLRP filed a federal complaint to get safe conditions of confinement for me and all the rest of the patients at CVH and WFH. I cried when I read the complaint. It gave me a glimmer of hope.

32. On May 2, 2020, even after a death from the virus and patient on our unit infected, staff were inconsistent in wearing masks and no one enforced the rules for masks and social distancing. In fear, I had been spending almost all my time in my room when on the unit. Almost no treatment was taking place on the unit.

33. By May 5, 2020, staff were almost always wearing their masks when they were around us. Many patients, however, were still not wearing masks and keeping six feet of social distance and staff were not enforcing the rules.

34. On May 7, 2020 our unit was taken off quarantine.

35. On May 11, 2020 the infected patient came back from the hospital and was confined to the isolation room on DN2. I was relieved that he survived. On or about May 13, 2020, the patient was released from isolation and was back on the unit with the rest of us.

36. From the start of this pandemic until May 13, 2020, we were never offered testing. We were offered one mask a week, continuing through the present time. There has been no consistent education and reinforcement about the importance of wearing a mask and keeping social distancing.

37. On May 13, 2020, administration told us that they were going to test everyone for the virus, but that such testing was voluntary.

38. Our unit was tested during the week of May 20, 2020. I initially declined because I was afraid to do it and then get quarantined or isolated or sent down to WFH Max where I had been mistreated. I changed my mind and requested to be tested but have not been offered testing again.

39. On May 22, 2020 I saw on the news that a fourth patient died at CVH. It is very scary to be locked up in WFH with no control over who I live with, where I live, how often my bathroom is cleaned and disinfected, how clean the phones are, and where and what I eat. I am just locked up waiting for the virus to come in with a staff-person who is upset and

frustrated for being mandated for another double shift from another unit and who caught the virus outside WFH and brought it in and will be our superspreader. All I can do is sit and wait and hope for the best.

Gail Litsky

Gail Litsky

State of Connecticut)
) ss: at Middletown
County of Middlesex)

Subscribed and sworn to before me on this 23rd day of May, 2020

Commissioner of the Superior Court

Exhibit 6

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

Thomas Wilkes, et al.,	)	
On behalf of themselves and	)	Civil No.: 3:20cv594
all other persons similarly	)	
situated,	)	
Plaintiffs,	)	
v.	)	
	)	
Ned Lamont, Governor, et al.,	)	
Defendants.	)	May 23, 2020

Affidavit of Francis Clarke

I, Francis Clarke, being of lawful age and understanding the obligation of an oath to tell the truth, after being so sworn, and upon personal knowledge, state and allege as follows:

1. I am a 72-year-old Veteran of the Vietnam War. I was honorably discharged as a Buck Sergeant, Specialist E5 in the United States Army.

2. I have never been admitted to Whiting Forensic Hospital before. I have never had treatment for a mental health condition until I was admitted to Whiting Forensic Hospital in 2019.

3. My sister Marion Clarke is my conservator. She was just recently appointed on January 10, 2020. WFH was the petitioner.

4. Before my admission to Whiting Forensic Hospital (WFH), I had my own apartment at 353 Main Street in Hartford, Connecticut.

5. I dropped out of high school to join the Army. After I returned home, I got my high school diploma, went the Manchester Community College and obtained an Associate Degree in Biology. My work includes working for the Post Office and for the state highway department.

6. I have Veterans Administration health care and Social Security retirement for income.

7. On October 18, 2019, I was in the front seat of my parked car in Glastonbury, Connecticut, when I was arrested by the police for driving on a suspended license and no car insurance. I was not driving at the time. I was sitting in the front seat of my car minding my own business.

8. On November 14, 2019, I returned to Superior Court in Manchester, GA 12 and was found not competent to stand trial. I was sent to Whiting Forensic Hospital maximum security service for competency restoration. I was sent to WFH U3. I am still on Unit 3.

9. I was not offered competency restoration in the community. I would have accepted that if offered.

10. I was not offered diversion or what my lawyer has told me is called Track 2. Track 2 is the offer to accept treatment as a voluntary or committed patient instead of the criminal commitment. If I would have

completed the voluntary treatment under Track 2, I could have had my charges Nollied.

11. I have been on WFH U3 for competency restoration. On or about February 10, 2020, I returned to Superior Court and was found not competent and not restorable and returned to WFH U3 for civil commitment.

12. On February 21, 2020, I went to probate court in Middletown, held at Connecticut Valley Hospital, for civil commitment. Judge Marino offered me the option of staying as a voluntary patient and working on a good discharge and I accepted it.

13. Shortly thereafter the Coronavirus outbreak started to hit WFH. I am 72 years old, have asthma and am at high risk for infection and death from Coronavirus.

14. I wanted to be discharged back to my apartment. WFH staff and my conservator disagree. They want me to go to the VA nursing home in Rocky Hill. But the VA nursing home in Rocky Hill is not taking any admissions because of the virus. So I have waited.

15. I am stable, not dangerous to self or others or gravely disabled. I have been ready for discharge for months and have been unnecessarily kept at WFH U3.

16. WFH Unit 3 has had patients and maybe staff test positive for the Coronavirus. As far as I know, I have not. I was tested for the virus on Monday, May 18, 2020.

17. I request immediate discharge to a safe place with appropriate help.

Francis E Clarke

Francis Clarke

State of Connecticut)
) ss: at Middletown
County of Middlesex)

Subscribed and sworn to before me on the 23st day of May, 2020.

Commissioner of the Superior Court

Exhibit 7

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

Thomas Wilkes, et al., On behalf of themselves and all other persons similarly situated, Plaintiffs,	)	Civil No.: 3:20cv594
v.	)	
Ned Lamont, Governor, et al., Defendants.	)	May 24, 2020

Affidavit of Rahab King

I, Rahab King, being of lawful age and understanding the obligation of an oath to tell the truth, after being so sworn, and upon personal knowledge, state and allege as follows:

1. I am a 38-year-old man.

2. I am an acquittee committed to the jurisdiction of the Psychiatric Security Review Board (PSRB). I was committed to the PSRB in August 2012.

3. I moved to Dutcher Hall from Whiting Forensic Hospital maximum service in July 2015. I worked my way up to a full Level 4 with six pass times in 2016 and have maintained it for four years.

4. My treatment team, Consulting Forensic Psychiatrist, the Forensic Review Committee and the PSRB all approved me for temporary leave in January 2020.

5. I was going out on temporary leave to a day program with Community Mental Health Affiliates (CMHA) in New Britain, Connecticut. I initially started with 1-day temporary leave and worked up to 3 days a week after a few weeks.

6. In the first week of March my temporary leaves were suspended due to a combination of a lease non-renewal and funding reduction experienced by CMHA.

7. I was told I had to find a new catchment area and Local Mental Health Authority provider in order to re-start temporary leaves.

8. I was making good progress through the temporary leave program.

9. To the best of my knowledge, all of the community temporary leave programs have stopped taking new admissions due to COVID-19 restrictions.

10. I am ready for full Phase 2 temporary leave, conditional release or discharge. My mental health condition has been stable for many years. I am compliant with treatment and medications. I am not a danger to myself or others and would be safe in community with residential services

or supportive housing with wrap-around mental health services.

Rahab King

Rahab King

State of Connecticut)
) ss: at Middletown
County of Middlesex)

Subscribed and sworn to before me on the 24th day of May, 2020.

Notary Public
Commissioner of the Superior Court

Exhibit 8

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

Thomas Wilkes, et al.,	)	
On behalf of themselves and	)	Civil No.: 3:20cv594
all other persons similarly	)	
situated,	)	
Plaintiffs,	)	
v.	)	
	)	
Ned Lamont, Governor, et al.,	)	
Defendants.	)	May 26, 2020

Affidavit of Richard Gudis

I, Richard Gudis, being of lawful age and understanding the obligation of an oath to tell the truth, after being so sworn, and upon personal knowledge, state and allege as follows:

1. I am an attorney licensed to practice law in the State of Connecticut.
2. I have practiced law in Connecticut since 2003.
3. I am the conservator for Tom Wilkes and Barbara Flood.
4. I have been a court-appointed attorney representing patients in psychiatric hospitals for the last eight years, primarily at Connecticut Valley Hospital (CVH), Whiting Forensic Hospital (WFH), and Lawrence and Memorial Hospital in New London.

5. I am currently a conservator for about eleven patients at CVH and WFH. I have been a conservator for many more patients at CVH who were successfully discharged to the community.

6. I also am a Major in the Connecticut National Guard. I have been called to active duty to assist with the state of emergency response and the emergency public health crisis but have remained in close contact with CVH staff and my clients during the crisis.

7. I have been Tom Wilkes' conservator of person since September 17, 2018 and his conservator of estate since October 2019. Tom Wilkes is a 67-year-old veteran of the Vietnam War.

8. Mr. Wilkes has chronic Hepatitis C, Dyslipidemia, Hypothyroidism, and obesity, caused primarily by many years of psychiatric medication.

9. Mr. Wilkes, due to his age and existing medical conditions, is at high risk of infection and death from COVID-19.

10. On May 4, 2020, Mr. Wilkes was still residing in B3S when he started experiencing nausea, vomiting, diarrhea, and a fever of 105.00. He was sent to a different unit then transferred to Middlesex Hospital. Fortunately, his fever broke and he stabilized and was sent back to CVH to the quarantine unit, Merritt 3D.

11. On or about May 14, 2020, Mr. Wilkes was transferred from the quarantine unit to Woodward 2 North.

12. I am working with the staff on the unit to get him discharged out of CVH.

13. I am the conservator of person and estate of Barbara Flood. I have been her conservator Since October 7, 2016. Ms. Flood is a 64-year-old woman who has been committed to CVH since June 2013. Ms. Flood's primary reason for being at CVH for so long is because she needs dialysis three times a week. Ms. Flood has end-stage renal failure. She has been on supplemental oxygen at times too.

14. Ms. Flood resides on Woodward 1 North. She has been considered discharge-ready by CVH staff for over a year. Ms. Flood is willing to go anywhere upon discharge. The primary problem is getting a community dialysis provider to agree to provide her treatment. Right now, Ms. Flood gets dialysis three times a week at CVH from DaVita Dialysis, a private dialysis provider who is on contract with CVH. For reasons unknown, DaVita refuses to treat her anywhere other than CVH.

15. Ms. Flood's end-stage renal failure and oxygen insufficiency place her at high risk of significant respiratory failure and organ failure if she were to contract COVID-19.

16. CVH must ensure that Ms. Flood and Mr. Wilkes are safe in Woodward Hall, including strictly enforcing social distancing rules, staff wearing PPE, testing and retesting of patients and staff for COVID-19 and frequent cleaning of their units and all of Woodward Hall.

17. The Coronavirus outbreak required the Connecticut Department of Mental Health and Addiction Services (DMHAS) to quickly adapt and implement innovative solutions to achieve the appropriate safe social distancing measures. The Department failed timely to implement even minimal protections for patients at CVH. I am aware that the State of Connecticut established special overflow facilities for numerous hospitals throughout the state of Connecticut as well as COVID-specific homeless shelters. DMHAS did not avail themselves of these resources.

18. DMHAS never contacted me to discuss alternative placements such as hotels, family units, supportive housing or shelters. In my opinion, the leadership of DMHAS and the State of Connecticut failed to display the minimal professional judgment I expected for the protection of my conserved persons.

19. This is an endemic problem with DMHAS. DMHAS is deficient in providing the resources to ensure patients can timely discharge to the most integrated setting. The State has failed to ensure that there are adequate

community mental health resources to ensure that patients can timely discharge to the most integrated setting, even before the virus hit. Now, with the virus in community spread throughout the state, the problem is compounded.

Richard Gudis

State of Connecticut)
) ss: at Middletown
County of Middlesex)

Subscribed and sworn to before me on the 26th day of May, 2020.

Commissioner of the Superior Court

Exhibit 9

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Renée D. Coleman-Mitchell, MPH
Commissioner

Ned Lamont
Governor
Susan Bysiewicz
Lt. Governor

COVID-19 Guidance for Long-Term Care Facilities — March 26, 2020

The Centers for Disease Control and Prevention (CDC) has published guidance on COVID-19 for long-term care facilities (LTCFs). The CDC LTCF guidance is also relevant and useful for long-term acute care hospitals and assisted living facilities. This memo supplements the CDC guidance.

The elderly and those with certain underlying medical conditions have high morbidity and mortality from infection with SARS-CoV-2, the virus that causes COVID-19. This virus spreads easily, and aggressive infection control practices are necessary to blunt the serious impact of COVID-19 in facilities while maintaining high-quality long-term care for your residents. We understand such a balance under these circumstances is very challenging, and we thank you for your efforts.

The health and safety of Connecticut patients and healthcare personnel is a top priority of the Connecticut Department of Public Health (DPH) as the COVID-19 pandemic progresses. As we learn more about COVID-19 and as the landscape of our healthcare system changes in response to the pandemic, guidance will continue to be adapted and modified. It is important to stay up-to-date on guidance on CDC's website for your facility type.

Questions about infection control, residents or staff with possible COVID-19, and possible clusters can be directed to the DPH Infectious Diseases Section (860-509-7995). Other questions about COVID-19 can be emailed to COVID19.dph@ct.gov.

Preventing Introduction of COVID-19 into LTCFs: Recommendations for Visitors and Staff

CDC recommends restricting visitors, with certain exceptions (e.g. end of life and compassionate care situations). This is also mandated by the State of Connecticut.[1] CDC also recommends cancellation of all trips outside of the facility, and residents who must regularly leave the facility for medically necessary reasons (e.g. hemodialysis) should wear a facemask whenever they leave their room: inside your facility, during transportation, and during medical visits outside the facility. Having a mask on residents who leave the LTCF will lower their risk of becoming infected outside the facility and subsequently transmitting infection within the LTCF.

DPH recommends assessing symptoms and temperatures for all personnel at the beginning of their shifts, preferably outside or near an entryway, away from residents. Social distancing during this process should be maintained. LTCFs should consider asking personnel to check their temperature at home and not come to the facility if they have a temperature 100.0°F or higher, or other signs or symptoms of respiratory illness. This will prevent infected personnel from exposing others during the start-of-shift screening process.

Personnel with respiratory symptoms or signs should be evaluated by their physician.[2] Staff should be reminded to stay home if ill. They should immediately notify supervisors, put on a mask, and leave the facility if they develop respiratory symptoms during a shift.[3] Those with documented or presumptive COVID-19 should not enter the facility and should not return to work until permitted in accordance with the latest CDC guidance.[4]

We recommend that staff movement within the facility be as limited as practicable. They should be assigned to particular areas of the facility, and movement between wings and floors should be limited. Identity staff who have jobs at other facilities as potential carriers of illness between facilities. Staff should practice social distancing with at least six (6) feet of separation from each other and from residents, except as necessary to deliver care.

Custodial services are essential, as SARS-CoV-2 spreads easily from contact with infected surfaces; adequate staffing for environmental and custodial services should be a priority.

Staff who had prolonged, close contact with anyone suspected or confirmed COVID-19 should be assessed to determine whether they should be furloughed or work with certain precautions. CDC has guidelines for this risk assessment of exposed asymptomatic healthcare workers.[2]

Hand Hygiene: For Residents and Staff

Careful hand hygiene is extremely important to prevent spread of COVID-19. Hand hygiene can be performed with either soap and water for 20 seconds or with hand sanitizer (containing ≥ 60% ethanol or ≥ 70% isopropyl alcohol). Soap and water should be used if hands are visibly dirty. Alcohol-based hand sanitizer may be more available and easier to use in healthcare facilities.[5]

Physical Separation and Common Areas

Residents need to stay separate from each other by six (6) feet or more. Therefore, when possible, they should not congregate in common areas for activities. Meals should not be served in common dining rooms.[6]

Cleaning materials

SARS-CoV-2 persists on environmental surfaces, and proper disinfection is an important component of infection control. Use an environmental services checklist to be sure that all potentially contaminated high touch surfaces are cleaned.[7,8] Use EPA approved disinfectants according manufacturer's instructions on contact time and dilution to ensure effectiveness.[9] Shared equipment (pulse oximeters, for example) should be disinfected according to manufacturer's guidelines.

Identification of Possible COVID-19 Cases

Early identification of infections is vital for preventing a COVID-19 outbreak. The first step includes frequent clinical assessment of residents and staff (as mentioned above).

All residents should be assessed at least once daily; some facilities may institute more frequent assessment. Assessments should include an inquiry about symptoms, and checking for signs of infection (temperature, and possibly oximeter readings). Long term care residents may have an atypical presentation of COVID-19. Persons with COVID-19 typically experience symptoms or signs of fever, cough, and shortness of breath. Elderly persons with SARS-CoV-2 infection may not have fever, and may instead present with non-specific symptoms and signs such as malaise, dizziness, diarrhea, sore throat, oxygen desaturation, loss of appetite, or mental status changes.[10] Particular attention should be made to identify sudden changes in behavior.

Immediately isolate any resident who is symptomatic or exhibits signs, and evaluate for COVID-19. They should be placed in a single room (when possible) with the door closed, and they should always have a mask on when outside their room.

Testing for SARS-CoV-2

Testing is only indicated for residents or staff with symptoms or signs consistent with COVID-19, even in situations where there has been contact with a COVID-19-positive person. As with any test, testing only those with symptoms lowers the risk of false-positive results. Testing informs patient management and infection control planning and influenza and respiratory viruses should also be considered. CDC guidance for infection control during nasal swabbing should be followed.[11]

Testing is increasingly available through commercial laboratories and is also available from the Connecticut State Public Health Laboratory (SPHL). Now is the time to determine if your send-out laboratory does COVID-19 testing, their requirements, and their turn-around-time. If you do not have access to timely commercial laboratory testing, you may submit specimen(s) to SPHL. COVID-19 testing at SPHL no longer requires prior approval from DPH Infectious Disease Section epidemiologists.

CDC provides guidance on specimen collection and handling.[11] Specimens must be transported on ice and accompanied by a SARS-CoV-2 test requisition form.[12] Healthcare facilities are responsible for arranging transport of specimen(s) to SPHL. For facilities that routinely send specimens to a local hospital laboratory for other testing, the hospital courier may transport the specimen to SPHL for you. SPHL can only perform a limited volume of tests each day; long term care residents with COVID-19 signs and symptoms will be prioritized for testing at SPHL if it is appropriately indicated on the requisition form. SPHL can receive specimens 24/7, and COVID-19 testing occurs 7 days a week. For more information: https://portal.ct.gov/DPH/Laboratory/Laboratory-Home/Katherine-A-Kelley-State-Public-Health-Laboratory

Appropriate Transfers from LTCFs to Hospitals

Connecticut's acute care hospitals are already starting to receive seriously ill COVID-19 cases, and numbers are rapidly rising. LTCFs play a vital role keeping acute care hospitals from becoming overwhelmed, allowing them to continue to function and care for any of your residents that need the intensity of care that only acute care hospitals can provide:

- Residents can be assessed for COVID-19 and test specimens can be collected on-site in LTCFs when hospital transfer is not indicated.
- Residents with suspected or confirmed COVID-19 can stay in LTCFs throughout the course of illness; transfer for acute care when that level of care becomes clinically indicated.
- LTCFs can receive patients with COVID-19 from acute care hospitals for LTCF-level of care during convalescence.

If a resident with suspected or confirmed COVID-19 requires transportation to a hospital for evaluation and care, please notify emergency medical services (EMS) who transport the resident and the receiving facility (e.g. emergency department) beforehand of potential COVID-19 so they can prepare accordingly.

Discharge of Patients with Confirmed or Suspected COVID-19 from Hospitals to LTCFs (or Assisted Living)

CDC provides guidance on when COVID-19 transmission-based infection control precautions can be discontinued.[13] Patients can be discharged from a hospital whenever clinically indicated, even when still on transmission-based precautions. When transmission-based precautions are still required, the patient should go to a facility with adequate personal protective equipment supplies and an ability to adhere to infection prevention and control recommendations for the care of COVID-19 patients. Preferably, the patient would be transferred to a facility that has already cared for COVID-19 cases, in a specific unit designated to care for COVID-19 residents. The patient should be housed in a single room and restricted to their room, or cohorted with other COVID-19-positive residents.

If transmission-based precautions have been discontinued according to CDC guidance[13], but the patient has persistent symptoms from COVID-19 (e.g., persistent cough), they should be placed in a single room and restricted to their room. If transmission-based precautions have been discontinued and the patient's symptoms have resolved, they do not require further restrictions.[13]

Personal Protective Equipment (PPE)

COVID-19 spreads through respiratory droplets from person-to-person. Surgical masks can block the droplets, and distancing people (at least 6 feet) can reduce the risk of respiratory droplet contamination. N95 respirators are only necessary when patients with COVID-19 undergo aerosol-generating procedures (e.g., open suction, nebulizer treatments). N95 respirators should be reserved for those procedures, to be performed by fit-tested personnel wearing a N95 respirator, full face shield or wrap-around goggles, gown, and gloves.[7] The door should be closed and the number of people in the room should be as few as possible.

CT DPH is aware that PPE supplies are running extremely low in healthcare facilities within the state and around the world. With shortages in the PPE supply chain, it is important to assess your PPE supply and utilization rate, and start measures to stretch your current supply. The first step to resupply is to procure PPE from your current supplier; DPH is working to bring more PPE to healthcare facilities, including LTCFs.

Maintaining close supervision and security of your PPE inventory during this period of scarcity is prudent. Access to your stock should be carefully controlled to ensure ready access for staff needing the PPE, while protecting the supply. CDC has guidance for optimizing all PPE (masks, gowns, eye protection) based on levels of supply.[14]

References: Please check the CDC and state COVID-19 websites regularly for updates.

1. Department of Public Health order implementing 30-day visitor restrictions at nursing homes and similar facilities: https://portal.ct.gov/-/media/Office-of-the-Governor/News/20200313-DPH-nursing-home-order.pdf
2. Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19) https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
3. COVID-19 Preparedness Checklist for Nursing Homes and other Long-Term Care Settings https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf
4. Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html
5. Frequently Asked Questions about Hand Hygiene for Healthcare Personnel Responding to COVID-2019: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/hcp-hand-hygiene-faq.html
6. Preparing for COVID-19: Long-term Care Facilities, Nursing Homes https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html
7. Infection control in healthcare settings https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
8. Preventing the Spread of Coronavirus Disease 2019 in Homes and Residential Communities: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html
9. EPA. List N: Disinfectants for Use Against SARS-CoV-2: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2
10. CDC. Clinician Outreach and Communication Activity (COCA). Coronavirus Disease 2019 (COVID-19) Update and Information for Long-term Care Facilities: https://emergency.cdc.gov/coca/calls/2020/callinfo_031720.asp
11. Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19): https://www.cdc.gov/coronavirus/2019-nCoV/lab/guidelines-clinical-specimens.html
12. Connecticut State Public Health Laboratory COVID-19 requisition form: https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/laboratory/labhome/lab-forms/2019nCoV-req20final.pdf
13. Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html
14. Strategies for Optimizing the Supply of PPE: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

Exhibit 10

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-30-NH

DATE: May 18, 2020

TO: State Officials

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Nursing Home Reopening Recommendations for State and Local Officials

Memorandum Summary

- CMS is committed to taking critical steps to ensure America's nursing homes are prepared to respond to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- **Recommendations for State and Local Officials:** CMS is providing recommendations to help determine the level of mitigation needed to prevent the transmission of COVID-19 in nursing homes. The recommendations cover the following items:
  - **Criteria for relaxing certain restrictions and mitigating the risk of resurgence**: Factors to inform decisions for relaxing nursing home restrictions through a phased approach.
  - **Visitation and Service Considerations:** Considerations allowing visitation and services in each phase.
  - **Restoration of Survey Activities:** Recommendations for restarting certain surveys in each phase.

Background

Nursing homes have been severely impacted by COVID-19, with outbreaks causing high rates of infection, morbidity, and mortality. The vulnerable nature of the nursing home population combined with the inherent risks of congregate living in a healthcare setting, requires aggressive efforts to limit COVID-19 exposure and to prevent the spread of COVID-19 within nursing homes.

Recommendations for States

This memorandum provides recommendations for State and local officials to help them determine the level of mitigation needed for their communities' Medicare/Medicaid certified long term care facilities (hereinafter, 'nursing homes") to prevent the transmission of COVID-19. We encourage State leaders to collaborate with the state survey agency, and State and local health departments to decide how these and other criteria or actions should be implemented in their state. Examples of how a State may choose to implement these recommendations include:

- A State requiring all facilities to go through each phase at the same time (i.e., waiting until all facilities have met entrance criteria for a given phase).
- A State allowing facilities in a certain region (e.g., counties) within a state to enter each phase at the same time.
- A State permitting individual nursing homes to move through the phases based on each nursing home's status for meeting the criteria for entering a phase.

Given the critical importance in limiting COVID-19 exposure in nursing homes, decisions on relaxing restrictions should be made with careful review of a number of facility-level, community, and State factors/orders, and in collaboration with State and/or local health officials and nursing homes. Because the pandemic is affecting communities in different ways, State and local leaders should regularly monitor the factors for reopening and adjust their plans accordingly. Factors that should inform decisions about relaxing restrictions in nursing homes include:

- **Case status in community:** State-based criteria to determine the level of community transmission and guides progression from one phase to another. For example, a decline in the number of new cases, hospitalizations, or deaths (with exceptions for temporary outliers).
- **Case status in the nursing home(s)**: Absence of any new nursing home onset[1] of COVID-19 cases (resident or staff), such as a resident acquiring COVID-19 in the nursing home.
- **Adequate staffing**: No staffing shortages and the facility is not under a contingency staffing plan.
- **Access to adequate testiug**: The facility should have a testing plan in place based on contingencies informed by the Centers for Disease Control and Prevention (CDC). At minimum, the plan should consider the following components:
    - The capacity for **all** nursing home **residents** to receive a single baseline COVID-19 test. Similarly, the capacity for all residents to be tested upon identification of an individual with symptoms consistent with COVID-19, or if a staff member tests positive for COVID-19. Capacity for continuance of weekly re-testing of all nursing home residents until all residents test negative;
    - The capacity for **all** nursing home **staff** (including volunteers and vendors who are in the facility on a weekly basis) to receive a single baseline COVID-19 test, with re-testing of all staff continuing every week (note: State and local leaders may adjust the requirement for weekly testing of staff based on data about the circulation of the virus in their community);
    - Written screening protocols for all staff (each shift), each resident (daily), and all persons entering the facility, such as vendors, volunteers, and visitors;
    - An arrangement with laboratories to process tests. The test used should be able to detect SARS-CoV-2 virus (e.g., polymerase chain reaction (PCR)) with greater than 95% sensitivity, greater than 90% specificity, with results obtained rapidly

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[1] A "new, nursing home onset" refers to COVID-19 cases that originated in the nursing home, and not cases where the nursing home admitted individuals from a hospital with a known COVID-19 positive status, or unknown COVID-19 status but became COVID-19 positive within 14 days after admission. In other words, if the number of COVID-19 cases increases because a facility is admitting residents from the hospital AND they are practicing effective Transmission-Based Precautions to prevent the transmission of COVID-19 to other residents, that facility may still advance through the phases of reopening. However, if a resident contracts COVID-19 within the nursing home without a prior hospitalization within the last 14 days, this facility should go back to the highest level of mitigation, and start the phases over.

(e.g., within 48 hours). Antibody test results should not be used to diagnose someone with an active SARS-CoV-2 infection.
    - A procedure for addressing residents or staff that decline or are unable to be tested (e.g., symptomatic resident refusing testing in a facility with positive COVID-19 cases should be treated as positive).
- **Universal source control**: Residents and visitors wear a cloth face covering or facemask. If a visitor is unable or unwilling to maintain these precautions (such as young children), consider restricting their ability to enter the facility. All visitors should maintain social distancing and perform hand washing or sanitizing upon entry to the facility.
- **Access to adequate Personal Protective Equipment (PPE) for staff:** Contingency capacity strategy is allowable, such as CDC's guidance at Strategies to Optimize the Supply of PPE and Equipment (facilities' crisis capacity PPE strategy would not constitute adequate access to PPE). All staff wear all appropriate PPE when indicated. Staff wear cloth face covering if facemask is not indicated, such as administrative staff.
- **Local hospital capacity:** Ability for the local hospital to accept transfers from nursing homes.

Contact: For questions or concerns regarding this memo, please contact DNH_TriageTeam@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Branch training coordinators immediately.

/s/
David R. Wright

Attachments:
Recommended Nursing Home Phased Re-opening for States

cc: Survey & Operations Group (SOG) Management

Attachment 1 – Recommended Nursing Home Phased Reopening for States

The reopening phases below cross-walk to the phases of the plan for Opening Up America Again, and includes_efforts to maintain rigorous infection prevention and control, as well as resident social engagements and quality of life. Note: The Opening Up America Guidance for communities includes visitation guidance for "senior care facilities." The term "senior care facilities" refers to a broader set of facilities that may be utilized by seniors, and is not specific to Medicare/Medicare certified long term care facilities (i.e., nursing homes), whereas, this guidance is specific to nursing homes.

Due to the elevated risk COVID-19 poses to nursing home residents, we recommend additional criteria for advancing through phases of reopening nursing homes than is recommended in the broader Administration's Opening Up America Again framework. For example:

- Nursing homes should not advance through any phases of reopening or relax any restrictions until all residents and staff have received a base-line test, and the appropriate actions are taken based on the results;
- States should survey those nursing homes that experienced a significant COVID-19 outbreak prior to reopening to ensure the facility is adequately preventing transmission of COVID=19; and
- Nursing homes should remain in the current state of highest mitigation while the community is in Phase 1 of Opening Up America Again (in other words, a nursing home's reopening should lag behind the general community's reopening by 14 days).

For additional criteria, please see the Appendix.

Status	Criteria for Implementation	Visitation and Service Considerations	Surveys that will be performed at each phase
Current state: Significant Mitigation and Phase 1 of Opening Up America Again	• Most facilities are in a posture that can be described as their highest level of vigilance, regardless of transmission within their communities.	• Visitation generally prohibited, except for compassionate care situations. In those limited situations, visitors. are screened and additional precautions are taken, including social distancing, and hand hygiene (e.g., use alcohol-based hand rub upon entry). All visitors must wear a cloth face covering or facemask for the duration of their visit. • Restricted entry of non-essential healthcare personnel. • Communal dining limited (for COVID-19 negative or asymptomatic residents only), but residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet). • Non-medically necessary trips outside the building should be avoided.	• Investigation of complaints alleging there is an immediate serious threat to the resident's health and safety (known as Immediate Jeopardy) • Revisit surveys to confirm the facility has removed any Immediate Jeopardy findings • Focused infection control surveys • Initial survey to certify that the provider has met the required conditions to participate in the Medicare Program (initial certification surveys)

Status	Criteria for Implementation	Visitation and Service Considerations	Surveys that will be performed at each phase

		• Restrict group activities, but some activities may be conducted (for COVID-19 negative or asymptomatic residents only) with social distancing, hand hygiene, and use of a cloth face covering or facemask.
		• For medically necessary trips away from of the facility:
		  o The resident must wear a cloth face covering or facemask; and
		  o The facility must share the resident's COVID-19 status with the transportation service and entity with whom the resident has the appointment.
		• 100% screening of all persons entering the facility and all staff at the beginning of each shift:
		  o Temperature checks
		  o Ensure all outside persons entering building have cloth face covering or facemask.
		  o Questionnaire about symptoms and potential exposure
		  o Observation of any signs or symptoms
		• 100% screening for all residents:
		  o Temperature checks
		  o Questions about and observation for other signs or symptoms of COVID-19 (at least daily)
		• Universal source control for everyone in the facility. Residents and visitors entering for compassionate care wear cloth face covering or facemask.
		• All staff wear appropriate PPE when they are interacting with residents, to the extent PPE is available and consistent with CDC guidance on optimization of PPE. Staff wear cloth face covering if facemask is not indicated.
		• All staff are tested weekly. All residents are tested upon identification of an individual with symptoms consistent with COVID-19 or if staff have tested positive for COVID-19. Weekly testing continues until all residents test negative.
		• Dedicated space in facility for cohorting and managing care for residents with COVID-19; plan to
			• Any State-based priorities (e.g., localized "hot spots," "strike" teams, etc.)

Status	Criteria for Implementation	Visitation and Service Considerations	Surveys that will be performed at each phase
		manage new/readmissions with an unknown COVID-19 status and residents who develop symptoms.	
Phase 2 of Reopening nursing homes and Opening Up America Again	• Case status in community has met the criteria for entry into phase 2 (no rebound in cases after 14 days in phase 1). • There have been no new, nursing home onset COVID cases in the nursing home for 14 days. • The nursing home is not experiencing staff shortages. • The nursing home has adequate supplies of personal protective equipment and essential cleaning and disinfection supplies to care for residents. • The nursing home has adequate access to testing for COVID-19. • Referral hospital(s) have bed capacity on wards and intensive care units.	• Visitation generally prohibited, except for compassionate care situations. In those limited situations, visitors are screened and additional precautions are taken, including social distancing, and hand hygiene (e.g., use alcohol-based hand rub upon entry). All visitors must wear a cloth face covering or facemask for the duration of their visit. • Allow entry of limited numbers of non-essential healthcare personnel/contractors as determined necessary by the facility, with screening and additional precautions including social distancing, hand hygiene, and cloth face covering or facemask. • Communal dining limited (for COVID-19 negative or asymptomatic residents only), but residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet). • Group activities, including outings, limited (for asymptomatic or COVID-19 negative residents only) with no more than 10 people and social distancing among residents, appropriate hand hygiene, and use of a cloth face covering or facemask. • For medically necessary trips outside of the facility: o The resident must wear a cloth face covering or facemask; and o The facility must share the resident's COVID-19 status with the transportation service and entity with whom the resident has the appointment. • 100% screening of all persons entering the facility and all staff at the beginning of each shift: o Temperature checks o Ensure all outside persons entering building have cloth face covering or facemask. o Questionnaire about symptoms and potential exposure o Observation of any signs or symptoms • 100% screening (at least daily) for all residents	• Investigation of complaints alleging either Immediate Jeopardy or actual harm to residents • Revisit surveys to confirm the facility has removed any Immediate Jeopardy findings • Focused infection control surveys • Initial certification surveys • State-based priorities (e.g., localized "hot spots," "strike" teams, etc.) • See Appendix for recommendations for prioritizing facilities to be surveyed

Status	Criteria for Implementation	Visitation and Service Considerations	Surveys that will be performed at each phase
		○ Temperature checks ○ Questions about and observation for other signs or symptoms of COVID-19 • Universal source control for everyone in the facility. Residents and visitors entering for compassionate care wear cloth face covering or facemask. • All staff wear all appropriate PPE when indicated. Staff wear cloth face covering if facemask is not indicated, such as administrative staff. • Test all staff weekly. Test all residents upon identification of an individual with symptoms consistent with COVID-19, or if staff have tested positive for COVID-19. Weekly testing continues until all residents test negative. • Dedicated space in facility for cohorting and managing care for residents with COVID-19; plan to manage new/readmissions with an unknown COVID-19 status and residents who develop symptoms.	
Phase 3 of Reopening nursing homes and Opening Up America Again	• Community case status meets criteria for entry to phase 3 (no rebound in cases during phase 2). • There have been no new, nursing home onset COVID cases in the nursing home for 28 days (through phases 1 and 2). • The nursing home is not experiencing staff shortages. • The nursing home has adequate supplies of personal protective equipment and essential cleaning and disinfection. supplies to care for residents. • The nursing home has adequate access to testing for COVID-19.	• Visitation allowed with screening and additional precautions including ensuring social distancing and hand hygiene (e.g., use alcohol-based hand rub upon entry). All visitors must wear a cloth face covering or facemask for the duration of their visit. • Allow entry of non-essential healthcare personnel/contractors as determined necessary by the facility, with screening and additional precautions including social distancing, hand hygiene, and cloth face covering or facemask. • Communal dining limited (for COVID-19 negative or asymptomatic residents only), but residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet). • Group activities, including outings, allowed (for asymptomatic or COVID-19 negative residents only) with no more than the number of people where social distancing among residents can be maintained, appropriate hand hygiene, and use of a cloth face covering or facemask.	• Normal Survey operations • All complaint and revisit surveys required to identify and resolve any non-compliance with health and safety requirements • Standard (recertification) surveys and revisits • Focused infection control surveys • State-based priorities (e.g., localized "hot spots," "strike" teams, etc. • See Appendix for recommendations for prioritizing facilities to be surveyed

Status	Criteria for Implementation	Visitation and Service Considerations	Surveys that will be performed at each phase
	• Referral hospital(s) have bed capacity on wards and intensive care units.	• Allow entry of volunteers, with screening and additional precautions including social distancing, hand hygiene, and cloth face covering or facemask. • For medically necessary trips outside of the facility: o The resident must wear a mask; and o The facility must share the resident's COVID-19 status with the transportation service and entity with whom the resident has the appointment. • 100% screening of all persons entering the facility and all staff at the beginning of each shift: o Temperature checks. o Ensure all outside persons entering building have cloth face covering or facemask. o Questionnaire about symptoms and potential exposure o Observation of any signs or symptoms • 100% screening (at least daily) for all residents o Temperature checks o Questions about and observation for other signs or symptoms of COVID-19 • Universal source control for everyone in the facility. Residents and visitors wear cloth face covering or facemask. • All staff wear all appropriate PPE when indicated. Staff wear cloth face covering if facemask is not indicated, such as administrative staff. • Test all staff weekly. Test all residents upon identification of an individual with symptoms consistent with COVID-19, or if staff have tested positive for COVID-19. Weekly testing continues until all residents test negative. • Dedicated space in facility for cohorting and managing care for residents with COVID-19; plan to manage new/readmissions with an unknown COVID-19 status and residents who develop symptoms.	

APPENDIX

Additional Recommendations

- Reminder: When a community enters phase 1 of Opening Up America Again, nursing homes remain at their highest level of vigilance and mitigation (e.g., visitation restricted except in compassionate care situations). Nursing homes do not begin to de-escalate or relax restrictions until their surrounding community satisfies gating criteria and enters phase 2 of Opening Up America Again.
- A nursing home should spend a minimum of 14 days in a given phase, with no new nursing home onset of COVID-19 cases, prior to advancing to the next phase.
- A nursing home may be in different phases than its surrounding community based on the status of COVID-19 inside the facility, and the availability of key elements including, but not limited to PPE[2], testing, and staffing. For example, if a facility identifies a new, nursing home onset COVID-19 case in the facility while in **any** phase, that facility goes back to the **highest** level of mitigation, and starts over (even if the community is in phase 3).
- States may choose to have a longer waiting period (e.g., 28 days) before relaxing restrictions for facilities that have had a significant outbreak of COVID-19 cases, facilities with a history of noncompliance with infection control requirements, facilities with issues maintaining adequate staffing levels, or any other situations the state believes may warrant additional oversight or duration before being permitted to relax restrictions.

State Survey Prioritization (Starting in Phase 2 of the above chart)

States should use the following prioritization criteria within each phase when determining which facilities to begin to survey first.

- For investigating complaints (and Facility-Reported Incidents (FRIs), facilities with reports or allegations of:
  1. Abuse or neglect
  2. Infection control, including lack of notifying families and their representatives of COVID-19 information (per new requirements at 42 CFR 483.80(g)(3))
  3. Violations of transfer or discharge requirements
  4. Insufficient staffing or competency
  5. Other quality of care issues (e.g., falls, pressure ulcers, etc.)

  In addition, a State agency may take other factors into consideration in its prioritization decision. For example, the State may identify a trend in allegations that indicates an increased risk of harm to residents, or the State may receive corroborating information from other sources regarding the allegation. In this case, the State may prioritize a facility for a survey higher than a facility that has met the above criteria.

- For standard recertification surveys:
  1. Facilities that have had a significant number of COVID-19 positive cases
  2. Special Focus Facilities
  3. Special Focus Facility candidates

[2] Facilities should review the Centers for Disease Control and Prevention's guidance on COVID-19 for healthcare professionals.

4. Facilities that are overdue for a standard survey (> 15 months since last standard survey) and a history of noncompliance at the harm level (citations of "G" or above) with the below items:
   - Abuse or neglect
   - Infection control
   - Violations of transfer or discharge requirements
   - Insufficient staffing or competency
   - Other quality of care issues (e.g., falls, pressure ulcers, etc.)

For example, a facility whose last standard survey was 24 months ago and was cited for abuse at a "G" level of noncompliance, would be surveyed earlier (i.e., prioritized higher) than a facility whose last standard survey was 23 months ago and had lower level deficiencies. We recognize that there are many different scenarios or combinations of timing of surveys and types of noncompliance that will exist. We defer to States for final decisions on scheduling surveys consistent with CMS survey prioritization guidelines.

Exhibit 11

CDC Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

How to Protect Yourself & Others

Older adults and people who have severe underlying medical conditions like heart or lung disease or diabetes seem to be at higher risk for developing serious complications from COVID-19 illness. More information on Are you at higher risk for serious illness.

Know how it spreads

- There is currently no vaccine to prevent coronavirus disease 2019 (COVID-19).
- The best way to prevent illness is to avoid being exposed to this virus.
- The virus is thought to spread mainly from person-to-person.
  - Between people who are in close contact with one another (within about 6 feet).
  - Through respiratory droplets produced when an infected person coughs, sneezes or talks.
  - These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.
  - Some recent studies have suggested that COVID-19 may be spread by people who are not showing symptoms.

Everyone Should

Wash your hands often

- Wash your hands often with soap and water for at least 20 seconds especially after you have been in a public place, or after blowing your nose, coughing, or sneezing.
- If soap and water are not readily available, use a hand sanitizer that contains at least 60% alcohol. Cover all surfaces of your hands and rub them together until they feel dry.
- Avoid touching your eyes, nose, and mouth with unwashed hands.

Avoid close contact

- Avoid close contact with people who are sick, even inside your home. If possible, maintain 6 feet between the person who is sick and other household members.
- Put distance between yourself and other people outside of your home.
  - Remember that some people without symptoms may be able to spread virus.
  - Stay at least 6 feet (about 2 arms' length) from other people.
  - Do not gather in groups.
  - Stay out of crowded places and avoid mass gatherings.
  - Keeping distance from others is especially important for people who are at higher risk of getting very sick.

Cover your mouth and nose with a cloth face cover when around others

others

- You could spread COVID-19 to others even if you do not feel sick.
- Everyone should wear a cloth face cover when they have to go out in public, for example to the grocery store or to pick up other necessities.
  - Cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
- The cloth face cover is meant to protect other people in case you are infected.
- Do NOT use a facemask meant for a healthcare worker.
- Continue to keep about 6 feet between yourself and others. The cloth face cover is not a substitute for social distancing.

Cover coughs and sneezes

- **If you are in a private setting and do not have on your cloth face covering, remember to always cover your mouth and nose** with a tissue when you cough or sneeze or use the inside of your elbow.
- **Throw used tissues** in the trash.
- Immediately **wash your hands** with soap and water for at least 20 seconds. If soap and water are not readily available, clean your hands with a hand sanitizer that contains at least 60% alcohol.

Clean and disinfect

- **Clean AND disinfect frequently touched surfaces daily.** This includes tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks.
- **If surfaces are dirty, clean them.** Use detergent or soap and water prior to disinfection.
- **Then, use a household disinfectant.** Most common EPA-registered household disinfectants will work.

Monitor Your Health

- **Be alert for symptoms.** Watch for fever, cough, shortness of breath, or other symptoms of COVID-19.
  - Especially important if you are running essential errands, going into the office or workplace, and in settings where it may be difficult to keep a physical distance of 6 feet.
- **Take your temperature** if symptoms develop.
  - Don't take your temperature within 30 minutes of exercising or after taking medications that could lower your temperature, like acetaminophen.
- Follow CDC guidance if symptoms develop.

Stop the Spread of Germs

COVID-19 Stop the Spread of Germs

Help stop the spread of COVID-19 and other respiratory illnesses by following these steps.

Handwashing Resources

Handwashing tips

Hand Hygiene in Healthcare Settings

More information

Symptoms

What to do if you are sick

If someone in your house gets sick

Frequently asked questions

Travelers

Individuals, schools, events, businesses and more

Healthcare Professionals

6 Steps to Prevent COVID-19

6 Steps to Prevent COVID-19 (ASL Version)

Social Distancing (ASL Video)

ASL Video Series: What You Need to Know About Handwashing

Page last reviewed: April 24, 2020

Exhibit 12

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Key Strategies to Prepare for COVID-19 in Long-Term Care Facilities (LTCFs)

Related Pages

Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes

Considerations for Memory Care Units in Long-term Care Facilities

Key Strategies for Long-term Care Facilities

Responding to Coronavirus (COVID-19) in Nursing Homes

Testing for Coronavirus (COVID-19) in Nursing Homes

Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19

COVID-19 cases have been reported in all 50 states, the District of Columbia, and multiple U.S. territories; many having wide-spread community transmission. Given the high risk of spread once COVID-19 enters a LTCF, facilities must act immediately to protect residents, families, and staff from serious illness, complications, and death.

1. **Keep COVID-19 from entering your facility:**
   - Restrict all visitors except for compassionate care situations (e.g., end-of- life).
   - Restrict all volunteers and non-essential healthcare personnel (HCP), including consultant services (e.g., barber, hairdresser).
   - Implement universal use of source control for everyone in the facility.
   - Actively screen anyone entering the building (HCP, ancillary staff, vendors, consultants) for fever and symptoms of COVID-19 before starting each shift; send ill personnel home. Sick leave policies should be flexible and non-punitive.
   - Cancel all field trips outside of the facility.

2. **Identify infections early:**
   - Actively screen all residents daily for fever and symptoms of COVID-19; if symptomatic, immediately isolate and implement appropriate Transmission-Based Precautions.
     - Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
   - Notify your state or local health department immediately (<24 hours) if these occur:
     - Severe respiratory infection causing hospitalization or sudden death
     - Clusters (≥3 residents and/or HCP) of respiratory infection
     - Individuals with suspected or confirmed COVID-19

3. **Prevent spread of COVID-19:**
   - Actions to take now:
     - Cancel all group activities and communal dining.
     - Enforce social distancing among residents.
     - Ensure all residents wear a cloth face covering for source control whenever they leave their room or are around others, including whenever they leave the facility for essential medical appointments.
     - Ensure all HCP wear a facemask or cloth face covering for source control while in the facility. Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required.

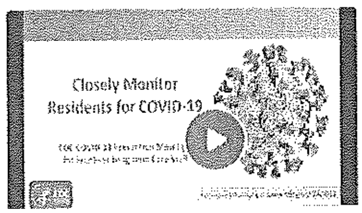
- If COVID-19 is identified in the facility, restrict all residents to their rooms and have HCP wear all recommended PPE for care of all residents (regardless of symptoms) on the affected unit (or facility-wide depending on the situation). This includes: an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and gown. HCP should be trained on PPE use including putting it on and taking it off.
  - This approach is recommended because of the high risk of unrecognized infection among residents. Recent experience suggests that a substantial proportion of residents could have COVID-19 without reporting symptoms or before symptoms develop.
  - When a case is identified, public health can help inform decisions about testing asymptomatic residents on the unit or in the facility.

4. Assess supply of personal protective equipment (PPE) and initiate measures to optimize current supply:
   - If you anticipate or are experiencing PPE shortages, reach out to your state/local health department who can engage your local healthcare coalition.
   - Consider extended use of respirators, facemasks, and eye protection or prioritization of gowns for certain resident care activities.

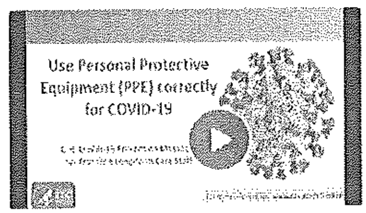
5. Identify and manage severe illness:
   - Designate a location to care for residents with suspected or confirmed COVID-19, separate from other residents.
   - Monitor ill residents (including documentation of temperature and oxygen saturation) at least 3 times daily to quickly identify residents who require transfer to a higher level of care.

Webinar Series - COVID-19 Prevention Messages for Long Term Care Staff

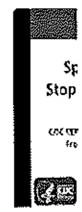
Clean Hands - Combat COVID-19



Closely Monitor Residents for COVID-19



PPE Lessons



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Additional Resources

Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings

Additional Infection Control Guidance for Nursing Homes and Long-Term Care Settings

Nursing Home and Long-Term Care Facility Checklist

Supporting Your Loved One in a Long-Term Care Facility

Page last reviewed: May 21, 2020

Exhibit 13

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Preparing for COVID-19 in Nursing Homes

Updated May 19, 2020

Related Pages

Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes

Considerations for Memory Care Units in Long-term Care Facilities

Key Strategies for Long-term Care Facilities

Responding to Coronavirus (COVID-19) in Nursing Homes

Testing for Coronavirus (COVID-19) in Nursing Homes

Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19

Summary of Changes to the Guidance:

- **Tiered recommendations to address nursing homes in different phases of COVID-19 response**
- **Added a recommendation to assign an individual to manage the facility's infection control program**
- **Added guidance about new requirements for nursing homes to report to the National Healthcare Safety Network (NHSN)**
- **Added a recommendation to create a plan for testing residents and healthcare personnel for SARS-CoV-2**

Background

Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 and other pathogens, including multidrug-resistant organisms (e.g., Carbapenemase-producing organisms, *Candida auris*). As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP).

Facilities should assign at least one individual with training in IPC to provide on-site management of their COVID-19 prevention and response activities because of the breadth of activities for which an IPC program is responsible, including developing IPC policies and procedures, performing infection surveillance, providing competency-based training of HCP, and auditing adherence to recommended IPC practices.

The Centers for Medicare and Medicaid Services (CMS) recently issued Nursing Home Reopening Guidance for State and Local Officials that outlines criteria that could be used to determine when nursing homes could relax restrictions on visitation and group activities and when such restrictions should be reimplemented. Nursing homes should consider the current situation in their facility and community and refer to that guidance as well as direction from state and local officials when making decisions about relaxing restrictions. **When relaxing any restrictions, nursing homes must remain vigilant for COVID-19 among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death.**

This guidance has been updated and reorganized according to core IPC practices that should remain in place even as nursing homes resume normal practices, plus additional strategies depending on the stages described in the CMS Reopening Guidance or at the direction of state and local officials. This guidance is based on currently available information about COVID-19 and will be refined and updated as more information becomes available.

These recommendations supplement the CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings and are specific for nursing homes, including skilled nursing facilities.

Additional Key Resources:

- Considerations for the Public Health Response to COVID-19 in Nursing Homes
- Interim Testing in Response to Suspected or Confirmed COVID-19 in Nursing Home Residents and Healthcare Personnel
- Considerations for Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes
- Webinar Series — COVID-19 Prevention Messages for Long-Term Care Staff
- Considerations for Memory Care Units in Long-Term Care Facilities
- Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19

Core Practices

These practices should remain in place even as nursing homes resume normal activities.

Assign One or More Individuals with Training in Infection Control to Provide On-Site Management of the IPC Program.

- This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the facility risk assessment.
- CDC has created an online training course that can be used to orient individuals to this role in nursing homes.

Report COVID-19 cases, facility staffing, and supply information to the National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module weekly.

- CDC's NHSN provides long-term care facilities with a customized system to track infections and prevention process measures in a systematic way. Nursing homes can report into the four pathways of the LTCF COVID-19 Module including:
  - Resident impact and facility capacity
  - Staff and personnel impact
  - Supplies and personal protective equipment
  - Ventilator capacity and supplies
- Weekly data submission to NHSN will meet the CMS COVID-19 reporting requirements.

Educate Residents, Healthcare Personnel, and Visitors about COVID-19, Current Precautions Being Taken in the Facility, and Actions They Should Take to Protect Themselves.

- Provide information about COVID-19 (including information about signs and symptoms) and strategies for managing stress and anxiety.
- Regularly review CDC's Infection Control Guidance for Healthcare Professionals about COVID-19 for current information and ensure staff and residents are updated when this guidance changes.
- Educate and train HCP, including facility-based and consultant personnel (e.g., wound care, podiatry, barber) and volunteers who provide care or services in the facility. Including consultants is important, since they commonly provide care in multiple facilities where they can be exposed to and serve as a source of COVID-19.
  - Reinforce sick leave policies, and remind HCP not to report to work when ill.
  - Reinforce adherence to standard IPC measures including hand hygiene and selection and correct use of personal protective equipment (PPE). Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities.

    - CDC has created training modules for front-line staff that can be used to reinforce recommended practices for preventing transmission of SARS-CoV-2 and other pathogens.
  - Educate HCP about any new policies or procedures.
- Educate residents and families on topics including information about COVID-19, actions the facility is taking to protect them and/or their loved ones, any visitor restrictions that are in place, and actions residents and families should take to protect themselves in the facility, emphasizing the importance of hand hygiene and source control.
- Have a plan and mechanism to regularly communicate with residents, families and HCP, including if cases of COVID-19 are identified among residents or HCP.

Implement Source Control Measures.

- HCP should wear a facemask at all times while they are in the facility.
  - When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Guidance on extended use and reuse of facemasks is available. **Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask if PPE is required.**
- Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. In addition to the categories described above cloth face coverings should not be placed on children under 2.
- Visitors, if permitted into the facility, should wear a cloth face covering while in the facility.

Have a Plan for Visitor Restrictions.

- Send letters or emails to families reminding them not to visit when ill or if they have a known exposure to someone with COVID-19.
- Facilitate and encourage alternative methods for visitation (e.g., video conferencing) and communication with the resident

- Post signs at the entrances to the facility advising visitors to check-in with the front desk to be assessed for symptoms prior to entry.
  - Screen visitors for fever (T≥100.0°F), symptoms consistent with COVID-19, or known exposure to someone with COVID-19. Restrict anyone with fever, symptoms, or known exposure from entering the facility.
- Ask visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility.
- Have a plan for when the facility will implement additional restrictions, ranging from limiting the number of visitors and allowing visitation only during select hours or in select locations to restricting all visitors, except for compassionate care reasons (see below).

Create a Plan for Testing Residents and Healthcare Personnel for SARS-CoV-2.

- Testing for SARS-CoV-2, the virus that causes COVID-19, in respiratory specimens can detect current infections (referred to here as viral testing or test) among residents and HCP in nursing homes.
- The plan should align with state and federal requirements for testing residents and HCP for SARS-CoV-2 and address:
  - Triggers for performing testing (e.g., a resident or HCP with symptoms consistent with COVID-19, response to a resident or HCP with COVID-19 in the facility, routine surveillance)
  - Access to tests capable of detecting the virus (e.g., polymerase chain reaction) and an arrangement with laboratories to process tests
    - Antibody test results should not be used to diagnose someone with an active SARS-CoV-2 infection and should not be used to inform IPC action.
  - Process for and capacity to perform SARS-CoV-2 testing of all residents and HCP
  - A procedure for addressing residents or HCP who decline or are unable to be tested (e.g., maintaining Transmission-Based Precautions until symptom-based criteria are met for a symptomatic resident who refuses testing)

- Additional information about testing of residents and HCP is available:
  - CDC Strategy for COVID-19 Testing Nursing Homes.
  - Considerations for Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes

Evaluate and Manage Healthcare Personnel.

- Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that support HCP to stay home when ill.
- Create an inventory of all volunteers and personnel who provide care in the facility. Use that inventory to determine which personnel are non-essential and whose services can be delayed if such restrictions are necessary to prevent or control transmission.
- As part of routine practice, ask HCP (including consultant personnel and ancillary staff such as environmental and dietary services) to regularly monitor themselves for fever and symptoms consistent with COVID-19.
  - Remind HCP to stay home when they are ill.
  - If HCP develop fever (T≥100.0°F) or symptoms consistent with COVID-19 while at work they should inform their supervisor and leave the workplace. Have a plan for how to respond to HCP with COVID-19 who worked while ill (e.g., identifying and performing a risk assessment for exposed residents and co-workers).
  - HCP with suspected COVID-19 should be prioritized for testing.
- Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19.
  - **Actively take their temperature*** and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace.
  - *Fever is either measured temperature >100.0°F or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of individuals in such situations.
  - HCP who work in multiple locations may pose higher risk and should be encouraged to tell facilities if they have had exposure to other facilities with recognized COVID-19 cases.
- Develop (or review existing) plans to mitigate staffing shortages from illness or absenteeism.
  - CDC has created guidance to assist facilities with mitigating staffing shortages.
  - For guidance on when HCP with suspected or confirmed COVID-19 may return to work, refer to Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)

Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices.

- Hand Hygiene Supplies:
  - Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym). Unless hands are visibly soiled, an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations.
  - Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- Respiratory Hygiene and Cough Etiquette:
  - Make tissues and trash cans available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.
- Personal Protective Equipment (PPE):
  - Perform and maintain an inventory of PPE in the facility.
    - Identify health department or healthcare coalition contacts for getting assistance during PPE shortages. The Supplies and Personal Protective Equipment pathway in the NHSN LTCF COVID-19 Module can be used to indicate critical PPE shortages (i.e., less than one week supply remaining despite use of PPE conservation strategies).
    - Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools.
  - Make necessary PPE available in areas where resident care is provided.
    - Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback promoting appropriate use by staff.
    - Facilities should have supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles).

- Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room.
- Implement strategies to optimize current PPE supply *even before shortages occur*, including bundling resident care and treatment activities to minimize entries into resident rooms. Additional strategies might include:
  - Extended use of respirators, facemasks, and eye protection, which refers to the practice of wearing the same respirator or facemask and eye protection for the care of more than one resident (e.g., for an entire shift).
    - Care must be taken to avoid touching the respirator, facemask, or eye protection. If this must occur (e.g., to adjust or reposition PPE), HCP should perform hand hygiene immediately after touching PPE to prevent contaminating themselves or others.
  - Prioritizing gowns for activities where splashes and sprays are anticipated (including aerosol-generating procedures) and high-contact resident care activities that provide opportunities for transfer of pathogens to hands and clothing of HCP.
    - **If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections (e.g., *Clostridioides difficile*)**
  - Implement a process for decontamination and reuse of PPE such as face shields and goggles.
  - Facilities should continue to assess PPE supply and current situation to determine when a return to standard practices can be considered.
- Implement a respiratory protection program that is compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training, and fit testing.
- Environmental Cleaning and Disinfection:
  - Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas;
  - Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
    - Use an EPA-registered disinfectant from List N on the EPA website to disinfect surfaces that might be contaminated with SARS-CoV-2. Ensure HCP are appropriately trained on its use.

Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with COVID-19.

- Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.
  - Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use.
- Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, implement use of Transmission-Based Precautions, prioritize for testing, transfer to COVID-19 unit if positive).
  - Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of SARS-CoV-2 testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. While awaiting results of testing, HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. **Cloth face coverings are not considered PPE and should only be worn by HCP for source control, not when PPE is indicated.**
- Have a plan for how roommates, other residents, and HCP who may have been exposed to an individual with COVID-19 will be handled (e.g., monitor closely, avoid placing unexposed residents into a shared space with them).
- Additional information about cohorting residents and establishing a designated COVID-19 care unit is available in the Considerations for the Public Health Response to COVID-19 in Nursing Homes

Create a Plan for Managing New Admissions and Readmissions Whose COVID-19 Status is Unknown.

- Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected.

Evaluate and Manage Residents with Symptoms of COVID-19.

- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19.
- Actively monitor all residents upon admission and at least daily for fever (T≥100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below.
    - Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0°F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- The health department should be notified about residents or HCP with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of each other.
    - Contact information for the healthcare-associated infections program in each state health department is available here: https://www.cdc.gov/hai/state-based/index.html
    - Refer to CDC resources for performing respiratory infection surveillance in long-term care facilities during an outbreak.
- Information about the clinical presentation and course of patients with COVID-19 is described in the Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 (COVID-19). CDC has also developed guidance on Evaluating and Reporting Persons Under Investigation (PUI).
- **If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community, follow the** Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. **This guidance should be implemented immediately once COVID-19 is suspected**
    - Residents with suspected COVID-19 should be prioritized for testing.
    - Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.
        - Residents with COVID-19 should, ideally, be cared for in a dedicated unit or section of the facility with dedicated HCP (see section on Dedicating Space).
        - As roommates of residents with COVID-19 might already be exposed, it is generally not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test.
    - Residents with known or suspected COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. **Cloth face coverings are not considered PPE and should not be worn when PPE is indicated.**
    - Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection.
        - Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any with new symptoms.
    - If a resident requires a higher level of care or the facility cannot fully implement all recommended infection control precautions, the resident should be transferred to another facility that is capable of implementation. **Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer.**
        - While awaiting transfer, residents should be separated from others (e.g., in a private room with the door closed) and should wear a cloth face covering or facemask (if tolerated) when others are in the room and during transport.
        - All recommended PPE should be used by healthcare personnel when coming in contact with the resident.
    - Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is newly identified in the facility; this could also be considered when there is sustained transmission in the community. The health department can assist with decisions about testing of asymptomatic residents.

- For decisions on removing residents who have had COVID-19 from Transmission-Based Precautions refer to the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

Additional Strategies Depending on the Facility's Reopening Status

These strategies will depend on the stages described in the CMS Reopening Guidance or the direction of state and local officials.

Implement Social Distancing Measures

- Implement aggressive social distancing measures (remaining at least 6 feet apart from others):
  - Cancel communal dining and group activities, such as internal and external activities.
  - Remind residents to practice social distancing, wear a cloth face covering (if tolerated), and perform hand hygiene.
  - Remind HCP to practice social distancing and wear a facemask (for source control) when in break rooms or common areas.
- Considerations when restrictions are being relaxed include:
  - Allowing communal dining and group activities for residents without COVID-19, including those who have fully recovered while maintaining social distancing, source control measures, and limiting the numbers of residents who participate.
  - Allowing for safe, socially distanced outdoor excursions for residents without COVID-19, including those who have fully recovered. Planning for such excursions should address:
    - Use of cloth face covering for residents and facemask by staff (for source control) while they are outside
    - Potential need for additional PPE by staff accompanying residents
    - Rotating schedule to ensure all residents will have an opportunity if desired, but that does not fully disrupt other resident care activities by staff
    - Defining times for outdoor activities so families could plan around the opportunity to see their loved ones

Implement Visitor Restrictions

- Restrict all visitation to their facilities except for certain compassionate care reasons, such as end-of-life situations.
  - Send letters or emails to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end of life situations.
  - Use of alternative methods for visitation (e.g., video conferencing) should be facilitated by the facility.
  - Post signs at the entrances to the facility advising that no visitors may enter the facility.
  - Decisions about visitation for compassionate care situations should be made on a case-by-case basis, which should include careful screening of the visitor for fever or symptoms consistent with COVID-19. Those with symptoms should not be permitted to enter the facility. Any visitors that are permitted must wear a cloth face covering while in the building and restrict their visit to the resident's room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.
- Considerations for visitation when restrictions are being relaxed include:
  - Permit visitation only during select hours and limit the number of visitors per resident (e.g., no more than 2 visitors at one time).
  - Schedule visitation in advance to enable continued social distancing.
  - Restrict visitation to the resident's room or another designated location at the facility (e.g., outside).

Healthcare Personnel Monitoring and Restrictions:

- Restrict non-essential healthcare personnel, such as those providing elective consultations, personnel providing non-essential services (e.g., barber, hair stylist), and volunteers from entering the building.
  - Consider implementing telehealth to offer remote access to care activities.

Definitions:

- **Healthcare Personnel (HCP):** HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).
- **Source Control:** Use of a cloth face covering or facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Facemasks and cloth face coverings should not be placed on children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- **Cloth face covering:** Textile (cloth) covers that are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. They are not PPE and it is uncertain whether cloth face coverings protect the wearer. Guidance on design, use, and maintenance of cloth face coverings is available.
- **Facemask:** Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.
- **Respirator:** A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in healthcare.

Additional Resources

Testing in Nursing Homes

Recorded webinar, Preparing Nursing Homes and Assisted Living Facilities for COVID-19

Long-term Care Facility Letter [1 page] to Residents, Families, Friends and Volunteers

Nursing Home and Long-Term Care Facility Checklist

Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings

Key Strategies to Prepare for COVID-19 in Long-Term Care Facilities

CMS Emergency Preparedness & Response Operations

Page last reviewed: May 19, 2020

Exhibit 14

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Responding to Coronavirus (COVID-19) in Nursing Homes

Considerations for the Public Health Response to COVID-19 in Nursing Homes

Related Pages

Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes

Considerations for Memory Care Units in Long-term Care Facilities

Key Strategies for Long-term Care Facilities

Responding to Coronavirus (COVID-19) in Nursing Homes

Testing for Coronavirus (COVID-19) in Nursing Homes

Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19

Background

This guidance is intended to assist nursing homes and public health authorities with response and cohorting decisions in nursing homes. This guidance supplements but does not replace recommendations included in the Interim Additional Guidance for Infection Prevention and Control for Patients with Suspected or Confirmed COVID-19 in Nursing Homes.

All facilities should adhere to current CDC infection prevention and control recommendations, including universal source control measures; visitor restrictions; screening of residents and HCP; and promptly notifying the health department [164 KB, 3 pages] about any of the following:

- Resident or HCP with suspected or confirmed COVID-19,
- Resident with severe respiratory infection resulting in hospitalization or death, or
- ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of each other.

These situations should prompt further investigation and testing for SARS-CoV-2, the virus that causes COVID-19.

Resident Cohorting

Considerations for establishing a designated COVID-19 care unit for residents with confirmed COVID-19

- Determine the location of the COVID-19 care unit and create a staffing plan before residents or HCP with COVID-19 are identified in the facility. This will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit.
  - Facilities that have already identified cases of COVID-19 among residents but have not developed a COVID-19 care unit, should work to create one unless the proportion of residents with COVID-19 makes this impossible (e.g., the majority of residents in the facility are already infected).
- Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19.
  - Depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, or cluster of rooms.
- Assign dedicated HCP to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility.
  - To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit.

- Assign environmental services [EVS] staff to work only on the unit.
  - If there are not a sufficient number of EVS staff to dedicate to this unit despite efforts to mitigate staffing shortages, restrict their access to the unit. Also, assign HCP dedicated to the COVID-19 care unit (e.g., NAs) to perform cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities. HCP should bring an Environmental Protection Agency (EPA)-registered disinfectant (e.g., wipe) from List N into the room and wipe down high touch surfaces (e.g., light switch, doorknob, bedside table) before leaving the room.
- Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected (e.g., each shift).
- Ensure HCP practice source control measures and social distancing in the break room and other common areas (i.e., HCP wear a facemask and sit more than 6 feet apart while on break).

- Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms.
- Ensure that HCP have been trained on infection prevention measures, including the use of and steps to properly put on and remove recommended personal protective equipment (PPE).
- If PPE shortages exist, implement strategies to optimize PPE supply on the unit, such as:
  - Bundle care activities to minimize the number of HCP entries into a room.
  - Consider extended use of respirators (or facemasks if respirators are not available), eye protection, and gowns. Limited reuse of PPE may also be considered.
  - Consider prioritizing gown use for high-contact resident care activities and activities where splash or spray exposures are anticipated.
- Assign dedicated resident care equipment (e.g., vitals machine) to the cohort unit. Cleaning and disinfection of shared equipment should be performed between residents and the equipment should not leave the cohort unit.

Considerations for new admissions or readmissions to the facility

- Newly admitted and readmitted residents with confirmed COVID-19 who have not met criteria for discontinuation of Transmission-Based Precautions should go to the designated COVID-19 care unit.
- Newly admitted and readmitted residents with COVID-19 who have met criteria for discontinuation of Transmission-Based Precautions can go to a regular unit.
  - If Transmission-Based Precautions have been discontinued, but the resident with COVID-19 remains symptomatic (i.e., persistent symptoms or chronic symptoms above baseline), they can be housed on a regular unit but should remain in a private room until symptoms resolve or return to baseline. These individuals should remain in their rooms to the extent possible during this time period. If they must leave their rooms, facilities should reinforce adherence to universal source control policies and social distancing [e.g., perform frequent hand hygiene, have the resident wear a cloth face covering or facemask (if tolerated) and remain at least 6 feet away from others when outside of their room].
- Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19.
  - All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown.
  - Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic SARS-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home.
- New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty.

Response to Newly Identified SARS-CoV-2-infected HCP or Residents

HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset

- Prioritize these HCP for SARS-CoV-2 testing. Exclude HCP with COVID-19 from work until they have met all return to work criteria.
- Determine which residents received direct care from and which HCP had unprotected exposure to HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset.
  - Residents who were cared for by these HCP should be restricted to their room and be cared for using all recommended COVID-19 PPE until results of HCP COVID-19 testing are known. If the HCP is diagnosed with COVID-19, residents should be cared for using all recommended COVID-19 PPE until 14 days after last exposure and prioritized for testing if they develop symptoms.
  - Exposed HCP should be assessed for risk and need for work exclusion.
- If testing is available, asymptomatic residents and HCP who were exposed to HCP with COVID-19 should be considered for testing (see information on testing below). If testing identifies infections among additional HCP, further evaluation for infections among residents and HCP exposed to those individuals should be performed as described above.

Resident with new-onset suspected or confirmed COVID-19

- Ensure the resident is isolated and cared for using all recommended COVID-19 PPE. Place the resident in a single room if possible pending results of SARS-CoV-2 testing.
  - Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit).
  - If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission.
- If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit.
- Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible,should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARS-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit).
  - Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room.
- Consider temporarily halting admissions to the facility, at least until the extent of transmission can be clarified and interventions can be implemented.
- Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infections.
  - Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms.
- Counsel all residents to restrict themselves to their room to the extent possible.
- HCP should use all recommended COVID-19 PPE for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents.
  - If HCP PPE supply is limited, implement strategies to optimize PPE supply, which might include extended use of respirators, facemasks, and eye protection and limiting gown use to high-contact care activities and those where splashes and sprays are anticipated. Broader testing could be utilized to prioritize PPE supplies (see section on using testing).
- Notify HCP, residents, and families and reinforce basic infection control practices within the facility (e.g., hand hygiene, PPE use, environmental cleaning).
  - Promptly (within 12 hours) notify HCP, residents, and families about identification of COVID-19 in the facility [164 KB, 3 pages] :
    - Provide educational sessions or handouts for HCP, residents, and families
    - Maintain ongoing, frequent communication with residents, families, and HCP with updates on the situation and facility actions
  - Monitor hand hygiene and PPE use in affected areas
- Maintain all interventions while assessing for new clinical cases (symptomatic residents):
  - Maintain Transmission-Based Precautions for all residents on the unit at least until there are no additional clinical cases for 14 days after implementation of all recommended interventions.

- If testing is available, asymptomatic residents and HCP who were exposed to the resident with COVID-19 (e.g., on the same unit) should be considered for testing
- The incubation period for COVID-19 can be up to 14 days and the identification of a new case within a week to 10 days of starting the interventions does not necessarily represent a failure of the interventions implemented to control transmission.

Use of Testing to Inform the Response to COVID-19 in Nursing Homes

Considerations for use of COVID testing to inform cohort decisions

- If testing supplies or capacity are limited, testing of symptomatic HCP and symptomatic residents should be prioritized.
    - If unit-wide or facility-wide testing is not available in response to newly identified SARS-CoV-2 infected residents or HCP, moving any residents other than those confirmed to have COVID-19 should be done with caution given the risk of asymptomatic infection; in those situations, all recommended COVID-19 PPE should be used during care of all residents on the affected unit or facility.
- If testing capacity allows, use of facility-wide testing following identification of newly identified SARS-CoV-2 infected residents or HCP could be particularly important. Facility-wide testing can help identify asymptomatic or pre-symptomatic residents with COVID-19 to guide movement into COVID-19 designated spaces.

For additional information on testing in response to COVID-19 in nursing homes please refer to Considerations for Use of Test-Based Strategies for Preventing SARS-CoV-2 Transmission in Nursing Homes.

Page last reviewed: April 30, 2020

Exhibit 15

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Testing Guidance for Nursing Homes

Interim Testing Guidance in Response to Suspected or Confirmed COVID-19 in Nursing Home Residents and Healthcare Personnel

Updated May 19, 2020

Related Pages

Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes

Considerations for Memory Care Units in Long-term Care Facilities

Key Strategies for Long-term Care Facilities

Responding to Coronavirus (COVID-19) in Nursing Homes

Testing for Coronavirus (COVID-19) in Nursing Homes

Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19

Summary of Changes to the Guidance:

- Included reference to the CMS Nursing Home Reopening Guidance for State and Local Officials , which addresses testing of residents and healthcare personnel in nursing homes
- Reorganized guidance to focus on how testing can be added to other infection prevention and control practices to keep COVID-19 out of nursing homes, detect cases quickly, and stop transmission

Nursing home residents are at high risk for infection, serious illness, and death from COVID-19. Testing for SARS-CoV-2, the virus that causes COVID-19, in respiratory specimens can detect current infections (referred to here as viral testing or test) among residents and healthcare personnel (HCP) in nursing homes. Viral testing in nursing homes is an important addition to other infection prevention and control (IPC) recommendations aimed at:

- Keeping COVID-19 out
- Detecting cases quickly
- Stopping transmission

Testing should not supersede existing IPC interventions.

Testing conducted at nursing homes should be implemented *in addition to* recommended IPC measures.

Testing should be used when results will lead to specific IPC actions.

Viral testing can be used to inform additional IPC actions necessary to keep SARS-CoV-2 out of facilities, detect COVID-19 cases quickly, and stop transmission. Testing practices should aim for rapid turn-around-times (e.g., less than 48 hours) in order to facilitate effective IPC action. At the current time, antibody test results should not be used to diagnose someone with an active SARS-CoV-2 infection and should not be used to inform IPC action.

While this guidance focuses on testing in nursing homes, it can also be applied to other long-term care facilities (e.g., assisted living facilities). Nursing homes should adhere to any state or federal testing requirements.

Keeping COVID-19 out

- Actively screen all HCP for fever and COVID-19 symptoms at the start of their shift; test any who screen positive.
  - HCP who have fever or symptoms should be excluded from work pending results of the test.
  - HCP who test positive for COVID-19 should be excluded from work until they meet return to work criteria.
- Facility leadership and local and state health departments should have a plan for meeting staffing needs to provide safe care to residents when HCP who test positive are excluded from work. CDC has created strategies to assist facilities with mitigating HCP shortages.
- Baseline testing of all residents and HCP along with weekly testing of all HCP are recommended for nursing homes as part of the reopening process . State and local officials may adjust the requirement for weekly testing of HCP based on the prevalence of the virus in their community, for example performing weekly testing in areas with moderate to substantial community transmission. Facilities performing such surveillance should have a plan for testing (including access to testing with a rapid-turnaround-time) and responding to results. Decisions should be based on guidance from state and local officials.

Detecting cases quickly

- Actively screen all residents for fever and COVID-19 symptoms each day and test any resident who exhibits fever or symptoms consistent with COVID-19.
- Test all residents and HCP in the nursing home if there is a new confirmed case of COVID-19; this refers to new SARS-CoV-2 infection in any HCP or any nursing home-onset SARS-CoV-2 infection in a resident. During the reopening process , nursing homes should test all residents and staff when there is a suspected or confirmed case in any resident or a confirmed case in any HCP.
  - When one case is detected in a nursing home, there are often other residents and HCP who are infected with SARS-CoV-2 and can continue to spread the infection, even if they are asymptomatic. Testing all residents and HCP as soon as there is a new confirmed case in the facility will identify infected individuals quickly to allow rapid implementation of IPC interventions (e.g., isolation, cohorting, use of personal protective equipment). When undertaking facility-wide testing, facility leadership should expect to identify multiple asymptomatic residents and HCP with SARS-CoV-2 infection and be prepared to cohort residents and mitigate potential staffing shortages. See Public Health Response to COVID-19 in Nursing Homes and Strategies to Mitigate Healthcare Personnel Staffing Shortages for more detail.
  - If testing capacity is limited, CDC suggests directing testing to residents and HCP on the same unit or floor of a new confirmed case.
  - If testing all residents on the same unit or floor is also not possible, CDC suggests directing testing to symptomatic residents and HCP and residents who have known exposure to a case (e.g., roommates of cases or those cared for by a known positive HCP).
  - See Considerations for Performing Facility-wide SARS-CoV-2 Testing Nursing Homes for additional details.

Stopping transmission

- After testing all residents and HCP in response to a new case, CDC recommends follow-up testing to ensure transmission has been terminated as follows:
  - Immediately test any resident or HCP who subsequently develops fever or symptoms consistent with COVID-19
  - Continue repeat testing of all previously negative residents (e.g., once a week) until the testing identifies no new cases of COVID-19 among residents or HCP over at least 14 days since the most recent positive result.
    - If test capacity is limited, CDC suggests directing repeat rounds of testing to residents who leave and return to the facility (e.g., for outpatient dialysis) or have known exposure to a case (e.g., roommates of cases or those cared for by a known positive HCP). For large facilities with limited test capacity, testing all residents on affected units could be considered, especially if facility-wide serial testing demonstrates no transmission beyond a limited number of units.
  - Continue repeat testing of all previously negative HCP (e.g., at least once a week, consider more frequent testing in settings where community incidence is high) until the testing identifies no new cases of COVID-19 among residents or HCP over at least 14 days since the most recent positive result.
    - If testing capacity is limited, CDC suggests directing repeat HCP testing to HCP who work at other facilities where there are known COVID-19 cases.

Definitions

- **Healthcare Personnel (HCP):** HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual HCP not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

- **Nursing home onset SARS-CoV-2 infections** refers to SARS-CoV-2 infections that originated in the nursing home. It does not refer to the following:
  - Residents who were known to have COVID-19 on admission to the facility and were placed into appropriate Transmission-Based Precautions to prevent transmission to others in the facility.
  - Residents who were not known to have COVID-19 on admission but who became positive within 14 days after admission, as long as these individuals had been placed into Transmission-Based Precautions upon admission to prevent transmission to others in the facility.

More Resources

- Responding to COVID-19 in Nursing Homes
- Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings
- Additional Infection Control Guidance for Nursing Homes and Long-Term Care Settings
- Nursing Home and Long-Term Care Facility Checklist

Page last reviewed: May 18, 2020

Exhibit 16

CDC Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes

Considerations for Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes.

Updated May 19, 2020

Related Pages

Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes

Considerations for Memory Care Units in Long-term Care Facilities

Key Strategies for Long-term Care Facilities

Responding to Coronavirus (COVID-19) in Nursing Homes

Testing for Coronavirus (COVID-19) in Nursing Homes

Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19

Purpose

CDC has recommendations for when nursing homes should test all residents and healthcare personnel (HCP) in nursing homes. This document describes considerations for performing facility-wide testing among nursing home residents and HCP. Facility-wide testing involves testing all residents and HCP for detection of SARS-CoV-2, the virus that causes COVID-19, and can be used to inform infection prevention and control (IPC) practices in nursing homes. This document is intended for health departments and nursing homes conducting viral testing for current infection, such as reverse-transcriptase polymerase chain reaction (RT-PCR).

For additional information about test-based strategies and the public health response to COVID-19 in nursing homes, please refer to:

- Interim Testing Guidance in Response to Suspected or Confirmed COVID-19 in Nursing Home Residents and Healthcare Personnel
- Considerations for the Public Health Response to COVID-19 in Nursing Homes

Preparing to perform facility-wide testing in nursing homes

- Health departments should develop a strategy for prioritizing testing among nursing home residents and healthcare personnel (HCP), depending on resources and goals.
  - Prioritize facilities based on the number of cases in the facility, community prevalence, or number of residents with recent healthcare exposures (e.g., recent hospitalization or receiving outpatient dialysis).
  - Plan for serial testing after the initial facility-wide testing to facilitate cohorting and identify new transmission events early.
    - Considerations for time intervals between testing include concern for ongoing transmission and logistics of repeat large scale testing.
  - Determine the type of Emergency Use Authorization or Food and Drug Administration approved viral test and the specimen source (e.g., nasopharyngeal, anterior nares) that will be used. Ensure availability of the required number of specimen collection kits and of personal protective equipment (PPE) needed for specimen collection.
  - If an infection control assessment has not already been performed, include an evaluation of IPC practices while conducting facility-wide testing. Testing should not supersede implementation of recommended IPC practices.

- Consider other factors prior to testing, such as identifying a clinician who will order testing and how testing for HCP and residents will be funded.
- Review relevant local, state and federal guidance and regulations on testing in nursing homes.
- See Interim Testing Guidance in Response to Suspected or Confirmed COVID-19 in Nursing Home Residents and Healthcare Personnel for further details.

- Health departments and nursing homes should have a plan to respond to results of the testing prior to initiating testing.
  - Ensure results of initial testing inform cohorting approaches in nursing homes.
    - If a nursing home identifies positive residents and is unable to cohort, health departments and nursing homes should decide whether it is feasible to move residents to another designated facility. If a facility is uncertain about their ability to cohort, then the facility should work with local authorities to identify infection prevention and control solutions based on test results.
  - Ensure plan to exclude positive HCP from work. Establish policies to mitigate possible HCP staff shortages as a result of testing.
  - Determine how testing might be used to inform discontinuation of Transmission-Based Precautions for residents and when positive HCP will be allowed to return to work.

Planning for specimen collection and data management

- Health departments and nursing homes should establish who is responsible for performing specimen collection from residents and HCP and a process for specimen collection and transport.
  - Ensure all HCP can be tested, not just those on duty at time of facility-wide testing.
  - Consider whether a nursing home facility's HCP can collect specimens from both residents and HCP or whether additional support is needed for specimen collection. The facility's HCP may need to be trained to collect specimens correctly. Training should include IPC requirements and correct PPE use.
  - Determine whether HCP can be tested at the nursing home or whether they will be tested offsite and how results will be shared with the facility and health department.
  - Determine a process that captures which residents and HCP were tested or were unable to be tested.

Coordinating reporting of testing results

- Laboratories that can quickly process large numbers of tests with rapid reporting of results (e.g., within 48 hours) should be selected for facility-wide testing intended to inform infection prevention initiatives to prevent and limit transmission.
  - Ideally, one laboratory should be selected to process specimens from both HCP and residents to facilitate data collection and analysis.
- If the designated laboratory sends results directly to the nursing home, the nursing home and health department should coordinate how all results will be shared with the health department.
- Ensure results are shared between facilities and health departments, even if multiple laboratories perform testing (e.g., state lab performs testing for residents and commercial laboratory performs testing for HCP).
- Health departments should develop a systematic method to receive testing results from laboratories and nursing homes.
- Health departments that receive results directly from surveillance systems or laboratories should ensure the results include date of testing, facility name, and the role of the individual tested (i.e., resident, HCP).
- Nursing homes should maintain records of HCP and residents who have positive tests; those records can facilitate reporting aggregate data into the National Healthcare Safety Network (NHSN) COVID-19 Module for LTCF.
- Data collection tools, which may include baseline epidemiologic information, developed by health departments should be shared with a responsible point of contact at each nursing home. The facility point of contact should be trained on how to collect and submit such data to ensure consistency across nursing homes.
- Testing should be carried out in a way that protects confidentiality to the extent possible and is consistent with applicable laws and regulations.
- Federal regulations require informing patients, staff, and families of the number of cases in the facility; facilities must have plans for meeting these regulations.
- When employers become aware of cases, the Recordkeeping and Reporting Occupational Injuries and Illness standard (29 CFR 1904), requires certain employers to keep a record of serious work-related injuries and illnesses including

work related COVID-19.

Recommendations for conducting swabbing

General considerations

- Follow CDC's Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19)
- The number of people present during specimen collection should be limited to only those essential for care and procedure support.
  - Visitors or other bystanders should not be present for specimen collection.
- Swabbing of multiple individuals should not be performed in the same room at the same time, unless appropriate separation between swabbing stations can be maintained (see below).

Consider if self-collection is appropriate

- PPE use can be minimized through self-collection while HCP remain at least 6 feet away of the individual being swabbed.
- The individual must be able to correctly self-swab and place the swab in transport media or sterile transport device and seal.
  - If the individual needs assistance, assistance can be provided by placing the swab into transport media or a sterile transport device and sealing it for them.
- If bulk-packaged swabs are used for sample collection, care must be exercised to avoid contamination of any of the swabs in the bulk-packaged container.

Location of specimen collection for nursing home residents

- Specimen collection should be performed one at a time in each resident's room with the door closed. An airborne infection isolation room is not required. Ideally for rooms with multiple residents, specimen collection should be performed one individual at a time in a room with the door closed and no other individuals present.

Location of specimen collection for HCP

- Ideally, specimen collection should be performed one individual at a time in a room with the door closed and no other individuals present. If individual rooms are not available, other options include:
  - Large spaces (e.g., gymnasiums) where sufficient space can be maintained between swabbing stations (e.g., greater than 6 feet apart).
  - An outdoor location, weather permitting, where other individuals will not come near the specimen collection activity.
- Considerations for multiple HCP being swabbed in succession in a single room:
  - Consider the use of portable HEPA filters to increase air exchanges and to expedite removing infectious particles.
  - Minimize the amount of time the HCP will spend in the room. HCP awaiting swabbing should not wait in the room where swabbing is being done. Those swabbed should have a face mask or cloth cover in place for source control throughout the process, only removing it during swabbing.
- Minimize the equipment kept in the specimen collection area. Consider having each person bring their own prefilled specimen bag containing a swab and labeled sterile viral transport media container into the testing area from the check-in area.

PPE for swabbing

- HCP in the room or specimen collection area should wear an N95 or higher-level respirator (or facemask if a respirator is not available) and eye protection. A single pair of gloves and a gown should also be worn for specimen collection or if contact with contaminated surfaces is anticipated.
  - If respirators are not readily available, they should be prioritized for other procedures at higher risk for producing infectious aerosols (e.g., intubation), instead of for collecting nasopharyngeal specimens.

- Extended use of respirators (or facemasks) and eye protection is permitted. However, care must be taken to avoid touching the necessary face and eye protection. If extended use equipment becomes damaged, soiled, or hard to breathe or see through, it should be replaced. Hand hygiene should be performed before and after manipulating PPE.
- Gloves should be changed and hand hygiene performed between each person being swabbed.
- Gowns should be changed when there is more than minimal contact with the person or their environment. The same gown may be worn for swabbing more than one person provided the HCP collecting the test minimizes contact with the person being swabbed. Gowns should be changed if they become soiled.
- Consider having an observer who does not engage in specimen collection but monitors for breaches in PPE use throughout the specimen collection process.
- HCP who are handling specimens, but are not directly involved in collection (e.g., self-collection) and not working within 6 feet of the individual being tested, should follow Standard Precautions; gloves are recommended, as well as a facemask for source control.

Cleaning and disinfection between individuals

- Surfaces within 6 feet of where specimen collection was performed should be cleaned and disinfected using an Environmental Protection Agency-registered disinfectant from List N if visibly soiled and at least hourly.
- Terminal cleaning and disinfection of all surfaces and equipment in the specimen collection area should take place at the end of each day. Resident rooms should be cleaned and disinfected in accordance with Implementing Environmental Infection Control in the Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings.

Definitions

- **Healthcare personnel (HCP):** HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, volunteer personnel).

Page last reviewed: May 19, 2020

Exhibit 17

Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19

This is an infection control assessment and response tool (ICAR) that can be used to help nursing homes prepare for coronavirus disease 2019 (COVID-19). This tool may also contain content relevant for assisted living facilities.

The items assessed support the key strategies of:

- Keeping COVID-19 out of the facility
- Identifying infections as early as possible
- Preventing spread of COVID-19 in the facility
- Assessing and optimizing personal protective equipment (PPE) supplies
- Identifying and managing severe illness in residents with COVID-19

The areas assessed include:

- Visitor restriction
- Education, monitoring, and screening of healthcare personnel[1] (HCP)
- Education, monitoring, and screening of residents
- Ensuring availability of PPE and other supplies
- Ensuring adherence to recommended infection prevention and control (IPC) practices
- Communicating with the health department and other healthcare facilities

Findings from the assessment can be used to target specific IPC preparedness activities that nursing homes can immediately focus on while continuing to keep their residents and HCP safe.

Additional Information for Personnel Conducting Assessments:

- The assessment includes a combination of staff interviews and direct observation of practices in the facility and can be conducted in-person or remotely (e.g., Tele-ICAR via phone or video conferencing). Provide a copy of the tool to the facility before completing the Tele-ICAR and encourage nursing home staff to take their own notes as you conduct the assessment.
- Background information in the light green boxes above each section being assessed provides context for the ICAR user. You should not read this aloud during the assessment process but can refer to it as additional information.
- Keep in mind that the goal of the assessment is to convey key messages to nursing homes and identify their COVID-19-specific preparedness needs. Note any IPC questions and concerns and address them after the ICAR is completed. If you need additional support and technical assistance during an assessment, know that you can engage state HD healthcare-associated infections/antibiotic resistance (HAI/AR) Program leads for support.
- Assessment activities provide an opportunity for dialogue and information sharing.
  - » Discuss the purpose of the assessment. Emphasize that it is not a regulatory inspection and is designed to ensure the facility is prepared to quickly identify and prevent the spread of COVID-19.
  - » Promote discussion by asking additional questions to prompt or probe. Use this opportunity to address concerns and offer available resources.

[1]Health care personnel (HCP) are defined as paid and unpaid persons serving in health care settings who have the potential for direct or indirect exposure to patients or infectious materials

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- To help you facilitate conversations with facilities, sample questions are provided in italics above each element being assessed. You do not have to ask these questions; however, they offer suggestions to help you continue the discussion, if needed. Be aware of applicable federal, state, county, or city rules, regulations such as CMS requirements for nursing homes and life safety code, and state government proclamations that may affect implementation of recommended practices.
- Provide feedback or a high-level summary immediately after the assessment, including elements in place and areas for improvement.
  - » Consider providing a copy of your assessment or a brief summary with feedback, answers to the facility's questions, and recommended next steps directly to the facility within 2-3 days.
- Consider scheduling a follow-up call with the facility after the assessment findings are shared.

Investigator: ______________________________ Date: __________

Good morning/afternoon. My name is _____ and I am calling from the _______ Department of Health. May I speak with someone who is in charge of infection prevention and control (IPC) at your facility?

Greetings, ____. My name is _____ and I am calling to discuss infection prevention and control (IPC) preparedness activities that your facility can immediately put into place to combat COVID-19 while continuing to keep your residents and healthcare personnel safe. I would like to go through an IPC consultation with you and your team, that is non-regulatory in nature and meant to be helpful. Is now a good time to talk? If not, when would work best?

Great. As background, infection control assessment and response surveys, also referred to as ICARs (eye-cars), were developed by CDC to help health departments assess IPC practices and guide quality improvement activities. ICARs are particularly useful for stopping the spread of pathogens during outbreaks. ICAR findings will be shared between the health department's Healthcare Associated Infections Program and CDC.

Before we begin, may I get your name and contact information? Is there another person at your facility who would be the primary contact for the health department? If yes, can I get their information also?

Facilities Demographics

Facility POC Name: ______________________________

Facility POC Title: ______________________________

POC Phone: __________ POC E-mail Address: ______________________________

Facility Name: ______________________________

Facility County: __________________ Number of beds in the facility: _____

Total number of residents in the facility: ________ Total number of staff in the facility: ______

Total number of units: _____

Specialty Units *(check all that apply)*: ☐ Vent/trach ☐ Dialysis ☐ Dementia/Memory ☐ Skilled Nursing ☐ Subacute Rehab ☐ Psychiatric care

These units have residents at higher risk for poor outcomes. Vent/trach units provide respiratory support and dementia/memory units are often secured, and limit resident movement to other locations.

Which of the following situations apply to the facility? *(Select all that apply)*

☐ No cases of COVID-19 currently reported in the surrounding community
☐ Cases reported in the surrounding community
☐ Sustained transmission reported in the surrounding community
☐ Cases identified in their facility (either among HCP and/or residents)
  If yes, please specify the number of cases among residents _______ and among HCPs _______
☐ Cluster of influenza-like illness (ILI) in facility (either among HCP and/or residents)
  If yes, please specify the number of cases among residents _______ and among HCPs _______

Have you received any prior information specific to preventing transmission of COVID-19? *(Select all that apply)*

☐ No
☐ Yes, from the health department
☐ Yes, from Centers for Medicare and Medicaid Services (CMS)
☐ Yes, from another source (Specify: ______________________________)

Visitor restrictions and non-essential personnel restrictions

Both CDC and CMS recommend restricting all visitors to nursing homes to prevent COVID-19 from entering the facility. Exceptions for compassionate care, such as end-of-life situations, may be considered on a case-by-case basis. All visitors should first have temperature and symptom screening (e.g., fever, new or worsening cough, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, and new loss of taste or smell) to safeguard residents. Ill visitors should not enter. Visitors who are granted access should perform frequent hand hygiene, wear a cloth face covering (for source control), and conduct their visit in a location designated by the facility such as the resident's room. Additional best practices include designating a single entrance for visitors, posting signage at entrances to the facility, and providing communication to residents and families.

Elements to be assessed	Assessment (Y/N)	Notes/Areas for Improvement
What is your current policy for visitors? **Facility restricts all visitation except for certain compassionate care situations, such as end-of-life situations.**	◯ Yes ◯ No	
Are there any exceptions to your visitation policy? What are those exceptions? **Decisions about visitation are made on a case-by-case basis.**	◯ Yes ◯ No	
If visitors are allowed in, what screening occurs? **Potential visitors are screened prior to entry for fever or symptoms of COVID-19. Those with symptoms are not permitted to enter the facility (e.g., fever, new or worsening cough, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, and new loss of taste or smell).**	◯ Yes ◯ No	
Are there any restrictions or requirements on visitors once they enter? Do you provide them with any additional information on hand hygiene? **Visitors that are permitted inside, must wear a cloth face covering while in the building and restrict their visit to the resident's room or other location designated by the facility. They are also reminded to frequently perform hand hygiene.**	◯ Yes ◯ No	
What is your policy for volunteers or non-medical service providers like a beautician, barber, or massage therapist? **Non-essential personnel including volunteers and non-medical service providers (e.g., salon, barbers) are restricted from entering the building.**	◯ Yes ◯ No	
What has your facility done to communicate with family members of residents? What have you told family members about visiting? **Facility has sent a communication (e.g., letter, email) to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end-of-life, and that alternative methods for visitation such as video conferencing will be made available by the facility.**	◯ Yes ◯ No	
Is the facility offering alternative means of communication instead of visits? What are those? **Facility has provided alternative methods for visitation such as video conferencing for residents.**	◯ Yes ◯ No	
Are there signs to prevent entrance into the facility (e.g., no visitors)? **Facility has posted signs at entrances to the facility advising that no visitors may enter the facility.**	◯ Yes ◯ No	

Education, Monitoring, and Screening of Healthcare Personnel (HCP)

*Education of HCP (including consultant personnel) should explain how the IPC measures protect residents, themselves, and their loved ones, with an emphasis on hand hygiene, PPE, and monitoring of their symptoms. Consultant personnel are individuals who provide specialized care or services (for example, wound core or podiatry) to residents in the facility on a periodic basis. They often work at multiple facilities in the area and should be included in education and screening efforts as they can be exposed to or serve as a source of pathogen transmission. If HCP work while ill, they can serve as a source of pathogen transmission within the facility. HCP should be reminded not to report to work when ill. All HCP should self-monitor when they are not at work and be **actively screened** upon entering the facility. Ideally, this would occur at the entrance to the facility, before they begin their shift. Screening includes temperature check and asking about symptoms like subjective fever, new or worsening cough, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, and new loss of taste or smell. If they have a fever of 100.0 F or higher or symptoms, they should be masked and sent home. Because symptom screening will not identify individuals who are infected but otherwise asymptomatic or pre-symptomatic, facilities should also implement universal source control policies requiring anyone in the facility to wear a facemask or cloth face covering. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required.*

Elements to be assessed	Assessment (Y/N)	Notes/Areas for Improvement
Have you provided any in-service training or education to the staff due to COVID-19? What was included in those? **Facility has provided education and refresher training to HCP (including consultant personnel) about the following:** • **COVID-19 (e.g., symptoms, how it is transmitted)**	◯ Yes ◯ No	
• **Sick leave policies and importance of not reporting to or remaining at work when ill**	◯ Yes ◯ No	
• **New policies for source control while in the facility**	◯ Yes ◯ No	
Do you ever audit or record performance of things like hand hygiene? Selection and use of personal protective equipment? Environmental cleaning? **Facility monitors HCP adherence to recommended IPC practices, including:** • **Hand hygiene**	◯ Yes ◯ No	
• **Selection and use of PPE; have HCP demonstrate competency with putting on and removing PPE**	◯ Yes ◯ No	
• **Cleaning and disinfecting environmental surfaces and resident care equipment**	◯ Yes ◯ No	
What is your current staffing capacity? **Facility is aware of staffing needs and has a plan in the event of staffing shortages.**	◯ Yes ◯ No	

Elements to be assessed	Assessment (Y/N)	Notes/Areas for Improvement
What is the current policy for facemasks for HCP inside the facility? What do you tell staff about wearing facemasks in common work areas with only co-workers present? If you are running low on facemasks, do you have a plan for when and which staff might use cloth face coverings for source control instead (those not providing direct care)? **Facility has implemented universal use of facemasks or cloth face coverings for HCP (for source control) while in the facility.**	◯ Yes ◯ No	
Facility has provided staff with education to use facemask or respirator if more than source control is required. *If there are shortages of facemasks, facemasks should be prioritized for HCP and then for residents with symptoms of COVID-19 (as supply allows). Cloth face coverings are not considered PPE and should not be worn instead of a respirator (or facemask if shortage of respirators) if more than source control is required.*	◯ Yes ◯ No	
What is the facility encouraging for staff in terms of social distancing? **All HCP are reminded to practice social distancing when in break rooms and common areas.**	◯ Yes ◯ No	
Have you started staff screening or check-ins? How does that work? Is this kept in a log? What do you do if someone has a fever or symptoms? **All HCP (including ancillary staff such as dietary and housekeeping and consultant personnel) are screened at the beginning of their shift for fever and symptoms of COVID-19 (actively records their temperature and documents they do not have fever, new or worsening cough, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell).**	◯ Yes ◯ No	
• **If they are ill, they are instructed to keep their cloth face covering or facemask on and leave the facility. HCP with suspected or confirmed COVID-19 should notify their supervisor at any facility where they work.**	◯ Yes ◯ No	
Has your facility had any symptomatic staff? How are they tracked or monitored? **Facility keeps a list of symptomatic HCP.**	◯ Yes ◯ No	

Education, Monitoring, and Screening, and Cohorting of Residents

Education of residents and their loved ones should include an explanation of steps the facility is taking to protect them and how visitors can serve as a source of pathogen transmission. The facility should ask residents to report if they feel feverish or have respiratory symptoms. They should actively monitor all residents upon admission and at least daily for fever and symptoms of COVID-19 (fever, new or worsening cough, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, and new loss of taste or smell). If they have a fever (temperature of 100.0 F or higher) or symptoms, they should be restricted to their room and put into appropriate Transmission-Based Precautions. Group activities such as communal meals, religious gatherings, classes, and field trips should be stopped to promote social distancing (residents remaining at least 6 feet apart from one another).

Facilities should plan to dedicate space to care for residents with COVID-19 even before they have an active case. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19 and would have dedicated HCP to deliver care within this space. Another consideration is how to manage new admissions or readmissians when COVID-19 status is unknown. Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents could be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their exposure (or admission). Testing at the end of this period could be considered to increase certainty that the resident is not infected. If an observation area has been created, residents in the facility who develop symptoms consistent with COVID-19 could be moved from their rooms to a single room in this area pending results of SARS-CoV-2 testing.

All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn by HCP when PPE is indicated.

Elements to be assessed	Assessment (Y/N)	Notes/Areas for Improvement
Have you provided any education to your residents on ways they can protect themselves (like washing hands, visitor restriction, social distancing)? **Facility has provided education to residents about the following:** • COVID-19 (e.g., symptoms, how it is transmitted)	○ Yes ○ No	
• Importance of immediately informing HCP if they feel feverish or ill	○ Yes ○ No	
• Actions they can take to protect themselves (e.g., hand hygiene, covering their cough, maintaining social distancing)	○ Yes ○ No	
• Actions the facility is taking to keep them safe (e.g., visitor restrictions, changes in PPE use, canceling group activities and communal dining)	○ Yes ○ No	
Are you screening residents? How are you screening them/what questions are you asking them? How often? What is included? **Facility assesses residents for fever and symptoms of COVID-19 (fever, new or worsening cough, difficulty breathing, chills, repeated shaking with chills, muscle pain, headache, sore throat, and new loss of taste or smell) upon admission and at least daily throughout their stay in the facility.**	○ Yes ○ No	
• Residents with suspected COVID-19 are immediately placed in appropriate Transmission-Based Precautions. *Note:* Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.	○ Yes ○ No	

Elements to be assessed	Assessment (Y/N)	Notes/Areas for Improvement
Are you keeping track of residents who are symptomatic? How? Facility keeps a list of symptomatic residents (link to respiratory infection surveillance tool): https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf)	◯ Yes ◯ No	
Has your facility made any changes to group activities (e.g., communal dining, religious activities [mass at Catholic facilities], gyms) or field trips? Facility has stopped group activities inside the facility and field trips outside of the facility.	◯ Yes ◯ No	
How are residents receiving meals? Has anything changed with communal dining? Facility has stopped communal dining.	◯ Yes ◯ No	
Additional actions when COVID-19 is identified in the facility or there is sustained transmission in the community (some facilities may choose to implement these earlier) *What is happening with resident movement in the facility? Are residents advised to stay in their rooms? Are they required to wear a facemask if they leave their rooms?* Residents are encouraged to remain in their rooms. • If there are cases in the facility, residents are restricted (to the extent possible) to their rooms except for medically necessary purposes.	◯ Yes ◯ No	
• If residents leave their rooms, they should wear a cloth face covering or facemask (if tolerated), perform hand hygiene, limit movement in the facility, and perform social distancing.	◯ Yes ◯ No	
How are ill residents monitored? How often are they monitored? What is included (e.g., symptoms, vitals, temp, oxygen saturation, respiratory exam)? • The facility monitors ill residents at least 3 times daily including evaluating symptoms, vital signs, and oxygen saturation via pulse oximetry to identify and quickly manage clinical deterioration.	◯ Yes ◯ No	
If there is a case within the facility in the future, have you made a plan for where the resident with COVID-19 will be placed? Facility has dedicated a space in the facility to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.	◯ Yes ◯ No	
How will this dedicated space be staffed? Facility has dedicated a team of primary HCP staff to work only in this area of the facility.	◯ Yes ◯ No	

Elements to be assessed	Assessment (Y/N)	Notes/Areas for Improvement
What is your plan for handling a resident who may have COVID-19? What is your plan for movement? What is your plan for testing? **Facility has a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, prioritize for testing, transfer to COVID-19 unit if positive).** Closely monitor roommates and other residents who may have been exposed to an individual with COVID-19 and, if possible, avoid placing unexposed residents into a shared space with them.	◯ Yes ◯ No	
What is your plan for managing new admission or readmissions when the resident's COVID-19 status is unknown? What PPE will be worn when caring for residents who have unknown COVID-19 status and are under observation? **Facility has a plan for managing new admissions and readmissions whose COVID-19 status is unknown.**	◯ Yes ◯ No	
Additional actions when COVID-19 is identified in the facility or there is sustained transmission in the community **Facility uses all recommended PPE for the care of all residents on affected units (or facility-wide depending on the situation).** Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is identified in the facility; this should also be considered when there is sustained transmission in the community. The health department can assist with decisions about testing of asymptomatic residents.	◯ Yes ◯ No	

Availability of PPE and Other Supplies

Major distributors in the United States have reported shortages of PPE. Shortages of alcohol-based hand sanitizers and refills and certain disinfectants have also been reported. Facilities should assess their current supplies of PPE and other critical materials as soon as possible and begin implementing strategies to optimize their current supply of PPE (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html). Examples of strategies described in those documents include extended use of facemasks and eye protection, which allow the same facemask and eye protection to be worn for the care of more than one resident. Gowns could be prioritized for select activities such as activities where splashes and sprays are anticipated (including aerosol generating procedures) and high-contact resident care activities that provide opportunities for transfer of pathogens to hands and clothing of HCP. If a facility anticipates or has a shortage, they should engage their health department and healthcare coalition for assistance.

- *Link to identifying your state HAI coordinator: https://www.cdc.gov/hai/state-based/index.html*
- *Link to healthcare coalition/preparedness: https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx*

Disinfectants used at a facility should be EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim against SARS-CoV-2. List N on the EPA website lists products that meet EPA's criteria for use against SARS-CoV-2 (https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2)

Elements to be assessed	Assessment (Y/N)	Notes/Areas for Improvement
How is your current supply of: facemasks and respirators; gowns; gloves; eye protection? Does your facility have enough supply of facemasks and respirators (gowns, gloves, etc.) for the next 1-2 weeks? **Facility has assessed current supply of PPE and other critical materials (e.g., alcohol-based hand sanitizer, EPA-registered disinfectants, tissues). (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html)**	◯ Yes ◯ No	
What is your facility doing to try and conserve PPE? Are you aware of the recommendations to conserve PPE? Do you have a backup plan if you don't have enough? **If PPE shortages are identified or anticipated, facility has engaged their health department and/or healthcare coalition for assistance.**	◯ Yes ◯ No	
Facility has implemented measures to optimize current PPE supply (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html).	◯ Yes ◯ No	
Where is your PPE located? Is it readily available for staff that need it? **PPE is available in resident care areas including outside resident rooms.** • **PPE here includes: gloves, gowns, facemasks, N-95 or higher-level respirators (if facility has a respiratory protection program and HCP are fit-tested) and eye protection (face shield or goggles).**	◯ Yes ◯ No	
How much disinfectant does your facility have on hand? Do you expect a shortage? **EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim against SARS-CoV-2 are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.**	◯ Yes ◯ No	
Are trash cans accessible throughout the facility? What about tissues? **Tissues and trash cans are available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.**	◯ Yes ◯ No	

Infection Prevention and Control Practices

Alcohol-based hand sanitizer (ABHS) is the preferred method of hand hygiene; however, sinks should still be stocked with soap and paper towels. Hand hygiene should be performed in the following situations: before resident contact, even if PPE is worn; after contact with the resident; after contact with blood, body fluids, or contaminated surfaces or equipment; before performing aseptic tasks; and after removing PPE.

Recommended PPE when caring for residents with suspected or confirmed COVID-19 includes gloves, gown, N-95 or higher-level respirator (or facemask if respirators are not available or HCP are not fit-tested), and eye protection (face shield or goggles). PPE should be readily available outside of resident rooms, although the facility should consider assigning a staff member to shepherd supplies and encourage appropriate use.

All EPA-registered, hospital-grade disinfectants have a contact time which is required to kill or inactivate pathogens. Environmental surfaces must remain wet with the product for the entire contact time duration to work appropriately. Contact times range from 30 seconds to 10 minutes. Keeping a surface wet for 10 minutes is seldom accomplished with a single application. It is important for facilities to know that their product is appropriate (List N as above) and is being used for the entire contact time. Also, it is helpful for the facility to assign responsibility for cleaning and disinfection of specific surfaces and equipment (who cleans what).

Elements to be assessed	Assessment (Y/N)	Notes/Areas for Improvement
When, during patient care, is hand hygiene expected? HCP perform hand hygiene in the following situations: • Before resident contact, even if gloves will be worn	◯ Yes ◯ No	
• After contact with the resident	◯ Yes ◯ No	
• After contact with blood, body fluids, or contaminated surfaces or equipment	◯ Yes ◯ No	
• Before performing an aseptic task	◯ Yes ◯ No	
• After removing PPE	◯ Yes ◯ No	
What does your facility recommend for hand hygiene? Is there a preference for soap and water or alcohol-based hand sanitizer? Facility has preference for alcohol-based hand sanitizer over soap and water	◯ Yes ◯ No	
What PPE is being used by HCP caring for anyone with suspected or confirmed COVID-19 HCP wear the following PPE when caring for residents with suspected or confirmed COVID-19 • Gloves	◯ Yes ◯ No	
• Isolation gown	◯ Yes ◯ No	
• N-95 or higher-level respirator (or facemask if a respirator is not available)	◯ Yes ◯ No	
• Eye protection (goggles or face shield)	◯ Yes ◯ No	

Elements to be assessed	Assessment (Y/N)	Notes/Areas for Improvement
How are staff taught to remove PPE? PPE are removed in a manner to prevent self-contamination and hand hygiene is performed immediately after removal.	◯ Yes ◯ No	
What product do you use for alcohol-based hand sanitizer – do you know the alcohol percentage? Are you experiencing any shortages in alcohol-based hand sanitizer? If so, how are you addressing? Hand hygiene supplies are available in all resident care areas. • Alcohol-based hand sanitizer* with 60-95% alcohol is available in every resident room and other resident care and common areas. *If there are shortages of alcohol-based hand sanitizer, hand hygiene using soap and water is still expected.	◯ Yes ◯ No	
Do you ever audit or record performance of things like hand hygiene? Selection and use of personal protective equipment? What do you do if you see someone not washing their hands appropriately? Hand hygiene and PPE compliance are audited.	◯ Yes ◯ No	
How often are shared equipment like blood pressure cuffs/machines cleaned? These need to be cleaned after every patient use. Who is responsible for that? Are you able to dedicate equipment to residents that may be symptomatic or a case like thermometers, BP cuffs, and stethoscopes? Non-dedicated, non-disposable resident care equipment is cleaned and disinfected after each use.	◯ Yes ◯ No	
What disinfectant is used at your facility? Is this ready-to-use (premixed) or does it need to be diluted by your staff? Have you checked to see if that product is effective for coronavirus (EPA List N)? EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim* against SARS-CoV-2 are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. • *See EPA List N: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2 • Name of EPA-registered disinfectant used in facility: ____________________________	◯ Yes ◯ No	
What is the contact time for the product? Remember that the contact time is how long a disinfectant needs to remain on a surface for it to be effective. The surface needs to be wet the entire time. Contact times can range from 30 seconds to 10 minutes; often the product is dry after 1-2 minutes so this means reapplying more until that contact time is met. [If they have a 10 minute product] Please make sure your staff are aware of that time and use it appropriately or consider changing to another product with a shorter time. Facility is aware of the contact time for the EPA-registered disinfectant and shares this information with HCP.	◯ Yes ◯ No	
Are disinfectants ready-to-use or do you have to mix/dilute them at the facility? How are they mixed/diluted? EPA-registered disinfectants are prepared and used in accordance with label instructions.	◯ Yes ◯ No	

Communication

Communicating is essential during an outbreak—with HCP, residents, families, the health department, transport personnel, and receiving facilities. Facilities should notify the health department about any resident with severe respiratory infection resulting in hospitalization or death, any resident or HCP with suspected or confirmed COVID-19, or if the facility identifies 3 or more new onset cases of respiratory illness among residents and/or HCP in 72 hours. These situations should prompt further investigation and testing for SARS-CoV-2. Should a higher level of care be indicated for a resident with suspected or confirmed COVID-19, the facility should communicate this information with transport personnel, the receiving facility, and the health department.

Elements to be assessed	Assessment (Y/N)	Notes/Areas for Improvement
Have you ever talked to the health department before for your facility? Why? Moving forward, what would make you reach out to the health department now? You should reach out if you have a known or suspected case in a resident or healthcare provider; if you have a resident with a severe respiratory infection; or a cluster of new-onset respiratory symptoms among residents and or staff. Generally, we say 3 or more over the course of three days. **Facility notifies the health department about any of the following:** • **COVID-19 is suspected or confirmed in a resident or HCP**	◯ Yes ◯ No	
• **A resident has severe respiratory infection resulting in hospitalization or death**	◯ Yes ◯ No	
• **A cluster of new-onset respiratory symptoms among residents or HCP (≥3 cases over 72 hours)**	◯ Yes ◯ No	
If you have known or suspect cases of COVID-19, how do you plan to communicate this with staff? With residents? With family members? **Facility has process to notify residents, families, and staff members about COVID-19 cases occurring in the facility.**	◯ Yes ◯ No	
What about if you transfer a known or suspect case to the hospital, do you have a way to communicate their status to EMS; outpatient facility like dialysis or transfusion clinic; hospital? **Facility communicates information about known or suspected residents with COVID-19 to appropriate personnel (e.g., transport personnel, receiving facility) before transferring them to healthcare facilities such as dialysis and acute care facilities.**	◯ Yes ◯ No	

At the conclusion of the ICAR, give the facility an opportunity to ask questions. Provide them with information about what to expect next (e.g., that they will receive a copy of the completed ICAR form, a recommendation letter, etc.).

Exhibit 18

SAMHSA
Substance Abuse and Mental Health Services Administration

Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19 Epidemic: March 20, 2020

Revised: May 7, 2020

Overview: COVID-19 is a novel coronavirus spread by the respiratory route and contact with contaminated surfaces. It appears to be highly contagious and has a significant morbidity and mortality rate. Because these attributes are known and because this agent has been identified as responsible for a global pandemic, it is essential that behavioral healthcare facilities implement plans to protect patients and staff from infection to the greatest extent possible. The following are offered as considerations aimed at decreasing the likelihood of infection and viral transmission and providing for the behavioral health needs of patients.

There are many options for treating mental and substance use disorders which have an evidence base and/or are best practices. These include inpatient, outpatient and residential treatment options. Because of the substantial risk of coronavirus spread with congregation of individuals in a limited space such as in an inpatient or residential facility, SAMHSA is advising that outpatient treatment options, when clinically appropriate, be used to the greatest extent possible. Inpatient facilities and residential programs should be reserved for those for whom outpatient measures are not considered an adequate clinical option; i.e.: for those with mental disorders that are life threatening, (e.g.: the severely depressed suicidal person or persons with life threatening substance use disorders (e.g.: at high risk for overdose, complications from withdrawal). It is recommended that intensive outpatient treatment services be utilized whenever possible. Comprehensive long term residential treatment programs, where COVID related precautions can be implemented (social distancing, isolating, testing, etc.) remain a viable treatment option when clinically indicated.

CDC has released guidance on the expanded use of telehealth services. SAMHSA strongly recommends the use of telehealth and/or telephonic services to provide evaluation and treatment of patients. These resources can be used for initial evaluations including evaluations for consideration of the use of buprenorphine products to treat opioid use disorder. Further, these resources can be used to implement individual or group therapies such as evidence-based interventions including cognitive behavioral therapy for mental and/or substance use disorders.

For inpatient/residential programs that plan to remain open during the current COVID-19 related emergency; care should be taken to consider CDC guidance on precautions in admitting new patients, management of current residents who may have been exposed to or who are infected with COVID-19, and visitor policies.