

WRITTEN STATEMENT OF MEGAN SIMS, RN

Written Statement Concerning COVID-19 Hospital Protocols

Submitted by: Megan Sims, Registered Nurse

Date: August 23, 2026

Mr. Chairman and distinguished members of the committee, my name is Megan Sims. I am a Registered Nurse and have worked at Cuyuna Regional Medical Center since September 2014. During the COVID-19 pandemic, I worked as a critical care and emergency department nurse. These observations occurred in the intensive care unit. I report only what I personally observed or reviewed while providing care.

Before COVID-19, the hospital generally had no set visiting hours. Under its COVID policy, patients in airborne isolation could not receive visitors until death was considered imminent. Nurses, nursing assistants, respiratory therapists, and most hospitalists continued in-person care. Face-to-face services from physical therapy, occupational therapy, dietary staff, and most other team members were generally suspended. Their notes stated that patients were monitored by nursing but excluded from those services because of isolation requirements and a COVID-19 diagnosis. The electronic record also automatically stated in every chart that care occurred during the COVID-19 pandemic. I witnessed decline in patients time and again from these services being withheld.

In April 2021, I cared for a woman admitted to the ICU with COVID pneumonia. She received remdesivir. I did not observe her or her family being offered other early treatments or medications being discussed for COVID treatment, including budesonide and vitamin D, and I was not given a reason why they were not offered. She remained in airborne isolation without the customary opportunities for ambulation, physical therapy, rehabilitation, dietary consultation, or broader face-to-face team assessment.

Her family repeatedly requested permission to visit. Her husband also had COVID-19, and the family was willing to sign a liability waiver or accept other conditions. Senior nursing leadership denied visitation under the COVID policy. Her family was permitted to enter only on the day she died, after death was considered imminent. Her recorded cause of death was COVID-19. As the nurse caring for her, I personally observed that the immediate event causing her death was a saddle pulmonary embolism. Her chart should document her treatment, isolation, excluded services, deterioration, pulmonary embolism, and recorded cause of death.

Afterward, I met with senior leadership and proposed a compassionate-care policy allowing family visits for critically ill patients before death was imminent. It was not adopted while the COVID restrictions remained in effect.

The hospital also required COVID-19 testing before admission or scheduled surgery, regardless of symptoms or reason for care. I observed asymptomatic patients, including patients with documented prior infection, placed in COVID isolation after a positive test. They then became subject to the same visitation and service restrictions. I also personally observed scheduled procedures postponed or canceled under this policy following a positive test, including for patients without COVID-19 symptoms.

When I questioned these policies, Infection Control, senior nursing leadership, and administration told me the hospital was following CDC, NIH, and CMS guidance and would not deviate. I did not independently identify which federal document directed each restriction. In September 2022, I again questioned administration about visitation, mobility, and medication protocols and was told the hospital was following "the guidelines" and would not deviate.

I respectfully ask the committee to examine how COVID guidance and hospital interpretations affected visitation, treatment options, rehabilitation, multidisciplinary assessment, isolation of asymptomatic patients, and postponed procedures. Hospital policies, service notes, treatment records, isolation orders, procedure records, and leadership communications should allow independent verification.

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Employed September 2014 to Present