

**Annual Report to the Vermont Legislature**  
**January 15, 2021**

**VERMONT LONG-TERM CARE OMBUDSMAN PROJECT**

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## Reporting Requirement to Vermont Legislature and Governor

The Office of the State Long-Term Care Ombudsman (Office) is to report to the General Assembly and Governor on or before January 15<sup>th</sup> of each year. The reporting requirement is required by 33 V.S.A. §7503. The Office is pleased to present our annual Legislative Report.

# The Vermont Long-Term Care Ombudsman Project

## 1. What is the Vermont Long-Term Care Ombudsman Project?

The Vermont Long-Term Care Ombudsman Project (VOP) is a project of Vermont Legal Aid. The VOP is made up of long-term care (LTC) ombudsmen. LTC ombudsmen are advocates trained to resolve problems. LTC ombudsmen assist residents of LTC facilities, and recipients of Choices for Care (CFC) living in the community, with complaints they have about their care.

### A. The role of the VOP is to:

- Promote the rights of residents and CFC recipients receiving long-term care services in Vermont
- Advocate for changes that lead to better care & better quality of life for residents and CFC recipients

### B. The VOP works with individuals who receive long-term care services and supports in:

- Nursing homes
- Residential care homes
- Assisted living residences
- Adult family homes
- The community through Choices for Care

### C. The responsibilities and duties of VOP ombudsmen are to:

- Investigate problems and concerns about long-term care services and supports
- Help people make their own decisions about their long-term care services and supports
- Assist persons on CFC in gaining access to long-term care services and supports in the community
- Visit LTC facilities regularly to interact with residents and monitor conditions
- Educate facility staff and other providers about the rights and concerns of individuals receiving long-term care services and supports
- Identify problem areas in the long-term care services and support systems and advocate for change
- Provide information to the public about long-term care services and supports

**D. The VOP is an independent voice:**

- Each year the Commissioner of the Department of Aging and Independent Living (DAIL) certifies that the VOP can carry out its responsibilities and duties free of conflict of interest. (See Appendix 3)
- The organizational structure of the VOP enhances its ability to operate free of conflict of interest. (The project is housed within Vermont Legal Aid and all ombudsmen are employees of Vermont Legal Aid.)
- No ombudsman or immediate family member of an ombudsman is involved in the licensing or certification of long-term care facilities or providers.
- LTC ombudsmen do not work for or participate in the management of any facility.

**E. Staffing for the Vermont Long-Term Care Ombudsman Project:**

- The VOP consists of six full-time staff: one State Long-Term Care Ombudsman and five local ombudsmen. The VOP also had three certified volunteer ombudsmen.

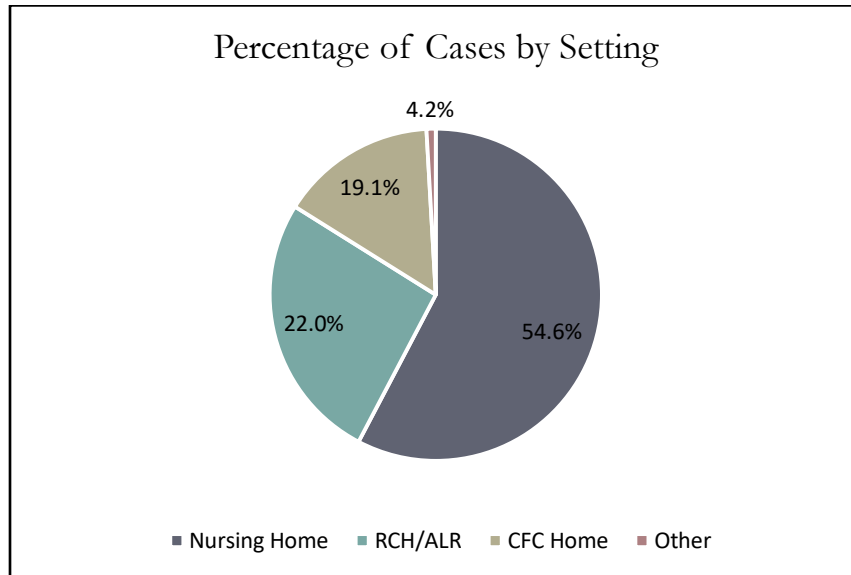
**2. How many cases and complaints are there?**

For FY 2020, the LTC Ombudsman Project worked on 282 cases and 449 complaints. Of the complaints resolved during FY 2020, more than 90% were fully or partially resolved to the satisfaction of the resident, recipient, or complainant.

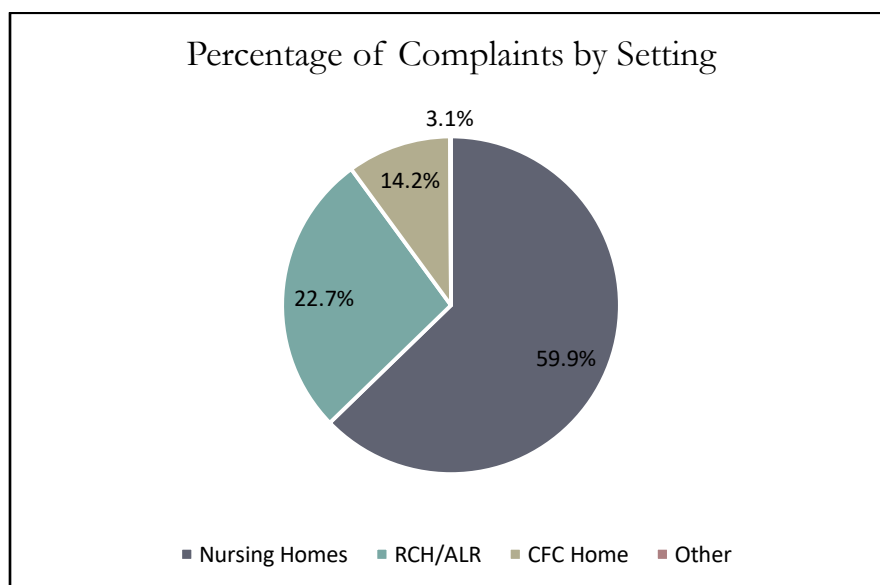
**3. Where do cases and complaints come from?**

Vermonters receive long-term care services and supports in different types of settings. Settings include licensed LTC facilities and the community (such as one's own home). No matter where long-term care services and supports are received, residents and CFC recipients must be treated with respect and dignity.

- In FY 2020, the number of cases by LTC setting broke down as follows:
  - Nursing home cases: **154**
  - Residential care home and assisted living residence cases: **62**
  - Community-based cases: **54**



- In FY 2020, the number of complaints by LTC setting broke down as follows:
  - Nursing home complaints: **269**
  - Residential care home and assisted living residence complaints: **102**
  - Community-based complaints: **64**



**4. What are the major complaint categories?**

Every year, ombudsmen field a range of complaints from LTC residents and CFC recipients. Major complaint categories for FY 2020 are shown, along with totals and percentages for each category, in the table below.

<b>FY 2020 Major Complaint Category</b>	<b>Total complaints</b>	<b>Percent (%)</b>
<b>Care</b>	<b>128</b>	<b>28.5%</b>
<b>Autonomy, Choice, Rights</b>	<b>92</b>	<b>20.5%</b>
<b>Admission, Transfer, Discharge, Eviction</b>	<b>68</b>	<b>15.1%</b>
<b>System: Others (non-facility)</b>	<b>30</b>	<b>6.7%</b>
<b>Activities, Community Integration and Social Services</b>	<b>30</b>	<b>6.7%</b>
<b>Financial, Property</b>	<b>26</b>	<b>5.8%</b>
<b>Dietary</b>	<b>20</b>	<b>4.4%</b>
<b>Environment</b>	<b>16</b>	<b>3.6%</b>
<b>Access to Information</b>	<b>14</b>	<b>3.1%</b>
<b>Complaints about an Outside Agency (non-facility)</b>	<b>10</b>	<b>2.2%</b>
<b>Facility Policies, Procedures and Practices</b>	<b>8</b>	<b>1.8%</b>
<b>Abuse, Gross Neglect, Exploitation</b>	<b>7</b>	<b>1.5%</b>
<b>Total</b>	<b>449</b>	<b>100%</b>

The top three major complaint categories by total and percentage (i.e., Care; Autonomy, Choice, Rights; and Admission, Transfer, Discharge, Eviction) for FY 2020 are the same as for FY 2019. Together, the three categories make up just over 64% of the complaints received by the VOP.

5. What are the major complaint categories by LTC setting?

A. Nursing Homes

Ombudsmen received complaints involving nursing home residents during FY 2020. The largest number of complaints, opened and closed during FY 2020 (n= 269), involved nursing home residents. The totals and percentages for each major category for nursing homes are listed below.

<b>FY 2020 Major Complaint Category</b>	<b>Total complaints</b>	<b>Percent (%)</b>
Care	84	31.2%
Autonomy, Choice, Rights	58	21.6%
Admission, Transfer, Discharge, Eviction	32	11.9%
Activities, Community Integration and Social Services	23	8.5%
Financial, Property	16	5.9%
Dietary	14	5.2%
Environment	13	4.8%
Access to Information	11	4.1%
System: Others (non-facility)	9	3.3%
Facility Policies, Procedures and Practices	5	1.8%
Complaints about an Outside Agency (non-facility)	2	1.0%
Abuse, Gross Neglect, Exploitation	2	1.0%
<b>Total</b>	<b>269</b>	<b>100%</b>

The top three major complaint categories by total and percentage (i.e., Care; Autonomy, Choice, Rights; and Admission, Transfer, Discharge, Eviction) for FY 2020 are the same as for FY 2019. Together, these three categories made up approximately 65% of the complaints concerning nursing home residents in FY 2020.



**B. Residential Care Homes & Assisted Living Residences**

The second largest source of complaints for the VOP is RCHs and ALRs. The major complaint categories for residents of RCHs and ALRs are the same as for nursing home residents.

<b>Complaint Category/number</b>	<b>Total Complaints</b>	<b>Percent (%)</b>
<b>Admission, Transfer, Discharge, Eviction</b>	<b>28</b>	<b>27.4%</b>
<b>Autonomy, Choice, Rights</b>	<b>22</b>	<b>21.6%</b>
<b>Care</b>	<b>16</b>	<b>15.7%</b>
<b>Activities, Community Integration and Social Services</b>	<b>7</b>	<b>6.9%</b>
<b>Dietary</b>	<b>6</b>	<b>5.9%</b>
<b>Financial, Property</b>	<b>6</b>	<b>5.9%</b>
<b>System: Others (non-facility)</b>	<b>5</b>	<b>4.9%</b>
<b>Abuse, Gross Neglect, Exploitation</b>	<b>5</b>	<b>4.9%</b>
<b>Access to Information</b>	<b>3</b>	<b>2.9%</b>
<b>Facility Policies, Procedures and Practices</b>	<b>2</b>	<b>2.0%</b>
<b>Environment</b>	<b>1</b>	<b>1.0%</b>
<b>Complaints about an Outside Agency (non-facility)</b>	<b>1</b>	<b>1.0%</b>
<b>Total</b>	<b>102</b>	<b>100%</b>

Like last year, the highest percentage of complaints involving residents of RCHs and ALRs were the complaints from the Admission, Transfer, Discharge, Eviction category. Despite the COVID-19 pandemic, involuntary discharge from residential care homes and assisted living residences remains a significant issue.

### **C. Community-Based Cases and Complaints**

In FY 2020, ombudsmen worked on 54 CFC community-based cases, which involved 64 complaints. Home health agencies (HHA) provide long-term care services and supports to CFC recipients living at home. Most community-based complaints made in FY 2020 were against home health agencies. Of the 64 community-based complaints received during FY 2020, 35 (54.6%) involved HHAs.

<b>Community-Based Entity</b>	<b>Total Complaints made for FY20</b>
<b>Home Health Agency</b>	<b>35</b>
<b>Area Agency on Aging</b>	<b>8</b>
<b>State Agency (DAIL, DCF)</b>	<b>7</b>
<b>AFC provider</b>	<b>4</b>
<b>DME Provider</b>	<b>2</b>
<b>Home care provider/LTC facility</b>	<b>2</b>
<b>Other</b>	<b>3</b>
<b>Green Mountain Support Services</b>	<b>2</b>
<b>ARIS</b>	<b>1</b>
<b>Total</b>	<b>64</b>

The majority of HHA complaints received by the VOP concerned staffing – specifically that the HHAs were not filling hours of the CFC recipient’s service plan. It is not unusual for the VOP to receive complaints from CFC recipients and relatives reporting that HHAs are not providing the home health services and coverage that recipients require to remain living in the community safely. Instances have been reported to the VOP where CFC recipients have been accepted by the HHA, and then told that they must wait two weeks before services would begin.

CFC recipients also reported frequent “no-shows” and last-minute cancellations by HHA staff – which leaves vulnerable individuals dependent on their caregivers for meals, personal care and assistance with activities of daily living in situations that jeopardize their health, safety and overall well-being. In addition, the VOP has received reports of recipient’s service hours being reduced or completely stopped.

When assisting CFC recipients with these staffing issues, ombudsman have at times been told by HHAs that they do not have the staff to fill the hours of a service plan. The VOP

finds this unacceptable, especially in light of Vermont’s home health regulations, which state that HHAs “shall provide or arrange for the provision of all designated services” to all persons eligible, and accepted, for services within an HHA service area.<sup>1</sup> Despite the consistent efforts by ombudsmen, CFC recipients continue to receive fewer home health services than they have been approved for by DAIL and under their service plan.

**6. Who makes complaints?**

The table below provides a snapshot of the persons making complaints to the VOP during FY 2020.

Who made complaints in FY2020?					
Complainant	Nursing Home	Residential Care/ Assisted Living	Community Setting/Other	Total Complaints Made	% of Total Complaints Made
Resident/recipient	123	54	52	229	51.0%
Resident representative Relative/Friend, Family	90	26	13	129	28.7%
Representative of other agency or program or org.	20	10	7	37	8.2%
Unknown	14	2	6	22	4.9%
Facility staff	10	2	0	12	2.7%
VOP	5	4	0	9	2.0%
Facility administrator or staff	2	4	0	6	1.3%
Ombudsman/ombudsman volunteer	4	0	0	4	1.0%
Other – concerned person not listed	1	0	0	1	0.2%
<b>Total</b>	<b>269</b>	<b>102</b>	<b>78</b>	<b>449</b>	<b>100%</b>

- The table reflects that just over 50% of the complaints taken by the VOP come from residents and CFC recipients.
- The second largest category is a close contact of the resident or CFC recipient.
- The top four categories from the table make up almost 93% of the complaints received by the VOP.

<sup>1</sup> REGULATIONS FOR THE DESIGNATION AND OPERATION OF HOME HEALTH AGENCIES, Section VIII, Required Functions and Administration, Section 8.2.

## 7. How do we describe our casework?

Below are case summaries for some of the complaints investigated and resolved by local ombudsmen during FY 2020.

- When the pandemic hit in March, the owner of an RCH decided a resident with a traumatic brain injury was too much to manage. The RCH decided that a nursing home would be a better place for the resident. The resident and his family did not agree. An ombudsman was contacted for help. The ombudsman organized discussions, which were attended by all the interested persons. In the end, a decision was made to honor the resident's preference of remaining at the RCH.
- An ombudsman was visiting with a resident prior to the start of a game of Bingo. The resident told the ombudsman that the staff person leading the Bingo was unhappy with the resident because the resident could not always hear the Bingo numbers being called out. The ombudsman talked with the staff person, reminding her of staff's responsibility to make accommodations for the needs of individual residents. The ombudsman then brainstormed with the staff person for ways in which resident needs could be met during Bingo. The staff person started using a microphone system during Bingo. The resident was also moved to a seat next to the staff person. The resident felt more comfortable, and enjoyed Bingo to a greater extent, after the changes.
- The daughter of a resident with advanced dementia contacted an ombudsman with two complaints. First, the daughter received promises that her mother would be brought to the dining area for regular "window visits" during the pandemic. The window visits did not occur. Second, the daughter requested (on several occasions) a copy of her mother's medical records. A copy was not provided. After assistance from an ombudsman, the resident was moved to a room with a window, allowing for regular window visits by her daughter. A copy of the resident's medical records was also provided to the daughter.
- A nursing home resident asked for help from an ombudsman because of Hoyer lift failures. The resident reported that the Hoyer lift frequently failed while she was in mid-air, leaving her to wait for staff to try to fix the issue. Each time this happened, the resident was left feeling anxious and embarrassed. The failures took place frequently. The resident was being lifted six times a day. The resident complained to staff, but nothing changed. The ombudsman scheduled a virtual meeting with the resident and staff. The resident, with the support of the ombudsman, was able to express her experiences in detail. Ultimately, the facility purchased new Hoyer lifts. The resident has not experienced a Hoyer lift failure since the purchase.

- The resident, at the SNF for a rehabilitation stay, made it clear that she wanted to return to home following rehab; facility staff, however, had told the resident that it was unsafe to return home and were encouraging her to remain at the SNF permanently. The resident called her ombudsman. The resident did not want to remain at the facility permanently, telling the ombudsman it was “too depressing” to stay at the SNF. With the resident’s consent, the ombudsman contacted the social worker at the SNF to convey the resident’s wishes and request a discharge planning meeting. A discharge meeting was held (the ombudsman attended). The resident restated her determination to return home. Following the meeting, the facility initiated the discharge process. Subsequently, the resident returned home with long-term care services and supports in place.
- A nursing home resident contacted an ombudsman because of the noise coming from another resident’s television. The noise could be heard through-out the night. The resident with the loud television liked to watch TV late into the night and had hearing loss. The ombudsman talked with staff. A meeting was held with both residents and staff. The meeting led to a plan being put in place whereby staff monitored the noise level of the television. Both residents were satisfied with the plan.
- An ombudsman was contacted by a nursing home resident who was not being allowed to go outside due to the COVID-19 pandemic restrictions. The resident was a blind double amputee and dialysis patient who was continuously under isolation precautions due to three times a week transport to hospital for dialysis. Pre-pandemic, the resident enjoyed sitting outside in the sun. While not wanting to put any staff or residents in jeopardy, the resident wanted to go outside, to sit, and feel the sun on his face. The ombudsman talked with the administrator about the resident wanting to go outside. After multiple discussions, a process was agreed upon which enabled the resident to go outside more often.
- Prior to COVID-19, a resident received assistance from a friend and relatives with his mail and paying bills. During the pandemic, the resident no longer got the assistance. The ombudsman contacted the facility and maintained communication with the resident’s family members. A series of virtual meetings followed. The meeting resulted in the restoration of the assistance the resident had been getting pre-pandemic – the resident was once again able to receive his mail and get help with paying his bills.
- A CFC recipient’s wheelchair was broken. Although a vendor agreed to fix the wheelchair as soon as possible, the recipient did not have the funds to have the part delivered overnight. The recipient gave the local ombudsman permission to speak with the HHA, the case manager, and the vendor. The HHA informed the local ombudsman that it did not have funds for overnight delivery; however, the case manager expressed a willingness to secure the necessary funds (which she was able to do). Later, the ombudsman confirmed with the

recipient that funds were secured, and contact was made with the vendor to overnight the needed part as soon as Medicaid provided approval.

- An ombudsman was contacted by a CFC recipient and her case manager because a durable medical equipment (DME) provider was not scheduling a necessary wheelchair assessment. After receiving the recipient's permission, the ombudsman contacted the DME provider. The ombudsman was told that the DME provider was not scheduling necessary appointments with the recipient because the recipient's home was too far from the provider's office. This was unacceptable to the ombudsman, who requested that the provider schedule an assessment with the recipient as soon as possible. An appointment was made for the recipient. Following the appointment, all necessary work on the wheelchair was completed.
- When a HCBS CFC recipient's care needs were not being met by a home health provider she sought an ombudsman's assistance. The recipient had recently discharged from a SNF. Prior to discharge, the recipient received assurances that her care needs would be met at home. Once home, the recipient was not getting her bathing/dressing needs met, was left alone for long stretches (meaning she was unable to get out of bed), was rushed through meals, and was missing meals. The ombudsman spoke with the home health agency. The ombudsman's discussions with the home health agency resulted in a scheduling shift (which the recipient agreed to). This change made it easier for the recipient's service plan hours to be filled. After the scheduling shift, the recipient reported being happy with the home health services being provided.

## 8. What non-complaint activities do we perform?

While an ombudsman's primary duty is to investigate complaints they also:

- Provide residents, CFC recipients, and their representatives information and guidance about how to approach facilities and home health providers with their concerns
- Support resident and family councils by helping them work with nursing and residential care homes to address facility-wide problems
- Educate facility and home health staff on resident rights and the role of the VOP
- Perform general visits at facility (NOTE: the VOP was unable, due to the state's emergency orders, to visit residents in person at LTC facilities for most of 2020 due to the COVID-19 pandemic).
- Assist residents with advance directives

A summary of some of the activities performed by the ombudsmen during FY 2020 is presented in the table below:

Snapshot of Non-complaint Related Activities in FY2020	
Activities	Number of Instances
Consultations to Individuals	470
Consultations to Facilities/Agencies	234
Pandemic outreach calls to LTC facilities	217
Facility visit/routine access (pre-pandemic)	199
Facility visit/casework (pre-pandemic)	114
Assist with Advance Directives	29
<b>Total</b>	<b>1,263</b>

The VOP expects that at some point in FY 2021, we will be back making in-person visits to residents living in LTC facilities. Until that time, the VOP will continue to think creatively about how best to regularly connect with LTC residents and CFC recipients during this time of COVID-19.

## 9. Who are our volunteers?

The Vermont LTC Ombudsman Project relies on volunteers to help us with our responsibilities and duties. Volunteers contributed 273.9 hours in FY 2020. Volunteers enable the project to maintain a greater presence in Vermont's 162 long-term care facilities. Volunteers do the work of paid ombudsmen, including responding to individual complaints, attending resident council meetings, and monitoring conditions in long-term care facilities. Before becoming a full-fledged volunteer, trainees must complete a comprehensive training program. The training program for all volunteers includes 20 hours of classroom training and independent study. Following the classroom and independent study requirements, the volunteer in training shadows a local ombudsman for 30 hours of facility-based training. When a trainee satisfactorily completes both the classroom and facility-based requirements, a recommendation is made for designation and certification – officially making the volunteer a representative of the office.

### *Thank you Volunteers!*

*Laurie Boerma  
Ann Crider  
Paula DiCrosta  
Michelle Rutman  
Nancee Schaffner*

## 10. How are we funded?

At the start of FY 2020, the Vermont LTC Ombudsman Project was level funded. The project received \$707,601 from DAIL to provide ombudsman services in the state. During the COVID-19 pandemic, the VOP received a one-time federal funding of \$100,000 under the CARES ACT. Funding categories included:

- \$ 84,172.00 OAA Title VII, chapter II
- \$223,614.00 OAA Title IIIB
- \$155,735.50 Medical Assistance Program (Global Commitment)
- \$244,079.50 State General Funds
- \$100,000.00 CARES ACT for the Ombudsman Program under Title VII of the OAA<sup>2</sup>
- **\$807,601.00 Total**

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<sup>2</sup> The funds expended from the CARES Act are to respond to the Coronavirus Emergency; expenditures have to be COVID-19 related. These federal funds are to remain available until September 30, 2021, to prevent, to prepare for, and respond to COVID-19. Vermont must submit final financial reports and liquidate the funds by December 30, 2021.



## **11. Systemic Advocacy**

The Office of the State LTC Ombudsman is required under state and federal law to address systemic problems that impact the quality of care and quality of life of individuals receiving long-term care in Vermont.

The Office uses information gained during complaint investigations, general visits, and consultations with residents, CFC recipients, family members, and providers to help guide our systemic advocacy.

Representatives of the Office serve on numerous workgroups, committees, and task forces related to long-term care services and supports in Vermont. In FY 2020, representatives of the Office served on the:

- Older Vermonters Act Work Group
- Consumer Voice Leadership Council
- Vermont Vulnerable Adult Fatality Review Team
- Vermont Legal Aid Individual Rights Task Force, and
- Vermont Legal Aid Residential Care Home Discharge Workgroup.

On the federal level, the LTC Ombudsman Project worked with other state ombudsman programs (through our affiliation with NASOP – the National Association of State Ombudsman Programs) on numerous fronts, including advocating that the reauthorization of the Older Americans Act strengthen and protect State Long-Term Care Ombudsman Programs by: (1) providing a separate authorization to fund ombudsman services provided to assisted living facility residents and (2) increasing federal funding.

## **12. Issues and Recommendations**

Listed below are the priority issues identified by the Vermont LTC Ombudsman Project, along with our recommendations for the state legislature:

### **A. COVID-19 cases and deaths at nursing homes.**

Even with the development of a vaccine, Vermont must not let down its guard in regard to COVID-19 and nursing homes. While there are now vaccines, better treatments, more testing, and better surveillance and systems in place than when the pandemic started, the epidemiology of the virus has not changed: nursing home residents remain at high risk for getting, and dying from, COVID-19.

According to the Centers for Disease Control and Prevention, at the start of the pandemic 2.1 million people lived in nursing homes or residential care facilities, representing 0.6% of the U.S. population. Yet residents in NH and RCH facilities accounted for 42 percent of all deaths from COVID-19, for states that report such statistics.<sup>3</sup> The proportion of deaths in LTC facilities in Vermont is similar to what has been reported nationally and internationally<sup>4</sup>, likely because the characteristics that make LTC residents at high risk (e.g., underlying vulnerabilities, density of nursing home facilities) are present in Vermont just as they are elsewhere.

### **Recommendations**

- Vermont must ensure that staff and residents continue to be prioritized for vaccination after January 2021 when it is expected that all current residents and staff who want to receive a vaccination will have been vaccinated.
  - Vermont must ensure that nursing homes, along with residential care homes and assisted living residences, have a process for vaccinating new residents and new staff after Phase 1 has been completed.
- It seems unlikely that the risk posed by COVID-19 for LTC residents and staff will dissipate soon; therefore, Vermont should remain proactive and continue to provide guidance to LTC facilities emphasizing infection control and best practices.
- Vermont should ensure that its regulatory agencies have sufficient means for enforcement.
- Vermont should prioritize the examination of the different conceptions on how best to design nursing homes. Shared rooms, shared bathrooms, shared staff = excellent conditions for viral transmission. Many have encouraged small-home models and other resident-centered models of care.

### **B. Staffing shortages at LTC facilities and home health agencies.**

Inadequate staffing levels at long-term care facilities and home health agencies remain significant problems for the individuals that the VOP serves. The issue has been exacerbated during COVID-19. Proper staffing and appropriate training are critical to quality care for individuals receiving long-term care services and supports no matter the setting. The quality of

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<sup>3</sup>[https://docs.google.com/spreadsheets/d/17JmyFzOd3ZEYCGpP0mK5IS\\_P10yPgCuYF8PYALKuTs8/edit#gid=0](https://docs.google.com/spreadsheets/d/17JmyFzOd3ZEYCGpP0mK5IS_P10yPgCuYF8PYALKuTs8/edit#gid=0)

<sup>4</sup> <https://www.healthvermont.gov/sites/default/files/documents/pdf/COVID19-Weekly-Data-Summary-1-8-2021.pdf>, p. 26.

care residents and CFC recipients are currently receiving is being significantly impacted, for the worse, by staffing shortages. Staffing shortages at LTC facilities and HHAs requires urgent attention by policymakers.

### **Recommendations**

- Vermont should explore ways to ensure that the pay of staff increases. Staff aides are poorly paid. Suggestions include hazard pay, health care coverage, paid sick leave, and ensuring payments flow to direct caregivers via wage floors and wage pass-throughs (all of which could lessen staff turnover, shortages and the spread of disease/infections).
- Vermont should realign Medicaid payments to LTC providers to better approximate the actual costs of providing long-term care services and supports to residents and CFC recipients.
- Vermont should establish minimum nurse and nurse aide staffing standards.
- Vermont should evaluate: (1) the extent to which HHAs are providing all designated services to all eligible, and accepted, CFC recipients, within each of the HHA's service area, and (2) the impact of the lack of designated services being provided to eligible and accepted CFC recipients. As part of the evaluation, Vermont should determine how to expand the number of home health service providers for CFC recipients to match the current need of CFC recipients for all designated services.

### **C. Social isolation and loneliness being experienced by persons receiving long-term care services.**

A survey of nursing home residents provided a rare look into how Covid-19 restrictions at nursing facilities have impacted resident lives (see **Survey of Nursing Home Residents Reveals Deep Emotional Toll of Social Isolation Under Covid-19<sup>5</sup>**). The survey asked residents how often they took part in common social activities after the COVID-19 restrictions were put into place, compared to before the start of the pandemic.

The findings showed a reduction in social activities and increased feelings of loneliness since the start of the COVID-19 pandemic. Specifically, the researchers found that social interactions, both outside and inside the nursing home, dropped. For instance, 93% percent of respondents reported that they did not leave their nursing home in a given week for

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<sup>5</sup> [https://altarum.org/sites/default/files/uploaded-publication-files/Nursing-Home-Resident-Survey\\_Altarum-Special-Report\\_FINAL.pdf](https://altarum.org/sites/default/files/uploaded-publication-files/Nursing-Home-Resident-Survey_Altarum-Special-Report_FINAL.pdf)

routine activities such as shopping and visiting family, compared to 42% before the outbreak. In addition, only 13% of residents responding to the survey reported eating their meals in the dining room, compared to 69% before COVID-19.

It is unclear as to whether loneliness and social isolation are currently being assessed by Vermont LTC providers. The more restrictive measures implemented in response to COVID-19, however, magnify the need of these providers to speak with residents and CFC recipients to learn more about their personal experiences, including feelings of loneliness and social isolation, during this time.

### **Recommendations**

- Vermont must encourage providers to assess each resident and CFC recipient for social isolation and loneliness and then create (and implement) ways to mitigate risks associated with social isolation and loneliness.
- Vermont should take steps to encourage providers to seek resident, recipient, and family input on social activities and ways to connect with other people.
- Vermont should regularly evaluate its guidance to LTC facilities about visitation. Its evaluation process should seek resident input.
- Vermont must ensure that LTC residents have compassionate care visits in a manner that is consistent with federal guidance.
- Vermont should ensure that LTC facilities provide residents with reliable, regular access to communication technology, along with assistance to use whichever technology is available and works best for the resident.
- Vermont should ensure that LTC facilities provide residents with opportunities to engage with the surrounding community and enable residents to maintain their community connections.
- Vermont should ensure that providers make staff available to families by phone to answer questions or concerns about resident health, safety, loneliness and social isolation.
- Vermont should encourage LTC facilities to find ways in which residents can leave their room every day and go outside if they wish.

#### D. Quality of Care.

During this time of COVID-19, VOP ombudsmen are concerned about the quality of care being provided to residents and CFC recipients. A months-long primary focus on COVID-19 has impacted quality of care. In addition, COVID-19 precautions and restrictions have meant that friends, family, and concerned persons have less in-person access to residents and CFC recipients. While the VOP understands that providers are doing their very best during these trying times, we have received enough concerns and complaints from residents, CFC recipients, and family members to know that quality of care is an issue requiring immediate attention.

#### **Recommendations**

- Vermont should encourage policies that increase the number of clinicians on site at LTC facilities and HHAs.
- Vermont should require LTC providers to increase quality transparency.
- Vermont should enable better enforcement and quality improvement through regulatory reform.<sup>6</sup>
- Vermont should ensure that LTC facility staff prepare daily updates on Covid-19 for residents and staff – and the updates, which should include staff/resident ratios, are distributed by various means accessible to residents and families, along with other stakeholders such as DAIL and the VOP.
- Vermont should act upon recommendations made by the Nursing Oversight Working Group in January of 2019.
  - Recommendations included the development and implementation of an Enhanced Licensing Process for the transfer of ownership of nursing home; and modification of the current Division of Rate Setting rules.<sup>7</sup>
  - Both recommendations could have meaningful impacts on quality of care for nursing home residents.

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<sup>6</sup> Before COVID-19, Vermont was actively rewriting the State’s residential care home and assisted living regulations. The rewrite has been on pause since the start of the pandemic.

<sup>7</sup> <https://legislature.vermont.gov/assets/Legislative-Reports/Act-125-Nursing-Home-Oversight-Final.pdf>

Respectfully Submitted,

A handwritten signature in dark ink, reading "Sean Londergan". The signature is fluid and cursive, with a long horizontal stroke at the end.

Sean Londergan, State Long-Term Care Ombudsman  
Vermont Long-Term Care Ombudsman Project  
[slondergan@vtlegalaid.org](mailto:slondergan@vtlegalaid.org)  
802.383.2227

## Appendix 1

### **HISTORY OF THE OMBUDSMAN PROGRAM**

#### **At the National Level:**

The Long-Term Care Ombudsman Program originated as a five-state demonstration project to address quality of care and quality of life in nursing homes. In 1978 Congress required that states receiving Older Americans Act (OAA) funds must have Ombudsman programs. In 1981, Congress expanded the program to include residential care homes.

The Nursing Home Reform Act of 1987 (OBRA '87) strengthened the Ombudsman's ability to serve and protect long-term residents. It required residents to have "direct and immediate access to ombudspersons when protection and advocacy services become necessary." The 1987 reauthorization of the OAA required states to ensure that Ombudsmen would have access to facilities and to patient records. It also allowed the state Ombudsman to designate local Ombudsmen and volunteers to be "representatives" of the State Ombudsman with all the necessary rights and responsibilities.

The 1992 amendments to the OAA incorporated the long-term care Ombudsman program into a new Title VII for "Vulnerable Elder Rights Protection Activities." The amendments also emphasized the Ombudsman's role as an advocate and agent for system-wide change.

#### **In Vermont:**

Vermont's first Ombudsman program was established in 1975. Until 1993, the State Ombudsman was based in the Department of Aging and Disabilities (DAD), currently DAIL. Local Ombudsmen worked in each of the five Area Agencies on Aging. In response to concerns that it was a conflict to house the State Ombudsman in the same Department as the Division of Licensing and Protection, which is responsible for regulating long-term care facilities, the legislature gave DAD the authority to contract for Ombudsman services outside the Department.

DAIL has been contracting with Vermont Legal Aid (VLA) to provide Ombudsman services for over 20 years. The Vermont Long-Term Care Ombudsman Project at VLA protects the rights of Vermont's long-term care residents and Choices for Care (CFC) recipients. The Project also fulfills the mandates of the OAA and OBRA '87. The State and Local Ombudsmen work in each of VLA's offices, which are located throughout Vermont.

In 2005 the Vermont legislature expanded the duties and responsibilities of the Ombudsman project. Act No. 56 requires Ombudsmen to service individuals receiving home-based long-term care through the home- and community-based Medicaid waiver, Choices for Care.

Appendix 2

**VERMONT LONG-TERM CARE OMBUDSMAN PROJECT**

**Vermont Legal Aid**

January 2021

**State Long-Term Care Ombudsman:**

**Sean Londergan**

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Burlington, VT 05401

802.383.2227

[slondergan@vtlegalaid.org](mailto:slondergan@vtlegalaid.org)

**Local Ombudsmen:**

<p>Katrina Boemig</p> <p><b>(Windham &amp; Windsor Counties)</b></p> <p>56 Main Street, Suite 301 Springfield, VT 05156 Phone: 802.495.0488 Fax: 802.885.5754 <a href="mailto:kboemig@vtlegalaid.org">kboemig@vtlegalaid.org</a></p>	<p>Michelle R. Carter</p> <p><b>(Washington, Orange &amp; Addison Counties)</b></p> <p>56 College Street Montpelier, VT 05602 Phone: 802.839.1327 Fax: 802.223.7281 <a href="mailto:mcarter@vtlegalaid.org">mcarter@vtlegalaid.org</a></p> <p>* Also covers Rochester, Hancock, Pittsfield, Stockbridge &amp; Granville</p>	<p>Alice S. Harter</p> <p><b>(Essex, Orleans, Caledonia, &amp; Lamoille Counties)</b></p> <p>177 Western Ave., Suite 1 St. Johnsbury, VT 05819 Phone: 802.424.4703 Fax: 802.748.4610 <a href="mailto:aharter@vtlegalaid.org">aharter@vtlegalaid.org</a></p>
<p>Alicia Moyer</p> <p><b>(Chittenden &amp; Franklin Counties)</b></p> <p>264 N. Winooski Avenue Burlington, VT 05401 Phone: 802-448-1690 Fax 802.863.7152 <a href="mailto:amoyer@vtlegalaid.org">amoyer@vtlegalaid.org</a></p>	<p>Jane Munroe</p> <p><b>(Rutland &amp; Bennington Counties)</b></p> <p>57 North Main Street, Suite 2 Rutland, VT 05701 Phone: 802.855.2411 Fax: 802.775.0022 <a href="mailto:jmunroe@vtlegalaid.org">jmunroe@vtlegalaid.org</a></p>	



## Appendix 3