

**Annual Report to the Vermont Legislature**  
**January 15, 2023**

**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 is responsible for providing information and recommendations to the General Assembly and state agencies on issues related to long-term care services and supports. The Office reports to the General Assembly and Governor on or before January 15<sup>th</sup> of each year, as required by 33 V.S.A. §7503. The Office is pleased to present our annual Legislative Report covering federal fiscal year 2022.

## The Vermont Office of the Long-Term Care Ombudsman

### 1. Executive Summary

The staff of Vermont's Office of the State Long-Term Care Ombudsman serve as watchdogs and advocates to protect and support Vermonters who receive long-term care. While Vermont recovers from the Covid-19 pandemic and reckons with a long-term care workforce shortage crisis, our work is more important than ever. We empower long-term care recipients and their families by providing information on individual rights and facility responsibilities, by bringing individuals and facility staff together to solve problems, and by reporting regulatory violations. The work helps to prevent abuse and neglect and to restore dignity for Vermont long-term care recipients.

The Office of the State Long-Term Care Ombudsman in federal FY2022, at-a-glance:

- We completed **1,201** non-complaint advocacy work such as in-person facility reviews.
- We investigated and addressed **507** complaints.
- We resolved **92.5%** of complaints to the satisfaction of the care recipient.
- The top complaint we received in FY2022 was involuntary facility discharge.
- Kaili Kuiper replaced Sean Londergan as the State Long-Term Care Ombudsman in April 2022.
- We returned to in-person visits in late spring of 2022.
- Alice Harter retired in July 2022 after thirty-one years as a long-term care ombudsman, reducing our staff from six to five local ombudsmen.

## **2. Vermont Office of the State Long-Term Care Ombudsman**

Vermont's Office of the State Long-Term Care Ombudsman is known as the Vermont Ombudsman Project or VOP. The VOP is housed in Vermont Legal Aid. The VOP is staffed by independent advocates called long-term care ombudsmen. Ombudsmen are trained to resolve problems long-term care recipients experience regarding their care.

### **A. The VOP's role:**

- Work one-on-one with long-term care recipients to promote their dignity and safety.
- Advocate for changes that lead to better care and greater quality of life for all long-term care recipients.

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

- Nursing homes
- Residential care homes
- Assisted living residences
- Home and community-based settings through Choices for Care

### **C. The VOP's responsibilities and duties include:**

- Visiting nursing homes, residential care homes, and assisted living residences regularly to interact with residents and monitor conditions.
- Investigating problems and concerns about long-term care services and supports.
- Helping individuals make their own decisions about their long-term care services and supports.

- Assisting persons receiving Choices for Care with issues related to their long-term care services and supports in the home and community-based settings.
- Educating care providers about the rights and concerns of Vermonters receiving long-term care services and supports in facilities and at home through Choices for Care.
- Identifying problem areas in the long-term care services and support systems and advocating for change.
- Acting as “explainers” for individuals who wish to execute an Advanced Directive
- Providing information to the public about long-term care services and supports.

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

- The VOP is housed within Vermont Legal Aid, an independent non-profit. This organizational structure enhances the VOP’s ability to operate free of outside influence.
- No ombudsman or immediate family member of an ombudsman is involved in the licensing or certification of long-term care facilities or providers, nor do they work for or participate in the management of any long-term care facility.
- Individual conflicts of interest for ombudsmen are identified and remedied.
- 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, last page of this report).

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

- The VOP currently consists of one State Long-Term Care Ombudsman and five local ombudsmen. The VOP also has two certified volunteer ombudsmen. Our small staff covers over 150 long-term care facilities in Vermont and all individuals receiving long term care in Vermont through the Choices for Care program.

### **3. Ombudsmen complaint summaries**

Below are examples of ombudsmen work during FY 2022:

#### **A. Care Complaints:**

Ombudsmen also commonly address complaints about the quality of care. We listen to the resident, educate them on their rights including the right to be treated with dignity, to voice grievances, and to receive appropriate care. We support the resident to speak directly to nursing home staff about their complaints or, if the resident prefers, we speak to staff on behalf of the resident and work to resolve the issue. Here are two examples of care complaints from FY2022:

- A nursing home facility resident had a number of complaints including staff failing to turn her every two hours to prevent bed sores, and staff not being properly trained in bathing care to avoid further skin irritation. The local ombudsman and resident worked with the staff to create a person-centered care plan for the resident that addressed these issues. The ombudsman also worked with facility staff to ensure the resident's wheelchair was repaired.
- The family of a resident living in a residential care facility contacted the VOP to express concerns about the resident's care. The resident has a history of dementia. The resident's personal care was declining, and the facility maintained that the resident had

become more aggressive and resistant to care. The ombudsman requested a care plan meeting. Hospice staff, the resident's family members, the local ombudsman, and facility staff developed a care plan for the resident that included appropriate ways to approach the resident's so that the resident will be comfortable accepting care.

## **B. Involuntary Discharge Complaints**

Ombudsmen commonly address complaints regarding long-term care facilities trying to force residents to move out against their will. This is called an involuntary discharge. We educate residents and their representatives about their appeal rights, ensure that they were given proper notice of the discharge, and investigate the reason for the discharge to determine whether an alternative solution could allow the resident to stay in their home. Additionally, an ombudsman might help a long-term care recipient appeal the involuntary discharge. Here are two discharge examples from FY2022:

- One local ombudsman advocated for four residents who received thirty-day discharge notices from the same facility. In each case, the nursing facility told the resident that the facility could no longer meet their needs. These residents were faced with the difficult prospect of finding a new home that could meet their unique care needs.

The ombudsman educated the individuals and their family members as to regulations, time frames, and details about the appeal process. In a few cases, she met with the resident and their family along with administrative staff to discuss why the facility determined that the facility could not meet the resident's needs. She encouraged the residents and their representatives to request the residents' records if they had questions about care that had or had not been given. When the administrator tried to



stall by saying the records had to be sent to the corporate office first, she reminded the administrator that the regulations give the resident “the right to view their records upon request.”

The ombudsman helped the residents appeal their discharges. In all four cases, the discharge notices did not meet the statutory requirements, lacking specific wording and clarity, and lacking required contact information. The result was that these discharges were rejected by Vermont’s Division of Licensing and Protection. The facility was not allowed to discharge these residents.

- A nursing home resident in his eighties was given notice that he must move out of the residential care home where he had lived for the last two years. The notice stated that he was being discharged because of the lifestyle he chose. This is not a valid reason for discharge. The local ombudsman appealed the discharge, and the decision was in his favor. He didn’t have to leave. He stated that he was relieved. He had thought he would be kicked out and have to wander the downtown streets in winter.

### **C. Collaboration with other VLA Projects:**

There are times when ombudsmen team with other VLA projects or outside agencies to solve a resident’s problem. Here is an example:

- An individual in his fifties was admitted to a nursing home after a surgery that left him physically disabled. He had a close family member who was his power of attorney and collaborated well with him. Unfortunately, this family member contracted covid and passed away. Another family member petitioned the court for guardianship and was given temporary guardianship. Despite the resident’s wishes to return home, the temporary guardian opposed this plan. The resident contacted the VOP and asked for help so he could return to his home. An ombudsmen worked with the resident to understand his problem and determined that he wanted to dissolve the guardianship so he could have control over his life.

The VOP referred the case to Vermont Legal Aid's Disability Law Project to oppose this guardianship. The client had a mental health evaluation that concluded he was competent to make his own decisions. He was released from guardianship. He was able to leave the nursing home and return to his home in the community.

#### **D. Complaint on behalf of all residents:**

In some cases, an ombudsmen will pursue a complaint on behalf of all residents due to issues the ombudsmen identifies when visiting a facility and speaking with residents there. Here is an example of an all-resident complaint from FY2022:

- During a facility visit, the local ombudsman witnessed severe issues and opened seven complaints on behalf of all residents. The complaints referred to the facility's failures in the following areas: (1) Responses to request for assistance; (2) Food Services; (3) Therapeutic Diet; (4) Supplies and Storage; (5) Housekeeping, laundry and pest abatement; (6) Dining and hydration; and (7) Dignity and Respect. The ombudsman notified regulators, and the Attorney General's office became involved in monitoring the facility.

The local ombudsman is attending all resident council meetings to assess improvements. She is also meeting with the investigator from the Attorney General's Office and the facility's new administrator to address concerns. The corporation that owns the facility has moved hiring control from the corporate level to the facility to increase staffing. The facility has implemented numerous improvements to food and maintenance. There has been a new Dining Committee established with Residents. This case will remain open until significant improvements have occurred and are maintained to protect the residents at this facility.

#### **4. Number of cases and complaints**

Across FY 2022, the LTC Ombudsman Project worked on **258 cases** and **507 complaints**. Nearly, ninety-three percent (**92.5%**) of the complaints worked on by ombudsmen were fully or partially resolved to the satisfaction of the resident, participant, or complainant.

#### **5. Number of cases and complaints by long-term care setting**

In FY 2022, the number of cases and complaints by setting was as follows:

- Nursing home cases and complaints: **141/341**
- Residential care home and assisted living residence cases and complaints: **63/98**
- Home and community-based cases and complaints: **54/68**

#### **6. Major complaint categories for all settings combined**

Every year, ombudsmen work on a range of complaints. The top three major complaint categories for FY 2022 are (1) Care; (2) Autonomy, Choice, Rights; and (3) Admission, Transfer, Discharge, Eviction. Together, the three categories make up 67.5% of the complaints received by the VOP. The top three major complaint categories for FY 2022 are the same as the previous reporting period.

Each major category is made up of several subcategories. By far, the top complaint subcategory for FY2022 was involuntary discharge, making up over 12% of all complaints.

The following table shows major complaint categories in all settings for all cases opened or closed in FY2022.

<b>Major Complaint Category</b>	<b>Number of complaints</b>	<b>Percent (%)</b>
<b>Care</b>	<b>168</b>	<b>33.1%</b>
<b>Autonomy, Choice, Rights</b>	<b>89</b>	<b>17.6%</b>
<b>Admission, Transfer, Discharge, Eviction</b>	<b>85</b>	<b>16.8%</b>
<b>Financial, Property</b>	<b>27</b>	<b>5.3%</b>
<b>Access to Information</b>	<b>24</b>	<b>4.7%</b>
<b>Dietary</b>	<b>24</b>	<b>4.7%</b>
<b>Facility Policies, Procedures, and Practices</b>	<b>18</b>	<b>3.6%</b>
<b>System – Others (non-facility)</b>	<b>18</b>	<b>3.6%</b>
<b>Environment</b>	<b>16</b>	<b>3.2%</b>
<b>Abuse, Gross Neglect, Exploitation</b>	<b>14</b>	<b>2.8%</b>
<b>Activities, Community Integration, and Social Services</b>	<b>12</b>	<b>2.4%</b>
<b>Complaints about an Outside Agency</b>	<b>12</b>	<b>2.4%</b>
<b>Total</b>	<b>507</b>	<b>100%</b>

<b>Cases and Complaints by County</b>		
<b>Counties</b>	<b>Number of Cases/Complaints</b>	
Addison county	9	11
Bennington county	26	79
Caledonia county	7	24
Chittenden county	52	110
Franklin county	22	41
Lamoille county	3	3
Orange county	3	4
Orleans county	6	16
Rutland county	36	83
Washington county	16	21
Windham county	13	18
Windsor county	16	35
County Unknown	49	62
<b>Total</b>	<b>258</b>	<b>507</b>

## 7. Major complaint categories for each setting

### A. Nursing Homes

In FY 2022, the most complaints to the VOP involved nursing home residents. The top three major nursing home complaint categories for FY 2022 by total and percentage are (1) Care; (2) Autonomy, Choice, Rights; and (3) Admission, Transfer, Discharge, Eviction. Together, the three categories made up 69.5% of nursing home complaints. The top three major complaint categories for FY 2022 are the same as the previous reporting period.

Major complaint categories for nursing homes are shown in the table below (along with the total and percentage for each category).

Major Complaint Category – Nursing Homes	Number of complaints	Percent (%)
Care	133	39.0%
Autonomy, Choice, Rights	67	19.6%
Admission, Transfer, Discharge, Eviction	37	10.9%
Dietary	21	6.2%
Financial, Property	17	5.0%
Access to Information	17	5.0%
Environment	15	4.4%
Facility Policies, Procedures and Practices	10	2.9%
Activities, Community Integration and Social Services	9	2.6%
Abuse, Gross Neglect, Exploitation	8	2.3%
System – Others (non-facility)	5	1.5%
Complaints about an Outside Agency	2	0.6%
<b>Total</b>	<b>341</b>	<b>100%</b>

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

The second most complaints to the VOP involve residential care homes and assisted living residences. The top three major complaint categories for FY 2022 by total and percentage are (1) Admission, Transfer, Discharge, Eviction; (2) Care; and (3) Autonomy, Choice, Rights. Together, the three categories made up approximately 67.3% of residential care home and assisted living residence complaints. The top three major complaint categories for FY 2022 and FY2021 are the same, except that in FY2021, “Autonomy, Choice, Rights” was the top category, “Admission, Transfer, Discharge, Eviction” was second, and “Care” was third.

Major complaint categories for residential care homes and assisted living residences are shown in the table below (along with the total and percentage for each category).

<b>Major Complaint Category – RCH and ALR</b>	<b>Number of Complaints</b>	<b>Percent (%)</b>
<b>Admission, Transfer, Discharge, Eviction</b>	<b>34</b>	<b>34.7%</b>
<b>Care</b>	<b>17</b>	<b>17.3%</b>
<b>Autonomy, Choice, Rights</b>	<b>15</b>	<b>15.3%</b>
<b>Financial, Property</b>	<b>7</b>	<b>7.1%</b>
<b>Access to Information</b>	<b>7</b>	<b>7.1%</b>
<b>Facility Policies, Procedures and Practices</b>	<b>6</b>	<b>6.1%</b>
<b>Abuse, Gross Neglect, Exploitation</b>	<b>5</b>	<b>5.1%</b>
<b>Dietary</b>	<b>3</b>	<b>3.1%</b>
<b>Activities, Community Integration and Social Services</b>	<b>2</b>	<b>2.0%</b>
<b>System – Others (non-facility)</b>	<b>2</b>	<b>2.0%</b>
<b>Total</b>	<b>98</b>	<b>100%</b>

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

In FY 2022, ombudsmen worked on 54 Choices for Care community-based cases, which involved 68 complaints. Most home and community-based complaints made in FY 2022 concerned home health agencies. Home health agencies (HHA) provide long-term care services and supports to Choices for Care participants living in community settings.

Major complaint categories in FY2022 for all non-facility complaints (which include home and community-based complaints) are shown in the table below. The top three categories of complaints were (1) Care; (2) Admission, Transfer, Discharge, Eviction; and (3) System – Others (non-facility).

<b>Major Complaint Category – HCBS</b>	<b>Number of Complaints</b>	<b>Percent (%)</b>
<b>Care</b>	<b>18</b>	<b>26.5%</b>
<b>Admission, Transfer, Discharge, Eviction</b>	<b>14</b>	<b>20.6%</b>
<b>System – Others (non-facility)</b>	<b>11</b>	<b>16.2%</b>
<b>Complaints about an Outside Agency</b>	<b>10</b>	<b>14.7%</b>
<b>Autonomy, Choice, Rights</b>	<b>7</b>	<b>10.3%</b>
<b>Financial, Property</b>	<b>3</b>	<b>4.4%</b>
<b>Policies, Procedures, and Practices</b>	<b>2</b>	<b>2.9%</b>
<b>Abuse, Gross Neglect, Exploitation</b>	<b>1</b>	<b>1.5%</b>
<b>Activities and Social Services</b>	<b>1</b>	<b>1.5%</b>
<b>Environment</b>	<b>1</b>	<b>1.5%</b>
<b>Total</b>	<b>68</b>	<b>100%</b>



## 8. Complainant categories

The VOP receives complaints about long-term care services from many different categories of people including but not limited to long-term care recipients, family members of long-term care recipients, and staff of long-term care facilities. In FY2022,

- Friends, relatives, and other close contacts of the resident or Choices for Care participant reported the majority of complaints (48.4%).
- Approximately 38% of VOP complainants were residents and Choices for Care participants.

The table below shows the categories of complainants by setting for cases closed in FY 2022.

<b>Who made complaints in FY2022?</b>					
<b>Complainant</b>	<b>Nursing Home</b>	<b>Residential Care/ Assisted Living</b>	<b>Community Setting/ Other</b>	<b>Total Complaints</b>	<b>% Of Total Complaints</b>
Resident Relative/Friend	156	5	18	<b>179</b>	<b>48.4%</b>
Resident/ Participant	111	7	23	<b>141</b>	<b>38.1%</b>
Representative of other org.	13	2	13	<b>28</b>	<b>7.6%</b>
Facility administrator or staff	11	1	1	<b>13</b>	<b>3.5%</b>
Unknown	3	0	0	<b>3</b>	<b>0.8%</b>
Ombudsman	5	0	0	<b>5</b>	<b>1.4%</b>
Other	0	1	0	<b>1</b>	<b>0.3%</b>
<b>Total</b>	<b>254</b>	<b>91</b>	<b>67</b>	<b>370</b>	<b>100%</b>

## 9. Non-complaint tasks performed by ombudsmen

Ombudsmen have a number of duties beyond complaints casework:

- Perform general visits to observe the care residents are receiving at long-term care facilities and to ensure that residents are aware of our services.
- Educate residents on their rights.
- Provide residents, Choices for Care participants, and their representatives with guidance and information about how to communicate with providers about their concerns.
- Support resident and family councils in addressing facility issues and concerns.
- Assist residents with advance directives.
- Educate facility and home health staff on resident rights and the role of the VOP.

The table below summarizes some of the duties performed by ombudsmen beyond complaint casework.

<b>Snapshot of Non-complaint Related Activities</b>	
<b>Activities</b>	<b>Number of Instances</b>
Information and Advice to Individuals	594
Trainings and Consultations to Facilities/Agencies	285
Pandemic outreach calls to LTC facilities	25
Facility/Home visits	126
Staff Training	87
Assist with Advance Directives	24
LTC Facility Survey Participation	30
Work with Resident/Family Councils	14
Other	16
<b>Total</b>	<b>1,201</b>

<b>Non-Complaint Activities by County</b>	
<b>Counties</b>	<b>Number of Activities</b>
Addison county	6
Bennington county	52
Caledonia county	25
Chittenden county	201
Franklin county	71
Lamoille county	45
Orange county	46
Orleans county	18
Rutland county	110
Washington county	109
Windham county	33
Windsor county	32
County Unknown	453
<b>Total</b>	<b>1,201</b>

**10. Project volunteers**

The VOP relies on certified volunteer ombudsmen to help us assist residents and Choices for Care participants with their issues and concerns. In FY 2022, volunteer ombudsmen contributed 165 hours to the program. Volunteers enable the project to maintain a greater presence in Vermont’s long-term care facilities (there are currently 156 facilities). Volunteers do the work of paid ombudsmen, including responding to individual complaints and monitoring conditions in long-term care facilities.

***Thank you  
Volunteers!***

*Nancee Schaffner  
Paula DiCrosta*

Before becoming an official ombudsman volunteer, trainees must complete a comprehensive training program. The training program for all volunteers includes 20 hours of classroom training and independent study, and an additional 30 hours spent shadowing a local ombudsman working in facilities. When a trainee passes a conflict-of-interest review and background check, satisfactorily completes both the classroom and facility-based requirements, and no concerns arise regarding the individuals' suitability for the job, they will officially be certified as a volunteer representative of the office.

## 11. Project expenditures

The project received \$843,956.96 from DAIL in FY2022 to provide ombudsman services across Vermont. Funding included both state and federal monies, as shown below:

- \$140,189.20 Federal OAA Title VII, Chapter II
- \$228,647.50 Federal OAA Title III, State Level
- \$41,500.50 Federal Title VII Ombudsman – American Rescue Plan Act
- \$83,418.09 Federal Title VII Ombudsman – CARES ACT
- \$16,683.62 Federal Title VII Ombudsman - CRRSA
- \$259,823.17 Federal Medical Assistance Program (Global Commitment)
- \$73,694.88 State General Funds
- \$843.956.96 Total

**Note: The VOP has been able to back-fill our budget with one-time Covid-recovery funds. Without this extra funding, the VOP would be running a \$76,000 deficit just to keep our current staff of five local ombudsman. Due to this ongoing budgetary shortfall, we were unable to replace a sixth ombudsman who retired in 2022.**

## **12. 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, visits with residents and Choices for Care participants, and consultations with family members and staff members to help guide our systemic advocacy.

Representatives of the Office have served on numerous workgroups, committees, and task forces related to long-term care services and supports in Vermont. In FY 2022, representatives of the Office served on the Self-Neglect Working Group, the Vermont Vulnerable Adult Fatality Review Team, and regional Choices for Care waiver team meetings.

## **13. Issues and Recommendations:**

Due to the severity of the problem, this report will focus recommendations on a single challenge facing Vermont's long-term care recipients.

### **A. Issue: Ongoing staffing shortages leading to decreased quality and availability of care at long-term care facilities and home health agencies.**

Staffing shortages continue to challenge facilities and home health agencies and prevent residents from receiving appropriate care.<sup>1</sup> In

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<sup>1</sup> See ICYMI: Workforce Shortages in Long Term Care Facilities Continue to Worsen, American Health Care Association and National Center for Assisted Living, May 24, 2022, <https://www.ahcancal.org/News-and-Communications/Press-Releases/Pages/ICYMI-Workforce-Shortages-In-Long-Term-Care-Facilities-Continue-To-Worsen.aspx>.

March 2022, 46% of nursing facilities in Vermont reported a staffing shortage.<sup>2</sup>

Examples of poor care due to staffing shortages identified by the VOP in 2022:

- Residents left in bed all day because of inadequate staffing to assist residents in transferring out of bed.
- Residents told to urinate and defecate in their clothes, being put in a diaper, or being catheterized, because there was inadequate staff to assist residents in accessing a toilet.
- Facilities failing to answer phones for significant periods of time.
- Residents with special needs tied to mental illness being neglected or discharged.
- Residents told they cannot leave their room or they cannot step outside because there is no one to supervise them.
- Residents not fed regularly and/or not given access to food between meals.
- Residents unable to access their personal funds.
- Residents' clothes not washed or not returned after being taken away for laundering. Some residents dressed in scrubs, because all of their personal clothing was missing.
- Vermonters increasingly cannot find any placement in long-term care facilities or any home health workers.
- Growing numbers of severely disabled Vermonters who live at home are not receiving sufficient care to meet their needs. Some are receiving no care at all.

Vermont's long-term care workforce shortage includes facility leadership. The VOP observed that several facilities in Vermont had 3-5 different facility heads in 2022. One nursing home in Vermont had at least seven

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<sup>2</sup> Nursing Facility Staffing Shortages During the Covid-19 Pandemic, Kaiser Family Foundation, April 4, 2022, Figure 2, Share of Nursing Facilities Reporting Staffing Shortages, as of March 20<sup>th</sup>, 2022, <https://www.kff.org/coronavirus-covid-19/issue-brief/nursing-facility-staffing-shortages-during-the-covid-19-pandemic/>.

separate facility heads from January 2022 to January 2023. We also observed significant turnover in social workers and directors of nursing. This instability makes it difficult to report issues to facilities and collaborate on solutions.

The VOP's complaint data reflects problems caused by low staffing. For example, the most common complaints relate to involuntary facility discharge. When staffing levels are insufficient, facilities are motivated to get rid of their most time-consuming residents, and involuntary discharges increase. The residents who are victims of involuntary discharge are often the residents with the greatest physical and mental health challenges – the most vulnerable residents.

### **B. Recommendations:**

- Vermont should track,
  - how many of Vermont's nursing facilities have openings month to month and of those that report they have openings, how many applicants they have refused each month.
  - how many Choices for Care participants living at home are unable to secure the long-term care services they need as documented in their care plans, month-to-month.
  
- Vermont should ask all areas of state government that are working on the staffing shortage to report on what they are doing on this issue and the timeline for implementation. This should be combined into a comprehensive report on state efforts, so Vermont leaders can assess whether Vermont can improve its approach to this problem. Vermont should then encourage and facilitate conversations among leaders and local community members to come up with new and creative solutions to the staffing problem. Local communities cannot be expected to solve

the staffing crisis, but they can play a role in reducing the harm while permanent solutions are being pursued.

- Vermont should regularly review local long-term care workforce wages to ensure that these wages are keeping up with national long-term care workforce wages and exceeding wages in Vermont for work that requires a lower level of skills. If Vermont's long-term care wages are found insufficient under either of these measures, Vermont must increase long-term care wages. This should include opportunities for advancement, so that long-term care staff can increase their skill level and receive a fair wage increase for doing so.<sup>3</sup>
- The federal government is expected to be coming out with nursing facility minimum staffing standards in the next few months. Vermont should assess the standards when they are released and consider whether additional standards are needed to protect long-term care recipients.
- Vermont should require a minimum percentage of nursing home revenue go towards resident care. This would reduce incentives for nursing homes to decrease investments in care to increase owner profits.
- Vermont must increase regulation of assisted living facilities, residential care facilities, and home health agencies so these entities cannot easily avoid responsibility for Vermonters in their care.
- Vermont must develop procedures to quickly address emergency situations caused by inadequate staffing and prevent individuals

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<sup>3</sup> See Tradeoffs, Turning Long-Term Care into a Long-Term Career, October 20, 2022. <https://tradeoffs.org/2022/10/20/workforce-shortage-long-term-care/>.



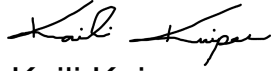
needing to be taken to the emergency room. Currently, Vermont does not have any entity with authority over nursing facilities and home health care agencies that can respond to emergency complaints outside of normal business hours. It is much better for the individual and Vermont's health care system if individuals can receive the proper care they need in their facility or in their home rather than sending them to the emergency room.

For example, a family member might visit a facility on a weekend and find that there is not adequate staffing in the facility to safely care for residents. Currently, the family member's options are to call the police, call an ambulance, or hope that everyone in the facility will be safe until Monday when the state resumes normal business hours. The family member should be able to report this issue immediately to a state regulator. A simple call by a state regulator to a long-term care administrator is often sufficient to bring in staff to address the emergency in the short-term. A more permanent solution can be explored when normal business hours resume.

- Vermont needs to support family caregivers, so those who wish to provide care to their loved ones do not burn out.
- Vermont should support Vermonters and their caregivers in accessing technology that can help Vermonters live safely in their homes.
- Vermont must sufficiently fund Vermont's Adult Protection Services, Survey and Certification, and the VOP. These entities work to identify and remedy situations where Vermonters are not receiving appropriate long-term care. This work is especially vital during a workforce shortage.

Thank you for taking the time to review the VOP's FY2022 annual report.

Respectfully Submitted,



Kaili Kuiper

State Long-Term Care Ombudsman

Vermont Long-Term Care Ombudsman Project

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## 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 DAAIL (Department of Aging and Independent Living). 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 participants. 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

**STAFF ROSTER**

**Vermont Long-Term Care Ombudsman Project**

**State Long-Term Care Ombudsman:**

**Kaili Kuiper**

56 College Street  
Montpelier, VT 05602

802.839.1329

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**Local Ombudsmen:**

<p><b>Katrina Boemig (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><b>Michelle R. Carter (Washington &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><b>Dawn Donahue (Essex, Orleans, Caledonia, Orange and Lamoille Counties)</b></p> <p>177 Western Ave., Suite 1 St. Johnsbury, VT 05819 Phone: 802.748.8721 Fax: 802.748.4610 <a href="mailto:ddonahue@vtlegalaid.org">ddonahue@vtlegalaid.org</a></p>
<p><b>Alicia Moyer (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><b>Kerry White (Rutland &amp; Bennington Counties)</b></p> <p>1085 Route 4, Suite 1A Rutland, VT 05701 Phone: 802.855.2411 Fax: 802.4486944 <a href="mailto:kwhite@vtlegalaid.org">kwhite@vtlegalaid.org</a></p>	

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*Agency of Human Services*

January 11, 2023

Kaili Kuiper  
State Long Term Care Ombudsman Program  
Vermont Legal Aid  
264 North Winooski Avenue  
Burlington, VT 05401

Dear Ms. Kuiper,

Pursuant to 33 V.S.A. §7503(10), on or before January 15 of each year the Office of the State Long-Term Care Ombudsman must “[s]ubmit to the General Assembly and the Governor a report on complaints by individuals receiving long-term care, conditions in long-term care facilities, and the quality of long-term care and recommendations to address identified problems.” 33 V.S.A. §7509 provides that the Department of Disabilities, Aging and Independent Living (“Department”) shall prohibit any Ombudsman, either paid or volunteer, Vermont Legal Aid staff and board, or any immediate family member of any Ombudsman, or Vermont Legal Aid staff and board, from having any interest in a long-term care facility or provider of long-term care which creates an organizational or individual conflict of interest in carrying out the Ombudsman’s responsibilities and directs the Department’s Commissioner to establish a committee of no fewer than five persons, who represent the interests of individuals receiving long-term care and who are not State employees, to assure that the Ombudsman is able to carry out all prescribed duties in the Older Americans Act and in state statute without a conflict of interest.

The Department utilizes the DAIL Advisory Board (“Board”) as the aforementioned committee. During its regularly scheduled monthly meeting on December 08, 2022, a subcommittee reported that assurances were received from you, the State Long Term Care Ombudsman, that to the best of your knowledge no Vermont Legal Aid staff, board, volunteers or their immediate family members have any interest in a long-term care facility or provider of long-term care which creates an individual or organizational conflict of interest in carrying out the Ombudsman’s responsibilities. By a unanimous vote the committee determined that the Ombudsman is able to carry out all prescribed duties without a conflict of interest, and the committee recommended that the Commissioner convey its assessment to both the General Assembly and the Governor as required by statute. This writing serves that purpose and is hereby submitted as an appendix to the Ombudsman’s annual report, as required by 33 V.S.A. §7509(b).

Respectfully submitted,



Monica White  
DAIL Commissioner  
Jason Pelopida, State Unit on Aging, DAIL  
Cc: Jeanne Hutchins, Chair DAIL Advisory Board