VERMONT OFFICE OF THE LONG-TERM CARE OMBUDSMAN

FY2025 ANNUAL REPORT TO THE VERMONT GENERAL ASSEMBLY
(October 1, 2024–September 30, 2025)

January 15, 2026

Submitted by:
STATE LONG-TERM CARE OMBUDSMAN
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Reporting Requirement to Vermont Legislature and Governor

The Office of the State Long-Term Care Ombudsman's duties include providing information and recommendations to Vermont's 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 15th of each year, as directed by 33 V.S.A. §7503.

We are pleased to present our annual Legislative Report covering federal fiscal year 2025.

A special thank you to Nancee Schaffner, our dedicated Volunteer Ombudsman, for contributing her time and efforts to advocate for Vermonters in long-term care facilities.

The Vermont Office of the State Long-Term Care Ombudsman

Vermont's Office of the State Long-Term Care Ombudsman, also known as the Vermont Ombudsman Program (VOP), protects, supports, and empowers Vermonters who receive long-term care. We serve as watchdogs and advocates. Certified ombudsmen visit residents, assess conditions, and resolve complaints in over 130 long-term care facilities across Vermont. Our ombudsmen also advocate for Choices for Care Medicaid recipients who receive long-term care in the community and engage in systemic advocacy. We provide Vermonters with information on resident rights and facility responsibilities; voice care recipients' concerns; bring care recipients, their families, and long-term care staff together to solve problems; and report long-term care regulatory violations. Our work helps to prevent harm and improve care recipients' quality of life.

I. The VOP in Federal FY2025, Summary:

- Our staff consisted of one State Long-Term Care Ombudsman, seven Local Ombudsmen, and one Volunteer Ombudsman.
- We investigated and addressed **567** complaints on behalf of Vermont long-term care recipients.
- We resolved **93%** of complaints to the satisfaction of the care recipient.
- The most common complaint topics in FY2025 concerned **involuntary discharge and quality of care**.
- In addition to our complaint resolution work, we completed:
  - Over **600** visits to long-term care facilities.
  - **370** instances of providing advice and information to individuals.
  - **175** instances of training to or consultation with facility staff.

II. How Ombudsmen Solve Vermonters' Long-Term Care Problems

The following case examples from FY2025 reflect the critical role of ombudsmen in safeguarding resident rights and well-being.

Helping residents access essential care: A developmentally disabled, elderly man who lives in a nursing facility in Vermont had been waiting over two years for a cataract operation. He was nearly blind. The Local Ombudsman arranged a care plan meeting and put pressure on the facility's social worker to set the appointments. Soon thereafter, the client had an appointment scheduled for an initial consultation. He ultimately had the surgery after nearly three years of waiting. The ombudsman received a call from the client's friend who stated, "He's ecstatic. He keeps looking at his hands, because he doesn't recognize them. He forgot what they look like. He's looking at his hands and explaining how wonderful it is. You were instrumental in that, and I can't thank you and he can't thank you enough for the work you are doing."

Supporting residents' right to make health care decisions: A woman in her fifties who had experienced a significant stroke was residing in a long-term care facility. The facility reported that she was unable to provide direction regarding her healthcare wishes, but she needed an Advance Directive.

The LTCO met with the woman in person and determined that she was able to understand questions, communicate her preferences, and meaningfully participate in decision-making despite limited verbal communication. With advocacy support, the woman completed a valid Advance Directive, communicating her preferences for future medical treatments.

Advocating for Vermonters who cannot advocate for themselves: A hospice nurse contacted the ombudsman program to report that a nursing facility was failing to adequately manage pain for residents on hospice care. The nurse observed residents who were actively dying and in pain,

while facility staff refused to follow hospice orders for pain management. Although hospice had prescribed pain medication every fifteen minutes, staff claimed that corporate policy limited all medication administrations to no more than 24 doses in a 24-hour period. The Local Ombudsman intervened to ensure residents' pain was properly addressed. As a result, the facility agreed to follow hospice orders for end-of-life comfort care.

Stopping abuse and neglect: A woman living in a nursing facility reported that staff were treating her roughly and without adequate regard to hygiene. A staff member confirmed witnessing some of the issues the woman described.

The Local Ombudsman facilitated meetings for the woman with the Administrator and Director of Nursing to ensure her concerns were addressed. The ombudsman also met with the woman and two representatives from Licensing and Protection to report her concerns.

Since then, the Administrator has worked diligently to resolve her concerns. The resident now reports that she is receiving good care.

Standing up for residents' dignity: A woman's son contacted the Local Ombudsman for help addressing poor care at his mother's nursing home. During family visits, they repeatedly found her oxygen tank disconnected, even though she was visually impaired and unable to detach it herself. She was also left for hours in a urine-soaked nightgown and abandoned on the commode for long periods, causing discomfort.

Additionally, the woman was placed in the dementia care unit despite not having dementia, leaving her isolated and depressed. The woman reported that nursing assistants entered her room without speaking to her, touched her without warning, and engaged in social conversations with other staff while providing care.

The ombudsman worked with the administrator to educate staff on person-centered care and improve personal care practices. They also collaborated with the dietitian to enhance her dietary options. The woman was moved out of the dementia unit and began participating in activities such as music

and spending time outdoors. She now reports feeling less alone and more empowered to ask for help.

Preventing involuntary evictions: A woman received a discharge notice from her long-term care facility for non-payment and non-compliance, because she had not enrolled in Long-Term Care Medicaid (LTCM) and she could not afford to private pay. The woman reported that her family member who is also her power of attorney needed assistance to complete the LTCM paperwork. The Local Ombudsman appealed the discharge notice and reached out to the family member. The Local Ombudsman then assisted the family member to gather the required documents and contact the assigned LTCM worker. After the Local Ombudsman facilitated a meeting between the family member and the LTCM worker, the woman's LTCM application was re-opened. As a result, the facility rescinded the discharge notice. The woman was ultimately approved for LTCM, and she continues to live in her facility.

Addressing Residents' needs to access supports outside of long-term care facilities: A man called the Local Ombudsman to complain that he has been unable to attend his dance therapy class for Parkinson's Disease which he has been attending for many years. He had recently moved to a long-term care facility, and the facility was unwilling to transport him to the therapy. The Local Ombudsman met with the man who expressed the profound importance that this therapy has had in his life. The Local Ombudsman contacted the facility social worker, the resident's Power of Attorney, and the class instructor to explore transportation options. Consequently, an SSTA application was submitted and approved, and the man resumed attending the class. The man attributes his participation in the dance troupe as the best medicine for his movement disorder and a source of intense joy and camaraderie.

III. Conditions in Long-Term Care Facilities and the Quality of Long-Term Care

The Vermont Ombudsman Program is required to report to the General Assembly and the Governor on conditions in long-term care facilities and the quality of long-term care. The ombudsman program observes dedicated and caring staff in long-term care facilities who are trying their best to provide good care with the resources available to them. However, we have significant concerns about the state of long-term care in Vermont. Below are Local Ombudsmen's top concerns:

- A lack of sufficient staffing for nursing facilities or home health care and overreliance on traveling staff
- Inadequate Personal Needs Allowance for residents on Long-Term Care Medicaid
- Poor quality of care
- Poor food quality and inadequate access to food
- A lack of staff competencies to care for residents with dementia or significant mental health issues
- Inadequate supports for individuals trying to apply for Long-Term Care Medicaid

Vermont's inability to maintain consistent and adequate long-term care staffing has negatively impacted the quality, availability, and affordability of long-term care in all settings. In 2025, the most common complaints the VOP received show that many facility residents are struggling to have their basic needs met. The top complaints were on the topics of facility staff failing to respond to individuals' requests for assistance, poor quality and inadequate access to food, and resident involuntary evictions. Here are some cases we worked on in 2025 that illustrate these issues:

Failure to provide basic medical care: A woman's daughter contacted the Local Ombudsman with concerns about her mother's care in a nursing home. During a visit, the daughter noticed her mother appeared significantly sicker than before. The woman was sent to the emergency

room, where doctors discovered a fist-sized pressure ulcer with surrounding necrotic tissue.

The Local Ombudsman assisted the family in reporting the issue to the Department of Licensing and Protection. Tragically, the woman later died from complications related to malnutrition and the untreated wound. The Director of Nursing subsequently apologized for this gross neglect and committed to implementing internal changes to prevent such a tragedy from happening again.

Failure to follow up on problems and communicate: An elderly woman's daughter contacted the Local Ombudsman to report that her mother was being neglected at her nursing facility resulting in the woman losing significant weight, falling frequently, and being repeatedly hospitalized. In addition, the facility was not adequately communicating with the family about these issues. The ombudsman intervened, working with the family and facility staff. To address the falls, the facility provided the woman with better seating, a lower bed, motion sensors, mats, and a small rail for support. To address the weight loss, the Local Ombudsman met with the facility doctor to go over her diagnoses and tests and engaged in a care plan meeting to address this with the team. The woman was prescribed a new medication, and her food consistency was adjusted appropriately. The Local Ombudsman also referred the woman to Vermont Legal Aid's Elder Law Project to assist the family working on long term care Medicaid and social security issues. Ultimately, the family still felt that the woman was not receiving adequate care at her facility. The Local Ombudsman helped the family move the woman to a facility where she could be closer to her family and receive better care. In addition, the Department of Licensing and Protection was notified about the care issues observed at the facility. In the end, the family told the ombudsman that they greatly appreciated her work to help their mother.

Failure to accommodate a resident after a fall: A man was sent from his assisted living facility to the hospital after a fall. While he was hospitalized, the facility submitted an emergency involuntary discharge request to

Licensing and Protection, seeking to bar him from returning to the facility. The facility argued that his care needs exceeded their ability to manage him due to his fall risk. They included a letter from a hospital nurse practitioner stating he required a higher level of care. Licensing and Protection approved the emergency discharge.

The man reported the emergency discharge to the ombudsman program and expressed that he wanted to return home after completing rehabilitation. The Local Ombudsman spoke with the hospital nurse practitioner, who stated that steps could be taken to accommodate his return, but the facility had refused to implement them. The ombudsman filed an appeal, arguing that the man should be given more time to recover and the facility should attempt to care plan for him before they decide whether or not they can meet his needs. The appeal cited assisted living regulations: *"The expectation is that individuals will be permitted to age in place... and not required to leave an assisted living residence involuntarily."* The ombudsman also noted that the nurse practitioner's letter did not support the facility's claim that the situation constituted an emergency.

The appeal requested additional rehabilitation time and collaboration with the facility to develop a care plan for the man's return. Licensing and Protection agreed, and the man won the right to return home after completing rehabilitation.

Lack of dietary planning and oversight: A man with significant Alzheimer's disease experienced rapid and medically concerning weight loss. The Director of Nursing told the man's daughter that these issues were a natural result of his Alzheimer's disease and could not be improved. His daughter observed that he was not eating facility-provided meals and food that she brought for him were not being consistently offered. The man's daughter contacted the ombudsman program for help.

The Local Ombudsman worked with the facility, the dietitian, and the man's daughter to address the concerns. Food texture was identified as a significant factor for this man's ability to safely consume and enjoy his food. The man's care plan was adjusted to emphasize his preferred foods,

appropriate food textures, increased nutritional supplementation, and the importance of staff oversight, including tracking when supplemental foods were provided.

The ombudsman engaged in follow-up meetings with the facility and the daughter to ensure the man's dietary plan was consistently applied. Once the man's nutrition improved significantly, his daughter reported that he became more engaged and communicative including speaking more and playing the piano.

Failure to offer food between meals: Local Ombudsmen have observed multiple facilities across the state that appear to be under spending on residents' food. One example is a recent trend of facilities failing to offer food to their residents between meals despite regulations requiring two daily offerings. These snacks are important for maintaining residents' weight and blood sugar levels and help create a more home-like environment. Numerous residents across multiple facilities have complained to the ombudsman program about this specific issue. While facilities often argue that snacks are available upon request and at activities, Local Ombudsmen point out that many residents will not remember that they have to ask, and not all residents can or want to attend activities. This is an ongoing issue that the ombudsman program is actively addressing at several facilities.

IV. Policy Recommendations:

To address some of the systemic issues faced by long-term care recipients, the Vermont Long-Term Care Ombudsman Program recommends the following:

1. **Implement an annual cost of living adjustment tied to the Social Security COLA to ensure that Vermonter's personal needs allowance keeps up with inflation**. The Personal Needs Allowance is the amount of money Vermont nursing home residents on Long-Term Care Medicaid are allowed to keep from their income to pay for anything not provided by the facility including clothing, shoes, haircuts, telephone, cable, internet, reading material, and activities away from the facility. The rest of their income goes to the cost of their care. While New Hampshire has implemented an automatic PNA increase to account for inflation, Vermont has not. Vermont's PNA amount has not increased from $79.93 in January 2024, an average of $2.60 per day. Nursing home residents have repeatedly told us that they do not have enough money to buy clothes. They also report that they cannot afford to buy all of the toiletries they need, hobby supplies, books, food outside of the facility, and gifts for their family and friends.
2. **Require employers to allocate a sufficient amount of Medicaid dollars to direct workers' wages.** As of 2022, over 20 states mandated that a certain percentage or amount of the rates paid to employers go to the workers.[1]
3. **Provide employment protections for Vermonters with caregiving responsibilities.** At least seven states, including Maine and New York, protect family caregivers from employment discrimination.[2] Because Vermont has an extreme shortage of long-term care workers, we must support family caregivers as much as possible.

[1] See, e.g. LTSS Worker Wage Pass-Through, AARP: https://ltsschoices.aarp.org/scorecard-report/2023/dimensions-and-indicators/ltss-worker-wage-pass-through.
[2] See, e.g. Family Responsibility Protected Classification, AARP https://ltsschoices.aarp.org/scorecard-report/2023/dimensions-and-indicators/family-responsibility-protected-classification.

V. VOP Long-Term Care Complaint Data

Across FY2025, we opened 311 cases with 493 complaints and closed 260 cases with 420 complaints. In total, the VOP worked on 356 unique cases and 567 unique complaints in FY2025. Ninety-three percent (93%) of the complaints the VOP closed in FY2025 were fully or partially resolved to the satisfaction of the resident or participant. Below, we break down these numbers by setting and complaint topic.

A. FY2025 Cases and Complaints by Long-term Care Setting

The VOP supports all long-term care residents including those in nursing homes, residential care homes, and assisted living facilities. The VOP also supports individuals who receive home-and-community-based services through the Choices for Care (CFC) program. The table below shows the number of cases and complaints by long-term care setting.

Number of Cases and Complaints Opened in FY2025 by Setting

Setting	Cases	Complaints
Nursing Homes	**204**	**352**
Residential care home and assisted living residence	**88**	**116**
CFC Home and Community Based services	**19**	**25**

B. Complaints by County

The table below shows the number of complaints received by the Long-Term Care Ombudsman Program in FY2025 by the county where the care was received.

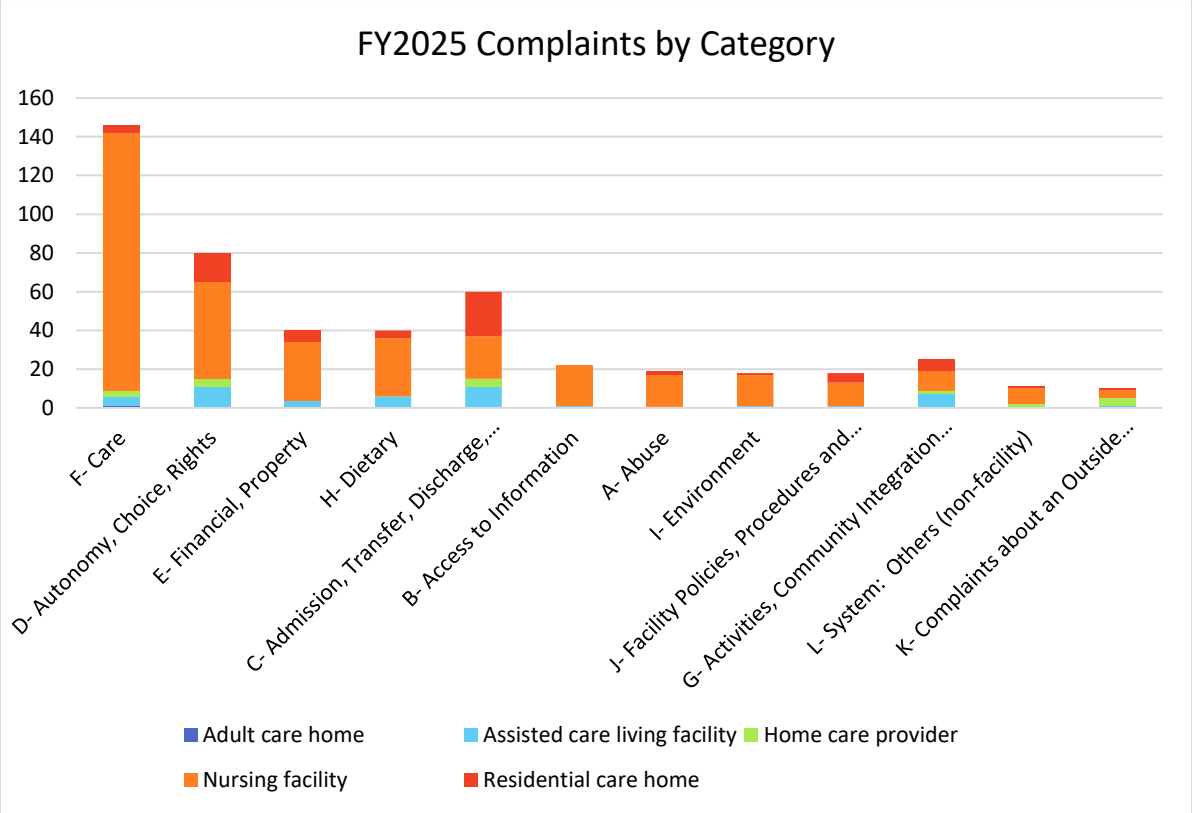
FY2025 Complaints to VOP by County

Counties	Complaint Number
Washington	124
Chittenden	67
Windsor	66
Bennington	60
Rutland	49
Caledonia	32
Orleans	32
Orange	20
Windham	17
Franklin	16
Addison	9
Lamoille	1
Total	493

C. Complaint categories for all settings

Ombudsmen work on a wide range of complaints. The top three primary complaint categories for FY 2025 were (1) Care; (2) Autonomy, Choice, Rights; and (3) Admission, Transfer, Discharge, Eviction. Together, the three categories make up 58% of the complaints the VOP received.

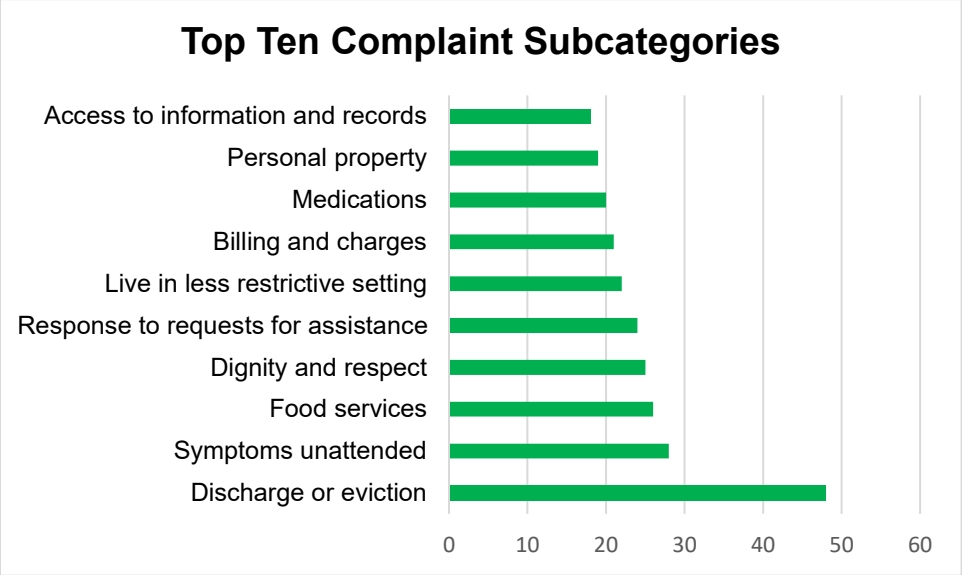
The following graph and table show major complaint categories in all settings for all cases opened in FY2025.



All Settings: Number and Percentage of Complaints to Ombudsmen by Complaint Category

Major Complaint Category	Number of Complaints	Percent (%)
Care	146	30%
Autonomy, Choice, Rights	82	17%
Admission, Transfer, Discharge, Eviction	62	13%
Financial, Property	40	8%
Dietary	40	8%
Activities, Community Integration, and Social Services	25	5%
Access to Information	22	4%
Abuse, Gross Neglect, Exploitation	19	4%
Environment	18	4%
Facility Policies, Procedures, and Practices	18	4%
System - Others (non-facility)	11	2%
Complaints about an Outside Agency	10	2%
Total	493	100%

Each major category can be broken down into several subcategories. By far, the top complaint subcategory for FY2025 concerned residents who were being involuntarily discharged (evicted) from facilities. The following graph and table show the top ten complaint subcategories in all settings for all cases opened in FY2025.



All Settings: Top Ten Complaint Subcategories

Sub-Categories	Count	Percent of all Complaints
Discharge or eviction	48	10%
Symptoms unattended	28	6%
Food services	26	5%
Dignity and respect	25	5%
Response to requests for assistance	24	5%
Live in less restrictive setting	22	4%
Billing and charges	21	4%
Medications	20	4%
Personal property	19	4%
Access to information and records	18	4%

D. Major complaint categories for each setting

Ombudsmen assist Vermonters with a different mix of issues within each care setting.

1. Nursing Homes

In FY 2025, most complaints to the VOP concerned nursing homes. Complaints about quality care made up 38% of nursing home complaints.

The table below shows the distribution of complaints to the VOP regarding nursing homes by complaint category.

Nursing Homes: Number of Complaints to VOP by Complaint Category

Major Complaint Category	Number of Complaints	Percent (%)
Care	133	38%
Autonomy, Choice, Rights	50	14%
Financial, Property	30	9%
Dietary	30	9%
Admission, Transfer, Discharge, Eviction	22	6%
Access to Information	21	6%
Abuse	16	5%
Environment	16	5%
Facility Policies, Procedures and Practices	12	3%
Activities, Community Integration and Social Services	10	3%
System: Others (non-facility)	8	2%
Complaints about an Outside Agency	4	1%
Total	**352**	**100%**

2. Residential Care Homes & Assisted Living Residences

In FY2025, almost 30% of complaints to the VOP for residential care home and assisted living facility residents were regarding Admission, Transfer, Discharge, and Eviction.

The table below shows the total distribution of complaints to the VOP regarding residential care homes and assisted living facilities by complaint category for FY2025.

Residential Care Home and Assisted Living Facilities: Number of Complaints to VOP by Complaint Category

Major Complaint Category	Number of Complaints	Percent (%)
Admission, Transfer, Discharge, Eviction	34	29%
Autonomy, Choice, Rights	26	22%
Activities, Community Integration and Social Services	13	11%
Financial, Property	10	9%
Dietary	10	9%
Care	9	8%
Facility Policies, Procedures and Practices	6	5%
Abuse	2	2%
Environment	2	2%
Complaints about an Outside Agency	2	2%
Access to Information	1	1%
System: Others (non-facility)	1	1%
Total	**116**	**100%**

3. Home and Community-Based Cases and Complaints

The VOP advocates for individuals who receive home-and-community-based services through the Medicaid Choices for Care Program. In FY2025, about half of complaints to the VOP concerning home-and-community-based services were related to admissions, transfer, discharge, and eviction or autonomy, choice, and rights.

The table below shows the distribution of complaints to the VOP regarding Choices for Care funded home-based services by complaint category for FY2025.

Home-Based Choices for Care: Number of Complaints to VOP by Complaint Category

Major Complaint Category	Number of Complaints	Percent (%)
Admission, Transfer, Discharge, Eviction	6	24%
Autonomy, Choice, Rights	6	24%
Care	4	16%
Complaints about an Outside Agency	4	16%
Activities, Community Integration and Social Services	2	8%
System: Others (non-facility)	2	8%
Abuse	1	4%
Total	**25**	**100%**

E. People Who Report Concerns to the VOP

The VOP receives concerns about long-term care services from many sources including long-term care recipients, family members of long-term care recipients, and long-term care facility staff. In FY2025,

- 39% of complaints were reported by facility residents or individuals receiving services at home through the Choices for Care program.
- Friends, relatives, and other close contacts of the resident or Choices for Care participant reported 40% of complaints.
- The remaining 21% of complaints were submitted by representatives of other agencies, facility staff or administration, or originated with ombudsman staff.

The table below shows who reported complaints in different settings for cases closed in FY 2025.

Number of Complaints by Complainant Type in FY2025

Person who submitted the Complaint	Nursing Home	Residential Care	Assisted Living	Community Setting/ Hospital/ Other	Total Complaints Opened	% Of Total Complaints
Resident Representative, Friend, Family	150	18	26	4	198	40%
Resident	134	23	18	16	191	39%
Facility Staff	41	20	4	0	65	13%
Representative of Other Agency or Program	9	5	0	5	19	4%
Ombudsman Program	14	2	0	0	16	3%
Other	4	0	0	0	4	<1%
Total	**352**	**68**	**48**	**25**	**493**	**100%**

VI. Additional Ombudsmen Advocacy Work

Ombudsmen have responsibilities outside of complaint-based casework:

- Performing general visits to observe the conditions and care residents are receiving at long-term care facilities and to ensure that residents are aware of our services.
- Educating residents on their rights.
- Providing residents, Choices for Care participants, and their representatives with guidance and information about how to communicate with providers about their concerns and how to submit complaints to facilities and state regulatory agencies.
- Supporting resident and family councils in addressing facility issues and concerns.
- Assisting residents with health care advance directives.
- Educating 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 outside of complaint casework in FY2025.

Ombudsmen Work Beyond Complaint Casework

Activity Types	Number Completed
Non-Routine Facility Visits	407
Routine Monitoring Facility Visits	363
Advice/Information to Individuals	320
Consult to Facility Staff	179
Work with Resident and Family Councils	56
Consult to CFC Provider	45
Advance Directive	28
Facility Survey Participation	14
Trainings to Care Provider Groups	6

VII. Ombudsman Systemic Advocacy

The VOP's state and federal statutory role includes addressing systemic problems with long-term care that impact Vermonters' quality of care and life. The VOP informs our systemic advocacy using insights we gain through our daily work with nursing facility residents, Choices for Care participants, family members of people receiving long-term care, long-term care staff, and other stakeholders.

In FY2025, the Long-Term Care Ombudsman Program's Systemic Advocacy work included monitoring proposed bills and regulations related to long-term care at the state and federal level, intervening in a nursing facility's certificate of need proceeding to expand bed capacity, and submitting comments on Medicare Supplement Health Insurance Plan rate increases.

In addition, the VOP advocates for long-term care recipients by serving on numerous workgroups, committees, and task forces related to long-term care services and supports in Vermont. In FY2025, representatives of the VOP served on the following workgroups, committees, and councils:

- Vermont Vulnerable Adult Fatality Review Team,
- The Governor's Council on Alzheimer's Disease and Related Diseases,
- The Veteran Community Partnership
- Complex Care Team at MissionCare at Bennington
- APS Rulemaking Work Group
- Vermont Legal Aid's Health Law Task Force,
- NALLTCO (National Association for Local Long-term Care Ombudsmen),
- NASOP (National Association for State Ombudsman Programs), and
- Vermont's regional Choices for Care Waiver Teams.

We also collaborated with the following entities:

- Age Well
- ARIS
- Athena Services
- BAYADA
- Bennington Project Independence
- Caledonia Home Health Care and Hospice
- Carla Kamel, Community Care Coordinator
- Central Vermont Medical Center
- Choice for Care Program
- Choice TBI Support Services
- Clara Martin Orange County
- Council on Aging (COA)
- Deer Oakes Counseling
- Department of Disabilities, Aging, and Independent Living
- Department of Vermont Health Access (DVHA)
- ERC VT Adult Services Division
- Flexible Choices
- Green Mountain Support Services
- HCRS
- Home Health and Hospice
- LTCCC
- MFRAU (Medicaid Fraud and Residential Abuse Unit)
- MOOVER Medicaid transport/volunteer drivers
- Money Follows the Person
- National Seating and Mobility
- Neighborhood Connections in Londonderry
- Northeast Kingdom Council on Aging
- Office of the Public Guardian
- Senior Solutions
- University of Vermont Medical Center
- Upper Valley Services
- Vermont Alzheimer's Association
- Vermont Legal Aid's Disability Law Project
- Vermont Legal Aid's Elder Law Project
- Vermont Legal Aid's Office of the Health Care Advocate
- VSHA
- VRS Disability Management
- VT Center for Independent Living
- VT Disability Division-PASRR
- Wayward Wheels

The Department of Disabilities, Aging, and Independent Living (DAIL) paid the VOP $1,164,348 to provide ombudsman services across Vermont in FY2025.

DAIL's FY25 funding for the VOP included both state and federal sources, as shown below:

Federal OAA Title VII, Chapter II	$121,130.94
Federal OAA Title III, State Level	$382,625.46
CFDA 93.778 Federal Medical Assistance Program (Global Commitment)	$269,795.51
State General Funds	$390,796.48
Total:	**$1,164,348.39**

The VOP team is proud of the work we do to protect, support, and empower Vermonters who receive long-term care. Thank you for taking the time to review the VOP's FY2025 annual report.

Respectfully Submitted,

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Appendix 1

HISTORY AND ROLE OF THE OMBUDSMAN PROGRAM

I. History

A. 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 states to have Ombudsman Programs if they receive Older Americans Act (OAA) funds. 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.

B. 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 (Department of Aging and Independent Living). Local Ombudsmen worked in each of the five Area Agencies on Aging. In response to concerns that housing the State Ombudsman in the same Department as the Division of Licensing and Protection, which is responsible for regulating long-term care facilities, created a conflict of interest, the legislature gave DAD/DAIL 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 Program at VLA protects the rights of Vermont's long-term care residents and Choices for Care participants. The program 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 Vermont Long-Term Care Ombudsman Program. The Vermont Ombudsman Program is now required to serve individuals receiving home-based long-term care through the home-and-community-based Medicaid waiver, Choices for Care.

II. Vermont Long-Term Care Ombudsman Program Today

Across the state of Vermont, the Vermont Long-Term Care Ombudsman Program currently covers over 6,000 long-term care beds in over 100 facilities plus all individuals receiving long-term care in Vermont through the Choices for Care program.

A. The VOP's focus

- 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's clients

- The VOP helps individuals who receive long-term care 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 conflicts of interest. (See Appendix 3, last page of this report).

E. Long-Term Care Ombudsman Certification Process

To become a certified ombudsman, all paid staff and volunteers must accomplish:

- 20 hours of classroom training
- 30 hours spent shadowing a Local Ombudsman
- Clearing conflict-of-interest and background checks

F. Staffing for the Vermont Long-Term Care Ombudsman Program:

- In federal fiscal year 2025 (October 1, 2024 to September 30, 2025), paid full-time VOP staff consisted of one State Long-Term Care Ombudsman and seven Local Ombudsmen positions.
- The VOP added an ombudsman position in Bennington County in November 2024 to provide increased oversight to pre-existing facilities in the area, including one with significant ongoing issues, and to provide oversight for the new Bennington facility that was created to accept hard-to-place individuals. With a full-time ombudsman physically present in Bennington county in 2025, our program identified and addressed three times the number of complaints in the county compared to 2024.
- The VOP has one certified volunteer ombudsman who monitors facilities and assists residents with their issues and concerns in Rutland county. In FY2025, this volunteer ombudsman donated over 200 hours to the program.

Appendix 2

VERMONT LONG-TERM CARE OMBUDSMAN PROJECT
Vermont Legal Aid
Helpline: 800-889-2047, Option 3
Helpline email: vophelpline@vtlegalaid.org
Fax: 802-495-0444

JANUARY 2026 STAFF ROSTER

State Long-Term Care Ombudsman:

Kaili Kuiper
56 College Street
Montpelier, VT 05602
802.839.1329

Local Ombudsmen:

Michelle R. Carter
(Statewide Hotline and Woodridge Nursing Home)

Nadia Lucchin
(Bennington Co.)

Kerry White
(Rutland and Addison Counties)

Dawn Donahue
(Washington, Orange, & Lamoille Counties)

Randi Morse
(Caledonia, Franklin, Essex, & Orleans Counties)

Volunteer Ombudsman:

Nancy Schaffner
(Rutland Co.)

Terry Kalahar
(Chittenden & Grand Isle Co.)

Alicia Moyer
(Windham & Windsor Counties)

VERMONT Department of
[phone] 802-241-2401 Agency of Human Services
[fax] 802-241-0386

Independent Living
Commissioner's Office
280 State Drive/HC 2 South
Waterbury, VT 05671-2020
www.dail.vermont.gov

January 7, 2026

Kaili Kuiper, State Long Term Care Ombudsman
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 as the aforementioned committee. During its regularly scheduled monthly meeting on November 13,2025 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,

Signed by:
Jill Bowen, PhD
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Dr. Jill Bowen, PhD
DAIL Commissioner

CC: Jason Pelopida, State Unit on Aging Director, DAIL
Jane Catton, Chair, DAIL Advisory Board