Annual Report to the Vermont Legislature
January 15, 2022

VERMONT LONG-TERM CARE OMBUDSMAN PROJECT

Submitted by:
STATE LONG-TERM CARE OMBUDSMAN
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Appendices

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 15th 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. 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 staffed by long-term care (LTC) ombudsmen. LTC ombudsmen are advocates trained to resolve problems. LTC ombudsmen advocate for and assist: (a) residents of nursing homes, residential care homes, and assisted living residences; and (b) home and community-based participants of Choices for Care (CFC).

A. The role of the VOP is to:

- Promote the rights of: (a) Vermont residents of nursing homes, residential care homes, and assisted living residences; and (b) Vermont home and community-based CFC participants
- Advocate for changes that lead to better care and greater quality of life for: (a) residents of nursing homes, residential care homes, and assisted living residences; and (b) home and community-based CFC participants

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 responsibilities and duties of VOP ombudsmen are to:

- Investigate problems and concerns about long-term care services and supports
- Help individuals make their own decisions about their long-term care services and supports
- Assist persons receiving CFC gain access to long-term care services and supports in the home and community-based settings
- Visit nursing homes, residential care homes, and assisted living residences regularly to interact with residents and monitor conditions
- Educate providers about the rights and concerns of Vermonters receiving long-term care services and supports in facilities and at home through CFC

- 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, last page of this report)
- 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
- Ombudsmen do not work for or participate in the management of any facility
- Individual conflicts of interest for ombudsmen are identified and remedied

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

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

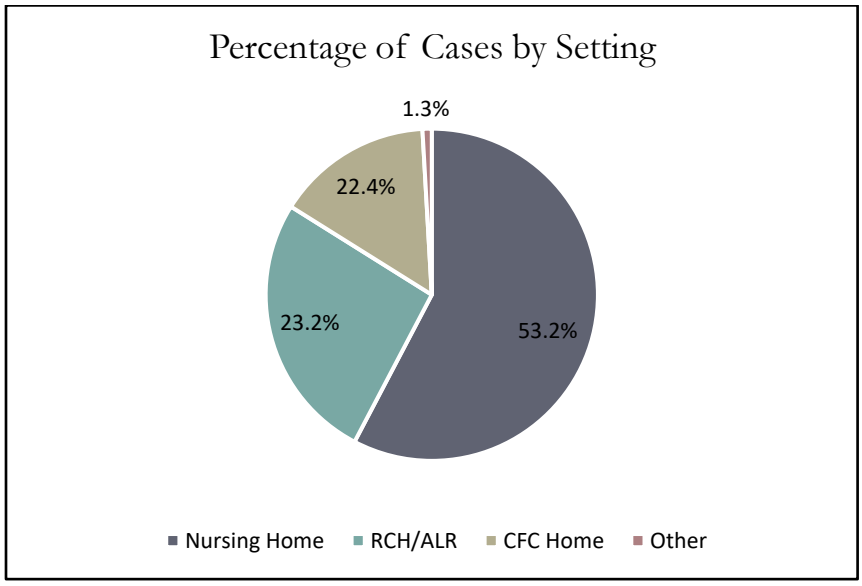
2. Number of case and complaints

For FY 2021, the LTC Ombudsman Project worked on **237 cases** and **412 complaints.** Approximately, eighty-one percent (81.3%) of the complaints worked on by ombudsmen were fully or partially resolved to the satisfaction of the resident, participant, or complainant.

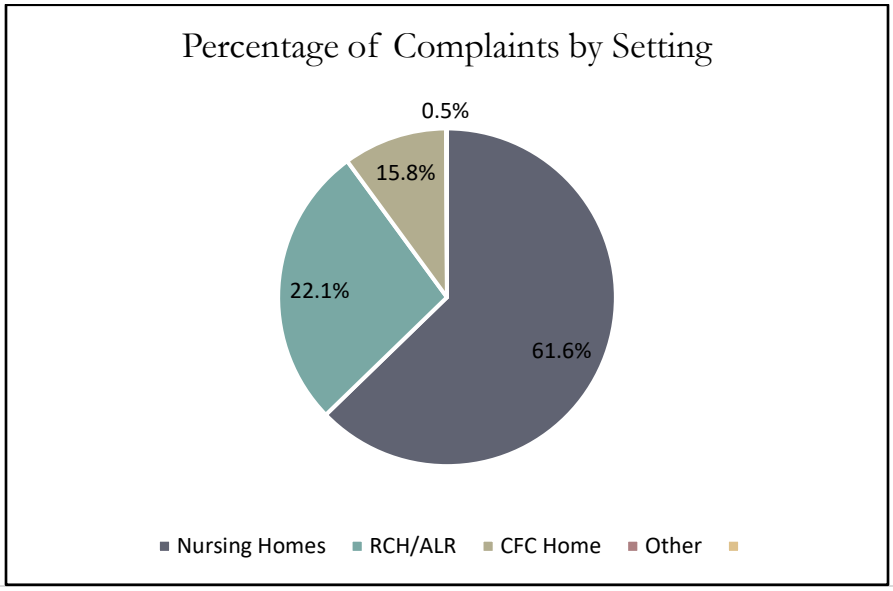
3. Number of cases ands complaint by long-term care setting

Vermonters receive long-term care services and supports in different settings. Settings include licensed facilities such as nursing homes, residential care homes, and assisted living residences. Services can also be received in community settings (such as a person's home). No matter the setting, those receiving services and supports must be treated with respect and dignity.

- In FY 2021, the number of cases by setting was as follows:
  - Nursing home cases: **126**
  - Residential care home and assisted living residence cases: **55**
  - Home and community-based cases: **53**



- In FY 2021, the number of complaints by setting was as follows:
  - Nursing home complaints: **254**
  - Residential care home and assisted living residence complaints: **91**
  - Home and community-based complaints: **65**



4. Major complaint categories for all settings combined

Every year, ombudsmen work on a range of complaints. Major complaint categories for FY 2021 are shown in the table below (along with total and percentage for each category).

The top three major complaint categories for FY 2021 by total and percentage from the table below are: 1. Care; 2. Autonomy, Choice, Rights; and 3. Admission, Transfer, Discharge, Eviction. Together, the three categories make up 68.6% of the complaints received by the VOP. The top three major complaint categories for FY 2021 are the same as the previous reporting period.

Major complaint categories for all settings combined is shown in the table below (along with total and percentage for each category).

Major Complaint Category	Total complaints	Percent (%)
Care	127	30.8%
Autonomy, Choice, Rights	88	21.4%
Admission, Transfer, Discharge, Eviction	68	16.5%
Financial, Property	26	6.3%
Access to Information	18	4.4%
System: Others (non-facility)	15	3.6%
Activities, Community Integration and Social Services	14	3.4%
Dietary	13	3.2%
Complaints about an Outside Agency (non-facility)	12	2.9%
Environment	11	2.7%
Facility Policies, Procedures and Practices	10	2.4%
Abuse, Gross Neglect, Exploitation	10	2.4%
Total	412	100%

5. Major complaint categories for each setting

A. Nursing Homes

In FY 2021, the most complaints involved nursing home residents.

The top three major complaint categories for FY 2021 by total and percentage are: 1. Care; 2. Autonomy, Choice, Rights; and 3. Admission, Transfer, Discharge, Eviction. Together, the three categories made up 72% of nursing home complaints. The top three major complaint categories for FY 2021 are the same as the previous reporting period.

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

Major Complaint Category	Total complaints	Percent (%)
Care	88	34.6%
Autonomy, Choice, Rights	55	21.7%
Admission, Transfer, Discharge, Eviction	40	15.7%
Financial, Property	16	6.3%
Access to Information	14	5.5%
Activities, Community Integration and Social Services	12	4.7%
Dietary	9	3.5%
Environment	7	2.8%
Facility Policies, Procedures and Practices	7	2.8%
Abuse, Gross Neglect, Exploitation	3	1.2%
System: Others (non-facility)	2	0.8%
Complaints about an Outside Agency (non-facility)	1	0.4%
Total	254	100%

B. Residential Care Homes & Assisted Living Residences

The second most complaints involve residential care homes and assisted living residences.

The top three major complaint categories for FY 2021 by total and percentage are: 1. Autonomy, Choice, Rights; 2. Admission, Transfer, Discharge, Eviction; and 3. Care. Together, the three categories made up approximately 65% of residential care home and assisted living residence complaints. The top three major complaint categories for FY 2021 are the same as previous reporting period.

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

Major Complaint Category	Total Complaints	Percent (%)
Autonomy, Choice, Rights	25	27.5%
Admission, Transfer, Discharge, Eviction	20	22.0%
Care	14	15.4%
Financial, Property	8	8.8%
Abuse, Gross Neglect, Exploitation	7	7.7%
Access to Information	4	4.4%
Dietary	4	4.4%
System: Others (non-facility)	3	3.3%
Environment	2	2.2%
Facility Policies, Procedures and Practices	2	2.2%
Activities, Community Integration and Social Services	2	2.2%
Complaints about an Outside Agency (non-facility)	0	0%
Total	102	100%

C. Home and Community-Based Cases and Complaints

In FY 2021, ombudsmen worked on 53 CFC community-based cases, which involved 65 complaints. Most home and community-based complaints made in FY 2021 concerned home health agencies. Home health agencies (HHA) provide long-term care services and supports to CFC participants living in community setting.

The majority of HHA complaints received by the VOP concerned staffing – specifically that the HHA were not filling the hours of a CFC participant's service plan. It is not unusual for the VOP to receive home and community-based complaints alleging that HHA are not providing the services that participants require to remain living in the community safely.

When assisting CFC participants with the staffing issues, ombudsmen have at times been told by HHA 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 HHA "shall provide or arrange for the provision of all designated services" to all persons eligible, and accepted, for services within an HHA's service area.[1] Despite the best efforts by ombudsmen, there are CFC participants who receive less home health services then have been approved for under their service plan.

In addition:

- CFC participants reported frequent "no-shows" (along with last-minute cancellations) by HHA staff. No-shows and cancellations leave vulnerable individuals in situations that jeopardize their health, safety, and overall well-being.

- The VOP has received reports of CFC participant's service hours being reduced or completely stopped.

- VOP was surprised to learn that two different HHA each requested a 60-day pause for some of the services which they provide. The requests were received by the Department of Disabilities, Aging, and Independent Living (DAIL) in late 2021.

    - VNA #1 requested a 60-day pause for personal care, respite, and companion services for new clients**.** The HHA's request was made in October and granted by DAIL. The pause was to be reevaluated in December 2021.

[1] REGULATIONS FOR THE DESIGNATION AND OPERATION OF HOME HEALTH AGENCIES, Section VIII, Required Functions and Administration, Section 8.2.

- VNA #2 requested a pause in homemaker services for 60 days as of 8/27/21 due to lack of staffing. The request was granted by DAIL. The VNA requested a 60-day extension.

Major complaint categories for "Other Complaints" (which includes home and community-based complaints) are shown in the table below (along with total and percentage for each category).

Major Complaint Category	Total Complaints	Percent (%)
Care	25	37.3%
Complaints about an Outside Agency	11	16.4%
System: Others	10	14.9%
Admission, Transfer, Discharge, Eviction	8	11.9%
Autonomy, Choice, Rights	8	11.9%
Financial, Property	2	3.0%
Environment	2	3.0%
Provider Policies	1	1.5%
Total	67	100%

6. Complainant categories

- Approximately 46% of complainants were residents and CFC participants.
- A close contact of the resident or CFC participant was also a large category (39.6%) of complainants.
- 96% of the complaints came from four categories of complainants.

The table below shows the categories of complainants by setting for FY 2021 (along with the total, and percentage, for each category of complainant).

Who made complaints in FY2021?					
Complainant	**Nursing Home**	**Residential Care/ Assisted Living**	**Community Setting/Other**	**Total Complaints Made**	**% Of Total Complaints Made**
Resident/participant	92	51	47	**190**	**46.1%**
Resident representative Relative/Friend, Family	125	26	12	**163**	**39.6%**
Unknown	14	10	3	**27**	**6.5%**
Representative of other agency or program or org.	12	2	3	**17**	**4.1%**
Facility staff	8	2	1	**11**	**2.7%**
Other – concerned person not listed	1	0	1	**2**	**0.5%**
VOP	1	0	0	**1**	**0.2%**
Ombudsman/ombudsman volunteer	1	0	0	**1**	**0.2%**
Total	**254**	**91**	**67**	**412**	**100%**

7. Ombudsmen complaint summaries

Below are examples of the kinds of work done by local ombudsmen during FY 2021.

- The wife of a residential care home (RCH) resident contacted the Ombudsman program to share concerns over drastic changes to family visits with her husband. The husband suffered from severe aphasia and dementia. He benefited greatly from his wife's visits, along with the outdoor art projects and dancing they did together. The wife was told by the RCH on several occasions it wasn't "fair" for the resident to receive so many visits when other residents had

no family to visit. The local ombudsman reached out to the owners of the RCH to discuss the decision and current Centers for Medicare and Medicaid (CMS) guidelines. The owner quickly apologized and admitted the pandemic had affected their judgement and would reverse the decision immediately. The family was happy with the outcome and the relationship with the RCH was maintained.

- The representative of a home and community-based CFC participant contacted an ombudsman because of an unexpected change in the participant's care plan. Among the changes made to the care plan was the discontinuation of an activity (assisted walking) viewed as very important to the participant's care and quality of life. The ombudsman was told that the care plan change was made unilaterally by the home health agency, without consultation with the participant – the representative was completely caught off guard by the changes. The representative indicated that this was not the first time that changes were made to the participant's care plan without the representative's input and with no advance notice. The ombudsman contacted the home health agency. A meeting was held with the home health agency staff, case manager, the participant's representative, and ombudsman. At the meeting, the home health agency agreed to reconsider the change in the care plan. In its reconsideration, the home health agency agreed to get the representative's input and review written information provided by the participant's primary care provider. Following the home health agency's reconsideration, the participant's care plan was restored to what it had been previously (including restoration of assistive walking).

- An ombudsman was contacted by a resident of a skilled nursing facility regarding an unsafe discharge. The resident was about to be discharged - however, she had not yet had a discharge meeting; a home health agency referral had not been made; assistive equipment for the home had not been ordered; and there were no resources for private duty care. The resident was wheelchair bound and unable to transfer independently. The resident shared with the ombudsman that she was going to ask the bus driver to put her into bed with no plan after that for her care. The ombudsman immediately contacted the business office and social worker to create a plan for a safe discharge. The resident discharged a week later safely with all needed services in place.

- A home and community-based CFC participant and her son sought assistance from an ombudsman because both felt a home health agency had been given enough time to staff the participant's service plan but had failed to do so. The home health agency continued to give the participant reasons as to why a service plan could not be staffed. The participant indicated that each time she asked the home health agency about her service plan, she was told to give the home health agency "two weeks" to get staffing in place. The participant had been approved for CFC six weeks prior (and had spent a week in a nursing home, as respite, due to a lack of staffing). The ombudsman spoke with a scheduler. The ombudsman was ultimately able to get the HHA to staff the participant's service plan.

- An ombudsman was contacted after a resident received a 30-day involuntary discharge notice. The resident had advanced dementia. After speaking with the ombudsman, the resident's representative (the daughter of the resident) understood her mother's rights. The ombudsman also observed that the discharge notice issued by the facility did not comply with Vermont regulations. The ombudsman realized that the facility would have to give the resident a new discharge notice. The ombudsman contacted the facility to ask about the involuntary discharge. The ombudsman asked staff if an involuntary discharge was appropriate. She asked the facility what efforts, interventions, and changes had been tried before deciding to involuntary discharge the resident? Why did the facility believe that another residence would be a better placement for the resident? It was agreed that the resident would be evaluated by a geriatrician. Afterwards, the resident's medications were changed - and the resident's behaviors improved. The facility did not proceed with the involuntary discharge and the resident remained at the facility.

- A home and community-based CFC participant contacted an ombudsman because he felt pressure to accept caregiving from an aide he did not trust. The participant was happy with his current caregivers; however, he was recently told that he should be open to receive care from another caregiver who he did not trust or feel safe with. The ombudsman scheduled a meeting with UVMHH, Age Well, and the participant (the ombudsman also attended). The meeting allowed the parties to express their feelings, and also provided an opportunity for the participant and providers to learn about each other (for example, the participant learned how the providers went about responding to calls for care and scheduling caregivers). After the meeting, the participant decided to receive his care during the third shift. The caregiver, who the participant expressed concerns about, did not work during the third shift.

- A hospitalized resident of a residential care home was cleared by a doctor to return to home. On her way home, the resident was informed by the administration from the residential care home that she would not be allowed to return. After receiving the unexpected news, the resident requested assistance from an ombudsman. The resident wanted to return to the residential care home. The ombudsman contacted the facility on the resident's behalf. She asked if the resident's rights would be honored, specifically, would the resident be allowed to remain at the facility while an appeal of the involuntary discharge was decided? The residential care home informed the ombudsman that the resident would not be allowed to return. Because the home would not allow the resident to return, she was forced to live at the hospital (without having any acute medical needs). The resident spent months living at the hospital. Finally, the resident was able to secure placement at an adult family care home due to the combined efforts of the ombudsman, hospital, and the State's complex care team. The situation above is not uncommon.

- A husband and wife moved to a shared campus long-term care community. The campus had an assisted living and a nursing home. The couple moved to the community in order to remain together. The wife required a higher level of care. She resided in a memory care unit within the nursing home, while her husband was in assisted living. Because of COVID-19 the husband and wife were told that their visits with each other could not be in-person. An ombudsman was asked to help. It took some time, but the ombudsman's knowledge of Vermont's COVID-19 guidance to long-term care facilities resulted in the facility understanding that the couple could visit with each other in-person.

- A shared living provider (SLP) alleged that a care coordinator from a designated agency intentionally sent a CFC home and community-based participant (who was living at the SLP's adult family care home under a housing agreement) to the ER/hospital for the sole purpose of getting the CFC participant out of the SLP's home. From the perspective of the SLP, the designated agency sent the CFC participant to the hospital instead of working further with the CFC participant. The participant was not able to return to the adult family care home.

- A home and community-based CFC participant contacted an ombudsman because her service plan was not being staffed fully by the VNA serving her county. The participant told the ombudsman that the VNA was inconsistent, at best, with providing staff for the participant's service plan. Further, the VNA was not providing any staff on weekends (both Saturday and Sunday). The ombudsman called the VNA. She was told that the VNA had an agency wide PCA storage (the VNA stated that they were having "tremendous difficulty" hiring PCAs – and indicated that another VNA was experiencing the same). Due to the PCA shortage, the VNA stated that it had to reduce services and prioritize clients by assessment of their need. As a result, most of their clients would experience a reduction in service plan hours.

- An ombudsman received a call from the administrator of an RCH, concerning a long-time resident, who was reportedly prone to angry outbursts. The outbursts frighten other residents. The resident had a severe stroke which left him with very limited verbal communication. The ombudsman scheduled a time to meet with resident and his guardian. The resident used a communication device, gestures, and pantomime to convey his thoughts. The resident expressed frustration about the facility's cook and the food (he found the food bland and the menu redundant). He shared some pictures of foods and described his culinary preferences. In addition, the resident communicated to the ombudsman that aides would put away his clothes whenever he was showering. The resident wanted to do this himself – plus the aides were combining his dirty clothes with clean clothes. This upset the resident. The ombudsman received permission to speak with the facility's staff in order to share with them what she had learned from the resident. The ombudsman later met with the resident and guardian a second time. At the meeting, the resident communicated that he,

along with three other residents, had met with staff about the food. The resident expressed upbeat feelings about the meeting. He felt that he and the other residents had been listened to, and since the meeting there, had been some very positive changes at the facility.

- An ombudsman was contacted by a home and community-based CFC participant about his powerchair. The participant experienced issues with the powerchair since receiving it. The participant felt the powerchair was defective and unsafe. On multiple occasions, the participant contacted the durable medical equipment provider about the powerchair He was not satisfied with their responses to his complaints. The ombudsman spoke with a staff member of the Disability Law Project (DLP) at Vermont Legal Aid about the participant's powerchair issues. The DLP offered to assist the participant.

- An ombudsman was contacted by the power of attorney (POA) of a home and community-based CFC participant. The POA reported that the home health agency had informed the POA that the participant would not receive CFC services after 11.5.2020. The ombudsman spoke with the participant by phone. The ombudsman received the participant's newly approved service plan (which had been approved by DAIL) and contacted a case manager supervisor. The case manager supervisor reviewed the service plan and contacted the home health agency. The home health agency then reinstated the participant's services.

8. Non-complaint activities performed by ombudsmen

In addition, working on cases and complaints, ombudsmen **also**:

- Provide residents, CFC 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.
- Educate facility and home health staff on resident rights and the role of the VOP.
- Perform general visits at facilities.
- Assist residents with advance directives.

The VOP hopes that conditions will allow for us to safely make regular in-person visits at nursing homes, residential care homes, and assisted living residences. In the meantime, the VOP will continue to work creatively to ensure that we regularly connect with residents and CFC participants.

The table below summarizes some of the activities performed by ombudsmen.

Snapshot of Non-complaint Related Activities	
Activities	**Number of Instances**
Consultations to Individuals	563
Consultations to Facilities/Agencies	164
Pandemic outreach calls to LTC facilities	162
Facility visit/routine access (pre-pandemic)	3
Facility visit/casework (pre-pandemic)	1
Assist with Advance Directives	11
Total	**904**

Thank you Volunteers!

Laurie Boerma
Ann Crider
Paula DiCrosta
Nancee Schaffner

9. Project volunteers

The Vermont LTC Ombudsman Project relies on volunteers to help us with assist residents and CFC participants with their issues and concerns. In FY 2021, volunteers contributed 68 hours to the program. Volunteers enable the project to maintain a greater presence in Vermont's long-term care facilities (there are currently 158 facilities). Volunteers do the work of paid ombudsmen, including responding to individual complaints and monitoring conditions in long-term care facilities. Before becoming an official volunteer of the project, trainees must complete a comprehensive training program. The training program for all volunteers includes 20 hours of classroom training and independent study. In addition to the classroom and independent study requirements, a 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.

10. Project funding

The project received $812,698 from DAIL to provide ombudsman services in the state. Funding included both state and federal monies, as shown below:

- $89,269.00 OAA Title VII, chapter II
- $223,614.00 OAA Title IIIB
- $311,471.00 Medical Assistance Program (Global Commitment)
- $88,344.00 State General Funds
- $100,000.00 CARES ACT for the Ombudsman Program under Title VII of the OAA

- $812,698.00 Total

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, visits with residents and CFC 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 2021, representatives of the Office served on the Self-Neglect Working Group and Vermont Vulnerable Adult Fatality Review Team.

On the federal level, the LTC Ombudsman Project has worked with other state ombudsman programs (through our affiliation with the National Association of State Ombudsman Programs) on many fronts, including advocating for the reauthorization of the Older Americans Act to strengthen and protect State Long-Term Care Ombudsman Programs.

12. Issues and Recommendations

Listed below are the priority issues identified by the Vermont Long-Term Care Ombudsman Project, along with our recommendations to the state legislature:

A. Staffing shortages at LTC facilities and home health agencies.

Staffing was an issue prior to COVID-19. The pandemic has exacerbated the issue. Inadequate staffing levels at long-term care facilities and home health agencies continues to be a significant problem for the individuals served by the VOP. Proper staffing and appropriate training are critical to quality care for all individuals receiving long-term care services and supports. Staffing shortages at LTC facilities and HHA requires urgent attention by policymakers.

Recommendations

- Vermont should determine the extent to which HHA are providing all designated services to all eligible and accepted CFC participants within each of the HHA's service area; and also evaluate the impact of the lack of designated services being provided to eligible and accepted CFC participants.

- Vermont should explore ways to ensure that the pay of staff increases. Suggestions have included hazard pay, health care coverage, and paid sick leave (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 participants.

- Vermont should establish minimum nurse and nurse aide staffing standards.

B. Quality of Care.

Ombudsmen are concerned about the quality of care being provided to residents and CFC participants due to a continued focus on COVID-19. In addition, COVID-19 precautions and restrictions has meant that friends, family and concerned persons have had less in-person contact with residents and CFC participants. While we understand that providers have been doing their very best during difficult times, ombudsmen have heard from so many residents, CFC participants 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 HHA.

- Vermont should require LTC providers to increase quality transparency.

- Vermont should enable better enforcement and quality improvement through regulatory reform.[2]

- 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 a nursing home; and modification of the current Division of Rate Setting rules.[3] Both recommendations could have meaningful impacts on quality of care for nursing home residents.

[2] Before COVID-19, Vermont was in the process of drafting critical revisions to the State's residential care home and assisted living regulations. The revision of these regulations remains paused due to the pandemic. We believe that this important work must be restarted and the sooner the better.

[3] https://legislature.vermont.gov/assets/Legislative-Reports/Act-125-Nursing-Home-Oversight-Final.pdf

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

The continued impact of COVID-19 necessitates that providers address loneliness and social isolation with residents and home and community-based CFC participants – it is important for all of us to learn more about their personal experiences, feelings, and thoughts about loneliness and social isolation.

Recommendations

- Vermont must encourage providers to assess each resident and CFC participant 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, participant, and family input on social activities and ways to connect with other people.

- 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 encourage LTC facilities to find ways in which residents can leave their room every day and go outside if they wish.

- 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.

Respectfully Submitted,

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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 DAIL (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 (CFC) 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) & Appendix 3 (DAIL Conflict of Interest Letter)

STAFF ROSTER

Vermont Long-Term Care Ombudsman Project

January 2022

State Long-Term Care Ombudsman:

Sean Londergan
264 North Winooski Avenue
Burlington, VT 05401
802.383.2227
slondergan@vtlegalaid.org

Local Ombudsmen:

Katrina Boemig **(Windham & Windsor Counties)** 56 Main Street, Suite 301 Springfield, VT 05156 Phone: 802.495.0488 Fax: 802.885.5754 kboemig@vtlegalaid.org	Michelle R. Carter **(Washington & Addison Counties)** 56 College Street Montpelier, VT 05602 Phone: 802.839.1327 Fax: 802.223.7281 mcarter@vtlegalaid.org * Also covers: Rochester, Hancock, Pittsfield, Stockbridge & Granville	Dawn Donahue **(Orange and Lamoille Counties)** 177 Western Ave., Suite 1 St. Johnsbury, VT 05819 Phone: 802.748.8721 Fax: 802.748.4610 ddonahue@vtlegalaid.org
Alice S. Harter **(Essex, Orleans, & Caledonia Counties)** 177 Western Ave., Suite 1 St. Johnsbury, VT 05819 Phone: 802.424.4703 Fax: 802.748.4610 aharter@vtlegalaid.org	Alicia Moyer **(Chittenden & Franklin Counties)** 264 N. Winooski Avenue Burlington, VT 05401 Phone: 802-448-1690 Fax 802.863.7152 amoyer@vtlegalaid.org	Kerry White **(Rutland & Bennington Counties)** 1085 Route 4, Suite 1A Rutland, VT 05701 Phone: 802.855.2411 Fax: 802.4486944 kwhite@vtlegalaid.org

VERMONT

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Commissioner's Office
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Agency of Human Services

January 13, 2022

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

Dear Mr. Londergan,

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 January 13, 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,

Mónica White
DAIL Commissioner

Cc: Jeanne Hutchins, Chair DAIL Advisory Board
Conor O'Dea, State Unit on Aging, DAIL