Special Review

Office of the State Auditor

Caring for Our Elders

Improving Nursing Home Care

A Review of the Oversight and Inspection of Nursing Homes by the Department of Aging and Disabilities

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Vermont State Auditor

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Mission Statement

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by the Department of Aging and Disabilities

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"You know, they haven't
developed a cure for old age yet."

- Margaret Perry, owner,
McGirr Nursing Home, Bellows Falls

Message from the State Auditor

Healthy people probably think of a nursing home the same way they view emergency rooms: "I'll never have to go there."

But life has a way of surprising us. And if we do visit an emergency room, or someday find ourselves living in a nursing home, one thing is sure: we'll want to be helped by experienced, compassionate professionals in a facility that gets high marks for its quality of life and quality of care.

Nursing homes, of course, are not the preferred living choice for everyone, but many Vermonters and their families are grateful for that option. With the population of people older than 65 expected to double in the next 20 years, thousands of Vermonters will surely need help with long-term care, and some of that care will take place in nursing homes. In fact, national experts estimate that 43 percent of people 65 years of age today will spend some time in a nursing home.

Last summer, workers at a central Vermont nursing home made headlines by pointing out that the home's chronic staffing shortages were putting the health of patients at risk. They blew the whistle on an unsafe situation.

A group of legislators also heard the nursing home workers. They asked my Office to examine State government's licensing, inspection and funding of nursing homes and how the State handles complaints of poor care.

We formally engaged Vermont's Department of Aging and Disabilities (DAD) on November 6, 2001. A week later DAD Commissioner Patrick Flood personally conducted a surprise investigation of that Central Vermont nursing home. The Commissioner found that nurses were sometimes caring for 12 to 14 residents each, about twice the number recommended by state guidelines. The Commissioner fined the home $3,000 in December and demanded increased staffing.

Vermont has a reputation of doing things a little bit differently than the rest of the country and my Office found this approach holds true regarding nursing homes and other long-term care issues.

Vermont has 45 licensed nursing homes with about 3,500 beds, serving 5,000 Vermonters a year. The people who work in them care very much for the well-being of their residents. However, not everything is perfect in Vermont nursing homes. Nursing home administrators worry about over-regulation and reimbursement levels from State government, and how to attract and keep good employees. Workers in some homes are concerned about their heavy workloads, low wages and the lack of affordable health insurance and other benefits.

But the good news is that problems of gross neglect, physical abuse and patient danger in Vermont nursing homes are rare.

Other states, though, have more serious problems. Florida, with almost 70,000 nursing home residents, is facing enormous challenges with staffing levels, quality concerns, abuse charges, and a crisis in the cost of liability insurance due to an avalanche of lawsuits. People are so concerned about the quality of care their relatives receive in nursing homes that they have asked the Florida Legislature to permit video surveillance of nursing home rooms by "granny cams" to document the kind of care people get.

In February the federal government announced the results of a multi-state study of nursing homes which concluded that 9 out of 10 nursing homes are understaffed, causing many residents to linger in their beds without proper care for bedsores or incontinence, risking more falls because no aide is nearby, and going longer without bathing and other care. Vermont nursing homes, in general, do not suffer from these staffing problems.

Though we noticed some strains and stresses in Vermont's nursing home system, there are achievements and new quality initiatives which Vermonters can take pride in.

For example, our review found that:

- The number of nursing homes showing "substantial compliance" with federal quality requirements is above the national average;
- None of last year's nursing home inspections showed a substandard quality of care;
- There were just eight isolated deficiencies indicating actual harm to a resident in last year's inspections;
- There have been only three criminal convictions for abuse in nursing homes in the past two years;
- Our nursing home "surveyors," or inspection teams, are doing a thorough job and help to educate nursing home administrators about meeting safety and quality requirements;
- The State Legislature supported under-paid nursing home workers by approving wage supplements totaling almost $8 million for the last two fiscal years; these funds, in almost every instance, have been spent properly by nursing homes;
- The State's Department of Aging and Disabilities and the nursing home industry have developed a new customer satisfaction survey program (posted on the Internet) that reports how current and former nursing home residents in many of our nursing homes rated their care;

- Investigations of allegations of abuse of nursing home residents are conducted in a timely manner;

- Nursing homes report that they are meeting the State's new staffing guidelines of three hours per day of direct care for each resident; and,

- The State is funding new pilot projects in Alzheimer care training, end-of-life care, and in reducing employee turnover that could benefit the entire nursing home system.

Our review also found areas of concern, as well as specific instances where state agencies could improve their work with Vermont's nursing homes. We found that:

- Federal inspection requirements do not allow alternative inspection methods that could provide more inspections of problem facilities and fewer inspections of top performers;

- As the demand for more nursing home inspections increases (at a cost of $3,000 to $5,000 per inspection), funding is not keeping pace;

- Inspection teams, composed almost entirely of registered nurses, could benefit from the inclusion of social workers, rehabilitation specialists, or dieticians if funding was available;

- Quality awards totaling $500,000 were given by the State to 15 nursing homes in the past three years without a financial reporting requirement to detail how the money was spent;

- Advertising of toll-free numbers for complaints should be improved; and,

- Results of the State's new nursing home "resident satisfaction survey" are hard to find on the State's website, and are not otherwise publicized well.

Our report notes that the work of direct care staff is critical to the delivery of quality medical and other services in a nursing home. However, this work is a constant and demanding challenge. Licensed nursing assistants (LNAs), also known as nurses' aides, provide most of the direct care in Vermont nursing homes - they comprise about 65 percent of the direct care workers. Registered nurses (RNs) comprise 15 percent and licensed practical nurses (LPNs) about 20 percent of the direct care workforce.

Nursing assistants face physically-demanding tasks for low wages, often with minimal benefits, and few career advancement opportunities. Back injuries are common. (Nursing homes have a high rate of ergonomics injuries, along with auto production, parcel delivery, meat and poultry packing plants.)

Vermont surveys show that nurses' aides are typically women with high-school educations who have been employed for less than five years. They earn less than $9 an hour after one year on the job. High turnover of nurses' aides affects the care patients receive, so it is troubling that in a recent survey by the Vermont Department of Health, 630 out of 2,507 nurse aides surveyed said they were likely to leave their job within 12 months.

If we treasure our elderly citizens, we must do a better job of rewarding nurses' aides - with better pay, paid sick days, health insurance and other benefits. Studies show that better compensation helps to reduce turnover rates; low turnover rates increase the quality of care in a nursing home.

Inadequate health insurance for nurses' aides also poses risks for residents. It is dangerous for patients to be cared for by people who don't go to the doctor when they're sick because they can't afford it, or because they don't have paid sick leave.

Outside of the scope of this review are concerns about future State policy that deserve mention.

Funding is a key concern. As the State budget tightens, State spending for nursing home care will be under great pressure. Commissioner Flood reported to Vermont seniors in the Spring 2002 issue of *The Elders Advocate*: "We must reduce nursing home expenditures by approximately $4 million this year, and $4 million again next year. This $8 million includes the federal Medicaid match, so it represents about $3.2 million in State dollars."

With the current worsening state revenue picture, these cuts might increase.

Vermont should also be concerned with the trend toward fewer Medicaid bed days and higher nursing home vacancy rates.

The increase in nursing home vacancy rates could cause a few more homes to close. (Three have shut down in the last two years, and during the last six years, a total of 257 beds have closed.) State leaders may wish to plan an orderly reduction of licensed Medicaid nursing home beds to minimize impacts to residents, workers, owners, and local communities.

The increasing number of seniors on Medicaid opting for long-term care services in their own homes presents another policy challenge. Private homes are not licensed or held to the high standards that a nursing home currently faces. The State will have to determine, absent new federal requirements and funding, what new inspections, if any, it should provide for long-term home care.

If we treasure our elderly citizens, we must do a better job of rewarding nurses' aides - with better pay, paid sick days, health insurance and other benefits. Studies show that better compensation helps to reduce turnover rates; low turnover rates increase the quality of care in a nursing home.

Despite possible adjustments in numbers, nursing homes will be a part of the long-term care picture in Vermont. We must help keep them places of high quality, where residents are valued and cared for well, and where tax dollars are spent effectively. Nursing home workers must be able to earn a living wage with good benefits and enjoy educational and advancement opportunities.

It is my hope that this nursing home review will help to educate Vermonters and policymakers about recent positive changes in nursing homes as well as new challenges facing nursing homes, workers, residents and state regulators.

We must be remain determined to address the needs of older Vermonters in nursing homes. As *The Boston Globe* editorialized on March 3, 2002, "Improvements in nursing homes will come when the wider society pays proper attention to an institution that cares for people at the margins of life."

Sincerely,

Elizabeth M. Ready

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Vermont State Auditor

We must help keep nursing homes places of high quality, where residents are valued and cared for well, and where tax dollars are spent effectively. Nursing home workers must be able to earn a living wage with good benefits and enjoy educational and advancement opportunities.

Key Abbreviations Used in this Report

AHS - Agency of Human Services

APS - Adult Protective Services

CMS - Centers for Medicare and Medicaid

DAD - Department of Aging and Disabilities

DLP - Division of Licensing and Protection

DRS - Division of Rate Setting

MDS - Minimum Data Set

HCFA - Health Care Financing Administration

HHS - U.S. Department of Health and Human Services

HRD - Hours/per resident/per day

MFRAU - Medicaid Fraud and Residential Abuse Unit

PATH - Department of Prevention, Assistance, Training and Health Access

PERC - Project Elder Reach Committee

VCIC - Vermont Criminal Information Center

Summary: Findings & Recommendations

Finding 1

The nursing home oversight process follows a highly proscribed federal survey process, which has numerous internal controls. These federal survey requirements leave little room for implementation of innovative or risk-based survey methodologies. Surveyors from Vermont's Division of Licensing and Protection have consistently met these requirements despite ongoing funding problems and also being responsible for inspection of a wide range of medical facilities in the state with unique guidelines.

Finding 1b

The percentage of Vermont nursing homes rated as in "substantial compliance" with guidelines has declined in recent years, but is still above the national average.

Recommendation 1

The Department of Aging and Disabilities should continue to advocate with the federal Centers for Medicare and Medicaid (CMS) to allow for licensing and survey processes that are more correlated to lack of quality and resident risk than regulatory proscription. One alternative inspection program suggested by the Department would require 75 percent of inspections to be conducted according to federal guidelines, but the remaining 25 percent could be performed using an alternate, less costly but nevertheless effective manner such as spot checks.

Finding 2

Vermont surveyors appear to be in substantial compliance with regulations regarding the standard surveys as currently conducted. However, we noted concerns in two areas:

- *Documenting surveyor conflicts of interests; and,*
- *Documenting on-site observations and "initial tour" data in the permanent survey file.*

Recommendation 2

DLP should develop, and require surveyors to annually update, a conflict of interest disclosure form.

Recommendation 2a

DLP should improve its procedures for surveyors to both note and file information about infections, or the absence of infections, gained from the Initial Tour and the general observations phase of each survey conducted.

Finding 3

The Division of Licensing and Protection's control system for monitoring and tracking complaints has minor flaws and should be improved with the introduction of a federal automated complaint tracking system tentatively scheduled for the fall of 2002.

Recommendation 3

Documentation should be provided when the surveyor opts against conducting an on-site investigation of a complaint.

Recommendation 3a

Complaint investigators should interview the ombudsman as well as the subject of the complaint in all investigations when possible.

Finding 4

Inter-agency cooperation in investigating and prosecuting allegations of abuse, neglect or exploitation is good. However:

- *Routine inter-agency communication which helps investigators spot potential problems is often slow;*
- *Investigative resources are reported to be inefficiently deployed on occasion; and,*
- *24-hour toll-free abuse and complaint reporting lines are promoted in a low-key way.*

Recommendation 4

DLP, DAD and MFRAU should develop new procedures for more efficient and timely inter-agency communication.

Recommendation 4a

DLP, MFRAU and other agencies involved in investigations of alleged nursing home abuse should study the feasibility of adopting a single, universal investigator's report or system that could use investigative resources more efficiently.

Recommendation 4b

DAD, DLP, the Office of Professional Regulation and the Attorney General's Office should create a fatality review committee for untimely and unexplained deaths in nursing homes and other elder care facilities.

Recommendation 4c

DAD, DLP and the Vermont Health Care Association should adopt a program to more widely distribute the telephone numbers for reporting abuse allegations or nursing home complaints.

Finding 5

All nursing home prospective employees get a Vermont convictions record check and an Vermont abuse registry check. Licensed professionals may get further scrutiny if they have worked in another state. Inspection teams typically review a nursing home's abuse prevention protocols during surveys. The goal of reducing the risk of abuse in nursing homes could be aided by requiring an additional national criminal background check on all nursing home employees.

Recommendation 5

State nursing home regulators should consider a national criminal background check requirement for all licensed and non-licensed nursing home workers, at no cost to the prospective employee, which could better prevent abuse and help assure higher safety for nursing home residents.

Finding 6

Incentive awards promote efforts to achieve higher quality in nursing homes, but benefits are hard to measure as recipients of the $25,000 annual awards do not have to file expenditure reports.

Finding 6a

New grant initiatives aim to improve Alzheimer's care, end-of-life care, and employee retention.

Recommendation 6

DLP and the Vermont Health Care Association should consider new award criteria addressing staffing and turnover ratios.

Recommendation 6a

DAD should require nursing homes receiving $25,000 quality awards to provide timely, detailed reports on how funds are spent.

Recommendation 6b

DAD should work to see that all nursing homes participate in the Resident Satisfaction Survey so they will be eligible to compete for the quality awards.

Recommendation 6c

DAD grant initiatives should have clear, measurable goals; projects should be evaluated periodically as to results that have been achieved; results and suggestions should be widely shared.

Finding 7

New minimum staffing regulations for nursing homes went into effect December 15, 2001, to help assure that nursing home residents will not be harmed due to inattention. Nursing homes are meeting the new standards and initial data reporting difficulties are being addressed and reduced.

Recommendation 7

None.

Finding 8

The Division of Rate Setting reports that nursing home wage supplements authorized by the Legislature are being used as intended. However, the State has no scientific survey method to determine how the rate of employee turnover (and impact on quality) might be affected by wage increases.

Recommendation 8

DRS and DAD should adopt more precise survey instruments to gauge turnover in the nursing home industry.

Recommendation 8a

DAD should advocate for wage enhancements that achieve a true living wage for direct care workers.

Finding 9

The Nursing Home Customer Satisfaction Survey is a positive step forward in helping consumers determine quality nursing facilities and helping providers to improve performance in key areas.

Recommendation 9

While continuing to update each facility's customer satisfaction survey, more efforts, such as periodic regional news releases, should be taken to alert the public as to results, and results should be posted more prominently on the DAD website. The website should also be evaluated for its ability to reach people.

Recommendation 9a

DAD should work to bring all nursing homes into the customer survey program so that Vermont consumers can compare all nursing homes.

Purpose, Scope & Methodology

Purpose

The Office of the State Auditor has conducted a review of the State's licensing, regulation, funding and oversight of nursing homes. This review was at the request of Senators Vincent Illuzzi and Janet Munt and Representatives Elaine Alfano, Steve Hingtgen, Robert Kiss, Michael Obuchowski, Donny Osman and David Zuckerman.

Authority

This review was conducted pursuant to the State Auditor's authority contained in 32 V.S.A. §§163 and 167, and was performed in accordance with the Government Auditing Standards issued by the Comptroller General of the United States whose goal is to provide reliable financial and performance information to meet the demands for a more responsive and cost-effective government.

Scope and Methodology

The scope of the review included an evaluation of the State's compliance and internal controls for licensing, regulating, funding and overseeing nursing homes.

The methodology involved a review of relevant laws, rules, regulations, policies, contracts, internal memoranda, and correspondence. We interviewed key personnel from the Division of Rate Setting and the Department of Aging and Disabilities including employees of the Division of Licensing and Protection. We also consulted the Long-Term Care Ombudsman and the Executive Director of the Vermont Health Care Association. We participated in portions of an annual nursing home survey including pre-planning. Our test work involved a review of the complaints log and a random review of complaint files. We reviewed inspection reports for several Vermont nursing homes. Finally, we reviewed various quality initiatives and a variety of supporting data.

A review differs substantially from an audit conducted in accordance with applicable professional standards. The purpose of an audit is to express an opinion. The purpose of a review is to identify findings and observations and to make recommendations so that the reviewed agency can better accomplish its mission and more fully comply with laws, regulations, and grant requirements. This review relied upon representations of, and information provided by a variety of State employees as well as upon discussions with nursing home administrators and others knowledgeable about the industry. If an audit had been performed, the findings and recommendations might or might not have differed.

Findings & Recommendations

Finding 1

The nursing home oversight process follows a highly proscribed federal survey process, which has numerous internal controls. These federal survey requirements leave little room for implementation of innovative or risk-based survey methodologies. Surveyors from Vermont's Division of Licensing and Protection have consistently met these requirements despite ongoing funding problems and also being responsible for inspection of a wide range of medical facilities in the state with unique guidelines.

Finding 1a

The percentage of Vermont nursing homes rated as in "substantial compliance" with guidelines has declined in recent years, but is still above the national average.

Discussion

The procedures for conducting nursing home surveys are promulgated by the Department of Health and Human Services' Center for Medicare and Medicaid Services (CMS), which was formerly the Health Care Financing Administration (HCFA).[1]

The Social Security Act, which governs the funding of nursing homes, requires an unannounced standard survey of each skilled nursing facility at least every 15 months. The statewide average interval of surveys must not exceed 12 months. "Any individual who notifies a skilled nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000."[2]

The survey must include, for a case-mix sample, the following:

- A survey of the quality of care, as measured by a variety of quality indicators and the sanitary and physical conditions of the environment;
- An audit of the accuracy of resident assessments and the adequacy of the plans of care; and,
- A review of compliance with residents' rights requirements.[3]

In Vermont, annual surveys are conducted over three or four days by teams of three to four nurse surveyors from DLP. Federal regulations require surveyors to successfully complete the CMS-approved training and testing program that can take up to a year to complete.

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[1] This name change occurred July 1, 2001. Some regulations, website and documentation still refer to the office as HCFA. Throughout this review we have referred to the office as CMS but used whichever name is actually listed on any document we reference.

[2] 42 U.S.C. 1395i-3 (g)(2)(A)(i).

[3] 42 U.S.C. 1395i-3 (g)(2)(A)(ii).

The policies and protocols that the survey team must follow for certifying skilled nursing facilities and for periodic inspections, or "surveys," are proscribed in extensive detail in the *State Operations Manual* published by CMS/HCFA. Chapter 7 of the Manual, which details the survey and enforcement process for nursing facilities, is 74 pages long. Appendix P, which details the survey protocol for long-term care facilities, provides 79 pages of single-spaced directives.

"It is not surprising that a study commissioned by the federal government shows that nine out of 10 nursing homes are understaffed. These essential institutions rarely get the attention they deserve from families until a prospective patient is elderly, infirm, and not in a condition to shop for adequate care. Younger people need to demand better staff ratios and reimbursement rates if conditions are to improve for their parents and, eventually, themselves."

- *Boston Globe* Editorial, March 3, 2002

The protocol includes seven specific tasks that must be performed as part of a standard survey. These tasks are:

Offsite survey preparation - This includes a review of the home's quality indicators, each resident's MDS (or minimum data set, which is essentially the assessment of their condition), previous complaints and surveys and contacting the long-term ombudsman to identify any additional areas of concern.

Entrance conference - The team coordinator meets with the facility's administrator and requests the actual work schedules for the survey time period as well as the previous two weeks. The administrator is handed a large notice that the survey is underway which is then posted in a number of conspicuous locations at the facility.

Initial tour - This occurs concurrently with the entrance conference.

Sample selection - The team makes a final determination regarding which residents and family members to interview and the closed records requiring review.

Information gathering - This includes general observations, kitchen and food service inspection, resident review, quality of life assessment, medication pass, quality assessment and assurance review and abuse prevention review. State rules provide detailed investigate protocols for each of these components.

Information analysis for determination of deficiencies - Reports of any deficiencies found on a survey are available to the public. The type, severity and preponderance of each deficiency is categorized and reported to CMS, the facility and any other interested party. Each deficiency is cited with a tag number identifying the concern and a letter designation from A to L representing the severity and prevalence. Letters closer to the beginning of the alphabet reflect less severe infractions while J, K and L represent immediate jeopardy to resident health or safety.

Exit conference - The general objective of the exit conference is to inform the facility of the survey team's observations and preliminary findings. The ombudsman and an officer of the organized residents group, if one exists, are invited, too. Residents may be invited, as well.

If the State survey team finds substandard care at a facility, an extended survey is immediately undertaken. (Substandard care is defined as any deficiency in the areas of resident behavior and facility practices, quality of life, or quality of care that constitutes immediate jeopardy or a widespread potential for more than minimal harm.) If an extended survey is required, the team looks in greater details at administrative issues and nursing and physician services. Tasks in an extended survey typically include a review of: the adequacy of staffing, in-service training, the infection control program, staff qualifications and responsibilities and the accuracy of resident assessments. (Two extended surveys have been done in the past two years.[4])

As part of a federal nursing home initiative begun in 1998, states were instructed to strengthen the nursing home inspection process and to toughen enforcement against poor performers. State survey agencies are currently required to:

- Impose immediate sanctions, such as fines, against nursing homes in more situations - including any time that a nursing home is found to have caused harm to a resident on consecutive surveys - even if the home quickly corrected the problem. Nursing homes that do not fix the problems will lose their ability to receive Medicare and Medicaid payments.

- Stagger surveys and conduct visits on weekends, early mornings and evenings, when quality, safety and staffing problems may be more likely to occur. Surveyors are required to conduct these "off-hour" surveys in at least 10 percent of the skilled nursing facilities each year. In Vermont, this translates to four or five off-hour surveys each year. DLP staff report that they schedule off-hour surveys at those homes where there have been problems, a lot of complaints, Ombudsman concerns and/or a change in management. For example, DLP conducted an off-hour survey in November 2001 at the Berlin Health and Rehabilitation Center, which had been the subject of numerous complaints.

- Conduct more frequent inspections of nursing homes with repeated serious violations without decreasing their inspections for other facilities. DLP designates at least two of the state's facilities as "special focus" facilities which are then subject to more frequent surveys and/or visits by the Licensing Chief and/or Commissioner.[5]

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[4] Communication, Division of Licensing and Protection, May 2, 2002.

[5] The "special focus facility" is a mandate for all states as one of CMS's (formerly HCFA) initiatives to assure that there is enhanced oversight in nursing homes that show significant problems with non-compliance. The selection of the possible "special focus facilities" is actually done on an annual basis by CMS. The data used to select the facility listing is based upon the deficiency data Vermont is required to input into the national reporting system (OSCAR). This includes info from standard surveys and substantiated complaint investigations. The State then must select two nursing homes from the list it receives, and once the selection is approved by CMS, enhanced oversight is done. The facilities receive at least two standard surveys/year (as compared to the annual), and the survey agency is required to submit a monthly report on each facility to the CMS Regional Office regarding any onsite activity, changes in administrative staff, etc., any proposed and implemented enforcement action, complaints noted, or changes in care. There is specific criteria the facility must meet in order to be removed from the list. The State Agency may add more facilities to the list (with CMS approval). The two facilities at this time are Berlin Health and Rehabilitation Center, Barre, and Gill Odd Fellows Home, Ludlow. Communication from Division of Licensing and Protection, May 2, 2002.

- Consider the performance of other facilities in a chain of nursing homes when determining appropriate penalties against another facility in the same chain.

- Nursing homes now may face fines of up to $10,000 for each serious incident that threatens residents' health and safety.[6]

DLP staff report that their surveyors are readily and frequently approached by staff, residents and family members with concerns. Contact includes everything from face-to-face meetings to more clandestine notes asking the surveyors to contact an employee or family member.

Nursing homes in Vermont perform relatively well against their peers in other states in regard to performance on standard surveys. Nonetheless, the State's performance has declined over the past three years, with the number of nursing homes in "substantial compliance" dropping from 52 percent in 1999 to 18 percent in 2001 (See Figure 1). DAD administrators say that this is not the result of increasing problems with nursing homes, but rather is caused more by new, stricter federal guidelines inspectors have to follow. "They've changed the scorecard," said DAD Commissioner Patrick Flood, "but the quality is still there."[7]

Figure 1

Vermont Nursing Home Standard Survey Results, 1999-2001

	Jun-99		Jun-00		Jun-01	
	Vermont	**U.S. Avg.**	**Vermont**	**U.S. Avg.**	**Vermont**	**U.S. Avg.**
Number of Surveys	44		45		44	
% with Substandard Quality Care	2%	5%	2%	5%	0%	4%
% in Substantial Compliance	52%	25%	40%	22%	18%	16%
% Deficiency Free	41%	19%	38%	17%	14%	12%
Average # of Deficiencies	1.6	5.2	2.4	5.9	3.2	6.2

CMS provides oversight of the State inspection process by conducting two types of oversight procedures on at least 10 percent of the annual surveys:

- Federal Monitor Survey, where the CMS team, based in Boston, surveys a facility after the State team; and,

- Federal Observer Survey, where the CMS team observes the survey team at work and assesses its performance against State protocols.

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6 "Assuring Quality Care for Nursing Home Residents," HCFA Fact Sheet dated September 28, 2000, available at http://www.hcfa.gov/facts/fs000928.htm.

7 Interview with DAD Commissioner Patrick Flood, March 7, 2002, conducted by George Thabault, Chief, Special Audits and Review, Office of the State Auditor.

The survey procedures outlined by CMS leave little latitude for State survey agencies to visit "problem" facilities much more frequently and/or reward quality nursing homes with less frequent inspections. Surveyors are State employees whose work is funded with Medicare and Medicaid funds targeted toward inspections conducted according to the federal protocol. After a survey is completed, a surveyor may return to see in person if a nursing home has fulfilled its plan to correct a deficiency or to investigate a specific complaint registered with DLP or the State's long-term care ombudsman.

(The Vermont Long-Term Care Ombudsman is a statewide program, carried out under contract for the State by Vermont Legal Aid. The Ombudsman project has approximately five full-time people in various counties who are resident advocates; they handle complaints about nursing home quality as well as many issues outside state regulation. The project also trains volunteers to visit nursing homes to help advocate for residents on legal and other matters.)

The timing of the State survey (once every 15 months but with a statewide average interval between surveys not to exceed 12 months) allows nursing homes that haven't had a recent inspection to anticipate the approximate time of an inspection. Also, a three-day inspection is only "unannounced" on the first day; for the second and third days, staff and management are well aware that surveyors are "in the building."

Some large states such as Florida have adopted an additional type of inspection, the surprise "spot check," to discover deficiencies and help nursing homes maintain quality standards. Spot checks of problem facilities may involve a range of state agencies in those states, but are not conducted according to the federal survey protocol, although issues important in that protocol may be reviewed. Vermont does not have a spot check inspection program due to funding limitations, though a single surveyor may visit a nursing home briefly to investigate a complaint.

A spot check program in Vermont would allow DLP to visit deficiency-prone nursing homes more frequently. It would be much less expensive than a full-blown survey, but such a program would require increased funds from Medicaid or a special State appropriation to institute.[8] One spot check inspector could perform two to three checks a week throughout the state. DAD has unsuccessfully petitioned federal officials in recent years to allow alternative inspection programs.

The federal inspection procedures are skewed toward reliance on reviewing data and documentation. Our observations of Vermont's survey staff indicate a balance between data collection and face-to-face communication with residents and staff. Nonetheless, we would note that the paperwork requirements of the entire federal regulatory framework, despite their intent, may be pushing care providers to spend an inordinately large time on paperwork and federal reporting at the expense of providing care.

Still, Vermont inspection teams are in the field often. In the past full fiscal year, the 45 nursing home facilities received a total of 212 inspection visits. Five homes were visited just two times; but 12 homes were visited six times or more. Re-visits may be made because of complaints, or to assure that a home has corrected previous problems.

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[8] Interview with DAD Commissioner Patrick Flood, March 7, 2002, conducted by George Thabault, Chief, Special Audits and Review, Office of the State Auditor.

Another serious issue regarding surveys is their cost, paid for by federal Medicaid funds. Depending on the duration and number of surveyors involved, a nursing home inspection can cost $3,000 to $5,000. Recently, CMS' Office of Health Standards and Quality asked Vermont officials to reduce the budget for the current federal fiscal year which ends September 30, 2002.

DAD Commissioner Patrick Flood returned an amended budget but also informed CMS officials:

"Vermont's amended budget is based solely on lowering the numbers to reflect the allocated budget and not on our anticipated actual costs of maintaining required work activity. In the past three years, Vermont has experienced a 7 to 12 percent increase in actual costs. The FFY 2002 allocation represents only a 5 percent increase and does not reflect our anticipated cost of the required survey work.

"We have made the following adjustments to meet the allocated budget:

- *Severely reduced staff training ...*
- *Cut nursing home and home health surveys by one each,*
- *Reduced travel ...*
- *Reduced anticipated home health agency complaints ...*
- *Reduced indirect estimate*
- *Severely reduced replacement equipment purchase ..."*[9]

Commissioner Flood added, "Our goal in making the listed reductions is to maintain as much of the required survey and certification activity as possible within the allocated budget. We do however doubt that the allocated budget will be sufficient to meet the actual survey work."

A national investigator found fault with Medicaid's approach to funding inspections of nursing homes.

David Zimmerman, Ph.D., Director of the Center for Health Systems Research and Analysis at the University of Wisconsin-Madison, testified on June 30, 1999 to Congress about financial support of the States' inspection efforts: "It is easy, of course, to appeal to the almighty dollar as the solution to the system's ills; but in this case the lack of funding is a major contributor to the set of factors explaining the dismal situation of nursing home quality assurance. Funding for survey operations and other quality assurance activities is piecemeal and inadequate. Each year it becomes a game of guesswork about how much money will be in the pot, and the ultimate answer is typically, 'not much' and 'not enough.'"

Recommendation 1

The DAD should continue to advocate with the federal Centers for Medicare and Medicaid (CMS) to allow for licensing and survey processes that are more correlated to lack of quality and resident risk than regulatory proscription. One alternative inspection program suggested by DAD would require 75 percent of inspections to be conducted according to federal guidelines, but the remaining 25 percent could be performed using an alternate, less costly but nevertheless effective manner such as spot checks.

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9 Letter from Patrick Flood, Commissioner, DAD, to Ronald Preston, Office of Health Standards and Quality, CMS, JFK Federal Building, Government Center, Boston, MA 02203, February 27, 2002.

Finding 2

Vermont surveyors appear to be in substantial compliance with regulations regarding the standard surveys as currently conducted. However, we noted concerns in two areas:

- ***Documenting surveyor conflicts of interests; and,***
- ***Documenting on-site observations and "initial tour" data in the permanent survey file.***

Discussion

The Code of Federal Regulation states that, "surveys must be conducted by a multidisciplinary team of professionals, which must include a registered nurse. Examples of professionals include, but are not limited to, physicians, physician assistants, nurse practitioners, physical, speech, or occupational therapists, registered professional nurses, dieticians, sanitarians, engineers, licensed practical nurses, or social workers."[10] The *State Operations Manual* that provides guidance for implementing these regulations states that, "Because of the strong emphasis on resident rights, the psychosocial model of care, and rehabilitative aspects of care in the regulations and survey process, the team should include social workers, registered dieticians, pharmacists, activity professionals or rehabilitation specialists, when possible."[11] The surveyors hired by Vermont's DLP are exclusively registered nurses. Job requirements include professional nursing experience and possession of, or eligibility for, a license to practice as an RN.

DLP has indicated that their surveyors all have clinical experience in long-term care and extensive training in the survey process. DLP's decision to use RNs was based on past experience. "At one time, generalist surveyors were used ... This was not an efficient use of staff ... Specialized disciplines were limited in their ability to review all aspects of resident care and services as required, were not able to participate in all required tasks of the survey process, and were not participants of the survey process for the duration of the survey. For example, the dietician could not do a medication pass or observe provision of personal care or treatment to evaluate adequacy of those services or determine regulatory compliance. Because of the generalists' specialty, they were not able to complete all tasks as the RNs can."[12] The Division adds, "Dieticians and social workers within the Agency are readily available when needed."

We would note that survey teams composed entirely of RNs are inherently predisposed to assess a facility from a nursing and clinical care perspective. While these concerns are a primary area of focus, they do not necessarily insure that quality of life issues are always being fully addressed. However, given the range of medical and health care facilities the department is responsible for inspecting, from mobile X-Ray facilities to hospitals, we recognize that using staff dollars in the most efficient way is an important goal.

When deficiencies are found at a nursing home, they are discussed at the exit conference with nursing home administrators, and later the DLP informs the nursing home by letter, detailing the level of seriousness of the deficiency. The letter asks the facility to submit an acceptable "plan of correction" within

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[10] 42 C.F.R § 488.314 (a).

[11] HCFA State Operations Manual §7201 available at http://www.hcfa.gov/pubforms/07_som/som_7000_to_7212.htm.

[12] Memo from from Laine Lucenti, Director, Division of Licensing and Protection, dated January 18, 2002.

Regulation Overload?

Margaret Perry is a nursing home administrator with a simple philosophy: patient care takes priority over an ever-increasing amount of regulations and paperwork. She feels her philosophy is in trouble in today's nursing home environment.

Perry is part-owner, along with other family members, of the 30-bed McGirr Nursing Home in Bellows Falls. She's been working there 30 years; her daughter, a registered nurse, is the home's Nursing Director, and her son helps with electrical and other maintenance.

Perry grew up near Laconia, New Hampshire, where her mother and grandparents helped to direct Belknap County's "county farm" which comprised a working farm, jail, homeless shelter, retirement and nursing homes.

She's been at the front lines of caring for elderly people for a long time and it has shaped her attitudes toward new regulations which aim to improve quality and protect nursing residents. "I think that many of the people writing the regulations have never had actual contact with nursing home work."

She says some of the new directives from state and federal regulators fly in the face of reason.

Case in point: precaution signs. Until recently, the staff at McGirr kept 3 x 5 index-type cards posted in a resident's room which would remind staff about the specific needs of that person - such as the need for a hearing aid, or reading glasses or if the person had a serious infection.

Federal inspectors who came to McGirr in February (just two weeks after an inspection by state surveyors) declared that the notices violated the patients' right to dignity. The cards were a civil rights violation.

"I don't think any of our patients would mind that the nurses and assistants had reminders about what they needed," Perry says. Instead of notices being posted about persons with serious infections, the home simply puts up a sign saying, "See Nurse."

Marie, Virginia and Mary enjoy fresh air and conversation on the spacious front porch at McGirr Nursing Home. (Picture, SAO Staff)

A more serious example is in the area of weight loss. "The federal regulators have now decided that weight loss is not acceptable. We spend an inordinate amount of time trying to get people to eat what they don't want to eat," Perry says. One recent patient became ill and lost weight. But, due to his kidney problems, the patient's doctor advised that it would not be a good idea to return the man to his previous 170 pounds. Nevertheless, the home was cited for not doing enough to re-establish the man's weight.

The chief goal of regulation and inspection should be to close down or shape up the bad homes, Perry says. "We've gone from wanting people to have good, responsible care … to inspecting at a nit-picking level. If you have two federal inspectors in your business for three days, they're bound to find something that's not quite right. It's the same for any hospital, school, or daycare."

"You know, they haven't developed a cure for old age yet," Perry notes. "And even though guidelines call for a nursing home patient to reach their 'highest practicable level of physical, mental or psychosocial well-being,' there are some things you just don't have the power to do."

10 days and to complete the plan or face a variety of penalties. A facility can have minor deficiencies and still achieve "substantial compliance" with rules and regulations, the highest rating. Often the survey agency conducts an on-site revisit to monitor compliance; in the past two years approximately 70 percent of nursing homes inspected were re-visited. In the case of homes that achieve substantial compliance but have a minor deficiency, DLP officially notifies the home by letter about the compliance and the minor deficiency. If the minor deficiency is at the A level, the home has the option of submitting a correction plan or not. In the case of B- or C-level deficiencies, the home must submit a correction plan.

Homes in substantial compliance with minor deficiencies do not receive a follow-up visit. Whether or not the minor problem has been taken care of will be assessed during the next regular standard survey or during a complaint investigation.

The *State Operations Manual* also requires surveyors to be free of conflicts of interest as defined in §7202. DLP currently has no documentation in its records that would disclose surveyor conflicts, such as a list of nursing homes where a surveyor may have worked recently.

A standard survey of Birchwood Terrace Healthcare of Burlington was conducted Jan. 28-30, 2002. In March, news organizations reported that at least four residents at Birchwood Terrace died of flu or flu-related illnesses between February 21 and February 25. The Department of Health reported a total of between 40 and 50 cases among the 150 residents between mid-February and early March. DLP said the nursing home took the proper steps to contain the flu situation.

Because an inspection had been completed three weeks before the flu-related deaths, we reviewed the Birchwood survey report file. The survey procedures require the nursing home administrator to provide the surveyors within one hour of the conclusion of the entrance conference a list of key personnel at the facility, including the "persons responsible for infection control and quality assurance."[13] This information was duly noted in the Birchwood survey file.

During the "initial tour" of the facility, protocol requirements call for the surveyors to "focus on" a range of care issues, including:

> *"7. Presence or prevalence (numbers) of infections including antibiotic resistant strains of bacteria, e.g. Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin Resistant Enterococcus (VRE), Clostridium Difficile (C-Diff) or other infections: urinary tract infections, draining wounds, eye infections, skin rashes (especially if spreading, undiagnosed, and/or not responding to treatment), respiratory infections, gastroenteritis including diarrhea, etc."*[14]

The survey file did not indicate any data on the presence or numbers of these infections "focused on" by the survey team during the initial tour. This may indicate that there was no special infection information to record, but the file does not indicate that directly.

After the initial tour, a number of pre-selected residents will be visited for in-depth interviews. On a form listing a range of medical and treatment issues for each person to be interviewed, there is a category titled "UTI/Antibiotics." A check there indicates a resident is being treated for a urinary tract infection. The pre-selected sample of residents selected for in-depth interviews may be adjusted as a result of the initial tour to include residents with UTI being treated with antibiotics.

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[13] "Survey Protocol for Long Term Care Facilities," State of Vermont, p. 12.

[14] Ibid., p. 16.

Recommendation 2

DLP should develop, and require surveyors to annually update, a conflict of interest disclosure form.

Recommendation 2a

DLP should improve its procedures for surveyors to both note and file information about infections, or the absence of infections, gained from the Initial Tour and the general observations phase of each survey conducted.

Finding 3

The Division of Licensing and Protection's control system for monitoring and tracking complaints has minor flaws and should be improved with the introduction of a federal automated complaint tracking system tentatively scheduled for the fall of 2002.

Discussion

Concerns and complaints about nursing homes can be made to either the Long-Term Care Ombudsman or the DLP. Each has different roles and responsibilities in regards to nursing home complaints. As a result, there is a significant discrepancy between the number of complaints directed to the DLP and the Ombudsman (See Figures 2 & 3).

Ombudsman are contacted by residents and their advocates about any problems that can adversely affect the resident including concerns about their care, the facility, their rights or even their family. The Ombudsman's goal is to have the complaint resolved. When complaints are not resolved, and the Ombudsman believes they relate to a facility's regulatory requirements, the Ombudsman refers them to the DLP. In the last six months of 2001, the Ombudsman program referred 18 complaints to the DLP on behalf of eight different residents. The DLP substantiated five of the 18.[15] For a complaint to be substantiated there has to be a violation of a nursing home regulation and evidence to back it up.

If the complaint is about issues that are outside the purview of federal participation requirements, an investigation is not conducted by the DLP. Some complaints may revolve around roommate, family, food or even financial concerns. These are outside the purview of the DLP.

The State is required by federal regulation to "establish procedures and maintain adequate staff to investigate complaints of violations of participation requirements."[16] The *State Operations Manual* provides guidance regarding the information that must be obtained at intake, the need for a control system to monitor and track the complaint and the investigation procedure. If an on-site survey is required, it should be unannounced. Substantiated complaints are reported as deficiencies. The State's Complaint Investigation Policy notes that the State will only investigate complaints related to issues occurring within the past twelve months, unless the complaint alleges actual or potential harm to a resident.

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[15] Letter from Vermont Ombudsman Project, January 18, 2002.

[16] 42 C.F.R § 488.332 (a).

Figure 2

Nursing Home Complaints Made to Vermont's Long-Term Care Ombudsman Federal FY 1998 – Federal FY 2001, By Type

Type of Complaint	FY 1998	FY 1999	FY 2000	FY 2001
Resident's Rights				
Abuse, Gross Neglect, Exploitation	15	16	13	3
Access to Information	7	9	13	8
Admission, Transfer, discharge	40	46	25	49
Autonomy, choice, rights, privacy	42	62	68	57
Financial & Property	27	42	33	29
Sub-total	*131*	*175*	*152*	*146*
Resident Care				
Care	67	64	118	81
Rehabilitation, maintenance of function	8	29	28	22
Restraints	10	3	3	4
Sub-total	*85*	*96*	*149*	*107*
Quality of Life				
Activities and Social services	14	25	22	16
Dietary	25	23	41	21
Environment	38	30	37	33
Sub-total	*77*	*78*	*100*	*70*
Administration				
Policies, procedures, attitudes, resources	3	6	8	2
Staffing	16	15	34	14
Sub-total	*19*	*21*	*42*	*16*
Problems with Other Agencies				
Certification, licensing agency	1	0	1	
State medicaid agency	8	5	1	1
Others	61	36	47	49
Sub-total	*70*	*41*	*49*	*50*
TOTAL	**382**	**411**	**492**	**389**

Complaints made to the DLP are often not substantiated. State rules note that "determination of whether the complaint happened is not enough. The investigator, usually a member of the surveyor staff, needs to determine noncompliant facility practices related to the complaint situation and which, if any, requirements are not met by the facility."[17] This means a surveyor may have an indication that an incident occurred where quality of care or resident rights were compromised, but does not have clear evidence of "noncompliant facility practices." Therefore, the complaint will not be substantiated.

Figure 3

Nursing Home Complaints Made to Division of Licensing and Protection

	FY 1998	**FY 1999**	**FY 2000**	**FY2001**
Complaints	71	58	78	74
Facility self-reports	3	24	16	16
Total	*74*	*82*	*94*	*92*
Substantiated	7	8	20	23
% substantiated	9.5	9.8	21.3	24

As part of our review, we checked a random sample of complaint folders to test compliance with State and federal policies and procedures. We reviewed the folders for evidence of the following to ascertain compliance with State and federal protocols:

- Entry in the complaint log book as required by State procedure;
- Date of complaint;
- Triage and prioritization of the complaint;
- Review of the intake form required by State and CMS procedures;
- On-site investigation conducted if needed and within the appropriate time frames established;
- Acknowledgement letter sent as required by CMS;
- Ombudsman contacted as directed by Appendix P - Survey Protocol of the *State Operations Manual;*
- Survey conducted as directed by Appendix P - Survey Protocol of State Operations Manual;
- Written memo to file as required by State procedure;
- Required CMS forms completed and file copy retained;
- Review by the complaint coordinator as required by State procedure; and,
- Information entered into the OSCAR[18] database as required by State and federal procedures.

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[17] HCFA State Operations Manual Appendix P, p. 75.

[18] CMS's **Online Survey, Certification, and Reporting (OSCAR)** database - Includes the nursing home characteristics, five resident characteristics (including Residents Who are Very Dependent in Eating, Residents Who are Bedfast, Residents With Restricted Joint Motion, Residents With Unplanned Weight Gain or Loss, and Residents With Behavioral Symptoms), and inspection results.

We found some deficiencies in regard to compliance with existing policies and procedures in our testing:

- In almost every case, there is evidence that medical records were thoroughly reviewed. There is no similar evidence that the individual making the complaint, the subject of the complaint and/or witnesses were interviewed. The complaint log book, however, shows that in almost all cases where a complainant is identified, that person received an acknowledgement that the complaint was received. The complaint log form before April 2000 shows whether the acknowledgement was by phone or letter, or both; after April 2000 the form was changed to reference only the date the complaint was acknowledged. This indicates direct contact but does not detail the type of conversation that may have occurred, and which is generally not appropriate for the log book. There are times, it should be noted, that the subject of the complaint cannot be interviewed due to their mental or physical condition.

- In a few cases, the investigation appears to consist entirely of medical records faxed to DLP.

- The complaint log does not indicate if an ombudsman was contacted regarding the complaint, though the tracking form in the permanent file may have this information.

- In two-thirds of our samples, there was no evidence that the Long-Term Ombudsman was contacted regarding the incidence of similar complaints at the facility.

- There is no clear documentation in the log book or file to indicate whether the complaint was actually reviewed by the complaint coordinator or entered into OSCAR. In half of our sample, the complaint was not entered in OSCAR.

- Procedures used to "triage" complaints for action by the DLP's complaint coordinator or designee are very specific. A numbering system is used: No. 1 indicates immediate jeopardy and must be investigated within two working days. No. 2 indicates actual harm and the investigation must be initiated within 10 working days of receiving the complaint. No. 3 refers to all other issues that doesn't indicate immediate jeopardy or actual harm. Such issues may be examined during the nursing home's next standard survey. However, there appears to be no requirement to put in writing why a complaint does not require an on-site visit.

The DLP reports that a high percentage of complaints received at its office resulted in on-site investigations. As of June 1 in the current federal fiscal year (October 1, 2001 to September 30), 2002, there have been 45 complaints and 32 on-site investigations. The previous year, 55 of 77 complaints resulted in on-site investigations. In addition, during the current federal fiscal year there have been 32 self-reports from facilities, resulting in 28 on-site, follow-up visits. Self-reports are mandatory filings by nursing home administrators about incidents where one or more deficiencies may have occurred, such as abuse or neglect.

The federal CMS office has developed a complaint tracking software which will connect with a federal database. The software will track complaints from the time of in-take through closure; it is being implemented first in six states from July through September 2002, and is scheduled to be implemented nationwide October 1.

Dialing for Help

The Vermont Department of Aging and Disabilities, Division of Licensing and Protection, regulates nursing homes and investigates complaints of poor care or conditions.

You can file a grievance by calling **1-800-564-1612** or **1-800-241-2345** (Voice/TTY), or by writing to the Division of Licensing and Protection, Ladd Hall, 103 South Main Street, Waterbury, Vermont 05671-2306.

A person outside the nursing home able to help residents resolve a problem or speak on their behalf can be reached through the Vermont Long-Term Care Ombudsman at **1-800-889-2047**. This program is operated by Vermont Legal Aid, under a contract with the State, and comprises a director, four regional ombudsmen, a volunteer coordinator, and more than a dozen volunteer ombudsman workers. Area volunteers try to visit each nursing home in the state on a regular basis; the four full-time regional ombudsmen are in more frequent contact with nursing home administrators.

The Ombudsman keeps all information confidential unless a person gives permission to use it. Ombudsman help is free of charge as federal and State governments provide approximately $400,000 per year for the office.

DLP officials are hoping to link a number of computer workstations to the software system to allow several investigators to connect with and use the tracking program from their workplace, rather than have to travel to a central computer to input data. The program keeps track of each complaint, all contacts, witness information and investigation results related to that complaint. The program has special reporting features that will help the department better monitor how quickly and thoroughly complaints are being addressed.

Recommendation 3

Documentation should be provided when the surveyor opts against conducting an on-site investigation of a complaint.

Recommendation 3a

Complaint investigators should interview the ombudsman as well as the subject of the complaint in all investigations when possible.

“Time to Share What I’ve Learned”

Volunteer Ombudsman Linda Sturgeon. (Picture, SAO Staff)

Linda Sturgeon is one of about 15 trained volunteer ombudsmen around the state. Working about five hours a week, Linda visits the Eden Park nursing home in Brattleboro, and perhaps one or two residential care homes in the area each week.

Her job? To listen, observe, hear complaints and special requests from residents. Sometimes she’ll assist someone with legal procedures like setting up a durable power of attorney for medical issues, or just sit and hear people’s stories. She may help a resident locate special equipment, like an oversized TV remote for a person with hand injuries.

“It feels really good that you can make a difference, that you can help someone be more comfortable,” Linda says. A resident of Putney since 1983, Linda, 55, is a visual artist who creates custom-made and handmade clothing to sell at juried arts and crafts shows. An artist with confidence in meeting and talking with people, Linda relates well with residents and opens her heart to their stories, histories and need for dignity and respect.

A special connection of Linda’s helped bring her to the ombudsman role. She helped care for her mother, Winifred, during the last years of life in California. “When my mom became suddenly ill, after quite a vigorous life, I went to the doctors with her, asked questions, and in the process became her advocate,” Linda recalls. “She was in a big HMO, and after the first few tests we had to fight for every service.”

After her mother’s passing, Linda realized she had amassed quite a bit of knowledge and experience about elderly health and care issues. “As painful as it was for me and my mother, I felt the experience could be useful for others,” she says. Linda answered an ad looking for people to become trained in ombudsman work.

After a couple of days in the classroom boning up on nursing home issues, Linda and other trainees went on tours of facilities with experienced leaders. “Mainly you learn to observe everywhere you go. You’re alert to call lights, smells, people calling for help, even a staff person leaning against the wall chewing gum.”

Spending time in nursing homes for the past year and a half, getting to know residents and their histories, has changed Linda’s outlook a little. “It’s easy to pigeonhole people,” she says. “It’s clear these people are still very much a part of the community - they’re not elderly people in a facility. They’re connected to their towns.”

Finding 4

Inter-agency cooperation in investigating and prosecuting allegations of abuse, neglect or exploitation is good. However:

- ***Routine inter-agency communication which helps investigators spot potential problems is often slow;***
- ***Investigative resources are reported to be inefficiently deployed on occasion; and,***
- ***The 24-hour toll-free abuse and complaint reporting lines are promoted in a low-key way.***

Discussion

In addition to federal and State regulations about the physical and operational standards for nursing homes, the State seeks to ensure quality of care in a nursing home by helping to prevent, detect and prosecute cases of abuse, neglect and exploitation.

Recent Vermont prosecutions of caregivers for abuse, sexual assault, and theft of money and drugs highlight the need for improving educational efforts about elder and nursing home abuse and how to prevent it. One licensed nursing assistant, for example, was prosecuted in 2001 for not following nursing home guidelines in moving a resident, resulting in a fracture of the resident's right tibia; the LNA tried to cover up the injury and failed to make a report. In another 2001 case, an LNA pled guilty to one count of abuse of an elderly and disabled adult after allegations that she had slapped a resident.

The goal of better serving and protecting Vermont's senior citizens from undetected abuse, neglect and financial exploitation in institutions and in their homes the prime focus of a one-year study by the Project Elder Reach Committee (PERC) established in the fall of 2000 by the Commissioner of the Department of Aging and Disabilities and the Attorney General.[19]

The report stated, "Efforts to protect Vermont's elders from abuse, neglect and exploitation are hampered by widespread ignorance of the nature of the problems and the legal and institutional arrangements for dealing with them. Increased efforts at training and education are needed, particularly targeted towards licensed professionals whose practices focus on elders, as well as towards groups of individuals that can be expected to come into contact with vulnerable seniors."[20]

The Project Elder Reach Committee (PERC) urged the State to adopt a standardized training program on elder abuse "which encompasses both civil and criminal statutory definitions, procedures, and remedies. The training program would include basic information on how to identify abuse, neglect and exploitation; what the law on reporting requires; and the investigative process."[21]

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[19] Project Elder Reach Committee Report, December 10, 2001.

[20] Ibid., p. 14.

[21] Project Elder Reach Committee Report, December 10, 2001.

DLP today is legally obligated to review all complaints and allegations of abuse. Nursing homes, like all health care providers, are under a legal obligation to report instances of suspected elder abuse, neglect or exploitation.[22] This includes making "self-reports" when a facility finds cause for suspected abuse. As the division of state government responsible for both Adult Protective Services (APS) and the State nursing home inspections, DLP must investigate any complaint when there is either:

- An allegation of abuse, neglect or exploitation of a resident;
- A deficiency in one of the skilled nursing facility requirements that may have occurred; or,
- A survey is needed to determine if a deficiency exists.[23] Follow-up APS investigations of self-reported incidents are announced; on-site complaint investigations are unannounced.

Several State agencies are involved in examining claims of abuse in a nursing home and acting on them. These include the State's Attorney's office, State Police, the Office of Professional Regulation in the Secretary of State's Office, DLP and its APS unit in the Department of Aging and Disabilities, and the Medicaid Fraud and Residential Abuse Unit (MFRAU) of the Attorney General's Office.

MFRAU, DAD and the Office of Professional Regulation have approved a referral protocol to better coordinate investigations of abuse allegations in Vermont nursing homes.

Attorney Linda Purdy, the MFRAU director, reported that the referral protocol generally works well and if a case is investigated, the agencies assign investigators to work together to minimize the number of interviews and requests for information that victims and witnesses have to participate in. "Intakes are quick; we decide within 24 hours to accept or decline a complaint," Purdy said. A key factor in the decision process is the higher burden of proof needed for a criminal prosecution than for a civil penalty which can be assessed administratively by DAD.[24]

It was noted from discussions with several agencies that there are times when three different investigators from three different agencies will work on an investigation. There are, of course, different aspects of concern and burdens of proof to consider for each agency; there is also an effort to schedule interviews with victims and witnesses together. But developing a system where a single investigator can prepare a universal case report usable by all affected agencies has the potential of being more efficient and allowing more cases to be investigated in person.

To help MFRAU keep abreast of potential problems in nursing homes, the referral protocol states: "The Division of Licensing and Protection will forward copies of all standard surveys of Medicaid-funded facilities to the Medicaid Fraud and Residential Abuse Unit."[25]

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[22] 33 V.S.A § 6903.

[23] HCFA State Operations Manual Appendix P, p. 73-74.

[24] Interview of MFRAU director Linda Purdy, conducted by George Thabault, Chief, Special Audits and Reviews, March 29, 2002.

[25] Referral Protocol, July 2001, approved by Medicaid Fraud and Residential Abuse Unit, Division of Licensing and Protection, and Office of Professional Regulation.

After the surveys of nursing homes are completed and accepted by the DLP, it takes approximately two to four months for copies to be forwarded to MFRAU.[26] If surveys indicate that a nursing home is experiencing a pattern of deficiencies that could rise to a level of civil administrative sanction, it would be helpful for MFRAU to learn about these surveys sooner. Both agencies have met to discuss ways to quicken the time between survey completion and notification to MFRAU. DLP reports that a new policy has recently been put into effect whereby a copy of the survey report is sent to MFRAU at the same time that it is sent to the provider who was inspected.

Other areas slated for improvement include more inter-agency communication about nursing homes with ongoing quality issues, and more face-to-face meetings to discuss abuse prevention and detection issues. For example, if DLP recommends to CMS that civil administrative penalties be applied against a nursing home, that information is forwarded to the federal CMS office in Boston. The information may be forwarded from there to another federal office, the United States Attorney's office in Vermont, which may then, days later, inform the MFRAU office in Waterbury, located in the same State office complex as the DLP.

Medicaid Fraud and Residential Abuse Unit Prosecutes Abuse Crimes

The Vermont Medicaid Fraud and Residential Abuse Unit is located in the Office of the Attorney General, with offices in Waterbury. It is a federally-funded State program which investigates and prosecutes Medicaid provider fraud and violations of State laws pertaining to fraud in the administration of the Medicaid program.

The unit, comprising two attorneys, two detectives, one auditor and an administrative assistant, reviews complaints of patient abuse, exploitation or neglect in health care facilities that receive Medicaid funds, or in any board and care facility with two or more disabled or elderly residents. The unit also investigates and prosecutes patient abuse, exploitation and neglect cases that have arisen in any Medicaid-funded program.

Allegations of abuse, neglect or exploitation of nursing home residents are very important, but they are not numerous in Vermont. In 2000, MFRAU received 26 complaints about abuse, neglect and exploitation in Vermont nursing homes and opened 17 investigations, all of which were later closed without merit due to unsubstantiated claims or insufficient evidence. In 2001, MFRAU received 28 complaints in the same category, opening 13 investigations. Seven of the investigations were closed without merit due to unsubstantiated claims or insufficient evidence; one is under active investigation; two involve criminal charges and are pending litigation; and three resulted in criminal prosecution and conviction.[27]

The PERC report noted another important inter-agency task would be to assemble a task force for statewide review of "suspicious, unexplained and/or untimely deaths of elders in home, community and facility-based settings."[28] The PERC reported noted: "Licensing and Protection has taken the first step in this effort by promulgating a regulation which requires nursing homes to report data to the Department of Aging and Disabilities for each resident death in certain circumstances."[29]

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[26] Interview of MFRAU director Linda Purdy, conducted by George Thabault, Chief, Special Audits and Reviews, March 29, 2002.

[27] Memo, MFRAU, Michelle L. Black, legal assistant, April 2, 2002. The three convictions resulted from charges of misdemeanor abuse, patient abuse, and abuse of elderly and unlicensed practice of nursing.

[28] Project Elder Reach Committee Report, op. cit., p. 18.

[29] Ibid.

The current reporting requirement is: "Any untimely death that occurs as a result of an untoward event, such as an accident that results in hospitalization, equipment failure, use of restraint, etc., shall be reported to the licensing agency by the next business day, followed by a written report that details and summarizes the event."[30]

It is one of our observations that the toll-free number for reporting complaints in nursing homes is not extensively promoted outside of being posted prominently in an important location: nursing homes. The number used for nursing homes regulated by DLP is the same one for its Vermont Adult Protective Services unit: 1-800-564-1612. APS promotes its services and the toll-free number to a wider audience.

During normal work hours the calls are handled by the Adult Protective Services staff. After hours, and on weekends and holidays, the calls are received by the Emergency Service Program (ESP) of the Department of Social and Rehabilitation Services which furnishes APS with written information concerning allegations of abuse, neglect and/or exploitation of the elderly or disabled adults that it receives. There is a protocol in place to get assistance for immediate emergencies.

Recommendation 4

DLP, DAD and MFRAU should develop new procedures for more efficient and timely inter-agency communication.

Recommendation 4a

DLP, MFRAU and other agencies involved in investigations of alleged nursing home abuse should study the feasibility of adopting a single, universal investigator's report or system that could use investigative resources more efficiently.

Recommendation 4b

DAD, DLP, the Office of Professional Regulation and the Attorney General's Office should create a fatality review committee for untimely and unexplained deaths in nursing homes and other elder care facilities.

Recommendation 4c

DAD, DLP and the Vermont Health Care Association should adopt a program to more widely distribute the telephone numbers for reporting abuse allegations or nursing home complaints.

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[30] Licensing and Operating Rules for Nursing Homes, 2.9 (b), Vermont Agency of Human Services, December 15, 2001.

Finding 5

All nursing home prospective employees get a Vermont convictions record check and an Vermont abuse registry check. Licensed professionals may get further scrutiny if they have worked in another state. Inspection teams typically review a nursing home's abuse prevention protocols during surveys. The goal of reducing the risk of abuse in nursing homes could be aided by requiring an additional national criminal background checks on all nursing home employees.

Discussion

State Registry of Licensed Nurse Assistants

Nurses' aides, who are most involved with direct care services for nursing home residents, cannot work for more than four months on a full-time basis without being included on the Vermont State Nurse Assistants Registry which shows they have "demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program."

Federal law requires the State to maintain a registry of nurses aides who:

- Have completed an approved nurse assistant training course (minimum of 75 hours);
- Have had the training requirement waived; and,
- Have been found by the State to have abused or neglected a resident or misappropriated resident property.

The Vermont Nursing Board, located in the Office of Professional Regulation, a division of the Secretary of State's office, maintains this registry. Currently there are 4,200 individuals on the active list of the registry.

The Nursing Board maintains, in a sense, two registries. One is an abuse registry, a list of all licensed nurses or nursing assistants found to have committed abuse. This list is duplicative of the abuse registry kept by the Adult Protection Services group in Waterbury; the list is not open to the public, but can be checked by employers such as nursing homes.

The other registry is the general list of licensed nurse assistants, which also includes details about disciplinary actions taken against licensed nurses and assistants by the Board of Nursing for matters other than abuse of patients, such as alcohol abuse, drug use violations, or "habitual intemperateness." The disciplinary actions taken by the Board of Nursing are public; they are posted on the Secretary of State/Office of Professional Regulation website.

Background Checks on Other Employees

Because federal law states that nursing homes cannot "employ individuals who have been (A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or (B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property…,"[31] nursing homes must apply to the Vermont Criminal Information Center (VCIC) for a Vermont or multi-state background check on a prospective employee.

Multi-state checks are sometimes required because regulations also say: "Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry, established under 42 U.S.C. §§1395i-3(e)(2)(A) or 1396r(e)(2)(A), which the facility believes will include information on the individual."[32]

Vermont Board of Nursing

The purpose and mission of the Vermont Board of Nursing is to protect the health, safety and welfare of the public by monitoring and regulating the education and practice of nursing in Vermont as defined by state law and rules.

With staff support from the Office of Professional Regulation, the Board licenses nurses and nursing assistants and endorses advanced practice registered nurses. The Board is also responsible for taking action against any nurse or nursing assistant who has been proven to have engaged in unauthorized or unprofessional practice or incompetency as defined by state law and rules.

The Board's Executive Director is Anita Ristau, who can be contacted at 828-3180 or aristau@sec.state.vt.us.

The Vermont Board of Nursing website is: http://vtprofessionals.org/opr1/nurses.

State law requires current or prospective employees to sign a release before criminal background checks can be undertaken:

> *"An employer may ask the commissioner for the record of convictions of a person who is a current employee or contractor or a person to whom the employer has given a conditional offer of a contract or employment. The request shall be in writing and shall be accompanied by a release by the current or prospective contractor or employee. If the person has a record of convictions, the commissioner shall inform the employer of the date and type of conviction."*[33]

Nursing homes are required to perform both a State Adult Abuse Registry (APS) check and a record check with the VCIC on employees or individuals who have been offered a position as a requirement of licensure and/or as part of facility Abuse Prevention Protocols.

For many years, the DLP processed VCIC checks as well as APS checks at no cost to the nursing home providers. Effective April 15, 2002, this system changed.

As of April 15, 2002 the DLP continues to process and conduct APS checks requested by nursing homes for free, but no longer processes VCIC checks. Nursing homes and other providers deal directly with VCIC.

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[31] CFR 42, Vol. 3, 483.13.

[32] Sec.10.4: Registry Verification, "Licensing and Operating Rules for Nursing Homes," Agency of Human Services, Department of Aging and Disabilities, 2001.

[33] 33 V.S.A. Chapter 69 §6914.

For a VCIC check, the prospective nursing home employee fills out the release form and the nursing home sends it to VCIC in Waterbury. VCIC does a computer check, based on name and date of birth only, to see if the person has any convictions on record in Vermont. There is no fee for this report.

Though not required, nursing homes could also ask for a convictions check in another state where the prospective employee lived or worked. The cost is $10 to VCIC, plus the fee charged by the other state, which, for example, is $10 in New Hampshire and $50 in New York.

A national criminal background check, supported by a fingerprint check, is also possible through VCIC but is not currently required of new nursing home employees. The cost is $15 for the fingerprinting, done at one of VCIC's identification centers (usually a designated municipal police office or sheriff's office, with at least one in every county). There is an additional $10 processing charge to VCIC, and the federal government charges $24 for each employee check and $18 for volunteers.

It costs $49, therefore, to do a full criminal background check on a prospective employee.

A national criminal background check requirement would help nursing homes prevent abuse of residents in two ways: The records check on current employees could reveal potentially dangerous employees; and, when nursing homes advertise for positions and clearly state that a national FBI-fingerprint-assisted background check will be conducted as part of the hiring process, individuals with something to hide may avoid applying.

Recommendation 5

State nursing home regulators should consider a national criminal background check requirement for all licensed and non-licensed nursing home workers, at no cost to the prospective employee, which could better prevent abuse and help assure higher safety for nursing home residents.

Finding 6

Incentive awards promote efforts to achieve higher quality in nursing homes, but benefits are hard to measure as recipients of the $25,000 annual awards do not have to file expenditure reports.

Finding 6a

New grant initiatives aim to improve Alzheimer's care, end-of-life care, and employee retention.

Discussion

Besides its regulatory role to identify and correct deficient care in nursing homes, the Department of Aging and Disabilities (DAD) has also tried to encourage improved quality of life and quality of care in nursing homes.

In 1998, DAD proposed changing a portion of the rate setting and funding process. After discussions with the nursing home industry, and with the approval of the Legislature, DAD decided to stop paying what was then called the "efficiency factor" (which gave an extra payment to facilities which kept costs low) and use those funds instead to promote quality.

"How do we spend $25,000?"

The first step in figuring out how to spend a $25,000 quality incentive award is to meet with the residents of your nursing home.

That's what Mary Lou Campbell did. She's the administrator of the Mt. Ascutney Hospital and Health Center nursing home which earned an award in 2001. "Our nursing director made a commitment to have zero deficiencies, and the staff worked very hard to accomplish that," Campbell notes. "We were excited to get the award."

"Everyone on the resident council agreed that people needed a new mattress," Campbell remembers. "Our mattresses were old, so we used half of the money to buy 66 new ones. We purchased pressure-prevention mattresses that have a triple density foam. Normally you don't have enough in the budget to replace them all like that."

With the rest of the funds, the home purchased new furniture to brighten up common and recreation areas. "Some of our pieces were old and shabby; the inspectors even commented on them one time," Campbell says. "The award has a made a big difference here."

Music time at Mt. Ascutney (Photo courtesy of Mt. Ascutney Hospital and Health Center).

The $25,000 award earned by the Roncalli Health Center of Rutland (formerly Pleasant Manor Nursing Home) was used primarily to construct a new outside porch and deck, complete with gazebo on it, for the 127-bed nursing home. "We also purchased a few air conditioners for common areas, as there is no central air conditioning in the building," says administrator Timothy Urich. "We also used some of the money for outings."

An award program, with specific criteria, and a grant program were developed.

The quality awards are given each May to the five nursing homes that "provide and sustain a superior quality of care in an efficient and effective manner." To be eligible for the award, a facility must meet all of the following criteria, based on data provided by March 30 for the current year award:

- No deficiencies in the most recent standard survey (with the exception of life safety);
- Substantial compliance in the prior standard survey;
- No substantiated complaints since the prior standard survey;
- Life safety deficiency score of five or less, with scope and severity less than E in the most recent full survey; and,
- Facilities must participate in the statewide resident satisfaction survey to be eligible. Results of the survey will be included among the evaluation criteria.

Facilities that meet all of the basic criteria are ranked according to their efficiency, based on a mathematical model developed by the Vermont Program for Quality in Health Care. This model uses a regression equation essentially to compare each home's cost per day to a mathematical peer group - the lower the score, the more efficient the facility. The efficiency factor is applied in the case of ties.

The five highest-rated facilities receive a quality incentive award of $25,000.

Facilities have flexibility in how they use the award as long as it is used to improve quality of life or care and the home's resident council is consulted in determining how to spend the funds.

DAD and the Vermont Health Care Association will be considering new criteria for the awards. Possible new award criteria include meeting the staffing guidelines on a regular basis and keeping turnover percentages of direct-care personnel below the statewide average.

In 1999, the first year of the program, five facilities each received $50,000. In 2000 and 2001, five facilities each received $25,000. The facilities receiving the award were:

1999
Brookside Nursing Home (Bradford)
Derby Green Nursing Home (Derby)
Redstone Villa (St. Albans)
Springfield Health and Rehabilitation Center (Springfield)
Woodridge Nursing Home (Berlin)

2000
Crescent Manor Care Center (Bennington)
Derby Green Nursing Home (Derby)
Eden Park (Brattleboro)
Pleasant Manor Nursing Home (now Roncalli Health Center-Rutland)
Mayo Healthcare (Northfield)

2001
Bennington Health and Rehabilitation (Bennington)
Mayo Healthcare (Northfield)
Mt. Ascutney Hospital and Health Center (Windsor)
Redstone Villa (St. Albans)
Verdelle Village (now Roncalli Health Center-St. Albans)

2002
Mt. Ascutney Hospital & Health Center (Windsor)
Derby Green Nursing Home (Derby)
Eden Park (Brattleboro)
Stratton House Nursing Home (Townshend)
Greensboro Nursing Home (Greensboro)

By reducing the grant awards from $50,000 to $25,000 each, additional funds became available for a quality incentive program. In the first year, DAD gave out 14 incentive grants totaling $134,000; the goal of the grants was to improve quality of life and care.

Examples of some of these awards and projects include:

- Bel-Aire Center, Newport: $12,398, new dining room lighting and surround stereo music system, and other common area improvements;

- Bennington Health and Rehabilitation Center, Bennington: $10,300, new walking path, garden areas and other outdoor improvements;

- Green Mountain Nursing Home, Colchester: $6,000, massage therapy sessions; and,

- Helen Porter Healthcare and Rehabilitation Center, Middlebury: $5,000, facility-wide excursion on Lake Champlain.

After a second year of grants, DAD consulted with the nursing home association, The Vermont Health Care Association, and decided to re-direct the money for statewide training and demonstration projects.

At the time of this report, DAD was in various stages of joint projects with the nursing home association:

1. The End of Life/Palliative Care pilot project provided four nursing homes with a total of $60,000 to test initiatives that could improve service to people at the end of life. The nursing homes (Bennington Health and Rehabilitation Center, Berlin Health and Rehabilitation Center, Derby Green and Stratton House) helped to develop a standardized physician's order form, a new palliative care protocol for symptom relief, new pain scale to help communication between patient and providers, and a comfort care booklet for patients and their families. (With additional funding, these efforts will be communicated to other nursing homes in Vermont.)

2. A pilot project related to improving quality of care for Alzheimer's patients began in early 2002.

3. Planning discussions are taking place for a pilot project related to improving working conditions in nursing homes using a "best practices" approach from the nursing homes with good indicators, such as low rates of employee turnover and absenteeism.

Recommendation 6

DLP and the Vermont Health Care Association should consider new award criteria addressing staffing and turnover ratios.

Recommendation 6a

DAD should require nursing homes receiving $25,000 quality awards to provide timely, detailed reports on how funds are spent.

Recommendation 6b

DAD should work to see that all nursing homes participate in the Resident Satisfaction Survey so they will be eligible to compete for the quality awards.

Recommendation 6c

DAD grant initiatives should have clear, measurable goals; projects should be evaluated periodically as to results that have been achieved; results and suggestions should be widely shared.

Finding 7

New minimum staffing regulations for nursing homes went into effect December 15, 2001 to help assure that nursing home residents will not be harmed due to inattention. Nursing homes are meeting the new standards and initial data reporting difficulties are being addressed and reduced.

Discussion

On December 15, 2001 new State regulations on minimum nursing home staffing levels went into effect. The new rules require nursing home residents to receive a weekly average of 3.0 direct care hours per day (in room) from registered nurses, licensed practical nurses and licensed nursing assistants. The rules were put forth in response to State concerns that inadequate staffing levels at nursing homes can compromise the quality of care residents receive.

Recent research has highlighted the problems with low staffing ratios. For example, the federal Department of Health and Human Services found in 1999 that, "Evidence suggests inadequate levels of nursing home staff contribute to quality of care problems."[34]

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34 "Quality of Care in Nursing Homes: An Overview," Office of the Inspector General, Department of Health and Human Services, March 1999.

A federal study released in August, 2000, "Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes - Phase I," concluded that, "raising staffing levels would likely lead to improved health outcomes among nursing facility patients," and that homes "needed to provide at least 2.9 hours of nursing care per patient per day in order to 'obtain optimal quality outcomes.'"[35] A draft second phase of the report declares that "Depending on the facility's size and other factors … 2.4 to 2.8 hours per resident day (HRD) are optimal for certified nurse's aides, with an additional 1.15 to 1.30 HRD delivered by licensed practical nurses or registered nurses." [36] The report concludes that going beyond 3.55 to 4.1 HRD does not significantly improve patient outcomes.[37]

The report, now being finalized by the federal Department of Health and Human Services, says the link between nursing home staffing levels and poor care is compelling. Seniors in poorly staffed homes are more likely to suffer from dehydration, bed sores, malnutrition, pneumonia and blood-borne infections, the report said. The report also noted that homes should have a nurse for every six residents during the 7 a.m. to 3 p.m. shift, but that only about 10 percent of homes in the U.S. meet that standard.[38] A report for April, 2001 showed that Vermont nursing homes averaged one nurse (RN or LPN) for each 17 residents during the day shift.[39]

The State's DLP developed a staffing reporting system for nursing homes and, since December 15, 2001 when the rules went into effect, has conducted seven audits to check for compliance in reporting hours worked, number of direct care employees who worked, and the number of residents each day, and found only minor reporting errors. The DLP looks at census figures, payroll and other data provided by each nursing home to evaluate the staffing reports a nursing home has submitted.

The hours/per resident/per day requirements are considered to be the baseline for staffing and do not absolve nursing homes from other state or federal guidelines they must address to "meet the needs of the residents." Nursing homes with high-need residents could meet the minimum staffing guidelines, in other words, but could also be liable for a deficiency finding if staff did not adequately address the needs of residents when they require more than the minimum hours of staffing.

A nursing home industry representative, in writing about the staffing rules before they were adopted, pointed out that "quantity does not equal quality:"

> *Of the seven homes with less than 3.0 hours of nursing care in the month of June, none of the seven received a deficiency above the level of E (potential for minimal harm); one was deficiency-free in its last state survey and one received the state of Vermont's Quality Award for the last two consecutive years. Of the seven homes with the highest total hours, none of them have received the annual Quality Award, none are deficiency-free, and two received deficiencies at the level of actual harm.*[40]

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35 "News Currents," *Provider* magazine, April 2002, p. 11.

36 Ibid.

37 Ibid.

38 "Study: Nursing Homes Understaffed," Associated Press, Washington, D.C. February 19, 2002.

39 Memo to Nursing Home Administrators from Laine Lucenti, DLP, May 28, 2001.

40 Mary Shriver, Vermont Healthcare Association, *The Burlington Free Press,* August 4, 2001.

It is the opinion of Patrick Flood, DAD Commissioner, that the new staffing minimum standards are helping nursing homes better staff their facilities and care for residents. "The staffing numbers are looking good," he said. "Most nursing homes were meeting the standard anyway, and the ones that weren't are coming up to the standard."[41] The information about daily direct care hours per resident at Vermont nursing homes is available at the Medicare website, www.medicare.gov, in the section titled "Nursing Home Compare."

The DLP asks nursing homes to report staffing levels each month, using daily totals; DLP and the Division of Rate Setting work to produce a weekly average number of daily hours of direct care per resident for each nursing home.

During the public comment period before the adoption of the staffing regulations, some resident advocates objected to the measurement of staffing levels on a daily or weekly basis, arguing that they should be measured on a shift basis. DAD successfully argued the case that "at times there are circumstances beyond the control of the facility, such as inclement weather or illness, that would result in daily staffing levels falling below the minimums. It is important to give facilities the flexibility to handle such situations and to balance the (staffing) requirement with how they want to manage their facilities."[42]

Resident advocates were concerned that by using aggregate numbers of hours worked, it would be possible for a nursing home to have dangerously low staffing on nights and weekends but meet the guidelines on paper due to higher numbers of staff working weekday shifts.

The DLP can review staffing hours for any day reported by a nursing home to spot potential problems. Also, DLP surveyors, in their regular survey procedures, examine a three-week period of staffing at a nursing home. Staffing is further scrutinized during the investigation of a complaint related to quality of care as well.

In addition, effective in January 2003, federal law will require facilities to post, for each shift, the number, but not the names of, licensed and unlicensed nursing staff directly responsible for patient care.

As nursing homes began to submit regular staffing information, a number of questions arose regarding a variety of issues including the proper way to account for daily overtime hours, LNA student service, administrators who occasionally perform direct care activities, and care by hospice or private duty nurses who aren't employees. Initial reporting difficulties have been smoothed out at this time, according to DLP.

Recommendation

None.

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41 Interview with Patrick Flood, conducted by George Thabault, Chief, Special Audits and Review, Office of the State Auditor, March 7, 2002.

42 Letter regarding Final Proposed Rule: Licensing and Operating Rules for Nursing Homes SOS # 01038, to Louise Corliss, APA Clerk, Office of the Secretary of State, from Dena Monahan, General Counsel, Agency of Human Services, Dept. of Aging and Disabilities, September 26, 2001.

Finding 8

The Division of Rate Setting reports that nursing home wage supplements authorized by the Legislature are being used as intended. However, the State has no scientific survey method to determine how the rate of employee turnover (and impact on quality) might be affected by wage increases.

Discussion

The 1999 Legislative session granted a wage supplement to the nursing home industry to help address widespread concerns about nursing home labor shortages and high employee turnover. The supplements, to enhance wages and benefits for nursing home workers, were paid out monthly to nursing homes, beginning in July of 1999.

The funds were raised by dedicating a portion of the "bed tax" (currently $2,768.69 per bed) that nursing homes pay to the State, and which are reimbursed by Medicaid at the matching rate of approximately 63 percent. For FY 2000 and FY 2001, the nursing homes have received a total of $7.9 million.[43] (DRS is forecasting a total wage supplement paid to nursing homes of $9.5 million for FY 02.[44]) What a home receives is based on the percentage of its resident population who receive Medicaid. So, homes with lower Medicaid participation rates receive a lower percentage of the wage supplement.

Other findings by Divison of Rate Setting:

- Accumulated industry spending on wages/benefits has increased by $22.5 million or 28 percent over the baseline period (4th quarter, 1998 annualized) or approximately $15 million more than the accumulative wage supplement of $7.9 million. Most of this can be attributed to the cost of living adjustments the nursing homes have received each year.

- Ninety-five percent of the accumulative wage supplement has been spent by the industry. Four homes did not spend 100 percent of their accumulated wage supplements; for two homes it was due to substantial declines in utilization levels accompanied by a contraction in their payroll base. The lower staffing levels kept wage growth below that needed to utilize the supplements.

- Increase in health care premium costs made up approximately 7 percent of the increase in spending from the baseline period to FY 01.[45]

DAD uses nursing home financial reports to determine by what amount each facility's average hourly wage has changed since the base year, and then summarizes this information (See Figure 4).

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[43] Memo to Patrick Flood, Commissioner, Department of Aging and Disabilities, from Gary P. Bergeron, Rate Setting and Auditing Chief, January 8, 2002.

[44] Allocation Methodology for Nursing Facility Transitional Wage Supplement (FY 002 Proposed Bed Tax Increase), Division of Rate Setting, December 26, 2001.

[45] Ibid.

Figure 4

Job Category	FY 98 ave. wage/hr	FY 01 ave. wage/hr*	Ave. % increase
RNs	16.32	19.64	20
LPNs	12.87	15.64	22
LNAs	8.24	10.03	22
Dietary	8.08	9.06	12
Maintenance	11.43	12.53	10
Laundry	7.81	8.66	11
Housekeeping	7.63	8.36	10
Average	**$10.07**	**$11.76**	**16.8**[46]

**some nursing home reports include overtime compensation*

While the nursing home industry has used the wage supplements for their intended purposes, it is difficult to say exactly what effect the wage supplements had on the job turnover rate in Vermont nursing homes, and what effect lower turnover rates have on the quality of patient care (See Figure 5 for recent turnover rates). DLP reports, "There does not seem to be a relation to deficiencies and turnover."[47]

One of the difficulties is the way DLP calculates turnover data. DLP relies on the number of W-2 wage reports, which due to the hiring practices of nursing homes, could include a lot of seasonal employees not in the direct care departments. A more refined approach to turnover data could involve using only the number of employees with one year of experience in the nursing home.

Another method is to more carefully document the separations per year in the direct care workforce and divide by the average size of the direct care work force during the year. A more accurate picture of turnover would help DAD and DRS assess labor issues in the nursing home industry.

Recommendation 8

DRS and DAD should adopt more precise survey instruments to gauge turnover in the nursing home industry.

Recommendation 8a

DAD should advocate for wage enhancements that achieve a true living wage for direct care workers.

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46 Bergeron, op.cit., January 8, 2002.

47 Communication, Laine Lucenti, DLP, May 6, 2002.

Figure 5

Comparison chart of statewide averages for nursing facility turnover rates, 1996-2001

	2001	2000	1999	1998	1997	1996
Total on Payroll	56%	51%	53%	50%	59%	51%
RNs	44%	33%	49%	34%	47%	28%
LPNs	22%	25%	35%	29%	45%	34%
LNAs	65%	55%	47%	61%	67%	55%

Finding 9

The Nursing Home Customer Satisfaction Survey is a positive step forward in helping consumers determine quality nursing facilities and helping providers to improve performance in key areas.

Discussion

In collaboration with DAD, the Vermont Association of Hospitals and Health Systems and the Vermont Health Care Association last year began a first-ever, statewide nursing home "resident satisfaction survey."[48]

Thirty five nursing homes participated in the process. Ten did not participate. Three of the 10 did not participate because the facility does not participate in Medicaid and state funds were not available to cover the costs of the survey. Others cited the extra paperwork or disinterest as reasons for not participating. Short-term and rehabilitation residents were surveyed immediately following discharge or as quickly as information was supplied by the facilities. Long-term residents were surveyed at least once during the year.

Residents receive a survey form from the facility with questions regarding their satisfaction with care and services. Resident responses are scored from very poor to very good. The average is the sum of all residents' ratings of a topic divided by the number of residents who rated that topic. For each nursing home, an overall score is calculated as the average of all section scores. These scores are then compared to the average scores of all Vermont nursing homes that participate in the survey. Residents' responses are confidential and only the aggregate answers are tabulated.

The company that administers the survey is Press Ganey Associates, Inc., of South Bend, Indiana. The Vermont Health Care Associations oversees the project for the State. Press Ganey charges $1.68 for every survey mailed. There is a tabulation and reporting charge of $647.50 for each facility's comprehensive survey report.[49] The survey instrument was field-tested before being adopted by Press Ganey. Surveys are optically scanned by Press Ganey, but hand-checked if there is any scanning problem. Comments are collected and included in the report to the nursing home. Press Ganey asserts that the current system produces results of high integrity because the risk of multiple or fraudulent survey submissions is very low.

This Survey Helps

"The survey is a good tool. Our report showed that residents weren't happy with the response times for their problems, so we got an extra full-time maintenance worker to share with the hospital. Residents also felt they weren't getting enough spiritual support so we hired a part-time chaplain to start a support program and trained volunteers to provide more of a spiritual presence for people."

Mary Lou Campbell, nursing home administrator at the Mt. Ascutney Hospital and Health Center in Windsor.

In order to have meaningful data, a facility must have at least 30 resident surveys returned or 50 percent of those mailed. Several facilities were unable to meet that criteria and are not included in the reports. Some other facilities have signed contracts with the survey company but for various reasons have not been able to coordinate their data. These facilities will participate in the next reporting period.

There is no post-survey audit done by Press Ganey due to the limited scope of the survey and the procedures in place which provide a low risk of fraud.[50] Auditing of mail-in survey generally requires, among several steps, a review of the readability of the forms, analysis of response rates, an independent recalculation of a sample of findings; a significant number of respondents typically must be reached by telephone or other means to verify the information they submitted. Press Ganey acknowledged that in smaller homes, where the person sending out the surveys knows a good deal about the residents, there is the possibility that a person who has complained frequently could be taken off the mailing list and this would not be detected by Press Ganey.

Vermont's survey results are posted on the DLP's website, but they are not easy to find. There is also no ongoing public education effort to inform Vermonters of the results. Giving consumers easy access to satisfaction surveys is important, experts say. Charlene Harrington, Ph.D., a professor of nursing and sociology at the University of California, San Francisco, testified to Congress on June 30, 1999, that "An Internet information system about nursing homes will allow consumers to make choices among the various nursing facilities and to obtain periodic information the quality of care in specific facilities. In the long run, having a consumer information system may encourage facilities to improve the quality of care they deliver in order to be more competitive. An Internet information system will bring poor quality into full public view so that the public will know what is going on behind the closed doors of the nation's nursing homes."

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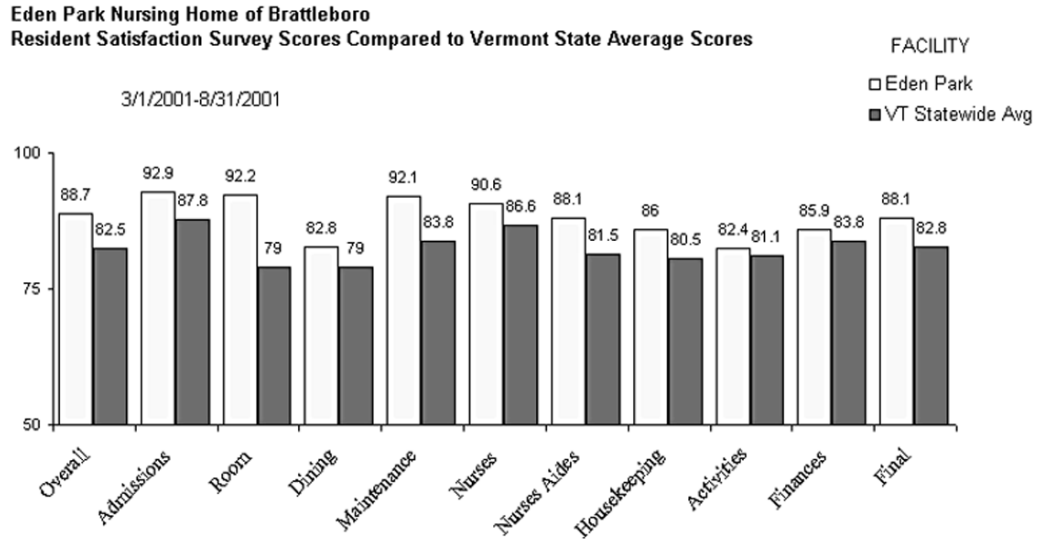
48 The customer survey was one of the key recommendations in "Nursing Home Quality Project Final Report," by the Vermont Project for Quality in Health Care, Inc., for the Vermont Department of Aging and Disabilities, Agency of Human Services.

49 Communication, Vermont Health Care Association, April 29, 2002.

50 Telephone interview with Harry Dose, Press Ganey Associates, Inc., by George Thabault, Chief, Special Audits and Review, Office of the State Auditor, April 30, 2002.

Sample Resident Satisfaction Survey



Recommendation 9

While continuing to update each facility's customer satisfaction survey, more efforts, such as periodic regional news releases, should be taken to alert the public as to results, and results should be posted more prominently on the DAD website. The website should also be evaluated for its ability to reach people.

Recommendation 9a

DAD should work to bring all nursing homes into the customer survey program so that Vermont consumers can compare all nursing homes.

Background

The Vermont nursing home industry is a relatively small universe. Forty-three Medicare or Medicaid-receiving nursing homes (of 45 total homes) operate within Vermont. (Two nursing homes do not participate in Medicare or Medicaid programs: The Arbors in Shelburne, and Mertens House in Woodstock. Of the 43 nursing homes receiving federal funds, all participate in the Medicaid program except the nursing home at Wake Robin in Shelburne which participates in Medicare only.)

In Fiscal Year (FY) 2000 the 42 Medicaid-receiving nursing facilities reported total patient revenue of $163,412,173 for the year. On average for FY 2000, the nursing homes received 57.94 percent of patient revenue from Medicaid (approximately $94.4 million), 17.81 percent from Medicare (approximately $29 million), 23.4 percent from private sources such as personal savings, private insurance, and HMOs (approximately $38 million), and less than 1 percent from other sources.[51] Nursing home charges are typically in the range of $3,000 to $4,000 per month per resident, and sometimes higher.

> "The people of Vermont are fortunate to have a very dedicated set of professionals carrying out the regulation of our nursing homes. We are also fortunate to have a very strong, yet fair, set of regulations. We are also fortunate to have many nursing home staff who care deeply about providing the best care they can and our nursing home care ranks among the best in the country. There can always be problems. When we know about them we address them quickly and thoroughly."
>
> ***– Patrick Flood, Commissioner, Vermont Department of Aging and Disabilities***

In addition to nursing homes, the State, through the DLP, also regulates approximately 115 residential care homes for the dual purposes of protecting the welfare and rights of residents and assuring they receive quality care. Residential care homes provide care to persons unable to live wholly independently, but who are not in need of the level of care and services provided at a nursing home. Residential care homes are licensed as either Level IV or Level III; they provide a total of approximately 2,200 beds. Both levels must provide room and board, assistance with personal care, general supervision and/or medication management. Level III homes must also provide the additional service of nursing overview.

DLP inspects a total of approximately 280 facilities including the nursing homes and residential care homes mentioned above. In addition, DLP regulates 139 Medicare or Medicaid providers and 96 other facilities, including six hospitals, 12 home health agencies, two ambulatory surgical centers, two portable X-Ray operations, seven end-stage renal dialysis centers, 25 rural health clinics, therapeutic community residences, a home for the terminally ill, and other facilities.

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[51] Gary P. Bergeron, Rate Setting & Auditing Chief, Division of Rate Setting, Agency of Human Services, January 16, 2002.

Vermont spends an estimated $15 million per year in Medicaid funds on alternatives to nursing home care, such as community-based waiver services, which allow Medicaid-eligible individuals needing long-term care services to remain in their homes, and enhanced residential care services which cost less than nursing homes. [52] This effort was spurred by Vermont's Act 160, passed in 1996, which required the State to shift approximately $20 million in Medicaid funds from nursing homes to community-based services by FY 2000. The State has trimmed licensed nursing home beds to 3,559, down from 3,848 in 1997; they serve slightly more than 5,000 residents each year.

Despite progress with alternatives to institutional care, nursing homes remain a critical component of both acute and long-term care services. Each year, nursing homes receive about 80 percent of the State's Medicaid long-term care expenditures, or an estimated $91 million of an estimated total of $113 million, in the fiscal year ending June 30, 2002.

By offering skilled nursing care, as well as assistance with activities of daily living, nursing homes provide rehabilitative care following hospitalization, specialized care and/or long-term living arrangements. Many people fear the loss of functions that can come with aging and the idea of being cared for by strangers. In fact, a recent study found that more than half of seriously ill hospital patients would not want to live permanently in a nursing home. Almost a third would rather die than do so.[53] Many people dislike the idea of nursing homes in general and fear how they and their loved ones will be treated as they age. This dislike and fear, along with the physical or mental vulnerability of many residents, may explain why nursing homes are one of the nation's most heavily regulated industries.

Vermont nursing homes range in size from 12 to 184 beds. Owners include the State (Vermont Veterans Home), hospitals, other non-profit corporations and for-profit corporations ranging from family businesses to a publicly-traded Canadian corporation, CPL REIT.[54] More than half of all licensed nursing home beds are owned and operated by for-profit nursing homes that are part of regional or national chains not based in Vermont. [55] All but two of the State's nursing homes (containing a total of 26 beds) are certified to participate in the Medicare and/or Medicaid programs. In FY 1998, 4.6 percent of Vermonters aged 65 and older resided in nursing homes.[56]

Public support of nursing homes is provided through:

- **Medicaid**, where federal funds are matched with State expenditures to pay for nursing home care for eligible low-income elderly and disabled people; and,

- **Medicare**, the federal insurance program which pays for certain nursing home care after a hospital stay. In Vermont, Medicaid has provided 55 to 60 percent of nursing home revenues during the past several fiscal years, while Medicare has provided 14 to 17 percent during the same period.

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[52] Department of Prevention, Assistance, Training and Health Access, FY 2002 Budget Book, Form 5.

[53] "Study: Nearly a Third of Seriously Ill Patients Would Rather Die than Live in a Nursing Home," Robert Wood Johnson Foundation press release about SUPPORT study that was first published in the November 22, 1995 issue of *The Journal of the American Medical Association*. Press release available at http://www.rwjf.org/app/rw_news_and_events/rw_new_media_article.jsp?id=983406545813.

[54] CPL Subacute, a subsidiary of CPL REIT, owns seven nursing homes in Vermont with a total of 766 beds.

[55] State Auditor's Review of the Department of Aging and Disabilities Implementation of Act 160, May 15, 2000, p .2.

[56] Murphey, David, PhD., *The Social Well-Being of Vermonters 2001: A Report on Outcomes for Vermont's Citizens*, Agency of Human Services, February 2001, p. 81.

Home & Community-Based Waivers

Medicaid's home and community-based services waiver program affords States the flexibility to develop and implement creative alternatives to institutionalizing Medicaid-eligible individuals. States may request waivers of certain Federal rules which impede the development of Medicaid-financed community-based treatment alternatives. The program recognizes that many individuals at risk of institutionalization can be cared for in their homes and communities, preserving their independence and ties to family and friends, at a cost no higher than that of institutional care.

The Social Security Act specifically lists seven services which may be provided: case management, homemaker services, home health aide services, personal care services, adult day health, habilitation and respite care. Other services, such as transportation, in-home support services, meal services, special communication services, minor home modifications, and adult day care, may be provided, subject to CMS approval. States have the flexibility to design each waiver program, and select the mix of waiver services to best meet the needs of the population they wish to serve.

Waiver services may be provided statewide or may be limited to specific geographic subdivisions.

Waiver services may be provided to the elderly and disabled, the physically disabled, the developmentally disabled or mentally retarded and the mentally ill. Waivers may also be targeted to individuals with a specific illness or condition, such as technology-dependent children or individuals with AIDS. Under the waiver program, States can make home and community-based services available to individuals who would otherwise qualify for Medicaid only if they were in an out-of-home setting.

To receive approval to implement a waiver, a State Medicaid agency must assure CMS that, on average, it will not cost more to provide home and community-based services than providing institutional care would cost. The Medicaid agency also must provide and document certain other assurances, including that there are safeguards to protect the health and welfare of recipients.

- Centers for Medicare and Medicaid, Washington, D.C.

Regulation of Nursing Homes

Nursing homes in Vermont are governed by the laws contained in Chapters 71 and 73 of 33 V.S.A. and Chapter 55 of 18 V.S.A. More detailed regulations are provided in the Licensing and Operating Rules for Nursing Homes, issued by DAD. New requirements pertaining to special care units, transfer and discharge appeals, staffing levels, options counseling and limiting the use of three- and four-bed rooms became effective December 15, 2001.

Any nursing home that receives federal funds through either the Medicaid or Medicare programs must meet the requirements of both the Social Security Act[57], which addresses quality of care in "skilled nursing facilities" and Title 42, Part 483 of the Code of Federal Regulations. These laws codify the 1987 enactment by Congress of the Nursing Home Reform Act (OBRA 87), which dramatically reformed nursing home regulations, added requirements pertaining to quality of care and resident rights and strengthened the Long Term Care Ombudsman program.

The federal regulations specify a variety of provisions in relation to quality of life, scope of services, resident assessments, resident's rights, administration and condition of the facility, and nurse aide training. These include:

- In general, "a skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident." [58]

- A nursing home "must provide services and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written plan of care."[59] Services "must be provided by qualified persons." [60]

- Nursing homes must have a registered nurse conduct an initial comprehensive assessment of each resident within 14 days of admittance and then formulate a comprehensive care plan. Facilities must conduct quarterly reviews of the assessment and update it at least annually and whenever there is a significant change in the resident's condition. [61] "Assessments gather information about the health and physical condition of a resident and how well a resident can take care of themselves. This includes assessing when help may be needed in activities of daily living (ADLs) or 'functional abilities' such as walking, eating, dressing, bathing, seeing, hearing, communicating, understanding, and remembering. Assessments also should examine a residents' habits, activities, and relationships in order to help him or her live more comfortably and feel at home in the facility ... The care plan is a strategy for how the staff will help a resident every day. This care plan says what each staff person will do and when it will happen ... The care plan is developed by an interdisciplinary team – nurse, nurse aide, activities and dietary staff, and social worker, with critical input from the resident and/or family members. All participants discuss the resident's care at a Care Plan Conference to make certain that all

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[57] The Act is codified in Title 42 Chapter 7 Subchapter 18 of the United States Code beginning with § 1395.

[58] 42 U.S.C. 1395i-3 (b)(1)(A).

[59] 42 U.S.C. 1395i-3 (b)(2).

[60] 42 U.S.C. 1395i-3 (b)(4)(B).

[61] 42 U.S.C. 1395i-3 (b)(3).

medical and non-medical issues, including meals, activities, therapies, personal schedule, medical and nursing care, and emotional needs are agreed upon and addressed."[62]

- The results of resident assessments are submitted electronically to the Minimum Data Set (MDS), a data repository maintained by the states and federal government.[63] MDS data is used:

  – to create a resident plan of care and monitor ongoing care;
  – to guide areas of focus for annual surveys;
  – to provide compiled nursing home information to consumers; and,
  – by researchers looking at the nation's nursing home system.

  Some of Vermont's larger nursing homes may employ one or two people full-time just to complete MDS forms. DLP has conducted 23 MDS audits since October 1, 2001 with a goal of verifying information affecting both patient care and financial reimbursement. DLP has set an error rate target of no more than 3 percent. In 21 audits, the error rate was below 2 percent; two other facilities had with error rates of 2.41 and 2.30 percent.[64]

- Nurses' aides must complete a training or competency evaluation program approved by the State and regular in-service education.[65] The State requires a minimum 75 hours of training.

- "A skilled nursing facility shall post daily for each shift the current number of licensed and unlicensed nursing staff directly responsible for resident care in the facility."[66]

State regulations generally parallel federal regulations, although the recent addition of minimum staffing requirements is more specific than the federal requirements.

Funding of Nursing Homes

Medicare payments are made by the federal government to certified providers via designated fiscal intermediaries. Medicaid payments are made according to the terms of the State's Medicaid Plan. Funding comes from Vermont's federal Medicaid grant and the State's General Fund appropriation required for the Medicaid match. There are extensive regulatory requirements for the development and terms of the State Plan, the management of grants and nursing home certification. [67]

Funding of nursing homes involves a number of State offices. DAD in Waterbury manages the expenditures for nursing homes, although the State appropriation is made to the Department of Prevention, Assistance, Training and Health Access (PATH), in the Agency of Human Services (AHS), which oversees Medicaid eligibility and payment processing. Rate determination is handled by the Division of Rate

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[62] From the "Assessment and Care Planning Fact Sheet," National Citizens Coalition for Nursing Home Reform website, http://www.nccnhr.org/public/50_156_453.cfm.

[63] 42 U.S.C. 1395i-3 (f)(6)(A).

[64] Communication, Laine Lucenti, DLP, April 19, 2002.

[65] 42 U.S.C. 1395i-3 (b)(5).

[66] 42 U.S.C. 1395i-3 (b)(8)(A).

[67] These regulations are codified in 42 CFR Part Subchapter C.

Setting (DRS), part of the central AHS office. Payments are processed in Williston by EDS, the State's Medicaid and Medicare claims processor.

The estimated long-term Medicaid expenditures for the current fiscal year ending June 30, 2002, are:

Nursing Homes	$91,073,235
Aged and disabled HCB Waiver	$19,338,429
Enhanced Residential Care HCB Waiver	$1,911,300
Traumatic Brain Injury Waiver	$2,163,653
Total:	**$113,486,617**

The State share of these expenses is 37.1 percent., or approximately $42.1 million.[68]

DAD's responsibilities include certifying the providers and establishing the case-mix score that determines reimbursement rates for each nursing home. The case-mix score is a method to address the variation in costs that result from variations in the degree of care required for a nursing home resident. The score is developed using the MDS information, which is collected during the regular assessments conducted on each nursing home resident, regardless of payer.

The director of the State's Division of Rate Setting (DRS) is charged with establishing "by rule procedures for determining rates for care of Medicaid recipients who are residents of Medicaid certified nursing homes."[69] The rules seek to "balance the competing policy objectives of access, quality, cost containment and administrative feasibility. Rates set under this payment system are consistent with the efficiency, economy and quality of care necessary to provide services in conformity with state and federal laws, regulations, quality and safety standards, and meet the requirements of 42 U.S.C. §1396a(a)(13)(A)." The rules are outlined in Medicaid Standards and Principles for Establishing Medicaid Payment Rates for Long-term Care Facilities, most recently updated in July 2001.

A National View

"Nobody is happy with the nation's nursing homes. Too many patients are receiving sub-standard care. Workers, particularly nurses' aides who provide the majority of direct care, suffer from low wages, lack of benefits, understaffing, inadequate training, and limited career opportunities. Families are often appalled at how their loved ones are treated. Owners and managers struggle with government reimbursements that do not allow higher pay or better treatment. Clearly, the $96.2-billion-a-year nursing home industry is failing its residents and workers."

Joan Fitzgerald, Associate Director of the Center for Urban and Regional Policy, in "Better-Paid Caregivers, Better Care."
The American Prospect, ***May 21, 2001.***

68 Communication, Jim Giffin, Business Manager, DAD, April 30, 2002.

69 33 V.S.A. §904.

Each fiscal quarter, DRS reviews the case mix score for each nursing home in Vermont along with historical cost figures in six cost categories – nursing care, resident component, indirect component, Director of Nursing, property and ancillary care. Rates are then set prospectively for each nursing home. Fact Books detailing Medicaid rates, case-mix scores, occupancy, staffing patterns and other information pertaining to nursing homes facilities are published twice each year by the DRS.

Department of Aging & Disabilities

The Department is the center of the Agency of Human Services' program management and policy development with respect to older persons and persons with disabilities. The Department has these stated goals:

- Assist older persons and adults with physical disabilities to live as independently as possible;
- Assist persons with disabilities to find and maintain meaningful employment; and,
- Assure quality of care and life to individuals receiving health care and/or long-term care services from licensed or certified health care providers and protect elderly and disabled adults from abuse, neglect and exploitation.

Licensing of Nursing Homes

In Vermont, a person cannot operate a nursing home "without first obtaining a license."[70] The nursing home must be under the supervision of a licensed administrator.[71] Annual licenses are issued by DAD's Division of Licensing and Protection (DLP) after receiving an application and making a determination "that the applicant and the facility meet the standards established."[72] These standards are detailed in the Licensing and Operating Rules for Nursing Homes adopted by the Secretary of the Agency of Human Services. Renewing a license is contingent upon the facility maintaining compliance with state and federal regulations.

Statute requires the rules for nursing home licensing to:

1. Require that nursing facilities provide the care and services necessary to help each resident attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with a comprehensive assessment and plan of care and prevailing standards of care as determined by the commissioner of aging and disabilities; and,
2. Promote a standard of care that assures that the ability of each resident to perform activities of daily living does not diminish unless the resident's ability is diminished solely as a result of a change in the resident's clinical condition.[73]

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[70] 33 V.S.A. §7103 (a).

[71] per 33 V.S.A. §7103 (b). Licensing requirements for nursing home administrators are detailed in 18 V.S.A. §§ 2001-2015.

[72] 33 V.S.A. §7105 (a).

[73] 33 V.S.A. §7117.

Prior to receiving a license, the DLP must inspect the facility.[74] Licenses are issued for a specific bed capacity to the named applicant and facility. They are not transferable or assignable.[75]

Federal certification of nursing homes, required for a home to receive Medicaid or Medicare funds, is done in accordance with specific survey protocols. The Act directs the Secretary of HHS to "make an agreement with any State which is able and willing to do so . . . for the purpose of determining whether an institution therein is a ... skilled nursing facility."[76] The DLP has an agreement with the Secretary of HHS and has been "federally designated to evaluate the performance and effectiveness of licensed/certified nursing homes in delivering safe and effective quality of care."[77]

Division of Licensing and Protection

Located in the Department of Aging and Disabilities, the DLP provides opportunities for individuals to choose a lifestyle which preserves individuality, dignity, autonomy, and self-determination consistent with their wants and needs. It assures the safety and well-being of elderly and disabled people by:

- Enforcing federal and state statutes and regulations;
- Investigating alleged abuse, neglect, and exploitation;
- Licensing facilities which provide care for the elderly or the disabled; and,
- Surveying and certifying facilities for participation in Medicare and Medicaid.

"This is achieved by a system of licensing and protective services, which includes education, assistance, prevention, sanctions, empowerment and promotion of positive change in a respectful manner," the DLP notes on its website.

It was noted during this review that Vermont does not currently require proof of liability insurance as a condition for getting a license to operate a nursing home. In Florida, press reports indicate that skyrocketing liability insurance costs have forced some nursing home operators to go without. The Florida Health Care Association reported to our Office that a study conducted by the University of Florida in late 2001 found that, "because of the unaffordability and unavailability of insurance, 19 percent of the nursing homes (in Florida) were without liability insurance."[78] The State of Florida mandated that, as of January 1, 2002, all nursing homes must carry liability insurance. The mandate does not specify a minimum amount of coverage nor that it be professional and general liability. All Vermont nursing homes currently report insurance premiums as one of their reportable costs, but the type and amount of coverage is not specified.

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[74] 33 V.S.A. §7108 (a).

[75] 33 V.S.A. §7105 (a).

[76] 42 U.S.C. 1395 aa (a).

[77] From Department of Aging and Disabilities FY 2002 Budget, Form 4.

[78] Communication, Bob Asztalos, Florida Health Care Association, May 7, 2002.

Improving Quality in Nursing Homes

Many factors beyond state and federal legislation combine to provide for a high "quality of life" and "quality of care" that a nursing home resident experiences. The key factors are obvious: a well-staffed facility with licensed, experienced, compassionate caregivers who respect a resident's need for dignity and privacy and who can consistently deliver and monitor quality care for the residents.

Other factors include ample social and recreational opportunities; a safe, homelike and clean environment; availability of assistive devices; excellent kitchen and food service program; competent medical staff and error-free medication system; and, a thoughtful and routinely monitored care plan.

Good nursing home administration contributes in many ways to the quality of care provided by LNAs, RNs and others with: careful screening and training of new employees; comprehensive guidelines and procedures related to a variety of situations beyond immediate resident care: infection control protocols; admissions and transfers; abuse prevention; reporting of and resolving complaints; quick correction of any deficiencies found in official inspections; proper building maintenance and security, and so on.

Residents, of course, experience nursing home quality in different ways. For some, food, hygiene and medical care might be the critical factors in a quality experience. For others, interpersonal reactions or hard-to-quantify elements of day-to-day living – such as a pleasing view from the window, quiet neighbors, the smell of the facility, or the ability to get around unassisted – might make the most difference.

Researchers M. Bliesmer and P. Earle in 1993[79] condensed previous research about what nursing home residents valued to 17 specific quality indicators:

Good staff attitude	Variety of food	Broad range of activities
Prompt attention	Daily activity choices	Physician availability
Homelike atmosphere	Privacy with physician	Room cleanliness
Privacy in room	Bathroom cleanliness	Strong administration
Practice of religion	Respect of rights	Community activities
Vehicle transportation	Problem resolution	

As part of this report, the State Auditor's Office also looked at several factors that have the potential to affect quality at Vermont nursing homes:

- Vermont's complaint reporting and resolution system;
- State wage supplement to the nursing home industry;
- New staffing requirements (effective December 15, 2001);
- Resident satisfaction surveys, quality grants, awards and new initiatives; and,
- Abuse investigation procedure.

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79 Bliesmer M., Earle P., "Nursing Home Quality Perceptions," *Journal of Gerontological Nursing,* 1993: 8(2): 27-34, cited in "Nursing Home Quality Project, Final Report," by the Vermont Program for Quality in Health Care, Inc. January, 1999.

Department Comments of Draft Review

State of Vermont

AGENCY OF HUMAN SERVICES

DEPARTMENT OF AGING AND DISABILITIES
Commissioner's Office
103 South Main Street
Waterbury VT 05671-2301
Voice 241-2401/TTY 241-3557
Fax (802) 241-2325

June 24, 2002

Elizabeth Ready, State Auditor
Auditor of Accounts
132 State Street
Drawer 33
Montpelier, VT 05633-5101

Dear Ms. Ready,

I want to acknowledge your review of our office's regulations and monitoring of nursing homes and thank your staff for the thorough and professional job they did.

We agree with your overall finding that the quality of care in Vermont nursing homes is among the best in the country. The data collected by the Centers for Medicare and Medicaid (CMS) support this finding. According to statistics kept by that office, Vermont has the second fewest number of nursing home deficiencies in the country.

We also concur with your finding that the federal survey process and budget hampers our ability to do more to support and monitor quality. We will continue to request permission from CMS for more flexibility in the survey process to better target problem facilities.

We can always improve our work and your office has made a number of other recommendations which we are already working on or will take a very close look at. We most certainly will continue to do everything we can to support recruitment and retention of care givers in Vermont nursing homes. The quality of care in all health care settings is directly related to the number and quality of the care givers.

Sincerely,

Patrick Flood

Patrick Flood
Commissioner

Table of Contents: Appendices

Appendix A

Division of Licensing & Protection: Vermont Nursing Home List

ARBORS NURSING HOME
687 HARBOR RD, SHELBURNE 05482
TEL: (802) 985-8600 Fax: (802) 985-9787
Licensed Capacity: 12
CHITTENDEN County

BEL-AIRE CENTER
35 BEL-AIRE DRIVE, NEWPORT 05855
TEL: (802) 334-2878 Fax: (802) 334-1008
Licensed Capacity: 44
ORLEANS County

BENNINGTON HEALTH & REHAB CENTER
2 BLACKBERRY LANE, BENNINGTON 05201
TEL: (802) 442-8525 Fax: (802) 442-7225
Licensed Capacity: 100
BENNINGTON County

BERLIN HEALTH & REHAB CENTER
98 HOSPITALITY DRIVE, BARRE 05641
TEL: (802) 229-0308 Fax: (802) 223-4864
Licensed Capacity: 152
WASHINGTON County

BIRCHWOOD TERRACE HEALTHCARE***
43 STARR FARM ROAD, BURLINGTON 05401
TEL: (802) 863-6384 Fax: (802) 865-4516
Licensed Capacity: 160
CHITTENDEN County

BROOKSIDE NURSING HOME OF BRADFORD
23 UPPER PLAIN, BRADFORD 05033
TEL: (802) 222-5201 Fax: (802) 222-5901
Licensed Capacity: 80
ORANGE County

BROOKSIDE NURSING HOME - WRJ
120 CHRISTIAN STREET, WHITE RIVER JCT. 05001
TEL:: (802) 295-7511 Fax: (802) 295-2533
Licensed capacity: 67
WINDSOR County

BURLINGTON HEALTH & REHAB CENTER
PO BOX 1107, BURLINGTON 05402
TEL: (802) 658-4200 Fax: (802) 863-8016
Licensed capacity: 168
CHITTENDEN County

CEDAR HILL HEALTH CARE CENTER
HCR 72, P.O. BOX 93, WINDSOR 05089
TEL: (802) 674-6609 Fax: (802) 674-5618
Licensed capacity: 39
WINDSOR County

CENTERS FOR LIVING AND REHABILITATION
160 HOSPITAL DRIVE, BENNINGTON 05201
TEL: (802) 447-1547 Fax: (802) 447-5482
Licensed capacity: 150
BENNINGTON County

CRESCENT MANOR CARE CENTERS
312 CRESCENT BLVD, BENNINGTON 05201
TEL: (802) 447-1501 Fax: (802) 442-7127
Licensed capacity: 90
BENNINGTON County

DERBY GREEN NURSING HOME
PO BOX 24, DERBY 05829
TEL: (802) 766-2201 Fax: (802) 766-2031
Licensed capacity: 23
ORLEANS County

EDEN PARK NURSING HOME – BRATTLEBORO
187 OAK GROVE AVE, BRATTLEBORO
TEL: (802) 257-0307 Fax: (802) 257-0309
Licensed capacity: 124
WINDHAM County

EDEN PARK NURSING HOME – RUTLAND
99 ALLEN STREET, RUTLAND 05701
TEL: (802) 775-2331 Fax: (802) 775-2331
Licensed capacity: 125
RUTLAND County

ELMORE HOUSE AT COPLEY MANOR
577 WASHINGTON HIGHWAY,
MORRISVILLE 05661
TEL: (802) 888-5201 Fax: (802) 888-8781
Licensed capacity: 30
LAMOILLE County

GILL ODD FELLOWS HOME
8 GILL TERRACE, P.O. DRAWER K,
LUDLOW 05149
TEL: (802) 228-4571 Fax: (802) 228-8008
Licensed capacity: 56
WINDSOR County

GREEN MOUNTAIN NURSING HOME
1102 ETHAN ALLEN AVENUE,
COLCHESTER 05446
TEL: (802) 655-1025 Fax: (802) 655-3025
Licensed capacity: 73
CHITTENDEN County

GREENSBORO NURSING HOME
47 MAGGIE'S POND RD, GREENSBORO
05841
TEL: (802) 533-7051 Fax: (802) 533-7054
Licensed capacity: 30
ORLEANS County

HAVEN HEALTH CENTER - RUTLAND
46 NICHOLS STREET, RUTLAND 05701
TEL: (802) 775-2941 Fax: (802) 773-2196
Licensed capacity: 127
RUTLAND County

HAVEN HEALTH CENTER - ST. ALBANS
596 SHELDON ROAD, ST ALBANS 05478
TEL: (802) 524-6534 Fax: (802) 524-2429
Licensed capacity: 120
FRANKLIN County

Helen Porter Healthcare and Rehabilitation Center
SOUTH STREET, MIDDLEBURY 05753
TEL: (802) 388-4001 Fax: (802) 388-3474
Licensed capacity: 105
ADDISON County

HOLIDAY HOUSE NURSING HOME
642 SHELDON ROAD, ST ALBANS 05478
TEL: (802) 524-2996 Fax: (802) 524-5289
Licensed capacity: 64
FRANKLIN County

MAPLE LANE NURSING HOME
P.O. BOX 500, BARTON HILL RD.,
BARTON 05822
TEL: (802) 754-2112 Fax: (802) 754-2113
Licensed capacity: 71
ORLEANS County

MAYO HEALTHCARE, INC.
71 RICHARDSON AVENUE, NORTHFIELD
05663
TEL: (802) 485-3161 Fax: (802) 485-6307
Licensed capacity: 50
WINDHAM County

MCGIRR NURSING HOME
33 ATKINSON STREET, BELLOWS FALLS
05101
TEL: (802) 463-4387 Fax: (802) 463-9670
Licensed capacity: 30
WINDHAM County

MENIG EXTENDED CARE
44 SOUTH MAIN STREET, RANDOLPH, VT
05060
Telephone: (802) 725-4441 Fax: (802) 728-2201
Licensed capacity: 20
ORANGE County

MERTEN'S HOUSE
73 RIVER STREET, WOODSTOCK 05091
TEL: (802) 457-4411 Fax: (802) 457-5722
Licensed capacity: 14
WINDSOR County

MORRISVILLE CENTER
72 HARRELL STREET, MORRISVILLE
05661
TEL: (802) 888-3131 Fax: (802) 888-7991
Licensed capacity: 90
LAMOILLE County

MOUNTAIN VIEW CENTER
PO BOX 6623, 9 HAYWOOD AVENUE,
RUTLAND 05702
TEL: (802) 775-0007 Fax: (802) 775-6895
Licensed capacity: 166
RUTLAND County

MT ASCUTNEY HOSPITAL & HEALTH CENTER
RR 1 BOX 6, WINDSOR 05089
TEL: (802) 674-6711Fax: (802) 674-7155
Licensed capacity: 66
WINDSOR County

NEWPORT HEALTH CARE CENTER
148 PROUTY DRIVE, NEWPORT 05855
TEL: (802) 334-7321 Fax: (802) 334-1548
Licensed capacity: 60
ORLEANS County

PINES REHABILITATION & HEALTH CENTER
601 RED VILLAGE ROAD, LYNDONVILLE 05851
TEL: (802) 626-3361 Fax: (802) 626-4056
Licensed capacity: 60
CALEDONIA County

PROSPECT NURSING HOME
34 Prospect St., Box 878, No. Bennington 05257
TEL: (802) 447-7144 Fax: (802) 447-3044
Licensed capacity: 21
BENNINGTON County

REDSTONE VILLA LLC
7 FOREST HILL DRIVE, ST ALBANS 05478
TEL: (802) 524-3498 Fax: (802) 524-3071
Licensed capacity: 30
FRANKLIN County

ROWAN COURT HEALTH & REHAB
378 PROSPECT STREET, BARRE 05641
TEL: (802) 476-4166 Fax: (802) 479-5679
Licensed capacity: 104
WASHINGTON County

SPRINGFIELD HEALTH & REHAB CENTER
105 CHESTER ROAD, SPRINGFIELD 05156
TEL: (802) 885-5741 Fax: (802) 885-5755
Licensed capacity: 102
WINDSOR County

ST. JOHNSBURY HEALTH & REHAB CENTER
1248 HOSPITAL DRIVE, ST. JOHNSBURY 05819
TEL: (802) 748-8757 Fax: (802) 748-6503
Licensed capacity: 110
CALEDONIA County

STARR FARM NURSING CENTER
98 STARR FARM ROAD, BURLINGTON 05401
TEL: (802) 658-6717 Fax: (802) 658-6432
Licensed capacity: 150
CHITTENDEN County

STRATTON HOUSE NURSING HOME
P.O. BOX 216, TOWNSHEND 05353
TEL: (802) 365-7344 Fax: (802) 365-7031
Licensed capacity: 18
WINDHAM County

THOMPSON HOUSE NURSING HOME
30 MAPLE STREET, PO BOX 1117, BRATTLEBORO 05302
TEL: (802) 254-4977 Fax: (802) 254-8842
Licensed capacity: 43
WINDHAM County

UNION HOUSE NURSING HOME
BOX 1, MAIN ST., GLOVER 05839
TEL: (802) 525-6600 Fax: (802) 525-6952
Licensed capacity: 44
ORLEANS County

VERMONT VETERANS HOME
325 NORTH AVE., BENNINGTON 05201
TEL: (802) 442-6353
Licensed capacity: 184
BENNINGTON County

VERNON GREEN NURSING HOME
ROUTE 142, VERNON 05354
TEL: (802) 254-6041 Fax: (802) 257-5362
Licensed capacity: 60
WINDHAM County

WAKE ROBIN - LINDEN NURSING CENTER
100 WAKE ROBIN DRIVE, SHELBURNE 05482
TEL: (802) 985-9400 Fax: (802) 985-8452
Licensed capacity: 30
CHITTENDEN County

WOODRIDGE NURSING HOME
PO BOX 550, BARRE 05641
Tel: (802) 371-4700 Fax: (802) 371-4720
Licensed capacity: 153
WASHINGTON County

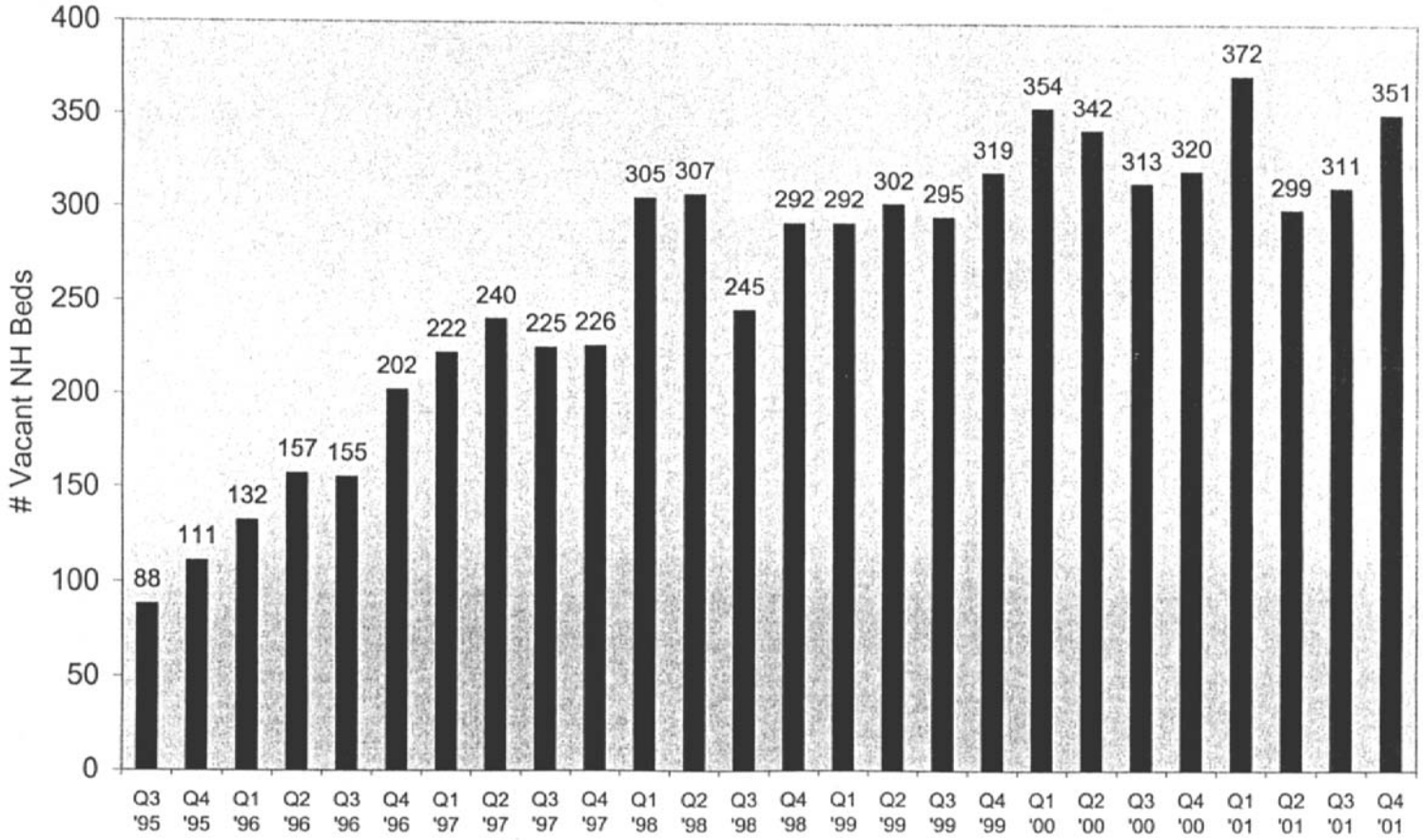
Appendix B

Fiscal Year 2000 Revenue Statistics - All Revenues

Facility	Total revenue	% Medicare Patient Serv $	% Medicaid Patient Serv $	% Private Patient Serv $
Bel Aire	2,202,306	14.95%	38.73%	33.77%
Bennington	4,750,293	19.14%	63.30%	12.38%
Berlin	7,419,338	23.56%	52.75%	20.12%
Birchwood Terrace	8,289,283	17.19%	48.37%	31.16%
Brookside - Bradford	3,618,475	15.27%	60.12%	21.19%
Brookside - WRJ	3,503,357	25.31%	38.56%	33.03%
Burlington	8,577,910	20.34%	54.46%	22.21%
Cedar Hill	2,454,720	4.30%	33.74%	39.50%
Centers for Living & Rehab	6,957,722	21.97%	60.53%	12.35%
Copley Manor	2,050,543	0.32%	71.59%	3.75%
Crescent Manor	4,637,781	15.11%	60.31%	22.16%
Derby Green	853,590	4.82%	62.23%	20.30%
Eden Park - Brattleboro	4,564,569	24.53%	57.70%	16.35%
Eden Park - Rutland	5,748,862	21.19%	56.18%	22.56%
Gifford	0	#DIV/0!	#DIV/0!	#DIV/0!
Gill Odd Fellows	2,691,966	14.99%	56.23%	14.82%
Green Mountain	3,609,830	8.28%	45.52%	42.39%
Greensboro	1,440,556	13.35%	55.44%	19.33%
Helen Porter	4,873,090	19.25%	65.31%	17.25%
Holiday House	3,324,439	27.35%	51.34%	18.69%
Linden Lodge	0	#DIV/0!	#DIV/0!	#DIV/0!
Maple Lane	3,245,237	9.45%	50.00%	25.57%
Mayo	2,179,097	6.02%	56.55%	35.38%
McGirr	1,142,538	9.68%	55.72%	29.06%
Morrisville Center	4,108,139	17.97%	66.40%	13.61%
Mountain View	8,074,849	21.28%	50.46%	25.87%
Mt. Ascutney Hospital	3,474,457	15.36%	69.85%	10.09%
Newport	1,815,370	23.39%	46.70%	26.03%
Pine Knoll	2,424,934	5.16%	66.62%	21.12%
Pleasant Manor	6,407,489	19.99%	52.85%	16.33%
Prospect	878,610	.13%	18.91%	79.32%
Redstone Villa	1,289,329	20.72%	56.47%	20.86%
Rowan Court	4,412,509	20.62%	70.83%	6.73%
Sager	1,234,054	0.00%	63.42%	34.30%
Springfield	4,783,560	30.61%	57.63%	9.12%
St. Johnsbury	5,540,816	23.47%	51.33%	20.00%
Starr Farm	8,468,137	25.93%	41.75%	26.94%
Stratton House	1,065,661	0.05%	49.65%	39.77%
Thompson House	2,682,498	4.59%	32.06%	42.98%
Union House	1,707,018	3.92%	74.39%	18.81%
Verdelle Village	5,652,051	21.13%	52.28%	20.81%
Vernon Green	2,929,793	3.36%	51.26%	38.88%
VT Veterans Home	9,012,104	5.53%	67.84%	11.29%
Woodridge	7,642,839	7.23%	54.69%	32.33%
Total	**171,739,719**	**16.94%**	**54.99%**	**22.26%**

Appendix C

Vermont's Vacant Nursing Home Beds
September 1995--December 2001



Change in capacity: Starr Farm +50 in 5/96; Maple Lane +4 in 10/96; Brookside Brad. +4 in 1/98; Sager -3 in 4/98; VT Vets -1 in 6/98; Gifford -53 in 1/99; Manor -10 in 1/99 & 5/00; Clarks -17 in 7/00; Helen Porter -13 in 1/01; Gifford +20 in 5/01; Linden Lodge -117 in 6/01; Sager -33 in 12/01. Omits Wake Robin, Arbors and Mertens.

VACBEDS.xls
3/7/02 JW@DAD

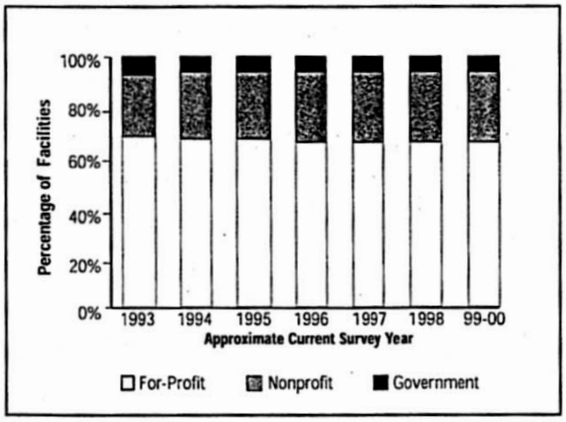
Appendix D

Facility Ownership and Control

Figure O-1 illustrates the trend in facility ownership since 1993. Facilities are considered to be for-profit if operated under private commercial ownership, such as an individual, partnership, or corporation. Facilities are nonprofit if operated under voluntary or other nonprofit auspices, including church related nonprofit corporations, and other nonprofit entities. Government facilities are operated by a government agency, such as a state, city or county, or the federal government, including facilities operated by the Veteran's Administration.

Although the percent of government operated facilities has remained relatively constant since 1993, the percentage of for-profit facilities has declined 2.1 percentage points while the percentage of nonprofit facilities has increased 2.4 percentage points from 1993 to 1999. The ownership structure of nursing facilities remains predominantly for-profit at just over 65%.

O-1: Trend in Nursing Facility Ownership



Source: HCFA - OSCAR Form 671: F12.

The data in figure O-2 show the percentage of facilities by state by ownership type for current surveys. More than a third of the nursing facilities in Alaska and Wyoming are government-owned facilities. Nationally, government-owned facilities represent 6.5% of all nursing facilities. Oklahoma has the highest percentage of for-profit nursing facilities, 82% compared to a national rate of 65.2%. Conversely, North Dakota has an ownership distribution that is 83% nonprofit and only 13.6% for-profit facilities.

O-2: Nursing Facility Ownership, 1999 - 2000

STATE	Total Facilities	Profit	Nonprofit	Government
United States	**17,023**	**65.2%**	**28.3%**	**6.5%**
Alabama	223	77.6%	13.0%	9.4%
Alaska	15	6.7%	60.0%	33.3%
Arizona	153	65.4%	32.0%	2.6%
Arkansas	271	78.6%	16.6%	4.8%
California	1,378	75.0%	20.9%	4.1%
Colorado	226	64.6%	25.7%	9.7%
Connecticut	258	76.7%	22.5%	0.8%
Delaware	43	44.2%	46.5%	9.3%
Florida	734	75.6%	22.5%	1.9%
Georgia	363	74.7%	18.2%	7.2%
Hawaii	45	44.4%	31.1%	24.4%
Idaho	82	63.4%	15.9%	20.7%
Illinois	870	64.9%	30.1%	4.9%
Indiana	572	73.8%	23.6%	2.6%
Iowa	470	52.1%	43.2%	4.7%
Kansas	396	50.5%	35.6%	13.9%
Kentucky	307	64.2%	32.6%	3.3%
Louisiana	338	74.9%	18.3%	6.8%
Maine	126	71.4%	24.6%	4.0%
Maryland	262	56.9%	39.7%	3.4%
Massachusetts	536	70.7%	26.7%	2.6%
Michigan	436	61.9%	28.2%	9.9%
Minnesota	437	28.1%	58.1%	13.7%
Mississippi	196	72.4%	13.8%	13.8%
Missouri	552	66.7%	24.1%	9.2%
Montana	104	34.6%	47.1%	18.3%
Nebraska	237	44.7%	33.8%	21.5%
Nevada	50	72.0%	16.0%	12.0%
New Hampshire	83	53.0%	32.5%	14.5%
New Jersey	361	62.0%	32.4%	5.5%
New Mexico	81	60.5%	32.1%	7.4%
New York	663	48.0%	43.7%	8.3%
North Carolina	411	73.2%	22.6%	4.1%
North Dakota	88	13.6%	83.0%	3.4%
Ohio	1,012	72.6%	24.1%	3.3%
Oklahoma	401	82.0%	12.7%	5.2%
Oregon	151	74.8%	21.2%	4.0%
Pennsylvania	778	42.0%	52.3%	5.7%
Rhode Island	101	75.2%	24.8%	0.0%
South Carolina	177	74.0%	13.0%	13.0%
South Dakota	114	36.8%	57.9%	5.3%
Tennessee	351	68.1%	22.2%	9.7%
Texas	1,251	80.9%	16.1%	3.0%
Utah	92	77.2%	18.5%	4.3%
Vermont	44	65.9%	31.8%	2.3%
Virginia	283	63.3%	32.9%	3.9%
Washington	278	68.7%	23.0%	8.3%
Washington DC	20	30.0%	60.0%	10.0%
West Virginia	141	65.2%	24.8%	9.9%
Wisconsin	422	48.1%	37.2%	14.7%
Wyoming	40	45.0%	15.0%	40.0%

Source: HCFA-OSCAR Form 671: F12, current surveys as of September 2000.

Appendix E

Vermont Division of Licensing and Protection
Survey Tracking Report
10/01/1998 through 09/30/2001

	FFY 1999	FFY 2000	FFY 2001
# of Standard Health Surveys*	47	43	43
# of Standard Surveys with No Deficiencies	24	7	8
%	51.1%	16.2%	18.6%
# of Standard Surveys in Substantial Compliance with Minor Deficiencies	3	0	4
%	6.4%	0.0%	9.3%
# of Standard Surveys w/ Deficiencies Indicating Potential for Harm (D, E, F)	13	28	22
%	27.7%	65.1%	51.1%
Isolated (D)	8	9	9
Pattern (E)	4	19	13
Widespread (F)	1	0	0
# of Standard Surveys with Deficiencies Indicating Actual Harm (G, H, I)	6	8	8
%	12.8%	18.6%	18.6%
Isolated (G)	5	7	8
Pattern (H)	1	1	0
Widespread (I)	0	0	0
# of Standard Surveys with Deficiencies Indicating Immediate Jeopardy	0	0	0
%	0.0%	0.0%	0
# of Standard Surveys with Substandard Quality of Care	N/A	0	0
%	N/A	0.0%	0.0%
Total Deficiencies Cited During Standard Surveys	62	134	152
Average # of Deficiencies Cited Per Standard Survey	1.3	3.1	3.5
Scope & Severity of All Deficiencies Cited			
Minor Deficiencies (A, B, C)	8	19	39
Potential for Harm (D, E, F)	45	102	101
Actual Harm - Isolated (G)	7	8	10
Actual Harm - Pattern (H)	1	5	0
Actual Harm - Widespread (I)	0	0	0
Immediate Jeopardy (J)	0	0	0
Deficiencies in State Regulations Only	5	0	2
Totals	66	134	152
Types of Deficiencies Cited			
Resident Rights	2	6	4
Restraints (not tracked in previous years)	2	3	3
Quality of Life	3	4	6
Resident Assessment	14	36	19
Quality of Care - Other (Included Pressure Sores in prior years)	18	41	47
Dietary	1	13	17
Nursing	1	2	4
Physical Environment	4	5	4
Administration	2	2	10
Other regulations	10	22	23
Pressure Sores (Included with Quality of Care in prior years)	4	0	9
Weight Loss/Dehydration		0	1
Abuse Prevention		0	3
Deficiencies in State Regulations Only	5	0	2
Totals	66	134	48

Appendix F

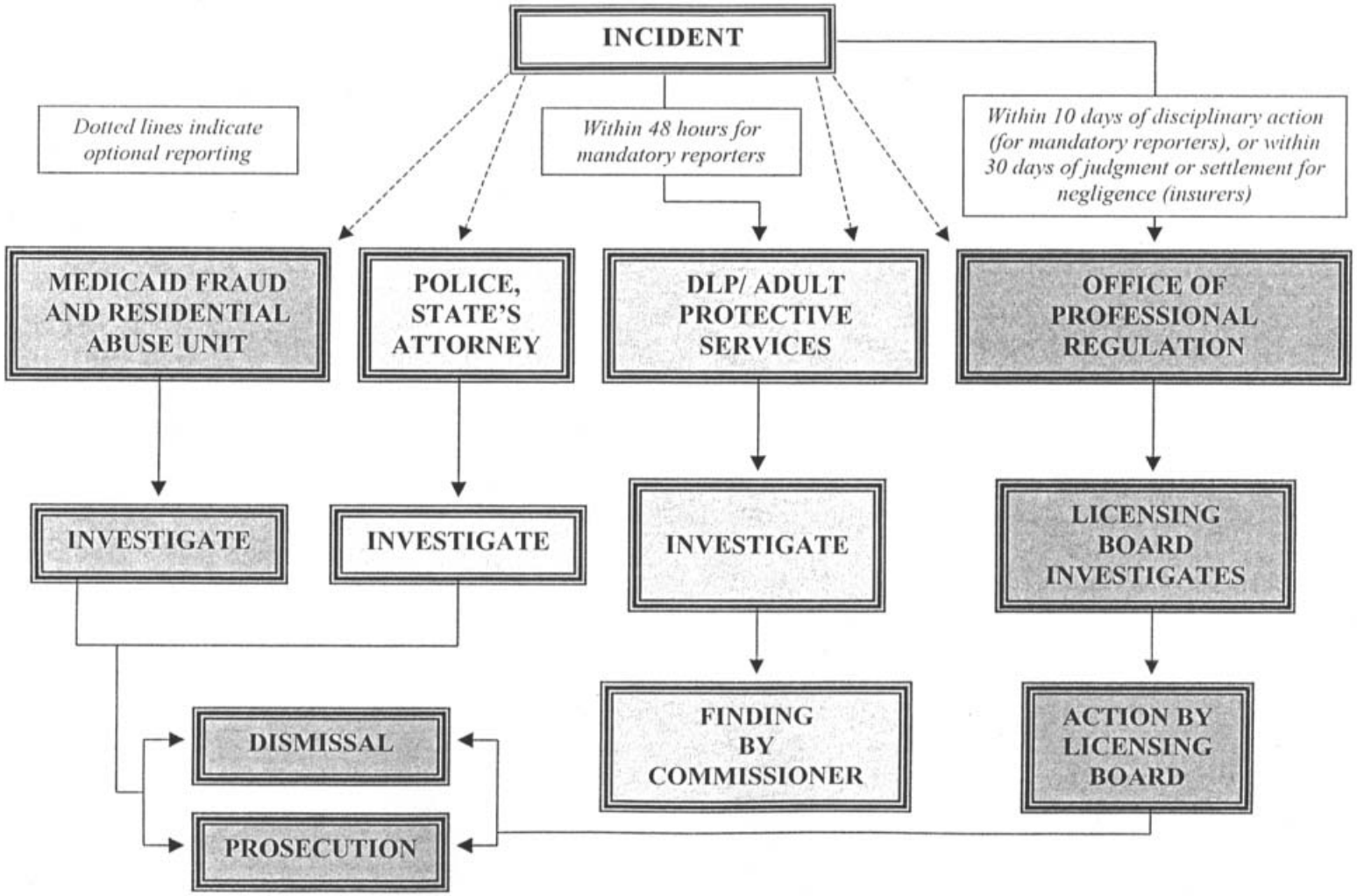
Division of Licensing & Protection: Nursing Home Staffing Ratios

Note: There are no federal requirements that specify nursing hours, it is generally accepted that an average of 3.0 direct care hours per resident per day will meet the resident needs. Staff numbers and hours can vary depending on occupancy of the facility at any given time.

Facility	October 2001 Direct Care Ratio	November 2001 Direct Care Ratio	December 2001 Direct Care Ratio
Bel-Aire Quality Care	3.35	3.33	3.25
Bennington Health & Rehab	3.18	3.26	3.21
Berlin Health & Rehab	3.07	2.64	3.17
Birchwood Terrace Healthcare	3.00	2.65	3.09
Brookside Nursing Home Bradford	3.59	3.40	3.47
Brookside Nursing Home WRJ	3.82	3.59	3.52
Burlington Health & Rehab	3.11	3.28	3.25
Cedar Hill Health Care Center	2.84	3.35	3.35
Centers for Living & Rehabilitation	3.83	3.55	3.56
Copley Manor	3.48	3.17	3.19
Crescent Manor	3.22	3.17	3.25
Derby Green	3.55	3.16	3.10
Eden Park of Brattleboro	3.81	3.48	3.38
Eden Park of Rutland	3.64	3.37	3.34
Gifford--Menig Extended Care	4.03	3.48	3.47
Gill Odd Fellows	2.90	2.53	2.60
Green Mountain	3.56	3.21	3.26
Greensboro	3.71	3.64	4.19
Helen Porter	3.78	3.61	4.25
Holiday House	4.89	4.46	4.55
Maple Lane	3.53	3.33	3.38
Mayo	3.12	3.16	3.10
McGirr	3.45	3.13	3.04
Morrisville Center	3.01	3.04	2.56
Mountain View Center	3.24	3.20	3.24
Mt. Ascutney Hospital & Health Ctr.	3.82	3.42	3.50
Newport Healthcare	3.03	2.56	2.57
Pine Knoll Rehabilitation Center	3.46	3.14	3.31
Pleasant Manor	3.36	3.27	3.23
Prospect	3.48	3.28	3.38
Redstone Villa	3.41	3.11	3.10
Rowan Court	3.47	3.55	3.50
Springfield Health & Rehab	3.22	3.13	3.16
St. Johnsbury Health & Rehab	3.35	3.15	3.12
Starr Farm	3.36	3.26	3.23
Stratton House	3.79	3.52	3.38
Thompson House	3.89	3.41	3.37
Union House	2.86	3.12	3.26
Verdelle Village	3.58	3.38	3.29
Vernon Green	3.29	3.26	3.24
Woodridge	3.36	3.55	3.45
Vermont Veteran's Home	4.11	3.52	3.58
Wake Robin	4.11	3.68	3.58
State Average	**3.47**	**3.28**	**3.32**

Appendix G

ABUSE REPORTING FLOW CHART



Appendix H

Allocation Methodology for Nursing Facility transitional Wage Supplement
FY02 Proposed Bed Tax Increase

Facility	# Beds	Tax per Bed	Total Incremental Revenue	Medicaid % of population	Provider Tax Reimbursement	Unreimbursed Tax	Total Wage Supplement	Net Impact
Bel Aire	44	$2,768.69	121,822	49.88%	60,767	61,056	102,451	41,395
Bennington	100	$2,768.69	276,869	62.77%	173,783	103,086	223,863	120,776
Berlin	152	$2,768.69	420,841	65.49%	275,602	145,239	374,553	229,315
Birchwood Terrace	160	$2,768.69	442,990	67.15%	297,477	145,513	440,996	295,483
Brookside - Bradford	80	$2,768.69	221,495	70.92%	157,090	64,405	217,168	152,762
Brookside - WRJ	67	$2,768.69	185,502	51.14%	94,868	90,634	201,527	110,893
Burlington	168	$2,768.69	465,140	66.77%	310,580	154,560	496,389	341,830
Cedar Hill	39	$2,768.69	107,979	52.62%	56,818	51,161	84,661	33,500
CLR	150	$2,768.69	415,303	52.86%	219,514	195,790	456,357	260,567
Copley Manor	30	$2,768.69	83,061	90.35%	75,047	8,014	87,231	79,217
Crescent Manor	90	$2,768.69	249,182	52.95%	131,941	117,241	258,107	140,865
Derby Green	23	$2,768.69	63,680	81.56%	51,935	11,745	43,515	31,771
Eden Park - Brattleboro	124	$2,768.69	343,318	70.94%	243,556	99,762	285,280	185,518
Eden Park - Rutland	125	$2,768.69	346,086	72.71%	251,639	94,448	309,441	214,993
Gifford	20	$2,768.69	55,374	0.00%	-	55,374	122,073	66,699
Gill Odd Fellows	56	$2,768.69	155,047	80.46%	124,753	30,294	130,940	100,646
Green Mountain	73	$2,768.69	202,114	60.15%	121,576	80,538	251,644	171,106
Greensboro	30	$2,768.69	83,061	72.95%	60,596	22,465	85,394	62,929
Helen Porter	105	$2,768.69	290,712	65.68%	190,941	99,772	332,460	232,689
Holiday House	64	$2,768.69	177,196	70.77%	125,407	51,789	178,602	126,813
Maple Lane	71	$2,768.69	196,577	66.18%	130,088	66,489	159,850	93,361
Mayo	50	$2,768.69	138,434	56.39%	78,062	60,373	132,756	72,383
McGirr	30	$2,768.69	83,061	58.68%	48,743	34,318	51,454	17,136
McKerley - Morrisville	90	$2,768.69	249,182	79.42%	197,912	51,270	203,161	151,891
McKerley - Rutland	166	$2,768.69	459,602	69.01%	317,159	142,444	350,737	208,294
Mt. Ascutney Hospital	66	$2,768.69	182,734	72.16%	131,855	50,878	178,396	127,517
Newport	60	$2,768.69	166,121	59.48%	98,808	67,313	85,086	17,772
[illegible] Knoll	60	$2,768.69	166,121	71.70%	119,102	47,020	127,504	80,484
[illegible]sant Manor	127	$2,768.69	351,624	78.34%	275,463	76,161	331,576	255,415
Prospect	21	$2,768.69	58,142	12.28%	7,143	51,000	39,574	(11,426)
Redstone Villa	30	$2,768.69	83,061	69.06%	57,361	25,700	53,832	28,132
Rowan Court	104	$2,768.69	287,944	84.87%	244,371	43,573	245,181	201,608
Sager	33	$2,768.69	91,367	72.62%	66,347	25,019	68,482	43,463
Springfield	102	$2,768.69	282,406	74.09%	209,245	73,161	279,472	206,311
St. Johnsbury	110	$2,768.69	304,556	63.65%	193,846	110,710	273,371	162,661
Starr Farm	150	$2,768.69	415,303	57.65%	239,434	175,869	399,650	223,781
Stratton House	18	$2,768.69	49,836	67.04%	33,408	16,428	57,650	41,222
Thompson House	43	$2,768.69	119,054	49.93%	59,438	59,616	121,914	62,298
Union House	44	$2,768.69	121,822	83.20%	101,352	20,470	83,543	63,073
Verdelle Village	120	$2,768.69	332,243	72.51%	240,897	91,346	302,895	211,550
Vernon Green	60	$2,768.69	166,121	64.07%	106,427	59,695	172,088	112,394
Woodridge	153	$2,768.69	423,610	64.12%	271,618	151,991	480,697	328,706
VT Veterans Home	184	$2,768.69	509,439	70.41%	358,696	150,743	724,944	574,201
Sub Total-Medicaid	3,592		9,945,133		6,610,664	3,334,470	9,606,466	6,271,996
Arbors	12	$2,768.69	33,224	0.00%	-	33,224	0	(33,224)
Mertens	14	$2,768.69	38,762	0.00%	-	38,762	0	(38,762)
Wake Robin	30	$2,768.69	83,061	0.00%	-	83,061	0	(83,061)
Total	3,648		10,100,180		6,610,664	3,489,517		6,116,949

Appendix I

Average Hourly Wage Comparison

ATTACHMENT B

Category: RN's

Facility	Straight Time -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 % Change	FY00-FY01 % Change	Total Compensation -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 %Change
Bel Aire	21.50	16.48	17.67	-18%	7.2%	22.19	16.71	18.23	-18%
Bennington	14.55	17.69	17.63	21%	-0.4%	15.15	18.31	18.21	20%
Berlin	18.00	19.04	19.58	9%	2.9%	18.31	19.53	20.30	11%
Birchwood Terrace	16.65	20.02	21.20	27%	5.9%	16.65	19.80	21.63	30%
Brookside-Bradford	16.53	17.99	18.64	13%	3.6%	16.69	18.34	19.27	15%
Brookside-WRJ	16.81	18.34	18.10	8%	-1.3%	16.94	18.59	20.34	20%
Burlington	18.09	18.56	19.53	8%	5.2%	18.88	19.22	20.94	11%
Cedar Hill	13.68	13.89	18.83	38%	35.5%	13.68	14.04	18.87	38%
Centers for Living & Rehab	17.57	20.55	19.46	11%	-5.3%	17.93	21.97	21.21	18%
Copley Manor	N/A	15.53	17.12		10.3%	N/A	16.26	18.36	
Crescent Manor	18.97	17.58	18.58	-2%	5.7%	19.20	17.75	18.89	-2%
Derby Green	12.09	12.86	13.94	15%	8.4%	12.11	12.93	14.92	23%
Eden Park-Brattleboro	15.37	17.08	19.48	27%	14.0%	15.46	17.62	19.61	27%
Eden Park-Rutland	14.65	15.32	18.08	23%	18.0%	14.75	15.44	18.32	24%
Gill Odd Fellows	15.87	20.02	22.70	43%	13.4%	16.05	20.39	23.04	44%
Green Mountain	19.00	20.12	17.49	-8%	-13.1%	19.13	20.28	18.05	-6%
Greensboro	13.91	14.67	15.06	8%	2.7%	14.00	15.10	15.93	14%
Helen Porter	14.91	15.27	15.82	6%	3.6%	15.48	16.68	17.64	14%
Holiday House	16.49	19.01	19.79	20%	4.1%	16.74	19.36	20.58	23%
Maple Lane	13.17	15.61	15.98	21%	2.4%	13.35	16.02	16.41	23%
Mayo	14.68	16.41	18.90	29%	15.2%	14.76	16.67	19.14	30%
McGirr	16.14	16.92	21.17	31%	25.1%	16.26	17.15	21.17	30%
Morrisville Center	17.61	17.62	19.22	9%	9.1%	18.51	17.96	19.86	7%
Mountainview Center	15.25	16.74	17.72	16%	5.8%	15.30	17.36	18.60	22%
Mt. Ascutney	18.34	19.56	21.05	15%	7.7%	18.92	20.05	22.22	17%
Newport	12.04	12.95	13.56	13%	4.7%	12.04	13.61	14.13	17%
Pine Knoll	13.98	16.03	20.95	50%	30.7%	14.13	16.19	20.99	49%
Pleasant Manor	14.96	19.35	19.24	29%	-0.6%	15.05	19.52	19.70	31%
Prospect	N/A	20.91	20.49		-2.0%	0.00	21.63	20.88	
Redstone Villa	15.02	16.51	19.80	32%	19.9%	15.20	16.83	19.39	28%
Rowan Court	15.04	17.25	19.20	28%	11.3%	15.78	18.32	20.49	30%
Sager	12.76	14.63	16.94	33%	15.8%	13.09	14.85	17.00	30%
Springfield	16.70	17.14	18.46	11%	7.7%	17.05	18.21	19.10	12%
St. Johnsbury	13.71	14.54	17.43	27%	19.9%	13.97	14.97	17.96	29%
Starr Farm	18.41	19.86	20.00	9%	0.7%	18.41	19.45	22.00	19%
Stratton House	17.44	18.07	18.27	5%	1.1%	17.44	18.22	18.47	6%
Thompson House	19.00	19.34	20.76	9%	7.3%	19.00	19.56	21.20	12%
Union House	14.20	13.65	16.24	14%	18.9%	14.46	14.08	16.84	16%
Verdelle Village	17.86	19.76	21.40	20%	8.3%	17.94	19.98	21.74	21%
Vernon Green	17.57	17.99	18.44	5%	2.5%	18.19	19.47	20.50	13%
Vt Veterans Home	16.64		19.03	14%	#DIV/0!	17.01		19.85	17%
Woodridge	19.31	21.30	21.00	9%	-1.4%	19.58	21.67	21.51	10%
Average	**16.04**	**18.02**	**18.90**	**18%**	**4.9%**	**16.32**	**18.49**	**19.64**	**20%**

Average Hourly Wage Comparison

ATTACHMENT B

Category: LPN's

Facility	Straight Time -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 % Change	FY00-FY01 % Change	Total Compensation -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 %Change
Bel Aire	11.87	12.10	13.86	17%	14.5%	12.03	12.33	14.28	19%
Bennington	10.97	12.43	12.86	17%	3.5%	11.40	12.76	13.21	16%
Berlin	13.16	14.69	14.89	13%	1.4%	13.47	15.14	15.72	17%
Birchwood Terrace	15.53	18.02	19.12	23%	6.1%	15.53	17.95	19.62	26%
Brookside-Bradford	14.35	15.67	15.73	10%	0.4%	14.44	15.93	16.55	15%
Brookside-WRJ	13.47	14.52	14.59	8%	0.5%	13.64	14.77	15.77	16%
Burlington	13.55	15.08	16.17	19%	7.2%	14.02	15.68	17.25	23%
Cedar Hill	12.46	13.08	13.07	5%	-0.1%	12.46	13.36	13.36	7%
Centers for Living & Rehab	11.49	12.68	12.21	6%	-3.7%	11.75	13.57	13.50	15%
Copley Manor	N/A	12.32	14.02	13.8%	N/A	13.38	15.22		13.7%
Crescent Manor	12.68	13.00	13.19	4%	1.5%	13.38	13.49	13.93	4%
Derby Green	10.91	11.99	12.53	15%	4.5%	10.93	12.20	13.52	24%
Eden Park-Brattleboro	11.58	11.60	13.99	21%	20.6%	11.74	12.17	14.24	21%
Eden Park-Rutland	12.40	12.40	12.82	3%	3.4%	12.42	12.55	13.23	7%
Gill Odd Fellows	13.29	16.41	17.63	33%	7.4%	13.42	16.73	17.89	33%
Green Mountain	13.35	17.15	14.00	5%	-18.3%	13.57	17.25	14.99	10%
Greensboro	10.94	11.98	12.92	18%	7.8%	11.07	12.29	13.54	22%
Helen Porter	12.37	13.51	14.71	19%	8.9%	13.11	15.04	16.70	27%
Holiday House	13.73	14.72	14.20	3%	-3.6%	14.00	15.01	14.76	5%
Maple Lane	11.05	13.12	13.32	21%	1.5%	11.29	13.52	13.75	22%
Mayo	12.33	14.02	15.54	26%	10.9%	12.47	14.18	15.92	28%
McGirr	11.53	12.37	12.21	6%	-1.3%	11.75	12.76	12.55	7%
Morrisville Center	15.57	16.91	16.51	6%	-2.4%	16.63	17.67	17.40	5%
Mountainview Center	11.75	12.90	13.73	17%	6.4%	12.26	13.66	14.57	19%
Mt. Ascutney	13.50	14.76	16.04	19%	8.6%	13.62	14.99	16.50	21%
Newport	10.90	11.70	12.87	18%	9.9%	10.90	12.16	13.78	26%
Pine Knoll	13.14	13.53	14.91	13%	10.2%	13.34	13.94	15.58	17%
Pleasant Manor	11.34	12.19	15.67	38%	28.5%	11.44	12.35	16.02	40%
Prospect	11.70	12.00	12.71	9%	5.9%	11.70	12.45	13.21	13%
Redstone Villa	12.14	13.73	15.89	31%	15.7%	12.47	14.16	16.42	32%
Rowan Court	12.66	15.04	16.26	28%	8.1%	13.13	16.26	17.12	30%
Sager	11.37	11.89	12.74	12%	7.2%	11.77	11.88	13.22	12%
Springfield	12.08	13.79	14.58	21%	5.8%	12.59	14.46	15.48	23%
St. Johnsbury	10.63	11.64	13.78	30%	18.4%	10.70	11.87	14.15	32%
Starr Farm	15.75	17.56	21.14	34%	20.4%	15.75	17.36	22.54	43%
Stratton House	12.63	12.89	13.46	7%	4.4%	12.63	12.99	13.62	8%
Thompson House	15.46	15.00	16.25	5%	8.3%	15.46	15.56	16.80	9%
Union House	11.17	11.78	13.61	22%	15.5%	11.47	12.17	14.37	25%
Verdelle Village	14.31	17.61	15.61	9%	-11.3%	14.34	17.99	16.00	12%
Vernon Green	13.73	13.77	14.05	2%	2.0%	14.40	15.79	15.73	9%
Vt Veterans Home	12.94		15.08	17%	#DIV/0!	13.16		15.73	19%
Woodridge	13.31	13.55	13.72	3%	1.2%	13.45	13.83	14.23	6%
Average	**12.60**	**14.13**	**14.88**	**18%**	**5.3%**	**12.87**	**14.61**	**15.64**	**22%**

Average Hourly Wage Comparison

ATTACHMENT B

Category: LNA's

Facility	Straight Time -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 % Change	FY00-FY01 % Change	Total Compensation -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 %Change
Bel Aire	7.61	7.47	8.07	6%	8.0%	7.66	7.45	8.27	8%
Bennington	7.60	8.47	9.19	21%	8.5%	7.71	8.58	9.35	21%
Berlin	8.32	9.59	9.55	15%	-0.4%	8.39	9.71	9.85	17%
Birchwood Terrace	10.17	11.57	12.46	22%	7.7%	10.17	11.50	12.99	28%
Brookside-Bradford	7.69	8.62	8.84	15%	2.5%	7.77	8.71	9.41	21%
Brookside-WRJ	8.80	9.35	10.34	18%	10.6%	8.86	9.46	10.96	24%
Burlington	8.31	9.62	10.20	23%	6.0%	8.45	9.84	10.93	29%
Cedar Hill	6.93	7.46	8.53	23%	14.3%	6.93	7.72	8.79	27%
Centers for Living & Rehab	8.02	8.78	9.45	18%	7.6%	8.15	9.08	9.86	21%
Copley Manor	N/A	7.97	8.85		11.0%	N/A	8.33	9.24	
Crescent Manor	8.54	9.32	8.70	2%	-6.7%	8.77	9.55	9.07	3%
Derby Green	6.14	6.78	7.02	14%	3.4%	6.18	6.89	7.17	16%
Eden Park-Brattleboro	8.69	8.58	9.37	8%	9.3%	8.76	8.85	9.44	8%
Eden Park-Rutland	7.70	8.67	8.74	13%	0.7%	7.73	8.73	8.83	14%
Gill Odd Fellows	9.36	11.21	11.81	26%	5.4%	9.45	11.41	12.27	30%
Green Mountain	9.20	11.41	9.48	3%	-16.9%	9.35	11.55	10.02	7%
Greensboro	7.29	8.07	8.42	16%	4.3%	7.36	8.41	8.89	21%
Helen Porter	8.34	8.95	9.53	14%	6.5%	8.51	9.43	10.28	21%
Holiday House	8.07	9.44	9.72	20%	2.9%	8.11	9.53	9.77	21%
Maple Lane	7.55	8.41	8.64	14%	2.7%	7.69	8.60	8.91	16%
Mayo	7.63	8.48	9.15	20%	7.9%	7.66	8.50	9.41	23%
McGirr	7.42	8.00	8.17	10%	2.1%	7.59	7.88	8.39	11%
Morrisville Center	8.10	8.72	8.81	9%	1.0%	8.21	8.83	9.35	14%
Mountainview Center	6.95	8.82	9.33	34%	5.7%	7.12	9.23	9.83	38%
Mt. Ascutney	9.81	10.94	11.61	18%	6.1%	9.88	11.11	12.24	24%
Newport	6.37	7.19	7.92	24%	10.2%	6.37	7.49	8.23	29%
Pine Knoll	6.87	7.97	8.30	21%	4.1%	6.95	8.18	8.52	23%
Pleasant Manor	7.97	8.41	8.54	7%	1.6%	7.99	8.50	8.79	10%
Prospect	6.81	7.25	7.77	14%	7.1%	6.81	7.50	7.99	17%
Redstone Villa	7.94	8.09	8.88	12%	9.8%	7.72	8.22	9.15	18%
Rowan Court	7.48	8.84	9.19	23%	4.0%	7.67	9.19	9.44	23%
Sager	6.57	7.15	8.35	27%	16.7%	6.73	7.33	8.70	29%
Springfield	7.86	8.60	9.39	19%	9.2%	8.07	8.92	9.70	20%
St. Johnsbury	7.02	7.72	8.92	27%	15.5%	7.09	7.87	9.17	29%
Starr Farm	9.77	11.15	11.95	22%	7.2%	9.77	11.05	13.33	36%
Stratton House	9.81	9.56	9.99	2%	4.5%	9.81	9.66	10.14	3%
Thompson House	9.38	10.37	11.98	28%	15.6%	9.38	10.50	12.13	29%
Union House	6.31	7.04	7.64	21%	8.5%	6.46	7.46	7.90	22%
Verdelle Village	7.82	8.57	9.13	17%	6.5%	7.85	8.65	9.19	17%
Vernon Green	9.42	9.67	9.48	1%	-2.0%	9.77	11.36	10.31	6%
Vt Veterans Home	9.83		11.53	17%		10.00		11.84	18%
Woodridge	9.07	10.25	10.46	15%	2.1%	9.15	10.45	11.05	21%
Average	**8.14**	**9.13**	**9.61**	**18%**	**5.3%**	**8.24**	**9.34**	**10.03**	**22%**

Average Hourly Wage Comparison

ATTACHMENT B

Category: Dietary

Facility	Straight Time -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 % Change	FY00-FY01 % Change	Total Compensation -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 %Change
Bel Aire	7.65	7.52	8.35	9%	11.1%	7.69	7.58	8.57	11%
Bennington	7.57	7.50	8.13	7%	8.3%	7.60	7.55	8.16	%
Berlin	7.25	7.87	7.31	1%	-7.1%	7.25	7.92	7.35	1%
Birchwood Terrace	10.33	12.67	12.69	23%	0.1%	10.33	12.82	13.46	30%
Brookside-Bradford	6.95	7.88	8.06	16%	2.3%	7.03	7.98	8.27	18%
Brookside-WRJ	8.54	9.26	10.09	18%	9.1%	8.56	9.28	10.11	18%
Burlington	8.14	8.37	9.48	16%	13.3%	8.23	8.43	8.95	9%
Cedar Hill	6.89	7.59	8.63	25%	13.7%	6.89	7.77	8.73	27%
Centers for Living & Rehab	8.80	10.12	10.26	17%	1.4%	8.82	10.18	10.67	21%
Copley Manor	N/A	7.41	8.35		12.8%	N/A	7.52	8.52	
Crescent Manor	9.01	8.65	8.91	-1%	3.0%	9.01	8.80	9.07	1%
Derby Green	7.54	8.12	8.50	13%	4.6%	7.61	8.18	8.56	12%
Eden Park-Brattleboro	7.58	7.74	8.15	8%	5.4%	7.68	7.88	8.25	7%
Eden Park-Rutland	7.39	7.91	8.31	12%	5.0%	7.41	7.93	8.34	13%
Gill Odd Fellows	8.89	10.23	10.06	13%	-1.7%	8.96	10.34	10.26	14%
Green Mountain	11.26	11.56	10.75	-5%	-7.0%	11.41	11.86	10.91	-4%
Greensboro	7.87	8.05	8.79	12%	9.2%	7.91	8.25	9.01	14%
Helen Porter	7.91	8.46	9.02	14%	6.6%	7.99	8.68	9.48	19%
Holiday House	9.05	8.86	8.77	-3%	-1.0%	9.11	8.99	8.96	-2%
Maple Lane	7.03	6.71	8.40	19%	25.1%	7.15	6.91	8.50	19%
Mayo	7.87	9.33	10.10	28%	8.2%	7.99	9.30	10.45	31%
McGirr	7.16	8.52	7.18	0%	-15.8%	7.23	8.68	7.26	0%
Morrisville Center	10.24	8.36	7.80	-24%	-6.7%	10.26	8.44	7.99	-22%
Mountainview Center	8.44	10.15	9.09	8%	-10.4%	8.51	10.31	9.32	10%
Mt. Ascutney	N/A	9.77	10.95		12.1%	N/A	9.88	11.46	
Newport	6.05	6.23	6.91	14%	10.8%	6.05	6.56	7.06	17%
Pine Knoll	7.36	8.19	9.03	23%	10.3%	7.42	8.28	9.14	23%
Pleasant Manor	6.90	7.44	7.62	11%	2.5%	6.97	7.51	7.81	12%
Prospect	8.33	8.50	7.23	-13%	-15.0%	8.33	8.62	7.35	-12%
Redstone Villa	6.55	6.65	7.47	14%	12.3%	6.55	6.66	7.54	15%
Rowan Court	6.60	7.57	8.74	32%	15.4%	6.66	7.73	8.86	33%
Sager	6.24	9.20	4.59	-26%	-50.1%	6.56	9.26	4.66	-29%
Springfield	7.59	8.22	9.25	22%	12.6%	7.62	8.25	9.33	22%
St. Johnsbury	6.74	7.32	8.13	21%	11.0%	6.78	7.34	8.19	21%
Starr Farm	8.43	8.99	9.70	15%	7.9%	8.43	9.14	10.13	20%
Stratton House	N/A	9.49	10.55		11.1%	N/A	9.77	11.03	
Thompson House	N/A	N/A	N/A			N/A	N/A	N/A	
Union House	6.40	6.01	7.11	11%	18.4%	6.57	6.15	7.35	12%
Verdelle Village	7.36	7.81	7.82	6%	0.1%	7.40	7.87	7.89	7%
Vernon Green	8.93	9.37	8.15	-9%	-12.9%	8.99	9.75	8.53	-5%
Vt Veterans Home	9.56		10.35	8%	#DIV/0!	9.71		10.67	10%
Woodridge	8.97	9.56	9.82	9%	2.7%	8.97	9.57	9.79	9%
Average	**8.03**	**8.53**	**8.87**	**11%**	**4.0%**	**8.08**	**8.64**	**9.06**	**12%**

Average Hourly Wage Comparison

ATTACHMENT B

Category: Plant Maintenance

Facility	Straight Time -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 % Change	FY00-FY01 % Change	Total Compensation -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 %Change
Bel Aire	10.24	11.22	10.46	2%	-6.8%	10.26	11.30	10.69	4%
Bennington	11.00	12.27	12.87	17%	4.9%	11.02	12.29	12.88	17%
Berlin	9.64	10.19	6.35	-34%	-37.6%	9.65	10.19	6.38	-34%
Birchwood Terrace	13.65	14.92	14.02	3%	-6.1%	13.65	15.06	15.73	15%
Brookside-Bradford	9.65	13.37	13.64	41%	2.0%	9.65	13.37	13.61	41%
Brookside-WRJ	8.81	9.43	10.62	21%	12.6%	8.88	9.60	10.74	21%
Burlington	12.18	12.58	12.51	3%	-0.6%	12.20	12.62	12.52	3%
Cedar Hill	N/A	N/A	N/A			N/A	N/A	N/A	
Centers for Living & Rehab	13.22	13.88	13.30	1%	-4.1%	13.22	14.33	14.08	7%
Copley Manor	N/A	11.93	10.93		-8.4%	N/A	12.11	11.66	
Crescent Manor	12.17	12.43	14.09	16%	13.3%	12.18	12.47	14.08	16%
Derby Green	10.27	N/A	N/A			10.27	N/A	N/A	
Eden Park-Brattleboro	12.59	13.87	14.31	14%	3.2%	12.62	13.91	14.31	13%
Eden Park-Rutland	13.89	13.88	11.99	-14%	-13.6%	13.89	13.88	12.00	-14%
Gill Odd Fellows	12.01	10.89	11.45	-5%	5.1%	12.05	10.96	11.68	-3%
Green Mountain	12.34	13.58	14.63	19%	7.7%	12.45	13.65	14.76	19%
Greensboro	9.26	10.85	10.00	8%	-7.8%	9.27	10.94	10.19	10%
Helen Porter	10.04	10.84	10.50	5%	-3.1%	10.07	10.96	10.81	7%
Holiday House	13.73	13.96	14.67	7%	5.1%	14.53	14.54	14.93	3%
Maple Lane	8.12	9.95	10.99	35%	10.4%	8.15	10.32	11.53	41%
Mayo	13.85	15.57	17.38	26%	11.7%	14.01	15.57	17.62	26%
McGirr	8.05	11.16	8.64	7%	-22.6%	8.05	11.42	8.64	7%
Morrisville Center	9.40	12.24	11.44	22%	-6.5%	9.64	12.68	11.93	24%
Mountainview Center	9.66	11.72	11.93	23%	1.8%	10.00	11.91	12.32	23%
Mt. Ascutney	N/A	13.39	15.19		13.4%	N/A	13.78	15.72	
Newport	10.49	7.75	8.47	-19%	9.3%	10.49	7.97	8.67	-17%
Pine Knoll	13.22	15.38	15.95	21%	3.7%	13.22	15.38	15.94	21%
Pleasant Manor	9.19	9.44	9.35	2%	-1.0%	9.23	9.60	9.78	6%
Prospect	13.11	13.70	14.94	14%	9.0%	13.11	13.89	15.18	16%
Redstone Villa	7.51	7.40	11.57	54%	56.4%	7.51	7.40	11.57	54%
Rowan Court	8.09	9.17	10.26	27%	12.0%	8.38	9.43	10.41	24%
Sager	8.12	14.88	15.30	88%	2.8%	8.12	14.88	15.30	88%
Springfield	11.35	12.65	12.36	9%	-2.3%	11.37	12.64	12.48	10%
St. Johnsbury	9.68	10.87	11.11	15%	2.2%	10.23	11.15	11.37	11%
Starr Farm	18.37	17.60	17.56	-4%	-0.2%	18.37	17.89	17.96	-2%
Stratton House	N/A	12.89	13.05		1.3%	N/A	12.92	13.14	
Thompson House	10.78	11.96	12.42	15%	3.8%	10.78	12.03	12.49	16%
Union House	14.72	17.79	14.78	0%	-16.9%	14.72	17.85	14.83	1%
Verdelle Village	11.23	12.04	11.91	6%	-1.1%	11.23	12.05	11.92	6%
Vernon Green	15.60	16.24	17.26	11%	6.3%	15.60	16.27	17.41	12%
Vt Veterans Home	11.90		12.08	2%	#DIV/0!	11.99		11.93	-1%
Woodridge	12.26	14.11	15.74	28%	11.5%	12.41	14.18	15.75	27%
Average	**11.35**	**12.39**	**12.38**	**9%**	**-0.1%**	**11.43**	**12.51**	**12.53**	**10%**

Average Hourly Wage Comparison

ATTACHMENT B

Category: Housekeeping

Facility	Straight Time -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 % Change	FY00-FY01 % Change	Total Compensation -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 %Change
Bel Aire	6.26	6.55	7.07	13%	8.1%	6.29	6.59	7.21	15%
Bennington	N/A	N/A	N/A			N/A	N/A	N/A	
Berlin	N/A	N/A	N/A			N/A	N/A	N/A	
Birchwood Terrace	9.78	10.60	11.37	16%	7.3%	9.78	10.64	11.47	17%
Brookside-Bradford	6.93	6.62	7.49	8%	13.1%	6.94	6.67	7.67	11%
Brookside-WRJ	8.38	9.23	10.16	21%	10.2%	8.39	9.26	10.22	22%
Burlington	N/A	N/A	N/A			N/A	N/A	N/A	
Cedar Hill	8.08	N/A	N/A			8.08	N/A	N/A	
Centers for Living & Rehab	7.26	7.69	7.92	9%	3.0%	7.29	7.85	7.99	10%
Copley Manor	N/A	6.43	7.13		11.0%	N/A	6.71	7.30	
Crescent Manor	7.75	7.00	7.81	1%	11.6%	7.78	7.10	7.90	2%
Derby Green	5.49	6.62	6.84	25%	3.2%	5.49	6.63	6.85	25%
Eden Park-Brattleboro	6.98	7.34	7.46	7%	1.6%	7.02	7.45	7.50	7%
Eden Park-Rutland	8.29	8.66	8.37	1%	-3.4%	8.31	8.73	8.41	1%
Gill Odd Fellows	8.27	8.90	9.17	11%	3.0%	8.30	8.97	9.20	11%
Green Mountain	7.60	8.32	9.13	20%	9.7%	7.65	8.35	9.47	24%
Greensboro	6.64	6.81	7.86	18%	15.3%	6.69	7.05	8.13	22%
Helen Porter	7.24	7.79	8.37	16%	7.4%	7.28	7.98	8.79	21%
Holiday House	9.25	9.31	8.46	-8%	-9.2%	9.25	9.31	8.51	-8%
Maple Lane	7.15	7.83	8.06	13%	3.0%	7.23	7.93	8.17	13%
Mayo	7.19	8.14	8.80	22%	8.1%	7.20	8.14	8.98	25%
McGirr	6.57	7.33	7.48	14%	2.1%	6.60	7.45	7.66	16%
Morrisville Center	6.91	7.60	7.96	15%	4.7%	6.96	7.71	8.02	15%
Mountainview Center	7.05	8.14	8.23	17%	1.1%	7.09	8.24	8.33	17%
Mt. Ascutney	N/A	7.91	8.62		9.0%	N/A	7.98	8.94	
Newport	5.73	6.58	7.00	22%	6.5%	5.73	6.58	7.06	23%
Pine Knoll	7.26	7.13	7.47	3%	4.8%	7.28	7.17	7.52	3%
Pleasant Manor	6.57	6.83	6.97	6%	2.1%	6.57	6.83	7.06	7%
Prospect	6.50	7.00	7.28	12%	4.0%	6.50	7.12	7.39	14%
Redstone Villa	6.68	6.81	7.04	5%	3.4%	6.68	6.84	7.08	6%
Rowan Court	N/A	N/A	N/A			N/A	N/A	N/A	
Sager	6.20	7.23	7.91	28%	9.4%	6.22	7.28	7.94	28%
Springfield	N/A	N/A	N/A			N/A	N/A	N/A	
St. Johnsbury	N/A	N/A	N/A			N/A	N/A	N/A	
Starr Farm	8.42	8.73	8.70	3%	-0.4%	8.42	8.81	9.15	9%
Stratton House	N/A	8.04	8.39		4.3%	N/A	8.06	8.42	
Thompson House	7.59	8.19	9.05	19%	10.5%	7.59	8.21	9.11	20%
Union House	6.72	7.16	7.28	8%	1.6%	6.91	7.48	7.56	9%
Verdelle Village	6.51	7.02	7.98	23%	13.8%	6.52	7.02	8.10	24%
Vernon Green	7.90	8.30	7.88	0%	-5.0%	7.90	8.41	7.96	1%
Vt Veterans Home	8.45		8.65	2%		9.06		8.98	-1%
Woodridge	7.89	8.01	8.39	6%	4.8%	7.92	8.02	8.44	7%
Average	**7.55**	**7.90**	**8.22**	**9%**	**4.0%**	**7.63**	**7.98**	**8.36**	**10%**

Average Hourly Wage Comparison

ATTACHMENT B

Category: Laundry

Facility	Straight Time -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 % Change	FY00-FY01 % Change	Total Compensation -Average Hourly Wage FY98	SFY00	SFY01	FY98-FY01 %Change
Bel Aire	7.36	7.33	9.43	28%	28.6%	7.36	7.35	9.68	31%
Bennington	N/A	N/A	N/A			N/A	N/A	N/A	
Berlin	N/A	7.33	9.43		28.6%	N/A	N/A	N/A	
Birchwood Terrace	11.11	11.93	12.56	13%	5.3%	11.11	11.97	12.83	15%
Brookside-Bradford	6.42	N/A	N/A			6.42	N/A	N/A	
Brookside-WRJ	6.69	7.85	9.01	35%	14.8%	6.69	8.01	9.04	35%
Burlington	N/A	N/A	N/A			N/A	N/A	N/A	
Cedar Hill	6.38	6.85	7.20	13%	5.1%	6.38	6.88	7.28	14%
Centers for Living & Rehab	8.38	9.41	9.83	17%	4.4%	8.38	9.69	9.86	18%
Copley Manor	N/A	6.82	8.04		18.0%	N/A	7.05	8.19	
Crescent Manor	9.15	8.35	8.04	-12%	-3.7%	9.15	8.45	8.12	-11%
Derby Green	N/A	N/A	N/A			N/A	N/A	N/A	
Eden Park-Brattleboro	7.23	7.43	7.86	9%	5.8%	7.23	7.48	7.99	10%
Eden Park-Rutland	7.90	7.98	8.88	12%	11.3%	7.90	8.10	8.97	14%
Gill Odd Fellows	10.63	12.30	14.73	38%	19.7%	10.63	12.51	14.66	38%
Green Mountain	8.45	9.67	3.70	-56%	-61.7%	8.45	10.06	3.68	-56%
Greensboro	6.38	6.73	7.79	22%	15.9%	6.38	7.49	7.79	22%
Helen Porter	6.64	7.14	6.92	4%	-3.1%	6.64	7.31	7.34	11%
Holiday House	8.71	7.57	9.64	11%	27.3%	8.71	7.65	9.78	12%
Maple Lane	6.87	7.39	7.51	9%	1.6%	6.87	7.53	7.76	13%
Mayo	5.69	6.45	7.90	39%	22.6%	5.69	6.45	8.00	41%
McGirr	6.57	N/A	7.48	14%		6.57	N/A	7.54	15%
Morrisville Center	7.06	7.27	7.30	3%	0.4%	7.06	7.30	7.37	4%
Mountainview Center	6.38	7.90	8.08	27%	2.3%	6.38	7.95	8.17	28%
Mt. Ascutney	N/A	N/A	N/A			N/A	N/A	N/A	
Newport	6.14	6.16	6.50	6%	5.7%	6.14	6.23	6.64	8%
Pine Knoll	7.32	7.06	7.37	1%	4.3%	7.32	7.34	7.44	2%
Pleasant Manor	6.83	7.29	7.46	9%	2.3%	6.83	7.29	7.62	12%
Prospect	N/A	N/A	N/A			N/A	N/A	N/A	
Redstone Villa	N/A	N/A	N/A			N/A	N/A	N/A	
Rowan Court	N/A	N/A	N/A			N/A	N/A	N/A	
Sager	6.73	7.72	7.86	17%	1.8%	6.73	7.85	7.94	18%
Springfield	N/A	N/A	N/A			N/A	N/A	N/A	
St. Johnsbury	N/A	N/A	N/A			N/A	N/A	N/A	
Starr Farm	8.31	9.82	10.30	24%	4.8%	8.31	9.88	10.39	25%
Stratton House	N/A	9.73	10.28		5.6%	N/A	9.74	10.30	
Thompson House	7.59	8.19	9.05	19%	10.5%	7.59	8.21	9.11	20%
Union House	5.72	6.05	6.71	17%	10.9%	5.72	6.35	6.89	21%
Verdelle Village	6.68	7.01	6.86	3%	-2.0%	6.68	7.11	6.98	5%
Vernon Green	8.36	8.93	9.12	9%	2.2%	8.36	9.12	9.55	14%
Vt Veterans Home	8.78		11.14	27%		8.78		11.38	30%
Woodridge	9.57	10.35	9.54	0%	-7.9%	9.57	10.61	9.92	4%
Average	**7.71**	**8.19**	**8.51**	**10%**	**3.9%**	**7.81**	**8.32**	**8.66**	**11%**

Appendix J

Mr. George Thabault
Office of the State Auditor
Montpelier, Vermont via e-mail April 12, 2002

Dear Mr. Thabault,

Thank you for your e-mail requesting information about challenges and changes in nursing homes today.

I hope you've had an opportunity to visit our website, **www.culturechangenow.com.** You will see stories there that tell of the successes of focusing on quality of life in nursing homes. We think of our initiative as deep or profound culture change. Nursing homes must change. We're at a 'breakpoint' in society. Our population of frail elders is growing. No one wants to go to a nursing home. People are looking for alternatives. People across the country are looking for answers.

Action Pact has been working with many organizations to discover answers. We work with our client organizations in three areas. Our clients create many solutions, but we usually see these three major components to deep culture change:

1.) Physical renovations to create home. Most of us live in comfortable space, that feels right to us. We often center our lives around our kitchen, living room. dining room. bedroom, bath, garden or yard. These are the spaces that need to comfort, to envelop us with a sense of peace, that reflect ourselves – our purpose and interests. We like small spaces, cozy, safe, ours. We might live in an apartment building with dozens of other families – but our family has its own space, its own privacy, its own look – and within our family homes, we, as individuals have our own rooms (sometimes shared with one other family member) that reflect who we are.

2.) Organizational redesign. Nursing homes are institutional. Historically, in order to demonstrate that we give good care and to assure physicians and hospitals that they can send patients to us, and because our caring professions have been honed in hospital systems, we have created the look and feel of hospitals – shiny floors, long hallways, rooms on both sides, two people to a room, hospital beds, nurses stations, lounges that look like waiting rooms instead of living rooms. The organization of our work has also been modeled after hospitals and institutions – consider medcarts, meal service via trays on carts, attending to 'patients' by working our way down a hallway, etc. Having the patient 'wait' until the professional is ready for them – whether that be the aide, doctor, the nurse, or the therapist. And that is what we see – residents 'waiting' to get up, 'waiting' for someone to assist them in the bathroom, waiting at the nurses station, 'waiting' in the dining room for the food carts/trays to arrive. Very much like a hospital. But who wants to live in a hospital? Even a few weeks of a rehab stay in a nursing home is too long to be living in such an institutional setting.

We must organize our work differently. We need to center, not on the institution with all its supposed efficiencies, but we must center our work on the residents, and in fact be 'directed' by the residents. We must realign our accountabilities, not up through individual departments, but into the cluster of residents living with a common kitchen, dining room and living room, which

we call a 'household.' This usually means consistent staff assigned to each household. These teams work to discover each of the 15 to 20 or so elders living in their community, shaping their daily life and routines around the needs, desires and interests of the individual elder.

3.) Personal transformation. By 'personal transformation' we really mean seeing the world differently, recognizing that this is not the end or a 'waiting' time but a continuation of the elder's good life. And it is the job of each and every person who 'gets it' to become involved and engaged. As we open our hearts to this truly sacred responsibility of working with the Elder to create home, we begin to see how we can work differently, how we can interact differently. We are happy in our jobs again, finding meaning and satisfaction that drove us to a care-giving role in the first place. We are truly making a difference in elders' lives. As we begin to find meaning and satisfaction in our jobs again, we stay longer (and, truthfully, most of us went into, or at least stayed, in long-term care because of our love of elders or our love of doing for others).

Families of residents can discover that there is a meaningful role for them to play as well – they are the ones, with their knowledge and relationships with the elder, who can help us make home and community happen again for their loved one.

Community members – volunteers, churches, children and teachers from schools – all have an opportunity to get involved and experience this personal transformation for themselves as well – to become more aware of the value Elders bring to our society and into our relationships, to find satisfaction and meaning in creating home for frail elders and at the same time, participating in reshaping the world of long-term care.

I have sent a *Culture Change Now Magazine* which will provide much more information for you. I have sent it Fed Ex Express Saver which means you should receive it by Wednesday at the latest.

I'm quite willing to provide other info as you need it or to answer questions, etc., but much is in this e-mail, on the website and in the magazine. After that, I'll be glad to fill in the blanks for you, answering your questions.

Good luck with your project and if I can be of further help, don't hesitate to connect with me. I work all over the country and in fact, am in eastern Pennsylvania every month for the next year, so it wouldn't be so hard for me to come your way to talk to a group or sit down to figure out if there is any way I can help you all in your Journey to a better life for elders.

Sincerely,

LaVrene Norton, MSW
Action Pact, Inc.. Culture Change in Long-Term Care www.culturechangenow.com
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The following is information about the photos used in this report, which were provided to the Vermont State Auditor's Office by Action Pact and *Culture Change Now!* magazine:

Cover: This picture of a woman and little girl was taken at the Meadowlark Hills Retirement Community in Manhattan, Kansas.

Page 3: This photo is of an elder and child at the Leelenlau Memorial Health Care Center in Northport, Michigan.

Page 5: Several women garden at Park Place Nursing Home in Mount Pleasant, Iowa.

Page 7: Elder residents are visited by children at Whispering Oaks Care Center in Peshtigo, Wisconsin.

Page 50: An elder curls up with her dog Reggie at the Meadowlark Hills Retirement Community.

To obtain additional copies of this report contact:

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This report is also available on our website:
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