From: Farnsworth, Karen
To: aharter@vtlegalaid.org
Cc: Merriam, Virginia; Monde, Steven; Mishaan, Jessica
Subject: PRA Request regarding Genesis Corp.
Date: Thursday, October 7, 2021 5:02:28 PM
Attachments: 2021-10-07 PRA Response.pdf
GENESIS PRELIMINARY REPORT DRAFT.pdf
GENESIS PRELIMINARY REPORT Aug 6 2021 FINAL.pdf

Ms. Harter,

Attached please find our response to your public records request, along with the documents you requested. If you have any questions, please contact me. Thank you.

Karen

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October 7, 2021

Alice Harter
Vermont Legal Aid
177 Western Avenue, Suite 1
St. Johnsbury, VT 05819

Dear Ms. Harter:

After review of your records request dated September 28, 2021, and received September 209, 2021, we have determined that the enclosed documents are responsive to your request. We have attached the Genesis Preliminary Report Draft and the Genesis Preliminary Report August 6, 2021 Final.

Thank you.

Sincerely,

Karen M. Farnsworth
Paralegal

Enclosures
Electronically Transmitted Only

GERALD J. COYNE
E-MAIL: GCOYNE@AFFILIATEDMONITORS.COM

VIA EMAIL

August 6, 2021

Medicaid Fraud and Residential Abuse Unit
Office of the Attorney General
109 State Street
Montpelier, Vermont 05609

Affiliated Monitors, Inc., the Quality of Care Reviewer in this matter, submits this First Annual Review of three facilities owned by Genesis HealthCare, Inc., located in Burlington, Berlin and St. Johnsbury, Vermont.

INTRODUCTION

Background of Genesis/Vermont Settlement

On February 20, 2020, Attorney General Donovan announced a settlement agreement with three Genesis HealthCare ("Genesis") subsidiary-operated nursing homes in Vermont: Burlington Health & Rehab ("Burlington"), Berlin Health & Rehab ("Berlin"), and St. Johnsbury Health & Rehab ("St. Johnsbury"). This settlement agreement resolved allegations of neglect that resulted in serious injury to three residents and the death of a fourth. As the press release announcing this settlement noted, "Each of these incidents was related to inadequate staff training and orientation, the use of visiting or third-party contractors, and the failure to adequately document and monitor the delivery of resident care services."[1]

Among the terms of the settlement, the Genesis centers agreed to engage an independent reviewer to perform annual reviews of the quality of care at each facility. Affiliated Monitors, Inc. ("Affiliated") was selected to serve as the Quality of Care Reviewer on behalf of the Attorney General.

[1] Each of the three facilities under review has changed ownership and name since the entry of the Settlement Agreement. For consistency and ease of reference, they will be referred to by the names in the Settlement Agreement.

Terms of the Administrative Agreement

Under the terms of the Settlement Agreement ("Agreement"), Affiliated Monitors, Inc. is required to produce a yearly performance evaluation for each of the three long term care and rehabilitation facilities owned by Genesis HealthCare, Inc.

Each review shall include, but not be limited to, the following components with respect to each of the Genesis Centers:

- A request for production of information and documents;
- An on-site visit;
- Review of clinical care policies and procedures;
- Review of human resource, hiring and training programs; and
- Review of the delivery of services to residents and a sample of resident care treatment records.

Under the terms of the Agreement, the Genesis Centers agreed "to provide Affiliated, without an affirmative request, and in a timely manner, all surveys, inspection reports, notices of violation, or any other document addressing the quality of care delivered to, or concerning the health or safety of, any of the Genesis Centers' residents." During this review, we learned that individual administrators were not aware of this requirement. All required reports were recently provided, and we have been advised that documents will be provided in a timely manner going forward.

The review process also includes on-site visits to conduct interviews as well as assessments of the facility's sanitation and cleanliness; building, equipment and environmental safety; availability and accessibility of medical and other safety equipment; policies and procedures related to resident services, including but not limited to transportation services; meal delivery services and laundry services, and the integration of third-party contractors providing direct or indirect services to the Genesis Centers' residents.

In addition, reviews shall include a review of clinical policies and procedures that shall include, but not be limited to:

- Facility staffing levels;
- Standards and timelines for documentation of clinical services;
- Initial evaluation and assessment of patients;
- Determination of appropriateness of patient admission/placement;
- Scheduling of patient care team planning meetings;
- Development, content and updating of patient treatment plans, including establishment of therapeutic goals, progress benchmarks, and expectations about patient behaviors;

- Physician involvement in patient evaluation and treatment planning;
- Application of restraints and monitoring of patients during use of restraints;
- Documentation of, and solutions to address, patient allergies, physical injuries, fall risks, and other patient health or safety issues;
- Review of any incident reporting documents; risk assessment tools; or abuse policies used by the Genesis Centers to determine the cause and origin of injuries and whether the injuries are reportable;
- Provision of physical assistance to patients who require such assistance;
- Discharge planning and after-care plan development, including patients who are planning to leave the facility against medical advice (AMA);
- Compliance with the Vermont Nursing Home Residents Bill of Rights (33 V.S.A. 7301) and incorporation of patient rights into admissions and clinical processes;
- Receipt of timely information about, and investigation of, resident (any family members') complaints, medication errors, falls, physical injuries, and other incidents which potentially affect patient welfare, and documentation of response to the same;
- Internal auditing of clinical treatment records to evaluate completeness and sufficiency of documentation; and
- Appropriateness and sufficiency of the forms used in documenting clinical services and events.

In addition, reviews shall address the human resource policies and training programs at each facility including, but not limited to:

- Policies and procedures regarding, and documentation of, screening and credentialing of employees, including background checks, licensure status, occupational disciplinary history and references;
- Development, content and manner of presentation of initial training for newly-hired employees;
- Development, content, frequency of documentation of ongoing training for existing employees;
- Policies, procedures and practices regarding the use and screening of temporary or contracted employees pro
- vided by a third party; and
- Policies, procedures and practices regarding the training of temporary or contracted employees provided by a third party.

Finally, the Agreement requires a review of the delivery of resident-care services including a review of a sample of patient records, performed pursuant to HIPPA-compliant Business Associate Agreements. The records review will focus on the quality and sufficiency of the documentation, and the delivery of patient care services, including but not limited to:

- Reason for patient admission;
- Patient presentation and clinical history;
- Findings from initial evaluation/assessment of patient;
- Participation by all members of patient evaluation and care planning team;
- Content and appropriateness of treatment plans;
- Use of restraints and/or seclusion and monitoring of patients during the use of the same;
- Delivery of treatment and/or services, including duration of therapies where appropriate;
- Documentation of patient progress/response to treatment and patient re-evaluations where appropriate, and
- Discharge planning.

SCOPE AND METHODOLOGY

This First Annual Review is based upon interviews conducted of employees at each of the facilities reviewed, as well as on extensive documentation provided by Genesis. In addition, it is based upon the review of medical records, as well as interviews with the current administrator at each facility.

As we will outline, the completion of this preliminary report was greatly impacted by the Covid-19 Pandemic. Most importantly, all interviews were conducted remotely. We are satisfied we have developed sufficient information and insight through our remote efforts to offer the observations and recommendations presented in this report. However, a number of the specific review criteria cannot be fully examined or confirmed without a live visit. To complete the annual review process, we will be visiting each facility in order to conduct additional interviews and validate the information we have been provided. Pursuant to the Administrative Agreement, the facilities will be advised of a two week window during which those visits will occur, and a supplemental report will be provided.

The Impact of the Covid-19 Pandemic

At that time of AMI's engagement, our plan was to conduct a preliminary visit to each facility later in March, 2020, followed by a Request for Information to the facilities, in anticipation of site visits to each facility and completion of our First Annual Review.

Instead, within a month of AMI's retention, the nation was struck by the Covid-19 pandemic. The nature of this pandemic struck congregate care facilities particularly hard. The tragic loss of lives

at the Burlington facility, where published reports stated that 68 residents were positive for Covid and 11 died, received attention in the national media, including the New York Times. But every facility was severely impacted by the pandemic, resulting in a year of unprecedented actions to control infection, and unimaginable isolation, including solitary meals and the elimination of visits and socializing activities for residents, coupled with a regulatory process whose focus was necessarily forced to pivot.

We acknowledge that the singular focus of these facilities, as well as those who regulate them, became infection control, and the health and safety of residents. The Centers for Medicare and Medicaid Services (CMS), for example, one of the nation's most important regulators of long term care facilities, suspended certain Federal and State Survey Agency surveys, to allow a focus on the implementation of proper infection prevention and control practices to prevent the development and transmission of Covid-19.

As we will discuss, the pandemic resulted in the delay of this report, and the collateral impact of the pandemic will affect these facilities and their residents for years to come. But no discussion of the pandemic would complete without the immediate acknowledgment of the true heroes of the pandemic – those front-line workers who risked their own health to care for our most vulnerable citizens, and who were motivated not by money but by professionalism and their love for those in their care. A popular phrase, originating in Silicon Valley but now in wide use, is "build the plane while you're flying it." One explanation of that phrase states: "The expression 'building the plane as you fly' … captures the feelings of risk and uncertainty that accompany designing innovations and testing them in real time with actual participants, all while being responsible for keeping existing operations running." As our nation's congregate care facilities responded to the Covid-19 pandemic, with its unprecedented challenges and the uncertainties surrounding virtually every aspect of the disease, that phrase describes the world that these facilities, their residents, and their workers confronted.

By March 10, 2020, although not appreciating the magnitude of the pandemic, AMI reached out to counsel for Genesis and suggested that we conduct our preliminary meetings with the administrators of each facility remotely. Counsel responded by advising that Genesis had suspended "Corporate and Regional" visitors to all facilities, but would work with us on remote interviews, then subsequently advised us of new CMS protocols which precluded any visits without quarantine. On March 12, 2020, the Genesis facilities were closed to visitors, and on or about March 16, 2020 the Burlington facility had its first confirmed case of Covid-19. (We were notified by Genesis shortly after midnight on March 17th of the first positive test result at the Burlington facility.)

We anticipated, incorrectly, that the pandemic would present a brief delay in our review process. Little did we anticipate not only the delay it would cause, but more importantly the loss of life that would result in the facilities being monitored, particularly in Burlington, or the impact Covid-19 would have on every aspect of the facilities' operations over the next year.

On April 7, 2020, AMI reached out to counsel for Genesis to check in, and it was agreed to look for tasks that could be completed at the corporate level such as the gathering of policies and procedures for our review, but which would allow the centers to continue their focus on infection control and clinical care.

On May 15, 2020, AMI sent our initial "Request for Information" to the Genesis counsel. Counsel immediately advised that due to the "focus on patient care at the centers" it would likely take more than 30 days to respond to our request. At that same time, we initiated the provision of a secure laptop computer from Genesis that would allow for the remote review of medical records.

On June 29, 2020, AMI reached out again to Genesis to see if it would be possible to travel to Vermont to meet with the administrators away from the actual facilities. For a variety of logistical reasons, that was not possible.

By August 12, 2020 we received the last of the documentation from Genesis in connection with our Request for Information. Unfortunately, we were still unable to travel, but nevertheless began our review of materials. In October, we arranged to conduct a "virtual" meeting with the Genesis team and the key staff from each facility to introduce ourselves to them, and to outline for them the processes we anticipated using to conduct our review. We discussed the likelihood that we would need to conduct our baseline review virtually.

Being mindful of the delays caused by Covid-19, we felt it was important to initiate our preliminary review process rather than wait further. Although we realized that virtual interviews are not as effective as live ones, our concern was that some oversight was better than further delay. We also recognized that a virtual interview necessarily lacks spontaneity. Each much be scheduled, through the facility. In addition, there was no opportunity to simply ask an employee to "show me" something they were discussing, or to walk around the facility to make direct observations, or conduct unscheduled interviews.

In anticipation of commencing our review, we renewed our request for a laptop to review medical records, which had been placed on hold at the start of the Covid pandemic. We requested that Genesis provide us with updated patient and staffing lists, anticipating that there had been changes in the several months since our lists had been provided.

In approximately October, 2020, we learned that Genesis would be selling the three facilities that are under review, although no details were provided. Media reports indicated that Genesis, as the parent of each facility, was in the process of selling numerous facilities nationwide to address rising costs and a cash shortage due to the pandemic. Thus, the sale process had developed both quickly and quietly. We were told initially that once the sale was completed, Genesis would remain at the facilities under a management agreement for a period of six months.

It was explained that the sale of the facilities included the real estate of the homes, but that the licensing of the homes could only be transferred with the approval of the Vermont Agency of Human Services after a more detailed review.

We were provided with the final updated information we sought on December 21, 2020. Using the updated information that had been provided, and at the suggestion of the Genesis counsel, we reached out directly to the administrator of each facility to initiate the interview phase of our preliminary review. Each administrator was interviewed to obtain from them preliminary information about their facility. The administrators interviewed were Ross Farnsworth (Burlington), Melissa Haupt (Berlin), and Michelle Pippa (St. Johnsbury). We also interviewed the State Long Term Care Ombudsman, as well as the individuals assigned to the county where each facility is located.

It was determined that for the purposes of our preliminary review, we would conduct interviews virtually, since the facilities were still not open to the public or accepting visitors. For each facility, we would interview a combination of key personnel, and non-supervisory staff who would be selected by Affiliated Monitors based upon the information provided by each facility. Key personnel generally included the Director of Nursing (or "Center Nursing Executive"); the Director of Activities, the Director of Social Services, the Scheduling Manager, the Director of Food Service; the Director of Maintenance, and the MDS Coordinator. In terms of non-supervisory staff, we sought a mixture of clinical staff (Certified Nursing Assistants/Licenses Nursing Assistants, Licensed Practical Nurses), and Food Service/Housekeeping staff.

During our preliminary interviews with the administrators, we learned of the universal issues of both recruiting and retaining staff, and the resulting reliance upon "travelers" who come to the facility to work on a temporary, contract basis. Because of the critical reliance upon travelers at each facility and the potential impact that could have on patient care, we included traveling staff at each facility in our interviews.

The scheduling of interviews took longer than anticipated because of a combination of factors. First, we learned that not all employees have e-mail addresses at work, and to reach the non-supervisory staff in particular, it was necessary to schedule through the facility administrator.

Even with that assistance, not all employees were prompt in responding. It is noteworthy that the level of assistance at each facility varied. The administrator at Berlin was extraordinarily responsive, and most interviews at that facility were scheduled with little difficulty. Unfortunately, it was harder to schedule interviews at the other facilities. We subsequently learned that the administrator and Center Nursing Executive at St. Johnsbury were in their final days at the facility, and we had to follow up often with the administrator at Burlington, where non-supervisory employees seemed particularly reticent about responding to our interview requests.

In addition, the virtual interview process made the identity of the employees being interviewed known to management, though not the content of their comments.

The distinct challenges of scheduling at each facility are significant because they were reflective of our findings as the result of these preliminary interviews. As the findings for each facility are discussed, it will be apparent that the atmosphere in each was quite different. The atmosphere and culture at each facility was clearly impacted by the facility's location, although there are, to be sure, issues common to each facility such as staffing, the impact of the facilities' sale, and even the challenge of delivering quality food service. Most importantly, the preliminary interviews revealed the direct impact of strong, positive leadership at the administrator level.

Dr. David Wilner, MD, FACP, AGSF completed a review of a representative sample of medical records at each facility. During the interview process, we learned that the electronic medical records for each facility were transferred from Genesis earlier this year. Unfortunately, not all were transferred due to volume, and records generated prior to a particular starting date remain with Genesis. Staff indicated that those records are available, but that they must specifically request access to them. Although we were initially concerned that this medical records transfer may adversely impact the quality of care, staff reported that has not been the case. Despite some concerns, the overall sentiment was that the transfer of records had been done efficiently. The lack of access to legacy records, however, did prevent access to admissions information about several longer term residents.

Anne Peepas, an experienced long term care administrator, conducted extensive interviews with the administrators of each facility as part of our review team, as well as with the Patient Care Coordinator.

It is important to note that the single overriding issue in virtually every staff interview was the impact of Covid 19, not only upon the homes or the homes' operations, but upon the residents. Employees of all levels expressed concern with how the pandemic had altered the lives of these individuals, starting most importantly with having no visitors, but including having no social activities, limited therapy (often without contact), and eating and living in their rooms. In

particular, the non-supervisory staff referred to the residents as "family" and frequently came to tears when discussing the difficulties of the past year.

Without minimizing the shortcomings and issues detailed in this report, it is important to remember that the past year has been like no other. Faced with unprecedented challenges, the staff at each facility were forced to deal with often changing health guidance while caring for high risk residents. There will inevitably be welcome changes as visits return, activities resume, and communal dining begins. Other issues, such as staffing, supervision, and management, however, will not be directly impacted by the loosening of Covid related restrictions. These issues existed prior to and during the Covid-19 pandemic, and continue today.

FINDINGS

Findings Common to All Facilities

A. Ownership

At the time of the Settlement Agreement, all three facilities reviewed were owned and operated by Genesis Healthcare. On its website, Genesis, which is headquartered in Kennett Square, Pennsylvania, describes itself as:

> "…a holding company with subsidiaries that, on a combined basis, comprise one of the nation's largest post-acute care providers with nearly 400 skilled nursing centers and senior living communities in 26 states nationwide. Genesis subsidiaries also supply rehabilitation therapy to approximately 1,200 locations in 46 states and the District of Columbia. Genesis' subsidiaries employ approximately 70,000 people, each one dedicated to the delivery of high-quality, personalized health care to all patients and residents."

These three facilities were acquired by Genesis in 2016, when state regulators approved a $39 million purchase by Genesis of the facilities in Burlington, Berlin and St. Johnsbury, along with two other long term care facilities, in Springfield and Bennington. The facilities were purchased from Revera Assisted Living, a Canadian company that was leaving Vermont. At the time of the approval, three of the facilities (St. Johnsbury, Springfield and Bennington) had four star, or above-average ratings from the U.S. Centers for Medicare and Medicaid Services, while Burlington

received a two star rating, and Berlin a rating of just one star. At the time, Genesis already owned four other facilities in Vermont.[2]

Shortly after the sale, there were publicly expressed hopes that being owned by a national chain such as Genesis would potentially bring additional resources to these facilities, and our interviews with staff confirmed that to be case. Numerous staff expressed that Genesis, either through regional or even national management levels, had staff available to discuss specific concerns or problems, and those staff were available, responsive, and helpful. We learned, for example, that when the St. Johnsbury facility reported concerns about behavioral issues of residents, Genesis actually sent a team to the facility to learn more about the situation and to train the staff, which the staff reported was extremely helpful. In areas such as resident activities and social services, there was high praise for the resources that Genesis "corporate" provided.

By 2019, however, two of the facilities that Genesis had purchased – St. Johnsbury and Berlin – were included in a publicly released list of five elder care facilities in the state that were candidates for increased scrutiny under the "Special Focus Facility Program" administered by the Centers for Medicare and Medicaid Services. Although it was stated at the time that the surveys leading to placement on the list might not reflect current quality, since negative information remained on a facility's "record" for several years, it was clear that concerns existed about both facilities.

On August 31, 2020, Genesis announced it was selling five of its Vermont facilities, including the three facilities subject to this review. Although the sale was announced, the identity of the buyers was not initially made public. Because the licenses for the operation of the facilities remained with Genesis, those licenses could not simply be sold, and would become subject to a separate review process. Thus, it was initially announced that while Genesis would continue to "own" the facilities until transfer of the licenses is approved, the facilities would be "operated" by the new ownership.

We learned that on October 30, 2020, the new owners purchased the real property and the non-operational assets of each facility, and that on November 4, 2020 an application to transfer licenses was initially filed with the Vermont Agency for Human Services, which remains pending.

The new ownership consists of three individuals: David Gamzeh, Akiva Glatzer and Akiko Ike. Gamzeh and Glatzer are currently licensed to operate Barre Gardens Nursing and Rehab. Management services for the facilities are now provided by Priority Healthcare Group, and a

[2] On the Medicare.gov website, accessed August 5, 2021, all three homes now receive a one star rating. The site was last updated on July 28, 2021. According to the website, "The overall rating is based on a nursing home's performance on three sources: health inspections, staffing, and quality of resident care measures." The star system of one to five stars is provided to allow the comparison of homes, and should be considered along with other sources.

number of the facilities' employees inaccurately refer the new owners as "Priority." We obviously take no position regarding the merits of these transfer applications, but do acknowledge the responsiveness of the new ownership group, and the full cooperation we have received from them, as well as from Dawn Murphy, who is the President of Clinical Services at Clinical Consulting Services, and who is coordinating clinical care for the new owners.

We are primarily concerned with the uncertainty that has been created by this potential sale, in part because it remains under consideration by regulators. It was remarkable how little understanding the rank-and-file staff had regarding the details of the sale, even going so far as not being aware of the identify of the buyers. That lack of knowledge no doubt contributes to the high anxiety we noted.

We have noted the relatively recent acquisition of these facilities by Genesis. Although long-time employees recall that process, the high turnover inherent in the workforce at these facilities dictates that this is the first change of ownership many have experienced. One of the tangible impacts of the ownership change occurred earlier this year. We were told that employees lost their banked sick time hours, and were paid for 50% of their accumulated vacation time. It was unclear, in speaking with employees, whether this decision was dictated by Genesis or by the new owners. But particularly for those who had been banking sick leave in anticipation of maternity leave, planned procedures or to care for family members, the decision had a devastating impact in terms of morale. To demonstrate the amount of staff turnover that occurs, two of the administrators noted that there is no longer much discussion of this issue because there are already so many new employees.

To the extent that stability in the leadership of these facilities is important, there have been constant and wholesale leadership changes since the sale was announced.

At the time of the sale, the administrator at St. Johnsbury publicly stated that she would be leaving the facility and transferring to another Genesis facility. Her replacement was announced, who was familiar to the staff in St. Johnsbury from previous work there, and whom many were looking forward to returning. Instead, he is now the administrator at the Burlington facility, and the administrator in St. Johnsbury is the former administrator of the Burlington facility.

The administrator at Berlin was held in extraordinarily high regard by her subordinates. She has left the facility, and been replaced by two interim administrators, with a new administrator scheduled to start on August 23.

The administrator from Burlington was reportedly replaced by the new ownership group. His immediate successor stayed briefly, and a new administrator is on board (who was previously

identified as the incoming administrator at St. Johnsbury). The former administrator of Burlington is now at St. Johnsbury.

Although the transfer of licenses has not been approved, there have already been impacts on the operation of the facilities because of the sale.

One impact that we repeatedly heard about was the fact that under the ownership of Genesis, Administrators prepared an annual budget, allowing individual department heads to know the amount of money they had to spend over the course of a year. Under the new ownership, however, administrators and department heads are not given a budget, and according to several, were not even asked for their input on budgeting. Although the overwhelming preference was to return to an environment of budgeting, that feeling was not universal. One current administrator stated, “If department managers need something they can come to me. [The new owners] might have an overall budget but I am comfortable asking for and justifying something I need, and I believe a good, capable manager can function without one.” Another administrator confirmed the current practice, but added, “We are told ‘tell us what you need and we will decide if you really need it.’” Still, he does not feel that residents go without things they need, because he and the other managers and administrators “fight hard to get what we need."

We also recognize that particularly with the ownership of the facilities remaining in transition, the new ownership group needs to take immediate steps to manage the revenue and expenses of the facilities.

As we previously noted, when the ownership of the facilities transferred, electronic medical records were transferred from Genesis to the new ownership. During that process, we were informed that records predating a specific date were copied and available as “PDF” copies only, but were not included in the transferred electronic medical records. We were told that these legacy records remain available, though there is now a process to gain access to them. In response to questions, no clinical staff reported any issues related to the quality of care to a resident due to the record transfer, but the review of medical records in conjunction with this review was limited in some aspects because of it.

A larger issue will occur if and when the licenses for the homes are transferred. Currently, the facilities continue to operate under Genesis procedures and policies. Once Genesis no longer holds those licenses, a new set of procedures and policies will replace those. Although it is reasonable to expect that many procedures and policies will remain consistent because they are based on law or best practices, there will be a wholesale changing of the administrative core of the facilities, that staff will need to be retrained on, recertified on, and reinspected on.

B. Policies

As a national chain, Genesis has a robust collection of policies that cover virtually every aspect of the operation of its facilities, ranging as examples from the hiring process of employees, to a comprehensive Code of Conduct for employees (HR 300), to Discharge Record Processing for residents (4.23). Many were produced to AMI in response to a Request for Information. The policies are dynamic and are updated when circumstances warrant, such as the publication of a policy specifically addressing infection control policies and procedures during COVID-19 (IC 405) issued on March 27, 2020. The policies we reviewed are comprehensive, specific, and clear to understand. Together, they outline expectations of how a facility should be operated.

As noted, these Genesis policies will remain in place as long as Genesis holds the license for each facility. At that point, we anticipate that the new policies implemented will continue to be common between the three facilities.

C. Funding Sources

Like most states, most long term care in Vermont is paid for by the Medicaid program, although some is paid for by long term care insurance or the personal resources of residents. Medicaid is a joint federal and state program that provides health coverage to over 72.5 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities. Medicaid is the single largest source of health coverage in the United States. Medicaid was designed to provide a government-funded health insurance plan for income-eligible people and people who are categorically eligible. The federal government establishes requirements for all states to follow but each state administers their own Medicaid program differently. The Department of Vermont Health Access (DVHA), within the State of Vermont's Agency of Human Services, is responsible for administering the Vermont Medicaid health insurance program. The Division sets Medicaid payment rates for services provided in Vermont licensed nursing homes (also referred to as nursing facilities) participating in the Medicaid program. The rates are set quarterly, based on each nursing home's costs which are annually reviewed by the Division's auditors for allowability.

The "Skilled Nursing Facility Medicaid Rates" are a key factor in the amount of funding a facility receives for each Medicaid funded resident. For April 2021, the per diem Medicaid rates for these facilities are:

Berlin	$240.21
Burlington	$300.21
St. Johnsbury	$219.20

The reimbursement system takes into account that some residents are more costly to care for than others. Thus, information gathered at the time of a resident's admission through the MDS process can have an important impact on subsequent Medicaid funding.

D. Staffing

All three facilities reviewed face a chronic shortage of clinical staff. One administrator interviewed described the clinical staff shortage as a two-part problem. The first part of the problem is locating staff, which is a chronic problem simply due to a shortage of qualified individuals. Although this problem is not unique to these three facilities, several persons interviewed noted that hiring staff is extremely competitive, and the pay a facility offers can have a major impact on its ability to recruit. The second part of the problem is retaining employees. One administrator interviewed described the problem this way:

> "Getting staff is a problem simply because of the size of the available pool. There appears to be a chronic shortage of staff. The keeping portion ebbs and flows, which results in the high use of travelers."

When permanent staff leave without an immediate replacement, or when there are simply not enough permanent employees to meet the facility's staffing needs, a facility generally depends upon a long term temporary employee, obtained through an agency, and generally referred to as a "traveler" because these employees often travel to the facility from another part of the country. Travelers come to a facility and generally work blocks of approximately 12 weeks. Most travelers interviewed described licensing rules that allowed them to work away from the home state, but required a periodic return to that jurisdiction. Because of the reliance upon travelers, we interviewed at least one traveler at each facility.

It was immediately apparent that although many observers simply lump "travelers" as a homogenous group, each individual traveler brings with them their own personal story of what led them to this unique work style. For some, it is a love of affordably experiencing other parts of the country. For others, it is a chance to visit family and friends. But other motivations are more personal. One traveler interviewed stated she had been a permanent employee at a long term care facility in Kentucky where a large number of residents had died of Covid. Each loss was personal

to her, and she became a traveler to find a way to continue to provide clinical care, but in an environment where she would be less attached to those she cared for.

The common perception is that travelers are primarily motivated by money. Without question, some are. Nevertheless, most travelers must pay for their own housing, and most said that to the extent they make a lot of money it is because they take so little time off. Travelers are often the first line a facility counts upon to fill vacant shifts, frequently by working overtime.

Because travelers are all professionally licensed, few reported any concerns about a lower level of clinical skills between travelers and permanent staff. By policy, all travelers are required to undergo an "onboarding" process that includes not just familiarization with each Center's policies, but also an assessment of the traveler's clinical skills. (We were provided with documentation of the onboarding process currently used for Licensed Nursing Assistants in St. Johnsbury.) In addition, travelers are required to shadow a member of the permanent staff prior to being assigned to work a regular shift. All we interviewed reported participating in an onboarding process upon their arrival. The Patient Care Coordinator expressed that she believes that the travelers get less orientation than in-house staff although they don't go on the floor until they have completed the competencies. According to her, how long they shadow seems to be governed by the results of the competencies.

When permanent staff were questioned about the clinical skill levels of travelers, there was no broadly held belief that travelers' skills were either lower or higher than the permanent staff as a whole. Some actually viewed travelers as resources who could share how similar procedures and practices are done differently in other systems or in other parts of the country.

The most commonly expressed concerns about the use of travelers generally was not a criticism of clinical skills, but rather the lack of stability that results from staffing turnover, and particularly the fact that when a traveler first arrives, the traveler is not as familiar with the nuances of each resident. The lack of stability in staff leads to inherent issues, particularly with residents who may have begun a cognitive decline.

As an example of the "ebb and flow" of the use of travelers, we were told in February that approximately 80% of the Burlington facility's clinical staff were travelers. By July that number had decreased to between 25% to 33%. At the same time, the St. Johnsbury facility estimated that about 75% of its employees were permanent, and Berlin estimated that about 60% were permanent. Because of the "ebb and flow" identified by the administrator we interviewed, the availability of permanent staff is a challenge for long term care facilities in Vermont, and is likely to remain a challenge.

A second staffing challenge for each of these facilities is the ability to have an adequate number of staff working. Federal regulations require nursing homes to have sufficient nursing staff with the appropriate competencies to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident. Resident care needs differ depending on the acuity level (or case mix) of the facility residents. Higher acuity rates require higher staffing levels.

Staffing is generally managed using the "Patient Per Day" or PPD formula, which is widely used to establish staffing levels, based upon the number of residents in a skilled nursing facility (census) and the number of clinical staff caring for them during each shift. There are a series of adjustments to that formula which take into account unique needs, and which allow certain positions to be counted against it, and which exclude other positions.

The federally mandated PPD is 2.7. Vermont adopted regulations in late 2001 to require a minimum of three hours of direct care per resident per day. Direct care includes nursing, personal, and restorative nursing care. At least two of the three hours must be standard nursing assistant care such as personal care, help with walking, and feeding that must be performed by licensed nursing assistant or equivalent staff. These two hours cannot include meal preparation, physical therapy, or recreational activities (VT Licensing and Operating Rules for Nursing Homes, §7. 13 (d)). We were told by two administrators that they are currently required to manage to a PPD of 3.3. Staffing levels at each facility were a point of concern to those we interviewed. Although staffing to a minimum level may meet legal requirements, it is apparent that doing so leaves virtually no flexibility in the assignment of personnel. As an example, one interviewee noted that at the time a facility had several bariatric patients. Though minimum staffing levels were met, the functional reality was that moving those patients required multiple staff to be involved in the process. So although minimum staffing levels were met, there would be inherent gaps is the availability of staff to interact with other residents for periods of time.

Having sufficient staff is a factor that is specifically covered by federal regulations, and on February 3, 2021 a survey of the Burlington facility by the Vermont Division of Licensing and Protection resulted in specific deficiencies regarding that facility's staffing levels at the time of the survey. Complaints included late delivery of medication, including pain medication; a patient who waited so long for assistance getting to the toilet that they went unescorted; and a resident who complained they had not received a shower in over two weeks due to a lack of staff. Residents reported long waits for staff to respond to call lights as well, a complaint we also heard during several interviews. Each of these examples could directly and adversely impact the quality of care a resident receives. While we recognize that the Survey on February 3 represents a "snapshot" of what inspectors found at that time, and that several other visits of the same facility did not identify any deficiencies, the number of patients and staff expressing the same concerns about staffing is concerning.

Specific staffing concerns at each facility will be addressed separately.

E. Dining and Housekeeping Services

The Dining and Housekeeping services at each facility are provided by Healthcare Services Group, which is a contractor. It was noted that menu selection is prepared by Healthcare Services. The menu for each facility includes both a specific menu item for each meal, as well as an "always available" selection.

Regardless of the facility, the Dietary Service directors interviewed reported there was little money left owner to provide residents with anything "extra." Regardless, Covid had a dramatic impact on the dining services, since communal meals were no longer allowed. Every facility dealt with the challenge of trying to deliver hot meals to residents. At every facility, staff reported either occasionally bringing treats in for residents, or even running out to a nearby store to purchase something the resident asked for to eat. Specific observations regarding each facility are included within the discussion of that facility.

F. Resident Transportation

Providing transportation to the residents of a facility is a critical service. It enables residents to keep critical medical appointments, such as dialysis, but is also important to simply allow the residents to experience the world away from the facility, which has both clinical and recreational value. Each of the three facilities reported having some means to transport residents, but none have a dedicated driver. In every case, the employee who is detailed to transport residents as a collateral duty has a primary duty as well. Simply put, no employee can be in two places at once. While one duty is being performed, the other is not.

G. Patient Care Coordinator

The Settlement Agreement required that Genesis "engage a roving Patient Care Coordinator who will perform duties at each of the Genesis Centers, for a minimum term of two years and a maximum term of three years." It further required that, "The Patient Care Coordinator shall be a full-time, contract employee of the Genesis Centers." The position was created, "to assist the Genesis Centers in providing their residents with the safest, most appropriate, and highest quality care."

Genesis selected Audrey Kerin, RN, CQS as the Patient Care Coordinator ("PCC"), and that selection was approved by the Attorney General. Ms. Kerin is a lifelong Vermonter with 37 years of clinical experience, including holding a registered nurse license in five states. She has worked in long term care throughout her career. At the time of her appointment, she was a clinical quality specialist for Genesis, providing clinical support to Genesis Healthcare centers in Vermont and New Hampshire. She has been employed by Genesis since 1996, and held a variety of positions,

including as a Director of Nursing and as a Manager of Clinical Operations. Ms. Kerin was eminently qualified for appointment to this position.

Because her previous position with Genesis involved contact regarding the clinical quality at each of the Centers subject to the Settlement Agreement, there was a seamless transition to her new role.

All centers reported having regular contact with the Patient Care Coordinator. The PCC advised that she visits each facility every two weeks, spending a full day at the facility. The PCC reported that she initially devoted all of her time to the three facilities covered in the Attorney General's agreement but since the sale, everyone was made aware that she would have responsibilities for other Genesis facilities as well. She begins by reviewing the census; admissions, discharges, and deaths; incident reports; infection control logs; and based on the information follows up with review of resident care plans, observation and conversation with residents, nursing staff and any other discipline that might be appropriate and rounds on the floor. She meets with the Administrator and Director of Nurses as necessary. She provides written reports to the Administrator, Director of Nurses, and Genesis staff, as well as to the new ownership group. In addition, she provides a written report to the Attorney General's office.

The PCC advised that when she is at a facility, she can get a sense of whether things are "going good or not" as she makes her rounds. Although she focuses on resident care issues, she also covers issues that overlap into other departments such as Housekeeping or Dining Services. She also reviews the "Grievance Log."

Under the Settlement Agreement, the Patient Care Coordinator is required to advise the Quality of Care Reviewer within 24 hours of learning of any situation that, in the Patient Care Coordinator's opinion, endangers the health or safety of any resident. No such reports have been received. In addition, the Settlement Agreement requires that the Patient Care Coordinator submit a written report for inclusion with the Quality of Care Reviewer's annual reports. That report will be included in the supplemental report following our live visits to the facilities.

Finally when asked, the PCC described the biggest challenges facing the facilities as stabilizing leadership and staffing and minimizing agency staff, observations which match ours.

H. Clinical Observations

Clinical observations are based upon the review of a sample of medical records from each facility. Each facility provided a roster of current residents, and Dr. Wilner selected the records to review. Although the identity of the resident was known to him, it was not included in the information he relayed.

As a result of this review, several common themes were noted.

All facilities use the "Point Click Care" system to maintain electronic medical records. As a result, much of the data in records is generally legible, with the exception being any handwritten notes. Due to the transfer of records between Genesis and the current owners, not all legacy records were available. Some charts of long term residents did have a digital file of previous records – some with a thousand or more pages. But in those cases where legacy records were available, it was not easy do search and locate specific information.

Information regarding each resident upon admission is gathered by a Minimal Data Set ("MDS") coordinator, who is responsible for gathering information on each resident for current and future assessment, including physical and mental states. It appears that the system is used to link the MDS to the resident's care plan to ensure coordination and consistency. The MDS entries were completed on time, as were care plans. Care plan meeting notes showing those who participated were generally included in records from the Berlin facility, but not from Burlington or St. Johnsbury. As a general observation, care plans frequently stated general goals, but did not include goals that were measurable or specific to each resident. In addition, care should be taken to ensure that each care plan record includes a notation of who created the document.

The records reviewed did not include a Medication Administration Record ("MAR"). A MAR, commonly referred to as a drug chart, is the report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional. The MAR is a part of a patient's permanent record on their medical chart. There have been documented complaints regarding the late administration of medication, such as during a survey at the Burlington facility on February 3, 2021, which should have been reflected in a MAR. We will follow-up on this issue during our live visit to determine if this information is captured elsewhere.

Also frequently missing from medical records were records of Occupational or Physical Therapy. We expect that these records are kept, but not in the EMR's that were reviewed, as these services are provided by a contractor. We will also follow-up on this issue.

Finally, one important benefit of electronic medical records is the ability to easily identify who made each entry. But that benefit is only realized if all credentialling information identifying the writers' disciplines and electronic signatures is entered. In a number of entries across all three facilities, credentialing information was not appropriately entered. In addition, our review of the medical records did not disclose whether the individual making an entry was a permanent staff member or a traveler.

<u>Findings Regarding Individual Facilities</u>

<u>Introduction</u>: We have already noted that each facility serves a unique community, each with its own challenges, and that our review involved interviews with both staff and each facility's administrator.

It is important to note that each of the administrators in place at the time of the conduct which led to the Settlement Agreement had left by the time that agreement was signed. Further, the administrators in place at the time of our staff interviews – in February and March 2021 – had either left the company or held a different position by the time the administrator of each facility was interviewed in June and July. We recognize the significant impact that an administrator has on a facility. Because of that impact and to avoid confusion, this report will distinguish comments made during the staff interviews, with the comments of the facility's administrator, each of whom were not in place until after those interviews occurred.

We will speak with the administrators once again when we visit each facility.

A. Burlington Health/Queen City Nursing and Rehabilitation

a. Results of Staff Interviews

At the time of the interviews of employees at this facility, in late February and early March, the administrator was Ross Farnsworth. The census at the time of our interviews was approximately 86 residents, with a maximum capacity of 126, although Covid restrictions likely reduced the capacity to 114. The multi-story facility is located in an urban setting, and largely draws its staff and residents from a metropolitan area.

The Center Nursing Executive has worked in long term care for 16 years, and described herself as having "worked up through the ranks" to her present position. She has been a registered nurse for over six years. Comments from her subordinates frequently refer to her "limited" experience as an RN given her current management responsibilities. There were no specifics offered regarding any adverse impact of that "limited" experience. Rather, her lack of nursing experience was pointed to, perhaps unfairly, by staff who found issue with her management style rather than her clinical skills. She reported that she arrived at Burlington as the Assistant Director of Nursing from the Genesis facility in Rutland in April 2019, and was promoted to her present position in November 2019.

In an attempt to assess the impact of the sale of the facilities on operations, the CNE stated that the sale of the facility was not complete, and could remain open for up to a year. Like others, she lacked specific details of the sale. She stated it was time consuming to "report to two masters" since she continued to report to Genesis as the license holder, while reporting to the new owners as the operators of the facility. She described the challenges of transferring the electronic medical

records between Genesis and the new owners, but indicated that these challenges have not adversely impacted resident care, because all necessary recent records had been included in the electronic transfer.

As the nursing executive, the CNE manages the level of clinical staff within the facility. Staffing is driven by the facility's current census, which also forms the basis for nearly all of the facility's revenue. While Medicaid funding mandates minimum levels of staffing coverage, there is little money to provide coverage beyond that amount. Although some supervisory staff are not included in the staffing equations, managing both coverage and costs in an environment driven by these formula presents a continuing challenge.

The CNE estimated that the current staffing mix at the facility was approximately 80% travelers and 20% permanent employees.

Based upon our interview with the CNE, it was apparent that there are staffing concerns at the facility, though the root of those seems to be in the reimbursement formulas set by CMS rather than local decisions. Since the CNE was the first interview at the facility, subsequent interviews were based, in part, on information she provided.

Subsequent interviews, however, painted a far more troubling picture of the facility.

Most staff interviewed described morale among staff as low, although there were varying reasons for that. Without question, the Covid-19 pandemic took a horrific toll on the Burlington facility, particularly in terms of the tragic deaths of residents. It is important to also recognize the pandemic's impact upon the morale of the staff that fought valiantly to protect and save the lives of the remaining residents.

Unrelated to the pandemic, others interviewed were more pointed about the lack of executive leadership at the facility. A number of staff complained that the Administrator and CNE were often absent from the facility at the same time, resulting in a leadership void, and that neither were generally available on nights or on weekends. Weekend coverage was a particularly sensitive point, since the lack of staff often resulted in last minute schedule changes on the weekends, making the scheduling of off-duty family events impossible. "Weekend coverage is always filled at the last minute," one staff member complained, "sometimes by salaried staff."

The administrator was described as "polarizing" resulting in a divide between those who see themselves as aligned with him – often the newer employees – and those who are not – often the longer-term employees. The atmosphere was described as "cliquish."

The staff was described as "overwhelmed" the same worker stated. "You have to ask, at what point does all of this affect patient care?" In fairness, no worker identified a specific adverse impact on patient care. Instead, the commonly expressed feeling was, "It impacts the staff, so at some point it as to impact the patients as well."

Nearly every worker interviewed said they had little if any direct interaction with the administrator. A commonly expressed feeling was that the staff is, "unappreciated and unsupported, and any complaints or suggestions fall on deaf ears." Even senior staff complained about the lack of direct feedback from the Administrator. "Our staff needs to be encouraged," one long time employee stated. "Everything is negative and micromanaged. There is no communication that is positive…This absolutely has an impact on the facility and on staff turnover. We need to improve the energy of the facility. We never see our leadership…It just needs to get better for our residents." One long time employee said, "I've only seen the DON three times in about three years, and the administrator once. If I walked by him in the hallway I doubt I'd recognize him."

One area of particular concern was the staffing in the Rehabilitation unit. At one point, that unit had been down to just three therapists, when the optimum amount would be between 14 and 16, in order to fully meet the demands for service. Patients were scheduled for less therapy than required, and in some cases disciplines were combined rather than having specialized therapists provide services. In order to provide just two hours of therapy each day to those residents who need it, it was estimated that the size of the rehab staff would need to double.

Although the staff generally shared the view that staffing levels are unacceptable, most recognized that staffing is driven by the "Patient Driven Payment Model" and by "Per Patient Day" calculations. Recognizing the inevitability of staffing concerns, one worker commented, "the facility is managed as well as can be, but is lacking leadership." In assessing the facility's leadership, it was termed, "highly directional, highly assigned, and task driven rather than people/morale driven" resulting in a "very tense atmosphere." Because minimum staffing is driven by complex rules and formula, there is rarely any excess staff ordered to work, so when an employee calls out sick, an employee who is already at work is frequently ordered to stay on, resulting in a 16 hour shift. Short staffing, however, has already resulted in frequent overtime and occasional double shifts, adding more stress to the system. One manager observed, "We get into a very cyclical pattern of asking more and more from those already working." Further, "we can't afford to have gaps in coverage, so we are even more at the mercy of travelers."

One experienced staff member stated that although the facility is dependent upon travelers, little effort is made to make them feel a part of the operation. "A lot of the travel staff has never met the DON or administrator, particularly if they work at night." Often, a majority of the evening and overnight staff are travelers. Although travelers must meet certain minimum licensing

qualifications, "you got your good and you got your bad." The principle complaint was the travelers simply don't know the residents and their unique habits and needs, and by the time they do learn them, it is time for the traveler to leave. In fairness, other clinical staff noted that although travelers do not know the residents as well, they virtually always work alongside permanent staff who do, and who will recognize nuanced behavior.

A number of employees who had been at the Burlington facility for several years described the facility as having been very well run until recently, although there is no universal agreement on when that decline began. One frequent comment was that the Genesis corporate model provided for regional and even national assets that could be called on to assist with a problem. Those working in program areas were particularly complimentary of the corporate support that was available. Genesis was described as responsive to calls for assistance or advice, and its resource related employees were viewed as well trained, accessible, and helpful. Several employees traced what they viewed as the decline of the Burlington facility to the fact that there had been four administrators in two years. Another long term non-supervisory employee stated, "This used to be a fabulous place to work." When asked how long ago that was, I was told, "about five years." Commenting on the executive turnover, another staff member stated, "Each of the ones we've had have been OK, but you need the experience and the stability of one who has been here for a while."

The lack of staffing during the evening shifts was particularly noted by the non-supervisory staff that actually is on duty during those hours. There may be up to 10 nurses working on day shift, but only three at night, when presumably residents are sleeping. Unfortunately, that is not always the case, particularly because a number of residents have mental health issues that limit their sleep. When a patient with mental health issues wakens, for example, they often simply don't want to go back to sleep. I asked how they manage when they have limited staff and patients needing attention. "On my floor," I was told, "we have to hustle. We get used to it. We constantly are walking the unit and trying to prevent things from happening."

Another long-term staff member, when asked if there was enough staff to do the job, replied, "If everyone is here – if there are no call outs, then yes. But we don't have anyone extra. But if one gets sick and calls out we are short. Other floors offer to help…that's true for both permanent staff and travelers. We all try to help one another out, but there's just no room for error."

On particular item that staff mentioned was that when it is anticipated the day shift will be short staffed, the overnight shift has been told in the past to wake patients as early as 4:30 AM to start the day by getting them cleaned and dressed. Unfortunately, breakfast is not served until 8:00 AM, so a patient may be sitting alone in their wheelchair for over three hours. "It's not fair," I was told, "It breaks my heart to do that." After hearing of this practice, other workers confirmed it occurs, although some staff have refused to participate, one noting that leaving a patient in a chair

that long often results in the need to bathe them again, negating any time savings. One said, "I won't do that. But they only do it with the people who can't say no…."

Staff reported that overall cleanliness at the facility has declined, although most staff had praise for the housekeeping staff who do the best they can with the limited resources they have. Housekeeping and food service are contracted to an outside company, so the staffing levels are not dictated by the facility's management alone. At one time, there was apparently one housekeeper for each side of a floor, who would clean every room, then move on to other cleaning. Now, with reduced staff, that is no longer possible.

With regard to the quality of food, staff stated that there are two menus available at all meals: a regular menu, and an "always available" menu that frequently consists of peanut butter and jelly. Staff frequently bring snacks and other items in to supplement the snacks available for residents, which have reportedly improved but still are described as "repetitive." Other staff reported running out to a nearby Cumberland Farms to buy a treat for a resident. Because of Covid all meals had to be eaten in a resident's room, which placed increased demands upon the staff who had to distribute the meals, and frequently feed individual residents. Staff interviewed seemed sensitive to the particular dietary requirements of individual residents.

Finally, those staff responsible for programming indicated that due to the transition in ownership, they have no idea what their budget will be as they emerge from Covid. At a time when programming will assume more significance than ever, the lack of budgeting was universally considered to be a detriment to longer range program planning.

The most commonly cited need was for increased staff training on how to deal with residents with dementia. It was generally felt that although there had been training in this area in the past, staff turnover, combined with the prevalence of the condition among residents, would be very beneficial.

b. <u>Administrator's Comments</u>

The current administrator of this facility, which has been renamed Queen City Nursing and Rehabilitation, is Sean Hallisey. He has been employed at the Burlington facility for 3 months. Prior to coming to Burlington, he was Administrator at St. Johnsbury from 2008-2017, where he was highly regarded by staff. He left to become administrator at Barre Gardens, which a long term facility owned those who have purchased the former Genesis facilities.

His direct reports are HR Director, Business Office Manager, Director of Nurses, Social Worker, MDS Coordinator, Activities, and Maintenance. While the Housekeeping and Dietary Managers

report to him, they are contracted through Healthcare Services Group and the Rehab Director is contracted through Remedy Rehab.

The last time the facility was visited by a government regulatory agency was in June, 2021. He states it was a complaint survey under Residents' Rights for failure to notify a resident's responsible party of a change in diagnosis and treatment in a timely manner. A plan of correction has been submitted.

The administrator believes the last time the kitchen was surveyed by a government agency was during the full survey in 2019 prior to the pandemic. He states that he personally has his own checklists for daily, weekly and monthly walk-throughs.

The overall physical condition of the facility is "average for a 50 plus year old building." The building has been maintained, with a secure roof and the replacement of mechanicals about 8 years ago, and there are no conditions the administrator is aware of that would impact the health or safety of a resident or employee. He would assess the cleanliness of the facility as average and improving. Upon his arrival he was able to secure an extra housekeeper and was able to get a floor tech three times per week.

The facility has a small bus for transport of residents and sometimes they use "quasi-public transportation such as rural community transport. The bus is small enough that it does not require a special license and the maintenance man is able to drive it. He did get approval to hire a part time bus driver but has not had any applicants.

The administrator describes the quality of the food as "pretty good." Kitchen cleanliness and presentation of food have improved in his estimation. The Dietary department is not operated with a budget but he feels he has enough experience to stay within a reasonable amount.

Mr. Hallisey states that the number of travelers is decreasing. They have approximately 90-100 total employees with about 25-30 of those being travelers. They use Prime Time, Career Staffing and TLC (a local company) for their travelers and the contracts run from 8-13 weeks. They do not use per diem staff in addition to travelers. He describes the on-boarding of travelers as a full orientation.

He feels he has enough staff to meet state requirements as long as there are no call-outs. He does not have any in-house per diem staff to fall back on so has to try to get regular staff to work extra.

Minimum Data Sets are completed by two staff members who total 1.5 FTE's. Burlington has the highest Medicaid per diem rate of the three facilities reviewed. Having a higher number of behavioral residents may also contribute to the higher rate.

The current census is 98 with a capacity of 126. Mr. Hallisey says the third floor unit is currently closed due to insufficient staff to open it.

Mr. Hallisey believes that medical care is provided in a very timely manner. Dr. Mark Pitcher has most of the residents but a few are attended by Dr. Williams from UVM. Dr. Pitcher has a nurse practitioner in the facility 3-4 days per week. They also have access to a wound care nurse from two local wound care vendors, Gentell and Medelite.

The facility is able to provide therapy services in all disciplines. Therapists are managed under Remedy Rehab Services. He states he needs one more PT to be able to open the third floor which he hopes to do in August.

He believes social services are adequately staffed with one social worker and they have recently added another activity assistant.

The administrator describes staff morale as slowly improving. He makes rounds on the floors at least daily to communicate with residents and ask them about their care.

Tom Carroll is HR Director and is responsible for screening and credentialing of employees and obtaining references. Mr. Hallisey says the travelers come with their own dossiers from their agencies but otherwise the screening is the same for in-house or traveling staff. HR does the Vermont background checks on both.

Mr. Hallisey states that the orientation process is the same for both in-house and travelers. They receive 2-3 days of classroom review of policies and procedures, followed by clinical competencies which are usually done by staff development and the unit manager. He says they are partnered with a current staff member of the same discipline for 3 days to a week depending on the results of competency testing. A new practice is to have them attend a breakfast for new staff and selected residents. On an annual basis they are reviewed on the required competencies such as infection control, fire, blood borne pathogens, and sexual harassment.

He states there is no budget or P&L statement received by himself or the department managers. If department managers need something, they can come to him, and he is comfortable taking a request to a higher level if warranted.

Mr. Hallisey states that although he is not a clinician, he is very involved in oversight of clinical services. He attends morning meetings where he gets information on fall, injuries, infections and other clinical issues. He also speaks with residents on a daily basis and hears about their physical concerns. He signs off on reports related to falls, wounds, and psychotropic drug use, and participates in the QAPI meetings. There are no reports or documentation related to restraint use because the facility is restraint free. He states he keeps up with discharge plans and after-care plan development through his one to one meetings with the social worker and also through participation in the utilization review meetings. He did say that he sometimes has to ask for follow up information on the discharge plans.

Resident rights are posted and given to the residents/families as part of the admission process. The grievance process and Resident Council is the primary way he hears about resident rights issues. The grievances are investigated and sometimes he meets one to one with the resident or family member. Depending on the severity of the grievance or incident report, a Root Cause Analysis might be done. The grievances then become part of the QAPI process.

Internal audit procedures to ensure accuracy and completeness of the medical records are mostly done by the unit manager, who uses checklists to make sure that required components of the record are completed. The MDS Coordinator also checks the records as part of the data collection process. If reeducation is needed, it is usually done by the Nurse Practice Educator.

The Patient Care Coordinator is at the facility every 2 weeks. He believes she reviews minutes of meetings, looks at accident and infection logs, makes rounds and talks to staff and residents. She then gives him and the DON a report of her findings.

According to the administrator, his top priority is to hire non-agency staff in order to reduce the reliance upon travelers. His other priority is re-opening the third floor unit which is basically dependent on staffing.

B. Berlin Health and Rehab/Berlin Meadows

a. Results of Staff Interviews

Berlin Health and Rehab is just 42 miles south of Burlington Health and Rehab, and minutes from Interstate 89. But the atmosphere in those facilities could not have been more different at the time staff interviews were conducted. And based on those interviews, the credit for this distinction lies clearly with the administrator of Berlin Health and Rehab, Melissa Haupt. (We learned after these interviews that Ms. Haupt had retired. Our interviews disclosed no plans that she would be leaving, from her or anyone else.)

Unlike the Burlington facility, the Berlin facility is located on a single level, separated into wings which branch out from the building's common areas. Since it is located in a far less densely developed area, it is not uncommon for wildlife to be seen out of the residents' windows, and during the Covid pandemic, family members who could not enter the facility were often able to maintain some visual contact with residents. At the time of our interviews, the resident census was approximately 85, although they could accommodate up to 115. Prior to Covid, the census was generally in the low 90's.

One of the facility's three wings focuses on long term care, another on rehabilitation, and the other on dementia and Alzheimer patients. A number of staff, including travelers, praised the Administrator's ability to better staff these units by matching staff with the needs of the residents.

The Director of Nursing is respected by the facility's staff. She started her career as a nurse's aide in 1989, then resumed her education, becoming an LNA, and then an LPN. She has been a nurse for 31 years, with 24 years of that time at the Berlin facility. She said she left briefly because she felt she needed to learn to manage, which would be difficult to do supervising her former colleagues. Instead she briefly went to what she called a sister facility. Prior to her promotion she worked as the supervisor of the facility's dementia unit. Becoming the DON approximately six months before our interview was "like a dream come true" for her. She described the home as, "truly a family atmosphere…It's like coming back home to me every time I come here." She was particularly proud of the way the staff pulled together during the Covid pandemic. "It took a staff that cared and understood and loved the residents and wanted to protect them." Both the Administrator and the DON were widely praised by staff for their hands-on presence during Covid, with both being willing to work the floors or do whatever else was required.

During the worst of Covid, 26 of the 28 patients on the dementia wing became ill. Nearly all staff were particularly proud of the way the staff responded to the pandemic, which was isolated to that wing alone. "As a result of those efforts," one manager stated, "the staff got stronger and more connected. They worked as a team, and focused on knowing their roles and education." While proud of their service, several described the experience as "like PTSD." Staff found the need to discuss their common experiences, which were not understood by those outside the facility. "Having been through the experience keeps everything else in perspective," one said. "As a result, everyone on the team is very approachable."

As an example of the staff's "team" effort, the Activities Director made daily visits to each resident, "just to check in" but also to distribute the "Daily Chronicle" which is an internally produced daily newspaper. More significantly, there was much concern early in the crisis on what would happen if staff members got sick. The Activities Director was one of several staff who responded by getting her LNA license so that she could help out on the facility's units.

Staffing levels, like at Burlington, are driven by specific formulas. Because most of the home's residents are paid for by Medicare (for rehabilitation patients) or Medicaid, with very few private paying residents, as a practical matter staffing is not flexible.

The DON praised the facility's staff, emphasizing that from her perspective, there are good internal communications, and the staff is strong at "problem solving."

Berlin's Director of Social Services has been at the Berlin facility for approximately 16 years, with the last 10 being in the activities program. She took over as Director of Social Services in October 2020.

The Director of Social Services described a busy – but manageable – workload spread throughout the facility. Her duties vary from developing plans of care, and hopefully discharge planning for rehabilitation patients; monitoring the "psycho-social" status and moods of longer term patients, with an eye towards depression and loneliness, to working with hospice to arrange care for terminally ill residents. She feels the facility benefits from strong management, and praised the administrator as being very involved, but not a micromanager. "She allows us to make decisions." During Covid, another long-time staff member praised the Administrator as being one who "didn't just stay on the sidelines and bark orders" and instead was, "very engaged."

Like other facilities, Berlin depends upon travelers, although the staffs' attitude towards traveling staff was more nuanced than at other facilities. The DON explained that there are limits to how many "terms" a traveler can work without returning to their "home" state of licensing, and that most terms are either 12 or 13 weeks. It is not uncommon for travelers to work multiple terms at the Berlin facility, which is apparently a fairly rare practice since a number of travelers are simply trying to combine work and travel. As one staff member pointed out, 'luring a traveler to Vermont in the winter is hard. Luring them back to Vermont in the winter or mud season is even harder.' One administrator noted that travelers do come to the facility with "a different mindset" but that in terms of quality of care there is no drop off between permanent and traveling staff.

When I asked her to assess the facility, the DON stated, "The most important thing a facility needs is stability. We have that here now."

Nearly all staff praised the cleanliness of the facility, particularly considering how hard it is to keep the facility clean during the winter months.

When asked what could be improved at the facility, one long time employee stated, "It's just a corporate thing. You lose something when there is corporate ownership. They should reward staff more for people who have shown loyalty. The raises they give out are minimal, and would boost morale tremendously."

I specifically inquired about the staff's interaction with the Patient Care Coordinator whose position was created by the Genesis Settlement Agreement. Although not all knew her by name, her role and function are widely understood. Although she frequently interacts directly with the DON, she is also present on the unit floors, and checks on items such as PPE, the code carts and

refrigerators – basically "anything we get audited on" - to make sure they are functioning properly and within required ranges. All that I spoke with were appreciative of her assistance.

In contrast to other facilities, nearly all staff responded positively when asked whether or not they would hesitate to have family or friends as residents of the facility, and in fact a number had direct experience with family members or friends seeking both rehab and long term care there.

The transition between Genesis and what most referred to as "Priority" was described as "for the most part smooth." "There have been some blips at the management level, but not at the patient care level," one long term manager noted. "I've been through other transitions and this one is going smoother than the others." The transfer of medical records was not cited as a problem by most staff. One manager stated that people from Priority had only met with staff at the facility one time. "We are hoping and praying that they don't make changes that hurt the facility or its residents."

In preparation for the preliminary interviews, notes from Resident's Council meeting were reviewed. The notes showed a long running series of complaints about food service that seemed to end at about the time a new food service manager had begun working at the facility. Because the food service and housekeeping are contract services, Genesis had limited control over day to day operations. Several staff identified food service as an area they would like to see improved. As in Burlington, staff reported bringing in treats and "comfort items" for residents because of the lack of variety among those the facility made available.

The current "Dietary Director" was hired by Healthcare Services Group in November 2019 shortly after she and her young family moved to Vermont to seek "more regular hours." Once her boss discovered her background, however, she was promoted to her present position. The timing of this promotion, in February 2020, matched the time that the chronic complaints about food seemed to tail off.

The director holds a Bachelor of Science degree from the Culinary Institute of America in Culinary Management, and well as in Culinary Arts. Although this is her "first nursing home" her previous experience was as the "Executive Sous Chef" as Smith & Wollensky's in Boston, and serving as a chef at both Boston University and TD Bank Garden, as well as at a number of other leading restaurants.

She does not create the menu for the facility. Healthcare Services Group directs the menu to ensure it provides variety and meets nutritional requirements. When the facility was operated by Genesis, Healthcare Services had a "Genesis specific" menu, but now she uses the company's "Legacy" menu instead. Under Genesis, residents were given soup and a sandwich at lunch, followed by a

heavier dinner meal. Under Priority, the main meal of the day is at lunch, with a lighter evening meal. She said most residents seem happy with that change. She supervises a staff of ten who produce three meals each day, plus snacks. During Covid all meals were packaged for delivery to patient's rooms. She stated her staffing is adequate, and that she is fully staffed. She is provided a budget to operate within, which must cover food and personnel. She said she is able to stretch her budget by preparing more meals herself rather than relying upon prepared foods, with the added benefit that the meals taste better and are healthier. She has used the money saved to purchase desert and snack items that would otherwise not be available for residents. She also attempts to provide special requests to residents because she "knows how important quality food is to them."

The interview with a traveling nurse at the Berlin facility was particularly insightful. She had been working at a long-term care facility in Tennessee when the pandemic hit. When 23 patients died at her facility in one month, she knew she had to find a place where she "could be more detached" from the those she cared for. This was her second tour at Berlin, and she would not have returned "if it wasn't a wonderful facility." What made the facility so outstanding was, "the Administrator. She has a complete open-door policy. I have never seen another facility like that." She stated the DON was also excellent: "Every place has it's quirks, but this facility is staffed better than any building I've been in during the last seven years."

When asked to elaborate further, she stated, "The numbers here make sense…the way the staff is distributed within the building. We aren't heavy in areas that don't need to be staffed as much, and where we need staff we have them. There is always someone there to help." In other places she has worked, "the numbers are 'legal' but here that's not a problem. There is no fudging of numbers."

She continued: "People are placed in the right positions, and I work throughout the building, so it's not just one area. For example, in a skilled unit, you need more therapists than aids; in a dementia unit, you need more aids than therapists. They seem to put a lot of thought into how they staff the units here, and how they allocate the personnel. It's a real team effort, which includes the scheduler. I also think the management here is willing to constantly regroup if necessary and remains flexible enough to change course. People here are willing to adapt."

When asked about the facility's overall cleanliness, she stated, "I've only been in one place cleaner."

Although Berlin utilizes travelers, the permanent staff seemed more accepting of them than at other facilities. One of the non-supervisory nursing staff interviewed explained that the travelers come to the facility with a variety of experiences. Without their experience, she said, the staff would not

be exposed to other ways of doing things, which sometimes produce better results, or greater efficiency. She viewed the travelers as an opportunity to learn how common nursing procedures are done in other parts of the country.

Virtually every interview included, at some point, the unsolicited comment that the staff truly cares about the facility's residents.

b. Administrator's Comments

When interviewed the interim administrator, Floyd Bradley, had been in his position at Berlin Meadows for approximately one week, having replaced a previous interim administrator. He works as an independent contractor and is licensed as an administrator in the states of New York, Pennsylvania and Vermont. He has worked as an administrator since May, 2014 in various facilities in NY and PA. He also has previous experience in a VNA.

Understandably, Mr. Bradley was not yet familiar with the details of the Settlement Agreement or its specific requirements. Mr. Bradley came to this position because he is familiar with Priority Healthcare.

His direct supervisor is Ryan Wisner, Regional Director for Priority. He does not report to anyone associated with Genesis. His direct reports are Nursing (DON, ADON), HR, Office staff, Maintenance, Dietary Manager and Housekeeping Manager although the Dietary and Housekeeping Managers are working through a contract with Healthcare Services Group.

The last time the facility was visited by a regulatory agency was on June 29, 2021. This was an unannounced complaint survey under Federal regulations. They were cited for issues related to proper administration and documentation of analgesic medications which are being responded to. He did not recall exactly when the last kitchen inspection was done but seemed to recall only one tag related to improper handwashing.

The administrator stated he would give the overall condition and cleanliness of the facility a "B". He describes the facility as "pretty clean" but it could be better. There is minimal staffing from Health Services Group and the staffing is not consistent. He would like to have a full time "floor guy" and they have placed ads but with no response.

They have a small bus for transporting residents to appointments and functions. They have a part-time driver but the Activity Director and Maintenance man can also drive.

He would give the overall food quality a "B". There had been a previous citation for the food temperature not being in a safe range when it got to the floor so he is getting a test tray once per week at random times for a short period to check the food temp. He would prefer not to use a commercial food supplier such as Health Services Group.

In describing his staff, Mr. Bradley feels that 60% are in-house and 40% are travelers. The travelers are mostly in the nursing department. The on-boarding process for travelers is managed by the HR Director, Janice Ashford, and as far as he knows, it is the same as the clinical on-boarding process for in-house staff.

He believes he has an adequate number of staff and meets the minimum regulatory standards. The current census is 91 with a licensed capacity of 115. The empty beds are mostly in one unit that was closed during Covid. They are required by Priority to manage to a PPD of 3.3. The person who makes out the nursing and aide schedules is responsible for assuring the PPD is met.

Nursing is responsible for charting the MDS data and there is an MDS coordinator who compiles and submits the data.

Mr. Bradley feels the physician coverage for the facility is adequate and timely. Dr. Kellogg is the Medical Director and as far as he knows is the only physician seeing residents. He also has a Nurse Practitioner who is in the building Monday – Friday. He mentioned that Priority has an arrangement with a group of doctors but isn't sure whether that has any impact on this facility.

They use a Genesis contract for in-house rehab. He feels the type of therapy and the staffing available is appropriate for the needs of the residents as they are able to offer Physical Therapy, Occupational Therapy and Speech Therapy.

Berlin currently has one fulltime Social Worker and the administrator feels that is sufficient to meet the needs of the residents. There is also a fulltime Activity Director. The administrator is assessing the adequacy of funding for the Activity program.

Staff morale was described as good, with a "can-do" attitude. The administrator has not heard any complaints or concerns about the change in benefits that occurred during the transition from Genesis to Priority. He said that there are long-term employees who remained and turnover hasn't been a big issue. He works to be accessible and responsive to staff, and he makes rounds on the units at least once per week but thus far only on the day shift.

There is a fulltime Human Resource Director, and the administrator has not been involved in the hiring, screening and credentialing of employees, leaving that responsibility to Human Resources.

Mr. Bradley stated that neither he nor his department managers participate in the development of the facility's budget.

He feels oversight of the facility's clinical services is provided by the Regional Director of Clinical Services to assure that the policies and procedures are being followed. He participates in the daily huddle and uses computer based progress notes and QAPI reports to stay abreast of issues related to falls and injuries. There are no reports related to restraint issues as the facility is restraint free. He keeps up with discharge planning through attending morning meeting and clinical meetings with nursing, social service, and rehab services.

At the time of his interview the administrator had just been introduced to the Patient Care Coordinator, and he was understandably not fully familiar with her role.

The administrator identified the greatest challenge facing the facility as increasing permanent local staff because that directly affects continuity of care for residents. The remoteness of the facility and Covid have made that particularly challenging.

Perhaps most importantly, we have been advised that an administrator has been identified, and is scheduled to start on August 23.

C. St. Johnsbury Health and Rehab/Northeast Vermont Nursing and Rehabilitation

a. Results of Staff Interviews

Located in the heart of Vermont's Northeast Kingdom, the St. Johnsbury facility ("STJ") faces a number of unique challenges. It was also a facility in transition at the time of staff interviews, as both the Administrator and Director of Nursing chose to remain with Genesis when the ownership of the facilities changed.

At the time of our interviews, the facility's census was 66, with a licensed capacity of 96. The highest census the DON could recall was 86 residents, and the facility's census was historically between 70 and 72 residents. Like Berlin, the STJ facility is located on a single floor.

The departing Administrator, Michelle Pippa, was generally well regarded by staff, although a number of staff were outspoken in their criticism of the cliques and favoritism that flourished under her. Some claimed that certain employees were allowed to leave the facility for the day after checking in, and others complained that she did not like to advocate with the corporate office on behalf of the facility's workers, such as when the workers tax forms were late in arriving. Overall

though, she was viewed as engaged in the daily operations of the facility, and caring for its residents.

At the time of the interviews, Pippa's replacement had been identified. He had previously been the administrator at the facility, and was generally well regarded by the staff, who looked forward to his return. (After completion of interviews, we learned that the incoming administrator was transferred to Burlington, and replaced by the administrator from Burlington.)

Although she was leaving the facility in a matter of days, the DON expressed her pride that during her time at the facility she had "deficiency free surveys." She had come to STJ in November 2019 from the Burlington facility. Overall, she assessed the facility as running "pretty well" and although there are areas that can be improved, she believed that a team was now in place that could successfully implement needed changes. She sees the keys to the facility's success as teamwork and the fact that the facility is "resident centered." She said unlike other facilities, STJ did not get hit particularly hard with Covid, "although it took a lot of hard work to achieve that result."

Perhaps due to its remote location, the STJ facility is even more dependent upon travelers than either Burlington or Berlin, with one estimate that up to 90% of nurses are travelers.

The DON stated that it is rare to see a drop-off in the skill level between permanent and traveler staff, "although it does happen." Travelers, however, cost the facility far more than permanent staff, so reliance upon traveling staff at levels approaching 90% is not sustainable in the long term. Staffing is always a challenge, and it is not uncommon at STJ for management staff to work the facility's floors.

Because travelers are so critical to the facility's staffing, the facility staff seems generally accepting of them. One unit manager formerly worked as a traveler, and her experiences have likely helped bridge that gap. It was stressed that one key to success in managing travelers is to have clear expectations of what is expected of them, and clear policies in place for them to follow. Particularly in light of their heavy use, it appears that the use of travelers at this facility is being well administered.

The challenge of recruiting and retaining staff is also made more difficult by the fact that the STJ facility is located across the street from the region's largest hospital. People who had worked at both facilities described the hospital as "a more welcoming environment, with more nurses on the floor and not as much focus on end of life care." The hospital, which faces the same geographic challenges as the STJ facility, is also apparently less reliant on travelers, likely due to those different working conditions.

In addition to the staffing issues related to the facility's location, several staff mentioned the prevalence of bad behaviors exhibited by residents, resulting in the need for more "behavior management" than at other facilities. Although no specific cause of these behaviors could be identified, the problems presented include Veteran's PTSD, dementia, and alcoholism. (There were some staff who felt that that the behavior issues at this facility are not significantly greater than in other long term care facilities.) When these problems were brought to the attention of Genesis, the company sent a resource team to work with the staff in order to better respond to the behaviors. The training provided by that team was praised by a number of staff, and cited as an example of the resources that Genesis could bring to address a particular problem. The Director of Activities also praised the resources that Genesis provided, which she termed, "amazing." A number of staff expressed concern that similar resources will not be available once the sale of the facilities is complete. Upon inquiry we were told that the purchaser will have resources available, though not on the same magnitude as Genesis had.

The staff at STJ were more outspoken about changes implemented by the facility's new owners which appear to the staff to be motivated by a desire to limit expenses. As one example, the monthly activities calendar that is distributed to each resident was printed in color under Genesis. Now, black and white copies of the calendar are run off on 8 ½ x 11 inch copy paper.

The staff at STJ, whose interviews were conducted after those at Burlington or Berlin, was the first to mention a significant issue regarding vacation and sick leave. During interviews of STJ employees, it was learned that either immediately before or after the transfer of the facility's ownership, employees were paid for 50% of their accumulated vacation, and lost all banked sick leave. This was apparently cashed out in the final paycheck received from Genesis, so it is unclear to most employees which owner actually made the decision to implement this change. Employees who had been banking sick leave in anticipation of maternity leave were particularly impacted by this action. More significantly, this action has had a clear impact on the morale of most employees.

Most interviews at the STJ facility produced additional complaints about the anticipated cost-cutting that would be coming. These ranged from a change in the briefs provided to residents which prompted complaints about comfort and (more importantly) leaking, to rumored reductions in maintenance and transportation. Transport drivers had already been reportedly terminated, and maintenance workers were told they would assume driving duties.

There was far more concern expressed about the sale of the facility expressed at STJ than at any other facility. The loss of vacation and sick leave was not mentioned at any other facility, but was frequently mentioned by STJ employees. In addition, there was a sense that despite a number of obstacles, things were running pretty well at the STJ facility. The departure of the Administrator and DON unquestionably added to the stress surrounding the sale, which may account for the

employees' heightened sensitivity towards it. It was also notable that there was a distinct lack of specific information among employees about who the facility was being purchased by. This lack of information was present throughout the interviews at each facility. There were numerous, and sometimes contradictory, statements made regarding who the homes were being purchased by. Without question, that lack of information contributed to the anxiety level among the staff. Some said that there was quite a bit of information being circulated early in the process, but that no new information had been distributed in recent weeks.

In addition, those managers who were responsible for programming at the STJ facility expressed the same concerns about their inability to budget for the coming year that their colleagues in other facilities expressed. And, as in the other facilities, the inability to budget was directly linked to the continuing uncertainty about the sale. Those that do know of their budget, such has housekeeping, have been told to prepare for significant reductions, which has resulted in even more uncertainty and concern regarding future programs. In addition, the authority to spend money has been curtailed. This has, according to some, resulted in delays to complete necessary maintenance and repairs, such as replacing doors.

Although the STJ facility is not new (it was described by one employee as "retro"), the long-time Director of Maintenance was praised for his efforts to modernize and standardize the facility at minimal cost. Taking the place of an employee who had held the position for nearly forty years, he described a facility that had been held together without comprehensive planning or repairs when he began nearly seven years ago. His initial time at the facility was spent repairing work that had not been done correctly, but he was proud to say that he recently completed a stretch of thirteen weeks without a single callback to the facility for an emergency repair. Longer term planning, he said, is critical to both efficiency and controlling the cost of repairs. When he came to the facility, for example, he found a variety of faucet fixtures throughout the building. Over time, he has replaced every faucet with a common style, making maintenance and repairs far easier. "We no longer have to keep an inventory of parts we may never use," he said.

Due to its remote location, the STJ facility does not enjoy the diverse sources of new residents that more centrally located facilities do. The facility does draw from several hospitals and home health agencies, although there is competition for other long-term care and rehabilitation facilities for the same residents. Because new resident admissions are no longer assessed on the basis of acuity, that factor no longer impacts the staffing that a new admission may generate. It was explained that the facility must therefore be mindful of the conditions and illnesses that residents suffer from, as certain patients can require far more resources than others, and a large census of patients with complex conditions can have an impact on both staffing and patient care. Bariatric residents, for example, may require multiple staff to move, bathe, and dress the patient, while others require a single staff member.

By far, the most frequently heard complaint at the STJ facility concerned the quality of food. The Dietary Manager was interviewed, and stated that before coming to STJ, he had worked as a cook and assistant manager at Barre Gardens, which is a long-term care facility in Barre whose food service is provided by the same vendor that the STJ facility utilizes. Upon his arrival at STJ, he was immediately installed as manager, without the benefit of a proper transition or training for the position. He was forced to rely upon a combination of on the job training and assistance from other managers, particularly the Dietary Manager from Berlin. Although the Dietary Manager was justifiably concerned about his ability to successfully perform, his efforts to feed the residents in these circumstances demonstrated a commendable commitment to them, and a sense of responsibility that is often lacking. We will follow up on this issue when we visit the facility.

b. Administrator's Comments

Ross Farnsworth has been the Administrator of the St. Johnsbury facility since April 8, 2021. He stated that he was previously the Administrator of the Genesis Burlington facility from December 2019 through his transfer to St. Johnsbury.

The administrator identified his direct supervisor is Ryan Wisner, Regional Director for Priority. He also has reporting requirements to the Regional Clinical Director for Genesis. He estimates he has 10 direct reports who are department heads or assistants although those in Dietary and Housekeeping are through contracts with Healthcare Services Group.

On the day of his interview, Mr. Farnworth reported that a surveyor was at the facility from the Vermont Division of Licensing and Protection doing a follow-up survey on the Plan of Correction related to deficiencies cited on 4/28/21 and 5/10/21 which resulted from complaint investigations. Those complaints alleged that residents' rights had been violated when a resident was discharged with medications belonging to another resident and several incidents of a resident being "unclothed" and in sight of windows, hallways and other residents.

Mr. Farnsworth stated that the surveyor walked through the kitchen in May but no issues were identified and he does frequent walk-throughs himself. On a scale of 1-10 he describes the condition and cleanliness of the facility in general as a 7. He states he does not believe there are any major or system issues that would affect the health or safety of residents or employees but that he gives the 7 score based on the contracted housekeeping staff and feels they could do a better job and be better trained by the contracted agency. Last month the Housekeeping Manager from the contracted agency left. One of the housekeepers volunteered to step into the position as there was no one else available.

The facility has a passenger bus dedicated to providing transportation for residents to/from appointments such as dialysis. A maintenance man has been trained as a driver and one of the aides handles the appointment schedules.

He would describe the quality of the food fed to the residents as a 7 and states it is difficult to manage a kitchen without a budget. He states the facility used to have a defined budged from Genesis but there is no dietary budget from Priority.

The administrator reported that neither he, nor any other managers, have access to a budget or participate in any budget development. As a result, he occasionally must address specific needs with Priority. He does not feel that residents go without because he and the managers "fight hard to get what they need."

He feels that the percentage of "travelers" has decreased significantly and about 75% of employees are their own staff. Travelers are mostly used in clinical positions. They basically use an agency called Career Staff for their traveling contracts but he believes that Career Staff gets travelers from other agencies as well. They do not use other contracted staff such as "per diem" staff but do have some of their own employees who function in a per diem capacity.

Mr. Farnsworth believes the on-boarding process for traveling staff is appropriate. He states they have a facility tour, are given a copy of the employee handbook, review general orientation modules in a classroom setting and shadow an employee. They are subjected to the same clinical competency evaluations as in-house staff.

He believes that, in general, they have sufficient clinical staff to meet the residents' needs but can always use more nurses and LNA's especially since they have about 55% of residents with behavior issues. They are able to meet the minimum regulatory staffing requirements. The current census is 70 with a capacity of 99. The empty beds are scattered throughout the facility because some of the residents with behavior issues could not have a roommate. Thus, the option of closing a unit to reduce costs is not practical.

There is an MDS Coordinator who is responsible for assuring that accurate information on patient care needs is collected and submitted. Because the facility's Medicaid per diem is almost $80 less than one of the other three facilities under review, he will examine if there is an opportunity to improve the capture of documentation.

Mr. Farnsworth believes the medical services are provided in a timely manner. Dr. Brinkley is the Medical Director and is the attending physician for 100% of the residents. He has a new Nurse Practitioner who started recently and is in-house 4-5 days per week. They have on-call arrangements for psychiatric services.

He believes their rehab services are adequate. They do not have a problem meeting residents' rehab needs. The facility has a newly started Social Worker but she is not totally new in that she

has worked at the facility in the past. There is a new Activities Director and she has two fulltime and one parttime activity assistants.

Overall, the administrator believes staff morale is high. He does not think the loss of benefits during the transition from Genesis to Priority has remained an issue affecting morale, possibly because so many employees are new and wouldn't have been affected. Mr. Farnsworth believes he is accessible to employees and participates in the daily "Huddles" which include the Administrator, DON and other department managers as needed.

Jason Caron is responsible for Human Resources and performs background, license and reference checks. Mr. Farnsworth is involved in interviewing any Department Heads and Department Heads interview their own staff. He doesn't feel he has had to settle for staff that is less qualified than he would like but said that new LPN grads do require more on-boarding and shadowing than someone who is experienced. He has also taken an aide and trained her as a scheduler.

New employees complete an orientation agenda. One-half day is spent in orientation with HR on employee policies and the employee handbook. Clinical orientation is done by the Center Nursing Executive. Competencies are completed by clinical staff prior to being allowed to independently perform tasks. He describes that much of the integration of new employees and particularly travelers is accomplished through the daily huddles involving the DON and NPE where new employees can learn about the needs of specific residents.

Mr. Farnsworth states he feels he has a good amount of oversight of clinical services as he participates in the daily huddles, clinical meetings, and has an opportunity to hear about discharge planning as part of the Utilization Review Committee. He also feels his participation in these meetings allows him the opportunity to address communication issues. He runs the QAPI meetings and therefore receives routine reports related to risk assessments, complaints, accidents and other issues falling under the purview of QAPI. The facility is restraint-free so there are no relevant reports or monitoring of residents in restraints.

With regard to resident rights, he states that the rights are posted on each unit, the lobby and a copy is given to residents/families on admission. Ombudsman visits and Resident Council has restarted following the pandemic and he receives reports from both areas of identified issues.

The Patient Care Coordinator is in his facility about once per week. He sees her role as observation of residents and review of medical records to identify deficiencies that affect resident care. Following her visit she meets with himself and the DON to discuss any findings that she has and to provide a report.

Mr. Farnsworth identified the biggest challenges facing the facility as hiring in-house staff to replace the housekeeping and dietary staff contracted from Healthcare Group Services, which is high on his list since HGS pays bare minimum both to line staff and managers resulting in high turnover. He doesn't see this as possible until the sale to Priority is finalized because the HGS

contract is held by Genesis. He also hopes that Priority will conduct a wage analysis and adjust the pay scale to improve the chances of hiring and keeping staff.

CONCLUSION AND NEXT STEPS

The Covid-19 pandemic has, without question, impacted the both the operation of these facilities, as well as our review of them. This review process was further complicated by the unanticipated sale of the facilities, and the complex nature of that transfer, which remains pending. The video interviews we conducted and the documents reviewed provide a limited insight into the homes, and because of that, we caution against making any final conclusions at this point.

It is, however, apparent that each of the three facilities faces certain common challenges, the most significant being the hiring and retention of staff. The comprehensive solution to this problem is elusive, and extends beyond these facilities to the long term care industry as whole. Each administrator recognizes this challenge, and works to address it.

The second major challenge facing each of these facilities is achieving stability in leadership. It is apparent that strong executive leadership has a direct impact on every aspect of a facility's operations and without it, differences among and between the facilities emerge. Achieving that stability will be assisted by the resolution of the current proceedings regarding the licenses for each facility following the sale of the facilities by Genesis.

The sale of these homes represents yet another challenge that must be addressed. Certain changes related to budgeting may well be necessary for the new owners to introduce efficiencies while controlling costs. The impact of new budgeting procedures will be a focus of future reviews. What is clear, however, is that the uncertainty surrounding the sale of these facilities has introduced a level of anxiety that has only added to a year of unprecedented anxiety already, and that anxiety will continue until the sale is finalized.

In focusing holistically upon the care that residents receive, these interviews are not intended to be simply another "survey" that forms part of each facility's extensive oversight. Rather, they are intended to provide a comprehensive overview of the quality of life for the residents of the home, and ultimately to improve the quality of the care they receive. The absence of drivers, for example, may seem like a minor point, but directly impacts the quality of life of a facility's residents. And the quality of food may be among the most critical issues impacting the quality of daily life.

During many interviews, staff thanked us for providing the opportunity to air their concerns. The staff at each facility includes a number of employees who have dedicated their careers to providing long term care, as well others who have only recently chosen that line of work. Those employees are the keys to each facility's success, and to the safety and care of its residents.

In order to complete this annual review, and assuming Covid-19 protocols permit, we intend to visit the facilities in September. We will issue a supplemental report following those visits which will incorporate the results of them.

We appreciate the opportunity to assist your office in the very important task.

Very truly yours,

Gerald J. Coyne
Managing Director
State Monitoring Services

First Annual Review of Genesis HealthCare Facilities
August 6, 2021

Affiliated Monitors, Inc., the Quality of Care Reviewer in this matter, submits this First Annual Review of three facilities owned by Genesis HealthCare, Inc., located in Burlington, Berlin and St. Johnsbury, Vermont.

INTRODUCTION

Background of Genesis/Vermont Settlement

On February 20, 2020, Attorney General Donovan announced a settlement agreement with three Genesis subsidiary-operated nursing homes in Vermont: Burlington Health & Rehab ("Burlington"), Berlin Health & Rehab ("Berlin"), and St. Johnsbury Health & Rehab ("St. Johnsbury"). This settlement agreement resolved allegations of neglect that resulted in serious injury to three residents and the death of a fourth. As the press release announcing this settlement noted, "Each of these incidents was related to inadequate staff training and orientation, the use of visiting or third-party contractors, and the failure to adequately document and monitor the delivery of resident care services."

Among the terms of the settlement, the Genesis centers agreed to engage an independent reviewer to perform annual reviews of the quality of care at each facility. Affiliated Monitors, Inc. ("Affiliated") was selected to serve as the Quality of Care Reviewer on behalf of the Attorney General.

Terms of the Administrative Agreement

Under the terms of the Administrative Agreement, Affiliated Monitors, Inc. is required to produce a yearly performance evaluation for each of the three long term care and rehabilitation facilities owned by Genesis HealthCare, Inc.

Each review shall include, but not be limited to, the following components with respect to each of the Genesis Centers:

- A request for production of information and documents;
- An on-site visit;
- Review of clinical care policies and procedures;
- Review of human resource, hiring and training programs; and

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- Review of the delivery of services to residents and a sample of resident care treatment records.

Under the terms of the Agreement, the Genesis Centers agreed "to provide Affiliated, without an affirmative request, and in a timely manner, all surveys, inspection reports, notices of violation, or any other document addressing the quality of care delivered to, or concerning the health or safety of, any of the Genesis Centers' residents." During this review, we learned that individual administrators were not aware of this requirement. All required reports were recently provided, and we have been advised that documents will be provided in a timely manner going forward.

The review process also includes on-site visits to conduct interviews as well as assessments of the facility's sanitation and cleanliness; building, equipment and environmental safety; availability and accessibility of medical and other safety equipment; policies and procedures related to resident services, including but not limited to transportation services; meal delivery services and laundry services, and the integration of third-party contractors providing direct or indirect services to the Genesis Centers' residents.

In addition, reviews shall include a review of clinical policies and procedures that shall include, but not be limited to:

- Facility staffing levels;
- Standards and timelines for documentation of clinical services;
- Initial evaluation and assessment of patients;
- Determination of appropriateness of patient admission/placement;
- Scheduling of patient care team planning meetings;
- Development, content and updating of patient treatment plans, including establishment of therapeutic goals, progress benchmarks, and expectations about patient behaviors;
- Physician involvement in patient evaluation and treatment planning;
- Application of restraints and monitoring of patients during use of restraints;
- Documentation of, and solutions to address, patient allergies, physical injuries, fall risks, and other patient health or safety issues;
- Review of any incident reporting documents; risk assessment tools; or abuse policies used by the Genesis Centers to determine the cause and origin of injuries and whether the injuries are reportable;
- Provision of physical assistance to patients who require such assistance;
- Discharge planning and after-care plan development, including patients who are planning to leave the facility against medical advice (AMA);
- Compliance with the Vermont Nursing Home Residents Bill of Rights (33 V.S.A. 7301) and incorporation of patient rights into admissions and clinical processes;
- Receipt of timely information about, and investigation of, resident (any family members') complaints, medication errors, falls, physical injuries, and other incidents which potentially affect patient welfare, and documentation of response to the same;

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- Internal auditing of clinical treatment records to evaluate completeness and sufficiency of documentation; and
- Appropriateness and sufficiency of the forms used in documenting clinical services and events.

In addition, reviews shall address the human resource policies and training programs at each facility including, but not limited to:

- Policies and procedures regarding, and documentation of, screening and credentialing of employees, including background checks, licensure status, occupational disciplinary history and references;
- Development, content and manner of presentation of initial training for newly-hired employees;
- Development, content, frequency of documentation of ongoing training for existing employees;
- Policies, procedures and practices regarding the use and screening of temporary or contracted employees provided by a third party; and
- Policies, procedures and practices regarding the training of temporary or contracted employees provided by a third party.

Finally, the Agreement requires a review of the delivery of resident-care services including a review of a sample of patient records, performed pursuant to HIPPA-compliant Business Associate Agreements. The records review will focus on the quality and sufficiency of the documentation, and the delivery of patient care services, including but not limited to:

- Reason for patient admission;
- Patient presentation and clinical history;
- Findings from initial evaluation/assessment of patient;
- Participation by all members of patient evaluation and care planning team;
- Content and appropriateness of treatment plans;
- Use of restraints and/or seclusion and monitoring of patients during the use of the same;
- Delivery of treatment and/or services, including duration of therapies where appropriate;
- Documentation of patient progress/response to treatment and patient re-evaluations where appropriate, and
- Discharge planning.

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SCOPE AND METHODOLOGY

This First Annual Review is based upon interviews conducted of employees at each of the facilities being reviewed, as well as on extensive documentation provided by Genesis. In addition, it is

based upon the review of medical records, as well as interviews with the current administrator at each reviewed facility.

As we will outline, the delivery of this preliminary report was greatly impacted by the Covid-19 Pandemic. Most importantly, all interviews were conducted remotely. We are satisfied we have developed sufficient information and insight through our remote efforts to offer the observations and recommendations presented in this report. However, a number of the specific review criteria cannot be fully examined or confirmed without a live visit. To complete the annual review process, we will be visiting each facility in order to conduct additional interviews and validate the information we have been provided. Pursuant to the Administrative Agreement, the facilities will be advised of a two week window during which those visits will occur, and a supplemental report will be provided.

The Impact of the Covid-19 Pandemic

At that time of AMI engagement, our plan was to conduct a preliminary visit to each facility later in March, 2020, followed by Request for Information to the facilities, in anticipation of site visits to each facility and completion of our Baseline Review.

Instead, within a month of retention, the nation was struck by the Covid-19 pandemic. The nature of this pandemic struck congregate care facilities particularly hard. The tragic loss of lives at the Burlington facility, where published reports stated that 68 residents were positive for Covid and 11 died, received attention in the national media, including the New York Times. But every facility was severely impacted by the pandemic, resulting in a year of unprecedented actions to control infection, and unimaginable isolation, including solitary meals and the elimination of visits and socializing activities for residents, coupled with a regulatory process whose focus was necessarily forced to pivot.

We acknowledge that the focus of these facilities, as well as those who regulate them, pivoted to a singular focus upon the health and safety of residents. The Centers for Medicare and Medicaid Services (CMS), for example, one of the most critical regulators of long term care facilities, suspended certain Federal and State Survey Agency surveys, to allow a focus on the implementation of proper infection prevention and control practices to prevent the development and transmission of Covid-19.

As we will discuss, the pandemic resulted in the delay of this report, and the collateral impact of the pandemic will affect these facilities and their residents for years to come. But no discussion of the pandemic would complete without the immediate acknowledgment of the true heroes of the pandemic – those front line workers who risked their own health to care for our most vulnerable citizens, and who were motivated not by money but by their love for those in their care. A popular phrase, originating in Silicon Valley but now in wide use, is "build the plane while your flying it." One explanation of that phrase states: "The expression 'building the plane as you fly' … captures the feelings of risk and uncertainty that accompany designing innovations and testing them in real time with actual participants, all while being responsible for keeping existing operations running." As our nation's congregate care facilities responded to the Covid-19 pandemic, with its

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unprecedented challenges and the uncertainties surrounding virtually every aspect of the disease, that was the world that these facilities, their residents, and their workers confronted.

By March 10, 2020, although not appreciating the magnitude of the pandemic, AMI reached out to counsel for Genesis and suggested that we conduct our preliminary meetings with the administrators of each facility remotely. Counsel responded by advising that Genesis had suspended "Corporate and Regional" visitors to all facilities, but would work with us on remote interviews, then subsequently advised of new CMS protocols which preclude any visits without quarantine. On March 12, 2020, the Genesis facilities were closed to visitors, and on or about March 16, 2020 the Burlington facility had its first confirmed case of Covid-19. (We were notified by Genesis shortly after midnight on March 17th of the first positive test result at the Burlington facility.)

We anticipated, incorrectly, that the pandemic would represent a brief delay in our review process. Little did we anticipate not only the delay it would cause, but more importantly the loss of life that would result in the facilities being monitored, particularly in Burlington, or the impact it would have on every aspect of the facilities' operations over the next year.

On April 7, 2020, AMI reached out to counsel for Genesis to check in, and it was agreed to look for tasks that could be completed at the corporate level such as the gathering of policies and procedures for our review, but which would allow the centers to continue their focus on infection control and clinical care.

On May 15, 2020, AMI sent our initial "Request for Information" to the Genesis counsel. Counsel immediately advised that due to the "focus on patient care at the centers" it would likely take more than 30 days to respond to our request. At that same time, we initiated the provision of a secure laptop computer from Genesis that would allow for the remote review of medical records.

On June 29, 2020, AMI reached out again to Genesis to see if it would be possible to travel to Vermont to meet with the administrators away from the actual facilities. For a variety of logistical reasons, that was not possible.

By August 12, 2020 we received the last of the documentation from Genesis in connection with our Request for Information. Unfortunately, we were still unable to travel, but nevertheless began our review of materials. In October, we arranged to conduct a "virtual" meeting with the Genesis team and the key staff from each facility to introduce ourselves to them, and to outline for them the processes we anticipated using to conduct our review. We discussed the likelihood that we would need to conduct our baseline review virtually.

Being mindful of the delays caused by Covid, we felt it was important to initiate our preliminary review process rather than wait further. Although we realized that virtual interviews are not as effective as live ones, our concern was that some oversight was better than further delay. We also recognized that a virtual interview necessarily lacks spontaneity. Each much be scheduled, through the facility. In addition, there was no opportunity to simply ask an employee to "show

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me" something they were discussing, or to walk around the facility to make direct observations, or conduct unscheduled interviews.

In anticipation of commencing our review, we renewed our request for a laptop to review medical records, which had been placed on hold at the start of the Covid pandemic. We requested that Genesis provide us with updated patient and staffing lists, anticipating that there had been changes in the several months since our lists had been provided.

In approximately October, 2020, we learned that Genesis would be selling the three facilities that are under review, although no details were provided. Media reports indicated that Genesis, as the parent of each facility, was in the process of selling numerous facilities nationwide to address rising costs and a cash shortage due to the pandemic. Thus, the sale process had developed both quickly and quietly. We were told initially that once the sale was completed, Genesis would remain at the facilities under a management agreement for a period of six months. Unfortunately, during this period our contact at Genesis became markedly less responsive, and we were not provided with the final updated information we sought, despite several follow-up messages, until December 21, 2020. We were also told by our contact that "since the sale" the individual facilities were not as responsive, as she no longer dealt with them on a regular basis.

It was explained that the sale of the facilities included the real estate of the homes only, and that the licensing of the homes could only be transferred after a more detailed state review. Thus, the sale of the facilities became a far more drawn out process than some had anticipated.

Using the updated information that had been provided, and at the suggestion of the Genesis counsel, we reached out directly to the administrator of each facility to initiate the interview phase of our preliminary review. Each administrator was interviewed to obtain from them preliminary information about their facility. The administrators interviewed were Ross Farnsworth (Burlington), Melissa Haupt (Berlin), and Michelle Pippa (St. Johnsbury). We also interviewed the State Long Term Care Ombudsman, as well as the individuals assigned to the county where each facility we were reviewing is located.

It was determined that for the purposes of our preliminary review, we would conduct interviews virtually, since the facilities were still not open to the public or accepting visitors. For each facility, we would interview a combination of key personnel, and non-supervisory staff who would be selected by Affiliated Monitors based upon the information provided by each facility. Key personnel generally included the Director of Nursing (or "Center Nursing Executive"); the Director of Activities, the Director of Social Services, the Scheduling Manager, the Director of Food Service; the Director of Maintenance, and the MDS Coordinator. In terms of non-supervisory staff, we sought a mixture of Certified Nursing Assistants/Licenses Nursing Assistants, Licensed Practical Nurses, and Food Service/Housekeeping staff.

During our preliminary interviews with staff, we learned of the universal issue of both recruiting and retaining staff, and the resulting reliance upon "travelers" who come to the facility to work on a temporary, contract basis. Because of the critical reliance upon travelers at each facility and the

potential impact that could have on patient care, we also identified at least one traveling staff at each facility to be interviewed.

The scheduling of interviews took longer than anticipated because of a combination of factors. First, we learned that not all employees have e-mail addresses at work. Thus, to reach the non-supervisory staff in particular, it was necessary to schedule through the facility administrator. Even with that assistance, not all employees were prompt in responding. It is noteworthy that the level of assistance at each facility varied. The administrator at Berlin was extraordinarily responsive. Most interviews at that facility were scheduled with little difficulty. Unfortunately, the same was not true at the other facilities. We subsequently learned that the administrator and Center Nursing Executive at St. Johnsbury were in their final days at the facility, and we had to follow up often with the administrator at Burlington, where non-supervisory employees seemed particularly reticent about responding to our interview requests.

In addition, the virtual interview process made the identity of the employees being interviewed known to management, though not the content of their comments.

The distinct challenges of scheduling at each facility are significant because they were reflective of our findings as the result of these preliminary interviews. As the findings for each facility are discussed, it will be apparent that the atmosphere in each was quite different. The atmosphere and culture at each facility was clearly impacted by the facility's location, although there are, to be sure, issues common to each facility such as staffing, the impact of the facilities' sale, and the challenge of delivering quality food service. Most importantly, the preliminary interviews revealed the direct impact of strong, positive leadership at the administrator level.

Dr. David Wilner completed a review of a representative sample of medical records at each facility. During the interview process, we learned that the electronic medical records for each facility were transferred from Genesis earlier this year. Unfortunately, not all were transferred due to volume, and records generated prior to a particular starting date remain with Genesis. Staff indicated that those records are available, but that they must specifically request access to them. Although the thought was that this medical records transfer may adversely impact the quality of care, staff reported that has not been the case. Despite some concerns, the overall sentiment was that the transfer of records had been done efficiently. The lack of access to legacy records prevented access to admissions information about several longer term residents.

Anne Peepas, a retired nursing home administrator, conducted extensive interviews with the administrators of each facility as part of our review team, as well as with the Patient Care Coordinator.

It is important to note that the single overriding issue in virtually every interview was the impact of Covid 19, not only upon the homes or the homes' operations, but upon the residents. Employees of all levels expressed concern with how the pandemic had altered the lives of these individuals, starting most importantly with having no visitors, but including having no social activities, limited therapy (often without contact), and eating and living in their rooms. In particular, the non-

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supervisory staff referred to the residents as "family" and frequently came to tears when discussing the difficulties of the past year.

Without minimizing the shortcomings and issues detailed in this report, it is important to remember that the past year has been like no other. Faced with unprecedented challenges, the staff at each facility were forced to deal with often changing health guidance while caring for high risk residents. There will inevitably be welcome changes as visits return, activities resume, and communal dining begins. Other issues, such as staffing, supervision, and management, however, will not be directly impacted by the loosening of Covid related restrictions. These issues existed prior to and during the Covid-19 pandemic, and continue today.

FINDINGS

Findings Common to All Facilities

Ownership

At the time of the Settlement Agreement, all three facilities were owned and operated by Genesis Healthcare. On its website, Genesis, which is headquartered in Kennett Square, Pennsylvania, describes itself as:

> "…a holding company with subsidiaries that, on a combined basis, comprise one of the nation's largest post-acute care providers with nearly 400 skilled nursing centers and senior living communities in 26 states nationwide. Genesis subsidiaries also supply rehabilitation therapy to approximately 1,200 locations in 46 states and the District of Columbia. Genesis' subsidiaries employ approximately 70,000 people, each one dedicated to the delivery of high-quality, personalized health care to all patients and residents."

These three facilities were acquired by Genesis in 2016, when state regulators approved a $39 million deal for Genesis to purchase the facilities in Burlington, Berlin and St. Johnsbury, along with two other long term care facilities, in Springfield and Bennington. The facilities were purchased from Revera Assisted Living, a Canadian company that was leaving Vermont. At the time of the approval, three of the facilities (St. Johnsbury, Springfield and Bennington) had four star, or above-average ratings from the U.S. Centers for Medicare and Medicaid Services, while Burlington received a two star rating, and Berlin a rating of just one star. At the time, Genesis already owned four other facilities in Vermont.

Shortly after the sale, there were publicly expressed hopes that being owned by a national chain such as Genesis would potentially bring additional resources to these facilities, and our interviews with staff confirmed that to be case. Numerous staff expressed that Genesis, either through regional or even national management levels, had staff available to discuss specific concerns or

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problems, and those staff were available, responsive, and helpful. We learned, for example, that when the St. Johnsbury facility reported concerns about behavioral issues of patients, Genesis actually sent a team to the facility to learn more about the situation and to train the staff, which the staff reported was extremely helpful. In areas such as resident activities and social services, there was high praise for the resources that Genesis "corporate" provided.

By 2019, however, two of the facilities that Genesis had purchased – St. Johnsbury and Berlin – were included in a publicly released list of five elder care facilities in the state that were candidates for increased scrutiny under the "Special Focus Facility Program" administered by the Centers for Medicare and Medicaid Services. Although it was stated at the time that the surveys leading to placement on the list might not reflect current quality, it was clear that concerns existed about both facilities.

On August 31, 2020, Genesis announced it was selling five of its Vermont facilities, including the three facilities subject to this review. Although the sale was announced, the identity of the buyers was not initially made public. Because the licenses for the operations of the facilities remained with Genesis, those licenses would become subject to a separate review process. Thus, it was initially announced that while Genesis would continue to "own" the facilities until transfer of the licenses is approved, the facilities would be "operated" by the new ownership.

We learned that on October 30, 2020, the new owners purchased the real property and the non-operational assets of each facility, and that on November 4, 2020 an application to transfer licenses was initially filed with the Vermont Agency for Human Services, which remains pending.

The new ownership is David Gamzeh, Akiva Glatzer and Akiko Ike. Gamzeh and Glatzer are currently licensed to operate Barre Gardens Nursing and Rehab. Management services for the facilities are now provided by Priority Healthcare Group, and a number of the facilities' employees inaccurately refer the new owners as "Priority." We obviously take no position regarding the merits of these transfer applications, but do acknowledge the responsiveness of the new ownership group, and the full cooperation we have received from them.

We are primarily concerned with the uncertainty that has been created by this potential sale, and the fact that it remains under consideration by regulators. It was remarkable how little understanding the rank-and-file staff had regarding the details of the sale, even going so far as not being aware of the identify of the buyers. That lack of knowledge no doubt contributes to the high anxiety we noted.

We have noted the relatively recent acquisition of these facilities by Genesis. Although long-time employees recall that process, the high turnover inherent in the workforce at these facilities dictates that this is the first change of ownership many have experienced. One of the tangible impacts of the ownership change occurred earlier this year. We were told that employees lost their banked sick time hours, and were paid for 50% of their accumulated vacation time. It was unclear, in speaking with employees, whether this decision was dictated by Genesis or by the new owners. But particularly for those who had been banking sick leave in anticipation of maternity leave,

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planned procedures or to care for family members, the decision had a devastating impact in terms of morale.

To the extent that stability in the leadership of these facilities is important, there have been constant and wholesale changes since the sale was announced.

The administrator at St. Johnsbury publicly stated that she would be leaving the facility and transferring to another Genesis facility. Her replacement was announced, who was familiar to the staff in St. Johnsbury from previous work there, and whom many were looking forward to returning. Instead, he is now the administrator at the Burlington facility, and the administrator in St. Johnsbury is the former administrator of the Burlington facility.

The administrator at Berlin was held in extraordinarily high regard by her subordinates. She has left the facility, and been replaced by two interim administrators while the search continues for a permanent administrator.

The administrator from Burlington was reportedly replaced by the new ownership group. His immediate successor stayed briefly, and a new administrator is on board (who was previously identified as the incoming administrator at St. Johnsbury). The former administrator of Burlington is now at St. Johnsbury.

Although the transfer of licenses has not been approved, there have already been impacts on the operation of the facilities because of the sale.

One impact that we repeatedly heard about was the fact that under the ownership of Genesis, Administrators prepared an annual budget, and individual department heads knew the amount of money they had to spend over the course of a year. Under the new ownership, however, administrators and department heads are not given a budget, and according to several, were not even asked for their input on budgeting. Although the overwhelming preference was to return to an environment of budgeting, that feeling was not universal. One current administrator stated, "If department managers need something they can come to me. [The new owners] might have an overall budget but I am comfortable asking for and justifying something I need, and I believe a good, capable manager can function without one." Another administrator confirmed the current practice, but added, "We are told 'tell us what you need and we will decide if you really need it.'" Still, he does not feel that residents go without things they need, because he and the other managers and administrators "fight hard to get what we need."

We also recognize that particularly with the ownership of the facilities remaining in transition, the new ownership group needs to take immediate steps to manage the revenue and expenses of the facilities.

When the ownership of the facilities transferred, electronic medical records were transferred from Genesis to the new ownership. During that process, we were informed that records predating a specific date were copied and available as "PDF" copies only, but were not included in the transferred electronic medical records. We were told that these legacy records remain available,

though there is now a process to gain access to them. In response to questions, no clinical staff reported any issues related to the quality of care to a resident due to the record transfer, but the review of medical records in conjunction with this review was limited in some aspects because of it.

A larger issue will occur if and when the licenses for the homes is transferred. Currently, the facilities continue to operate under Genesis procedures and policies. Once Genesis no longer holds those licenses, a new set of procedures and policies will replace those. Although it is reasonable to expect that many procedures and policies will remain consistent because they are based on law or best practices, there will be a wholesale changing of the administrative core of the facilities, that staff will need to be retrained on, recertified on, and reinspected on.

Policies

As a national chain, Genesis has a robust collection of policies that cover virtually every aspect of the operation of its facilities, ranging as examples from the hiring process of employees, to a comprehensive Code of Conduct for employees (HR 300), to Discharge Record Processing for residents (4.23). The policies are dynamic and updated when warranted, such as the publication of a policy specifically addressing infection control polices and procedures during COVID-19 (IC 405) issued on March 27, 2020. The policies we reviewed are comprehensive, specific, and clear to understand. Together, they outline expectations has how a facility should be operated.

As noted, these Genesis policies will remain in place as long as Genesis holds the license for each facility. At that point, we anticipate that the new policies will continue to be common between the three facilities.

Funding Sources

Like most states, long term care in Vermont is paid for by a variety of government programs, with the vast majority of care paid for by the Medicaid program. Medicaid is a joint federal and state program that provides health coverage to over 72.5 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities. Medicaid is the single largest source of health coverage in the United States. Medicaid was designed to provide a government-funded health insurance plan for income-eligible people and people who are categorically eligible. The federal government establishes requirements for all states to follow but each state administers their own Medicaid program differently. The Department of Vermont Health Access (DVHA), within the State of Vermont's Agency of Human Services, is responsible for administering the Vermont Medicaid health insurance program. The Division sets Medicaid payment rates for services provided in Vermont licensed nursing homes (also referred to as nursing facilities) participating in the Medicaid program. The rates are set quarterly, based on each nursing home's costs which are annually reviewed by the Division's auditors for allowability.

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The "Skilled Nursing Facility Medicaid Rates" are a key factor in the amount of funding a facility receives for each Medicaid funded resident. For April 2021, the per diem Medicaid rates for these facilities are:

Berlin	$240.21
Burlington	$300.21
St. Johnsbury	$219.20

The reimbursement system takes into account that some residents are more costly to care for than others. Thus, information gathered at the time of a resident's admission can have an important impact on subsequent Medicaid funding.

Staffing

All three facilities reviewed face a chronic shortage of clinical staff. One administrator interviewed described the clinical staff shortage as a two-part problem. The first part of the problem is locating staff, which is a chronic problem simply due to a shortage of qualified individuals. This problem is not unique to these facilities. The second part of the problem is retaining employees. One administrator interviewed described the problem this way:

> "Getting staff is a problem simply because of the size of the available pool. There appears to be a chronic shortage of staff. The keeping portion ebbs and flows, which results in the high use of travelers."

When permanent staff leave without an immediate replacement, or when there are simply not enough permanent employees to meet the facility's staffing needs, a facility generally depends upon a long term temporary replacement, obtained through an agency, and generally referred to as a "traveler" because these employees generally travel to the facility from another part of the country. Travelers come to a facility and generally work blocks of approximately 12 weeks. Most travelers interviewed described licensing rules that allowed them to work out of state, but required a periodic return to their home jurisdiction. Because of the reliance upon travelers, we interviewed at least one traveler at each facility.

It was immediately apparent that although many observers simply lump "travelers" as a homogenous group, each individual traveler brings with them their own personal story of what led them to this unique work style. For some, it is a love of affordably experiencing other parts of the country. For others, it is a chance to visit family and friends across the country. But other motivations are more personal. One traveler interviewed stated she had been a permanent employee at a long term care facility in Kentucky where a large number of residents had died of Covid. Each loss was personal to her, and she became a traveler to find a way to continue to provide clinical care, but in an environment where she would be less attached to those she cared for.

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The common perception is that travelers are primarily motivated by money. Without question, some are. Nevertheless, most travelers must pay for their own housing, and most said that to the extent they make a lot of money it is because of the fact that they take so little time off. Travelers are often the first line a facility counts upon to fill vacant shifts, frequently by working overtime.

Because travelers are all professionally licensed, few reported any concerns about a lower level of clinical skills between travelers and permanent staff. By policy, all travelers are required to undergo an "onboarding" process that includes not just familiarization with each Center's policies, but also an assessment of the traveler's clinical skills. In addition, travelers are required to shadow a member of the permanent staff prior to being assigned to work a regular shift. All we interviewed reported participating in an onboarding process upon their arrival. The Patient Care Coordinator expressed that she believes that the travelers get less orientation than in-house staff although they don't go on the floor until they have completed the competencies. How long they shadow seems to be governed by the results of the competencies.

When permanent staff were questioned about the clinical skill levels of travelers, there was no broadly held belief that travelers' skills were either lower or higher than the permanent staff as a whole. Some actually viewed travelers as resources who could share how similar procedures and practices are done differently in other systems or in other parts of the country.

The most commonly expressed concerns about the use of travelers generally was not a criticism of clinical skills, but rather the inherent lack of stability that results from staffing turnover, and particularly the fact that when a traveler first arrives, the traveler is not as familiar with the nuances of each resident. The lack of stability in staff leads to inherent issues, particularly with residents who may have begun a cognitive decline.

As an example of the "ebb and flow" of the use of travelers, we were told in February that approximately 80% of the Burlington facility's clinical staff were travelers. By July that number had decreased to between 25% to 33%. At the same time, the St. Johnsbury facility estimated that about 75% of its employees were permanent, and Berlin estimated that about 60% were permanent. Regardless of the "ebb and flow" identified by the administrator we interviewed, the availability of permanent staff is a challenge for long term care facilities in Vermont, and is likely to remain a challenge.

A second staffing challenge for each of these facilities is the ability to have an adequate number of staff working. US nursing homes are required to have sufficient nursing staff with the appropriate competencies to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident. Resident care needs differ depending on the acuity level (or casemix) of the facility residents. Higher acuity rates require higher staffing levels.

Staffing is generally managed using the "Patient Per Day" or PPD formula, which is widely used to establish staffing levels, and are determined by the number of residents in a skilled nursing facility (census) and the number of clinical staff caring for them during each shift. There are a

series of adjustments to that formula which allow certain positions to be counted against it, and which exclude other positions.

The federally mandated PPD is 2.7. We were told by an administrator that they are currently required to manage to a PPD of 3.3. Staffing levels at each facility were a point of concern to those we interviewed. Although staffing to a minimum level may meet legal requirements, it is apparent that doing so leaves virtually no flexibility in the assignment of personnel. As an example, one interviewee noted that at the time a facility had several bariatric patients. Though minimum staffing levels were met, the functional reality was that moving those patients required multiple staff to be involved in the process. So although minimum staffing levels were met, there would be inherent gaps is the availability of staff to interact with other residents for periods of time.

Having sufficient staff is a factor that is specifically covered by federal regulations, and on February 3, 2021 a survey by the Vermont Division of Licensing and Protection resulted in specific deficiencies regarding that facility's staffing levels at the time of the survey. Complaints included late delivery of medication, including pain medication; a patient who waited so long for assistance getting to the toilet that they went unescorted; and a resident who complained they had not received a shower in over two weeks due to a lack of staff. Residents reported long waits for staff to respond to call lights as well, a complaint we also heard during several interviews. Each of these examples could directly and adversely impact the quality of care a resident receives. While we recognize that the Survey on February 3 represents a "snapshot" of what inspectors found at that time, and that several other visits of the same facility did not identify any deficiencies, the number of patients and staff expressing the same concerns about staffing is concerning.

Specific staffing concerns at each facility will be addressed separately.

Dining and Housekeeping Services

The Dining and Housekeeping services at each facility are provided by Healthcare Services Group, which is a contractor. It was noted that menu selection is prepared by Healthcare Services. The menu for each facility includes both a specific menu item for each meal, as well as an "always available" selection. Specific observations regarding each facility are included within the discussion of that facility.

Resident Transportation

Providing transportation to the residents of a facility is a critical service. It enables residents to keep critical medical appointments, but is also important to simply allow the residents to experience the world away from the facility, which has both clinical and recreational value. Each of the three facilities reported having some means to transport residents, but none have a dedicated driver. In every case, the employee who is detailed to transport residents as a collateral duty has a primary duty as well. Simply put, no employee can be in two places at once. While one duty is being performed, the other is not.

Patient Care Coordinator

The Settlement Agreement required that Genesis “engage a roving Patient Care Coordinator who will perform duties at each of the Genesis Centers, for a minimum term of two years and a maximum term of three years.” It further required that, “The Patient Care Coordinator shall be a full-time, contract employee of the Genesis Centers.” The position was created, “to assist the Genesis Centers in providing their residents with the safest, most appropriate, and highest quality care.”

Genesis selected Audrey Kerin, RN, CQS as the Patient Care Coordinator. Ms. Kerin is a lifelong Vermonter with 37 years of clinical experience, including holding a registered nurse license in five states. She has worked in long term care throughout her career. At the time of her appointment, she was a clinical quality specialist for Genesis, providing clinical support to Genesis Healthcare centers in Vermont and New Hampshire. She has been employed by Genesis since 1996, and held a variety of positions, including as a Director of Nursing and Manager of Clinical Operations. Ms. Kerin was eminently qualified for appointment to this position.

Because her previous position with Genesis involved contact regarding the clinical quality at each of the Centers subject to the Settlement Agreement, there was a seamless transition to her new role.

All centers reported having regular contact with the Patient Care Coordinator. The PCC advised that she visits each facility every two weeks, spending a full day at the facility. The PCC reported that she initially devoted all of her time to the three facilities covered in the Attorney General’s agreement but since the sale, everyone was made aware that she would have responsibilities for other Genesis facilities as well. She begins by reviewing the census; admissions, discharges, and deaths; incident reports; infection control logs; and based on the information follows up with review of resident care plans, observation and conversation with residents, nursing staff and any other discipline that might be appropriate and rounds on the floor. She meets with the Administrator and Director of Nurses as necessary. She provides written reports to the Administrator, Director of Nurses, and Genesis staff, as well as to the new ownership group. In addition, she provides a report to the Attorney General’s office.

The PCC advised that when she is at a facility, she can get a sense of whether things are “going good or not” as she makes her rounds. Although she focuses on resident care issues, she also covers issues that overlap into other departments such as Housekeeping or Dining Services. She also reviews the “Grievance Log.”

Under the Settlement Agreement, the Patient Care Coordinator shall advised the Quality of Care Reviewer within 24 hours of learning of any situation that, in the Patient Care Coordinator’s opinion, endangers the health or safety of any resident. No such reports have been received. In addition, the Settlement Agreement requires that the Patient Care Coordinator submit a written report for inclusion with the Quality of Care Reviewer’s annual reports. That report will be included in the supplemental report following our live visits to the facilities.

Finally when asked, the PCC described the biggest challenges facing the facilities as stabilizing leadership and staffing and minimizing agency staff, observations which match ours.

Clinical Observations

Clinical observations are based upon the review of a sample of medical records from each facility. Each facility provided a roster of current residents, and Dr. Wilner selected the records to review. Although the identity of the resident was known to him, it was not included in the information he relayed.

As a result of this review, several common themes were noted.

All facilities use the "Point Click Care" system to maintain electronic medical records. As a result, much of the data in records is generally legible, with the exception being any handwritten notes.

Information regarding each resident upon admission is gathered by a Minimal Data Set ("MDS") coordinator, who is responsible for gathering information on each resident for current and future assessment, including physical and mental states. It appears that the system is used to link the MDS to the resident's care plan to ensure coordination and consistency. The MDS entries were completed on time, as were care plans. Care plan meeting notes showing those who participated were generally included in records from the Berlin facility, but not from Burlington or St. Johnsbury. As a general observation, care plans frequently stated general goals, but did not include goals that were measurable or specific to each resident. In addition, care should be taken to ensure that each care plan record includes a notation of who created the document.

The records reviewed did not include a Medication Administration Record ("MAR"). An MAR, commonly referred to as a drug chart, is the report that serves as a legal record of the drugs administered to a patient at a facility by a health care professional. The MAR is a part of a patient's permanent record on their medical chart. There have been documented complaints regarding the late administration of medication, such as during a survey at the Burlington facility on February 3, 2021, which should have been reflected in a MAR. We will follow-up on this issue during our live visit to determine if this information is captured elsewhere.

Also frequently missing from medical records were records of Occupational or Physical Therapy. We expect that these records are kept, but not in the EMR's that were reviewed, as these services are provided by a contractor. We will also follow-up on this issue.

Finally, our review of the medical records did not disclose whether the individual making an entry was a permanent staff member or a traveler.

Findings Regarding Individual Facilities

Introduction: We have already noted that each facility serves a unique community, each with its own challenges, and that our review involved interviews with both staff and each facility's administrator.

It is important to note that each of the administrators in place at the time of the conduct which led to the Settlement Agreement had left by the time that agreement was signed. Further, the administrators in place at the time of our staff interviews – in February and March 2021 – had either left the company or held a different position by the time the administrator of each facility was interviewed in June and July. We recognize the significant impact that an administrator has on a facility. Because of that impact and to avoid confusion, this report will distinguish comments made during the staff interviews, with the comments of the facility's administrator, each of whom were not in place until after those interviews occurred.

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Burlington Health/Queen City Nursing and Rehabilitation

A. Results of Staff Interviews

At the time of the interviews of employees at this facility, in late February and early March, the administrator was Ross Farnsworth. The census at the time of our interviews was approximately 86 residents, with a maximum capacity of 126, although Covid restrictions likely reduced the capacity to 114. The multi-story facility is located in an urban setting, and largely draws its staff and residents from a metropolitan area.

The Center Nursing Executive has worked in long term care for 16 years, and who described herself as having "worked up through the ranks" to her present position. She has been a registered nurse for over six years. Comments from her subordinates frequently refer to her "limited" experience as an RN given her current management responsibilities. There were no specifics offered regarding the adverse impact of that "limited" experience. Rather, her lack of nursing experience was pointed to, perhaps unfairly, by staff who found issue with her management style rather than her clinical skills. She reported that she arrived at Burlington as the Assistant Director of Nursing from the Genesis facility in Rutland in April 2019, and was promoted to her present position in November 2019.

In an attempt to assess the impact of the sale of the facilities on operations, the CNE stated that the sale of the facility was not complete, and could remain open for up to a year. Like others, she lacked specific details of the sale. She stated it was time consuming to "report to two masters" since she continued to report to Genesis as the license holder, while reporting to the new owners as the operators of the facility. She described the challenges of transferring the electronic medical records between Genesis and the new owners, but indicated that these challenges have not adversely impacted resident care, because all necessary recent records had been included in the electronic transfer.

As the nursing executive, the CNE manages the level of clinical staff within the facility. Staffing is driven by the facility's current census, which also forms the basis for nearly all of the facility's revenue. While Medicaid funding mandates minimum levels of staffing coverage, there is little

money to provide coverage beyond that amount. Although some supervisory staff are not included in the staffing equations, managing both coverage and costs in an environment driven by these formula presents a continuing challenge.

The CNE estimated that the current staffing mix at the facility was approximately 80% travelers and 20% permanent employees.

Based upon our interview with the CNE, it was apparent that there are staffing concerns at the facility, though the root of those seems to be in the reimbursement formulas set by CMS rather than local decisions. Since the CNE was the first interview at the facility, subsequent interviews were based, in part, on information she provided.

Subsequent interviews, however, painted a far more troubling picture of the facility.

Most staff interviewed described morale among staff as low, although there were varying reasons for that. Without question, the Covid-19 pandemic took a horrific toll on the Burlington facility, particularly in terms of the tragic deaths of residents. It is important to also recognize the pandemic's impact upon the morale of the staff that fought valiantly to protect and save the lives of the remaining residents.

Unrelated to the pandemic, others interviewed were more pointed about the lack of executive leadership at the facility. A number of staff complained that the Administrator and CNE were often absent from the facility at the same time, resulting in a leadership void, and that neither were generally available on nights or on weekends. Weekend coverage was a particularly sensitive point, since the lack of staff often resulted in last minute schedule changes on the weekends, making the scheduling of off-duty family events impossible. "Weekend coverage is always filled at the last minute," one staff member complained, "sometimes by salaried staff."

The administrator was described as "polarizing" resulting in a divide between those who see themselves as aligned with him – often the newer employees – and those who are not – often the longer-term employees. The atmosphere was described as "cliquish."

The staff was described as "overwhelmed" the same worker stated. "You have to ask, at what point does all of this affect patient care?" In fairness, no worker identified a specific adverse impact on patient care. Instead, the commonly expressed feeling was, "It impacts the staff, so at some point it as to impact the patients as well."

Nearly every worker interviewed said they had little if any direct interaction with the administrator. A commonly expressed feeling was that the staff is, "unappreciated and unsupported, and any complaints or suggestions fall on deaf ears." Even senior staff complained about the lack of direct feedback from the Administrator. "Our staff needs to be encouraged," one long time employee stated. "Everything is negative and micromanaged. There is no communication that is positive…This absolutely has an impact on the facility and on staff turnover. We need to improve the energy of the facility. We never see our leadership…It just needs to get better for our

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residents." One long time employee said, "I've only seen the DON three times in about three years, and the administrator once. If I walked by him in the hallway I doubt I'd recognize him."

One area of particular concern was the staffing in the Rehabilitation unit. At one point, that unit had been down to just three therapists, when the optimum amount would be between 14 and 16, in order to fully meet the demands for service. Patients were scheduled for less therapy than required, and in some cases disciplines were combined rather than having specialized therapists provide services. In order to provide just two hours of therapy each day to those residents who need it, it was estimated that the size of the rehab staff would need to double.

Although the staff generally shared the view that staffing levels are unacceptable, most recognized that staffing is driven by the "Patient Driven Payment Model" and by "Per Patient Day" calculations. Recognizing the inevitability of staffing concerns, one worker commented, "the facility is managed as well as can be, but is lacking leadership." In assessing the facility's leadership, it was termed, "highly directional, highly assigned, and task driven rather than people/morale driven" resulting in a "very tense atmosphere." Because minimum staffing is driven by complex rules and formula, there is rarely any excess staff ordered to work, so when an employee calls out sick, an employee who is already at work is frequently ordered to stay on, resulting in a 16 hour shift. Short staffing, however, has already resulted in frequent overtime and occasional double shifts, adding more stress to the system. One manager observed, "We get into a very cyclical pattern of asking more and more from those already working." Further, "we can't afford to have gaps in coverage, so we are even more at the mercy of travelers."

One experienced staff member stated that although the facility is dependent upon travelers, little effort is made to make them feel a part of the operation. "A lot of the travel staff has never met the DON or administrator, particularly if they work at night." Often, a majority of the evening and overnight staff are travelers. Although travelers must meet certain minimum licensing qualifications, "you got your good and you got your bad." The principle complaint was the travelers simply don't know the residents and their unique habits and needs, and by the time they do learn them, it is time for the traveler to leave. In fairness, other clinical staff noted that although travelers do not know the residents as well, they virtually always work alongside permanent staff who do, and who will recognize nuanced behavior.

A number of employees who had been at the Burlington facility for several years described the facility as having been very well run until recently, although there is no universal agreement on when that decline began. One frequent comment was that the Genesis corporate model provided for regional and even national assets that could be called on to assist with a problem. Those working in program areas were particularly complimentary of the corporate support that was available. Genesis was described as responsive to calls for assistance or advice, and its resource related employees were viewed as well trained, accessible, and helpful. Several employees traced what they viewed as the decline of the Burlington facility to the fact that there had been four administrators in two years. Another long term non-supervisory employee stated, "This used to be a fabulous place to work." When asked how long ago that was, I was told, "about five years." Commenting on the executive turnover, another staff member stated, "Each of the ones we've had have been OK, but you need the experience and the stability of one who has been here for a while."

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The lack of staffing during the evening shifts was particularly noted by the non-supervisory staff that actually is on duty during those hours. There may be up to 10 nurses working on day shift, but only three at night, when presumably residents are sleeping. Unfortunately, that is not always the case, particularly because a number of residents have mental health issues that limit their sleep. When a patient with mental health issues wakens, for example, they often simply don't want to go back to sleep. I asked how they manage when they have limited staff and patients needing attention. "On my floor," I was told, "we have to hustle. We get used to it. We constantly are walking the unit and trying to prevent things from happening."

Another long-term staff member, when asked if there was enough staff to do the job, replied, "If everyone is here – if there are no call outs, then yes. But we don't have anyone extra. But if one gets sick and calls out we are short. Other floors offer to help…that's true for both permanent staff and travelers. We all try to help one another out, but there's just no room for error."

On particular item that staff mentioned was that when it is anticipated the day shift will be short staffed, the overnight shift has been told in the past to wake patients as early as 4:30 AM to start the day by getting them cleaned and dressed. Unfortunately, breakfast is not served until 8:00 AM, so a patient may be sitting alone in their wheelchair for over three hours. "It's not fair," I was told, "It breaks my heart to do that." After hearing of this practice, other workers confirmed it occurs, although some staff have refused to participate, one noting that leaving a patient in a chair that long often results in the need to bathe them again, negating any time savings. One said, "I won't do that. But they only do it with the people who can't say no…."

Staff reported that overall cleanliness at the facility has declined, although most staff had praise for the housekeeping staff who do the best they can with the limited resources they have. Housekeeping and food service are contracted to an outside company, so the staffing levels are not dictated by the facility's management alone. At one time, there was apparently one housekeeper for each side of a floor, who would clean every room, then move on to other cleaning. Now, with reduced staff, that is no longer possible.

With regard to the quality of food, staff stated that there are two menus available at all meals: a regular menu, and an "always available" menu that frequently consists of peanut butter and jelly. Staff frequently bring snacks and other items in to supplement the snacks available for residents, which have reportedly improved but still are described as "repetitive." Other staff reported running out to a nearby Cumberland Farms to buy a treat for a resident. Because of Covid all meals had to be eaten in a resident's room, which placed increased demands upon the staff who had to distribute the meals, and frequently feed individual residents. Staff interviewed seemed sensitive to the particular dietary requirements of individual residents.

Finally, those staff responsible for programming indicated that due to the transition in ownership, they have no idea what their budget will be as they emerge from Covid. At a time when programming will assume more significance than ever, the lack of budgeting was universally considered to be a detriment to longer range program planning.

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The most commonly cited need was for increased staff training on how to deal with residents with dementia. It was generally felt that although there had been training in this area in the past, staff turnover, combined with the prevalence of the condition among residents, would be very beneficial.

B. Administrator's Comments

The current administrator of this facility, which has been renamed Queen City Nursing and Rehabilitation, is Sean Hallisey. He has been employed at the Burlington facility for 3 months. Prior to coming to Burlington, he was Administrator at St. Johnsbury from 2008-2017, where he was highly regarded by staff. He left to become administrator at Barre Gardens, which a long term facility owned those who have purchased the former Genesis facilities.

His direct reports are HR Director, Business Office Manager, Director of Nurses, Social Worker, MDS Coordinator, Activities, and Maintenance. While the Housekeeping and Dietary Managers report to him, they are contracted through Healthcare Services Group and the Rehab Director is contracted through Remedy Rehab.

The last time the facility was visited by a government regulatory agency was in June, 2021. He states it was a complaint survey under Residents' Rights for failure to notify a resident's responsible party of a change in diagnosis and treatment in a timely manner. A plan of correction has been submitted.

The administrator believes the last time the kitchen was surveyed by a government agency was during the full survey in 2019 prior to the pandemic. He states that he personally has his own checklists for daily, weekly and monthly walk-throughs.

The overall physical condition of the facility is "average for a 50 plus year old building." The building has been maintained, with a secure roof and the replacement of mechanicals about 8 years ago, and there are no conditions the administrator is aware of that would impact the health or safety of a resident or employee. He would assess the cleanliness of the facility as average and improving. Upon his arrival he was able to secure an extra housekeeper and was able to get a floor tech three times per week.

The facility has a small bus for transport of residents and sometimes they use "quasi-public transportation such as rural community transport. The bus is small enough that it does not require a special license and the maintenance man is able to drive it. He did get approval to hire a part time bus driver but has not had any applicants.

The administrator describes the quality of the food as "pretty good." Kitchen cleanliness and presentation of food have improved in his estimation. The Dietary department is not operated with a budget but he feels he has enough experience to stay within a reasonable amount.

Mr. Hallisey states that the number of travelers is decreasing. They have approximately 90-100 total employees with about 25-30 of those being travelers. They use Prime Time, Career Staffing and TLC (a local company) for their travelers and the contracts run from 8-13 weeks. They do

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not use per diem staff in addition to travelers. He describes the on-boarding of travelers as a full orientation.

He feels he has enough staff to meet state requirements as long as there are no call-outs. He does not have any in-house per diem staff to fall back on so has to try to get regular staff to work extra.

Minimum Data Sets are completed by two staff members who total 1.5 FTE's. Burlington has the highest Medicaid per diem rate of the three facilities reviewed. Having a higher number of behavioral residents may also contribute to the higher rate.

The current census is 98 with a capacity of 126. Mr. Hallisey says the third floor unit is currently closed due to insufficient staff to open it.

Mr. Hallisey believes that medical care is provided in a very timely manner. Dr. Mark Pitcher has most of the residents but a few are attended by Dr. Williams from UVM. Dr. Pitcher has a nurse practitioner in the facility 3-4 days per week. They also have access to a wound care nurse from two local wound care vendors, Gentell and Medelite.

The facility is able to provide therapy services in all disciplines. Therapists are managed under Remedy Rehab Services. He states he needs one more PT to be able to open the third floor which he hopes to do in August.

He believes social services are adequately staffed with one social worker and they have recently added another activity assistant.

The administrator describes staff morale as slowly improving. He makes rounds on the floors at least daily to communicate with residents and ask them about their care.

Tom Carroll is HR Director and is responsible for screening and credentialing of employees and obtaining references. Mr. Hallisey says the travelers come with their own dossiers from their agencies but otherwise the screening is the same for in-house or traveling staff. HR does the Vermont background checks on both.

Mr. Hallisey states that the orientation process is the same for both in-house and travelers. They receive 2-3 days of classroom review of policies and procedures, followed by clinical competencies which are usually done by staff development and the unit manager. He says they are partnered with a current staff member of the same discipline for 3 days to a week depending on the results of competency testing. A new practice is to have them attend a breakfast for new staff and selected residents. On an annual basis they are reviewed on the required competencies such as infection control, fire, blood borne pathogens, and sexual harassment.

He states there is no budget or P&L statement received by himself or the department managers. If department managers need something, they can come to him, and he is comfortable taking a request to a higher level if warranted.

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Mr. Hallisey states that although he is not a clinician, he is very involved in oversight of clinical services. He attends morning meetings where he gets information on fall, injuries, infections and other clinical issues. He also speaks with residents on a daily basis and hears about their physical concerns. He signs off on reports related to falls, wounds, and psychotropic drug use, and participates in the QAPI meetings. There are no reports or documentation related to restraint use because the facility is restraint free. He states he keeps up with discharge plans and after-care plan development through his one to one meetings with the social worker and also through participation in the utilization review meetings. He did say that he sometimes has to ask for follow up information on the discharge plans.

Resident rights are posted and given to the residents/families as part of the admission process. The grievance process and Resident Council is the primary way he hears about resident rights issues. The grievances are investigated and sometimes he meets one to one with the resident or family member. Depending on the severity of the grievance or incident report, a Root Cause Analysis might be done. The grievances then become part of the QAPI process.

Internal audit procedures to ensure accuracy and completeness of the medical records are mostly done by the unit manager, who uses checklists to make sure that required components of the record are completed. The MDS Coordinator also checks the records as part of the data collection process. If reeducation is needed, it is usually done by the Nurse Practice Educator.

The Patient Care Coordinator is at the facility every 2 weeks. He believes she reviews minutes of meetings, looks at accident and infection logs, makes rounds and talks to staff and residents. She then gives him and the DON a report of her findings.

According to the administrator, his top priority is to hire non-agency staff in order to reduce the reliance upon travelers. His other priority is re-opening the third floor unit which is basically dependent on staffing.

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Berlin Health and Rehab/Berlin Meadows

A. Results of Staff Interviews

Berlin Health and Rehab is just 42 miles south of Burlington Health and Rehab, and minutes from Interstate 89. But the atmosphere in those facilities could not be more different. And based on the staff interviews conducted, the credit for this distinction lies clearly with the administrator of Berlin Health and Rehab, Melissa Haupt. (We learned after these interviews that Ms. Haupt had retired. Our interviews disclosed no plans that she would be leaving, from her or anyone else.)

Unlike the Burlington facility, the Berlin facility is located on a single level, separated into wings which branch out from the building's common areas. Since it is located in a far less densely

developed area, it is not uncommon for wildlife to be seen out of the residents' windows, and during the Covid pandemic, family members who could not enter the facility were often able to maintain some visual contact with residents. At the time of our interviews, the resident census was approximately 85, although they could accommodate up to 115. Prior to Covid, the census was generally in the low 90's.

One of the facility's three wings focuses on long term care, another on rehabilitation, and the other on dementia and Alzheimer patients. A number of staff, including travelers, praised the Administrator's ability to better staff these units by matching staff with the needs of the residents.

The Director of Nursing is respected by the facility's staff. She started her career as a nurse's aide in 1989, then resumed her education, becoming an LNA, and then an LPN. She has been a nurse for 31 years, with 24 years of that time at the Berlin facility. She said she left briefly because she felt she needed to learn to manage, which would be difficult to do supervising her former colleagues. Instead she briefly went to what she called a sister facility. Prior to her promotion she worked as the supervisor of the facility's dementia unit. Becoming the DON approximately six months before our interview was "like a dream come true" for her. She described the home as, "truly a family atmosphere…It's like coming back home to me every time I come here." She was particularly proud of the way the staff pulled together during the Covid pandemic. "It took a staff that cared and understood and loved the residents and wanted to protect them." Both the Administrator and the DON were widely praised by staff for their hands-on presence during Covid, with both being willing to work the floors or do whatever else was required.

During the worst of Covid, 26 of the 28 patients on the dementia wing became ill. Nearly all staff were particularly proud of the way the staff responded to the pandemic, which was isolated to that wing alone. "As a result of those efforts," one manager stated, "the staff got stronger and more connected. They worked as a team, and focused on knowing their roles and education." While proud of their service, several described the experience as "like PTSD." Staff found the need to discuss their common experiences, which were not understood by those outside the facility. "Having been through the experience keeps everything else in perspective," one said. "As a result, everyone on the team is very approachable."

As an example of the staff's "team" effort, the Activities Director made daily visits to each resident, "just to check in" but also to distribute the "Daily Chronicle" which is an internally produced daily newspaper. More significantly, there was much concern early in the crisis on what would happen if staff members got sick. The Activities Director was one of several staff who responded by getting her LNA license so that she could help out on the facility's units.

Staffing levels, like at Burlington, are driven by specific formulas. Because most of the home's residents are paid for by Medicare or Medicaid, with very few private paying residents, as a practical matter staffing is not flexible.

The DON praised the facility's staff, emphasizing that from her perspective, there are good internal communications, and the staff is strong at "problem solving."

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Berlin's Director of Social Services has been at the Berlin facility for approximately 16 years, with the last 10 being in the activities program. She took over as Director of Social Services in October 2020.

The Director of Social Services described a busy – but manageable – workload spread throughout the facility. Her duties vary from developing plans of care, and hopefully discharge planning for rehabilitation patients; monitoring the "psycho-social" status and moods of longer term patients, with an eye towards depression and loneliness, to working with hospice to arrange care for terminally ill residents. She feels the facility benefits from strong management, and praised the administrator as being very involved, but not a micromanager. "She allows us to make decisions." During Covid, another long-time staff member praised the Administrator as being one who "didn't just stay on the sidelines and bark orders" and instead was, "very engaged."

Like other facilities, Berlin depends upon travelers, although the staffs' attitude towards traveling staff was more nuanced than at other facilities. The DON explained that there are limits to how many "terms" a traveler can work without returning to their "home" state of licensing, and that most terms are either 12 or 13 weeks. It is not uncommon for travelers to work multiple terms at the Berlin facility, which is apparently a fairly rare practice since a number of travelers are simply trying to combine work and travel. As one staff member pointed out, 'luring a traveler to Vermont in the winter is hard. Luring them back to Vermont in the winter or mud season is even harder.' One administrator noted that travelers do come to the facility with "a different mindset" but that in terms of quality of care there is no drop off between permanent and traveling staff.

When I asked her to assess the facility, the DON stated, "The most important thing a facility needs is stability. We have that here now."

Nearly all staff praised the cleanliness of the facility, particularly considering how hard it is to keep the facility clean during the winter months.

When asked what could be improved at the facility, one long time employee stated, "It's just a corporate thing. You lose something when there is corporate ownership. They should reward staff more for people who have shown loyalty. The raises they give out are minimal, and would boost morale tremendously."

I specifically inquired about the staff's interaction with the Patient Care Coordinator whose position was created by the Genesis Settlement Agreement. Although not all knew her by name, her role and function are widely understood. Although she frequently interacts directly with the DON, she is also present on the unit floors, and checks on items such as PPE, the code carts and refrigerators – basically "anything we get audited on" - to make sure they are functioning properly and within required ranges. All that I spoke with were appreciative of her assistance.

In contrast to other facilities, nearly all staff responded positively when asked whether or not they would hesitate to have family or friends as residents of the facility, and in fact a number had direct experience with family members or friends seeking both rehab and long term care there.

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The transition between Genesis and what most referred to as "Priority" was described as "for the most part smooth." "There have been some blips at the management level, but not at the patient care level," one long term manager noted. "I've been through other transitions and this one is going smoother than the others." The transfer of medical records was not cited as a problem by most staff. One manager stated that people from Priority had only met with staff at the facility one time. "We are hoping and praying that they don't make changes that hurt the facility or its residents."

In preparation for the preliminary interviews, notes from Resident's Council meeting were reviewed. The notes showed a long running series of complaints about food service that seemed to end at about the time a new food service manager had begun working at the facility. Because the food service and housekeeping are contract services, Genesis had limited control over day to day operations. Several staff identified food service as an area they would like to see improved. As in Burlington, staff reported bringing in treats and "comfort items" for residents because of the lack of variety among those the facility made available.

The current "Dietary Director" had been hired by her company in November 2019 shortly after she and her young family moved to Vermont to seek "more regular hours." Once her boss discovered her background, however, she was promoted to her present position. The timing of this promotion, in February 2020, matched the time that the chronic complaints about food seemed to tail off.

The director holds a Bachelor of Science degree from the Culinary Institute of America in Culinary Management, and well as in Culinary Arts. Although this is her "first nursing home" her previous experience was as the "Executive Sous Chef" as Smith & Wollensky's in Boston, and serving as a chef at both Boston University and TD Bank Garden, as well as at a number of other leading restaurants.

She does not create the menu for the facility. The company she works for - "Healthcare Services Group" – directs the menu to ensure it provides variety and meets nutritional requirements. When the facility was operated by Genesis, Healthcare Services had a "Genesis Specific" menu, but now she uses the company's "Legacy" menu instead. Under Genesis, residents were given soup and a sandwich at lunch, followed by a heavier dinner meal. Under Priority, the main meal of the day is at lunch, with a lighter evening meal. She said most residents seem happy with that change. She supervises a staff of ten who produce three meals each day, plus snacks. During Covid all meals were packaged for delivery to patient's rooms. She stated her staffing is adequate, and that she is fully staffed. She is provided a budget to operate within, which must cover food and personnel. She said she is able to stretch her budget by preparing more meals herself rather than relying upon prepared foods, with the added benefit that the meals taste better and are healthier. She has used the money saved to purchase desert and snack items that would otherwise not be available for residents. She also attempts to provide special requests to residents because she "knows how important quality food is to them."

The interview with a traveling nurse at the Berlin facility was particularly insightful. She had been working at a long-term care facility in Tennessee when the pandemic hit. When 23 patients died

at her facility in one month, she knew she had to find a place where she "could be more detached" from the those she cared for. This was her second tour at Berlin, and she would not have returned "if it wasn't a wonderful facility." What made the facility so outstanding was, "the Administrator. She has a complete open-door policy. I have never seen another facility like that." She stated the DON was also excellent: "Every place has it's quirks, but this facility is staffed better than any building I've been in during the last seven years."

When asked to elaborate further, she stated, "The numbers here make sense…the way the staff is distributed within the building. We aren't heavy in areas that don't need to be staffed as much, and where we need staff we have them. There is always someone there to help." In other places she has worked, "the numbers are 'legal' but here that's not a problem. There is no fudging of numbers."

She continued: "People are placed in the right positions, and I work throughout the building, so it's not just one area. For example, in a skilled unit, you need more therapists than aids; in a dementia unit, you need more aids than therapists. They seem to put a lot of thought into how they staff the units here, and how they allocate the personnel. It's a real team effort, which includes the scheduler. I also think the management here is willing to constantly regroup if necessary and remains flexible enough to change course. People here are willing to adapt."

When asked about the facility's overall cleanliness, she stated, "I've only been in one place cleaner."

Although Berlin utilizes travelers, the permanent staff seemed more accepting of them than at other facilities. One of the non-supervisory nursing staff interviewed explained that the travelers come to the facility with a variety of experiences. Without their experience, she said, the staff would not be exposed to other ways of doing things, which sometimes produce better results, or greater efficiency. She viewed the travelers as an opportunity to learn how common nursing procedures are done in other parts of the country.

Virtually every interview included, at some point, the unsolicited comment that the staff truly cares about the facility's residents.

B. Administrator's Comments

When interviewed the interim administrator, Floyd Bradley, had been employed as interim Administrator at Berlin Meadows for approximately one week, having replaced a previous interim administrator. He works as an independent contractor and is licensed as an administrator in the states of New York, Pennsylvania and Vermont. He has worked as an administrator since May, 2014 in various facilities in NY and PA. He also has previous experience in a VNA.

Understandable, Mr. Bradley was not yet familiar with the details of the Settlement Agreement or its specific requirements. Mr. Bradley came to this position as he was familiar with Priority Healthcare.

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His direct supervisor is Ryan Wisner, Regional Director for Priority. He does not report to anyone associated with Genesis. His direct reports are Nursing (DON, ADON), HR, Office staff, Maintenance, Dietary Manager and Housekeeping Manager although the Dietary and Housekeeping Managers are working through a contract with Healthcare Services Group.

The last time the facility was visited by a regulatory agency was on June 29, 2021. This was an unannounced complaint survey under Federal regulations. They were cited for issues related to proper administration and documentation of analgesic medications which are being responded to. He did not recall exactly when the last kitchen inspection was done but seemed to recall only one tag related to improper handwashing.

The administrator stated he would give the overall condition and cleanliness of the facility a “B”. He describes the facility as “pretty clean” but it could be better. There is minimal staffing from Health Services Group and the staffing is not consistent. He would like to have a FT “floor guy” and they have placed ads but with no response.

They have a small bus for transporting residents to appointments and functions. They have a part-time driver but the Activity Director and Maintenance man can also drive.

He would give the overall food quality a “B”. There had been a previous citation for food temp not being in a safe range when it got to the floor so he is getting a test tray once per week at random times for a short period to check the food temp. He would prefer not to use a commercial food supplier such as Health Services Group.

In describing his staff, Mr. Bradley feels that 60% are in-house and 40% are travelers. The travelers are mostly in the nursing department. The on-boarding process for travelers is managed by the HR Director, Janice Ashford, and as far as he knows, it is the same as the clinical on-boarding process for in-house staff.

He believes he has an adequate number of staff and meets the minimum regulatory standards. The current census is 91 with a licensed capacity of 115. The empty beds are mostly in one unit that was closed during Covid. They are required by Priority to manage to a PPD of 3.3. The person who makes out the nursing and aide schedules is responsible for assuring the PPD is met.

Nursing is responsible for charting the MDS data and there is an MDS coordinator who compiles and submits the data.

Mr. Bradley feels the physician coverage for the facility is adequate and timely. Dr. Kellogg is the Medical Director and as far as he knows is the only physician seeing residents. He also has a Nurse Practitioner who is in the building Monday – Friday. He mentioned that Priority has an arrangement with a group of doctors but isn’t sure whether that has any impact on this facility.

They use a Genesis contract for in-house rehab. He feels the type of therapy and the staffing available is appropriate for the needs of the residents as they are able to offer Physical Therapy, Occupational Therapy and Speech Therapy.

Berlin currently has one fulltime Social Worker and the administrator feels that is sufficient to meet the needs of the residents. There is also a fulltime Activity Director. The administrator is assessing the adequacy of funding for the Activity program.

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Staff morale was described as good, with a "can-do" attitude. The administrator has not heard any complaints or concerns about the change in benefits that occurred during the transition from Genesis to Priority. He said that there are long-term employees who remained and turnover hasn't been a big issue. He works to be accessible and responsive to staff, and he makes rounds on the units at least once per week but thus far only on the day shift.

There is a fulltime Human Resource Director, and the administrator has not been involved in the hiring, screening and credentialing of employees, leaving that responsibility to Human Resources.

Mr. Bradley stated that neither he nor his department managers participate in the development of the facility's budget. He administers his budget by staffing to a PPD of 3.3.

He feels oversight of the facility's clinical services is provided by the Regional Director of Clinical Services to assure that the policies and procedures are being followed. He participates in the daily huddle and uses computer based progress notes and QAPI reports to stay abreast of issues related to falls and injuries. There are no reports related to restraint issues as the facility is restraint free. He keeps up with discharge planning through attending morning meeting and clinical meetings with nursing, social service, and rehab services.

At the time of his interview the administrator had just been introduced to the Patient Care Coordinator, and he was understandably not fully familiar with her role.

The administrator identified the greatest challenge facing the facility is increasing permanent local staff because that directly affects continuity of care for residents. The remoteness of the facility and Covid have made that particularly challenging.

St. Johnsbury Health and Rehab/Northeast Vermont Nursing and Rehabilitation

A. Results of Staff Interviews

Located in the heart of Vermont's Northeast Kingdom, the St. Johnsbury facility faces a number of unique challenges. It is also a facility in transition, as both the Administrator and Director of Nursing chose to remain with Genesis when the ownership of the facilities changed.

At the time of our interviews, the facility's census was 66, with a licensed capacity of 96. The highest census the DON could recall was 86 residents, and the facility's census was historically between 70 and 72 residents. Like Berlin, the STJ facility is located on a single floor.

The departing Administrator, Michelle Pippa, was generally well regarded by staff, although a number of staff were outspoken in their criticism of the cliques and favoritism that flourished under her. Some claimed that certain employees were allowed to leave the facility for the day after checking in, and others complained that she did not like to advocate with the corporate office on

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behalf of the facility's workers, such as when the workers tax forms were late in arriving. Overall though, she was viewed as engaged in the daily operations of the facility, and caring for its residents.

At the time of the interviews, Pippa's replacement had been identified. He had previously worked at the facility, and was generally well regarded by the staff, who looked forward to his return. (After completion of interviews, we learned that the incoming administrator was being transferred to Burlington, and was being replaced by the administrator from Burlington.)

Although she was leaving the facility in a matter of days, the DON expressed her pride that during her time at the facility she had "deficiency free surveys." She had come to STJ in November 2019 from the Burlington facility. Overall, she assessed the facility as running "pretty well" and although there are areas that can be improved, she believed that a team was now in place that could successfully implement needed changes. She sees the keys to the facility's success as teamwork and the fact that the facility is "resident centered." She said unlike other facilities, STJ did not get hit particularly hard with Covid, "although it took a lot of hard work to achieve that result."

Perhaps due to its remote location, the STJ facility is even more dependent upon travelers than either Burlington or Berlin, with one estimate that up to 90% of nurses are travelers.

The DON stated that it is rare to see a drop-off in the skill level between permanent and traveler staff, "although it does happen." Travelers, however, cost the facility far more than permanent staff, so reliance upon traveling staff at levels approaching 90% is not sustainable in the long term. Staffing is always a challenge, and it is not uncommon at STJ for management staff to work the facility's floors.

Because travelers are so critical to the facility's staffing, the facility staff seems generally accepting of them. One unit manager formerly worked as a traveler, and her experiences have likely helped bridge that gap. It was stressed that one key to success in managing travelers is to have clear expectations of what is expected of them, and clear policies in place for them to follow. Particularly in light of their heavy use, it appears that the use of travelers at this facility is being well administered.

The challenge of recruiting and retaining staff is also made more difficult by the fact that the STJ facility is located across the street from the region's largest hospital. People who had worked at both facilities described the hospital as "a more welcoming environment, with more nurses on the floor and not as much focus on end of life care." The hospital, which faces the same geographic challenges as the STJ facility, is also apparently less reliant on travelers, likely due to those different working conditions.

In addition to the staffing issues related to the facility's location, several staff mentioned the prevalence of bad behaviors exhibited by residents, resulting in the need for more "behavior management" than at other facilities. Although no specific cause of these behaviors could be identified, the problems presented include Veteran's PTSD, dementia, and alcoholism. (There were some staff who felt that that the behavior issues at this facility are not significantly greater

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than in other long term care facilities.) When these problems were brought to the attention of Genesis, the company sent a resource team to work with the staff in order to better respond to the behaviors. The training provided by that team was praised by a number of staff, and cited as an example of the resources that Genesis could bring to address a particular problem. The Director of Activities also praised the resources that Genesis provided, which she termed, "amazing." A number of staff expressed concern that similar resources will not be available once the sale of the facilities is complete. Upon inquiry we were told that the purchaser will have resources available, though not on the same magnitude as Genesis had.

The staff at STJ were more outspoken about changes implemented by the facility's new owners which appear to the staff to be motivated by a desire to limit expenses. As one example, the monthly activities calendar that is distributed to each resident was printed in color under Genesis. Now, black and white copies of the calendar are run off on 8 ½ x 11 inch copy paper.

The staff at STJ, whose interviews were conducted after those at Burlington or Berlin, was also the first to mention a significant issue regarding vacation and sick leave. During interviews of STJ employees, it was learned that either immediately before or after the transfer of the facility's ownership, employees were paid for 50% of their accumulated vacation, and lost all banked sick leave. This was apparently cashed out in the final paycheck received from Genesis, so it is unclear to most employees which owner actually made the decision to implement this change. Employees who had been banking sick leave in anticipation of maternity leave were particularly impacted by this action. More significantly, this action has had a clear impact on the morale of most employees.

Most interviews at the STJ facility produced additional complaints about the anticipated cost-cutting that would be coming. These ranged from a change in the briefs provided to residents which prompted complaints about comfort and (more importantly) leaking, to rumored reductions in maintenance and transportation. Transport drivers had already been reportedly terminated, and maintenance workers were told they would assume driving duties.

There was far more concern expressed about the sale of the facility expressed at STJ than at any other facility. The loss of vacation and sick leave was not mentioned at any other facility, but was frequently mentioned by STJ employees. In addition, there was a sense that despite a number of obstacles, things were running pretty well at the STJ facility. The departure of the Administrator and DON unquestionably added to the stress surrounding the sale, which may account for the employees' heightened sensitivity towards it. It was also notable that there was a distinct lack of specific information among employees about who the facility was being purchased by. This lack of information was present throughout the interviews at each facility. There were numerous, and sometimes contradictory, statements made regarding who the homes were being purchased by. Without question, that lack of information contributed to the anxiety level among the staff. Some said that there was quite a bit of information being circulated early in the process, but that no new information had been distributed in recent weeks.

In addition, those managers who were responsible for programming at the STJ facility expressed the same concerns about their inability to budget for the coming year that their colleagues in other facilities expressed. And, as in the other facilities, the inability to budget was directly linked to

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the continuing uncertainty about the sale. Those that do know of their budget, such has housekeeping, have been told to prepare for significant reductions, which has resulted in even more uncertainty and concern regarding future programs. In addition, the authority to spend money has been curtailed. This has, according to some, resulted in delays to complete necessary maintenance and repairs, such as replacing doors.

Although the STJ facility is not new (it was described by one employee as “retro”), the long-time Director of Maintenance was praised for his efforts to modernize and standardize the facility at minimal cost. Taking the place of an employee who had held the position for nearly forty years, he described a facility that had been held together without comprehensive planning or repairs when he began nearly seven years ago. His initial time at the facility was spent repairing work that had not been done correctly, but he was proud to say that he recently completed a stretch of thirteen weeks without a single callback to the facility for an emergency repair. Longer term planning, he said, is critical to both efficiency and controlling the cost of repairs. When he came to the facility, for example, he found a variety of faucet fixtures throughout the building. Over time, he has replaced every faucet with a common style, making maintenance and repairs far easier. “We no longer have to keep an inventory of parts we may never use,” he said.

Due to its remote location, the STJ facility does not enjoy the consistent sources of new residents that more centrally located facilities do. The facility does draw from several hospitals and home health agencies, although there is competition for other long-term care and rehabilitation facilities for the same residents. Because new resident admissions are no longer assessed on the basis of acuity, that factor no longer impacts the staffing that a new admission may generate. It was explained that the facility must therefore be mindful of the conditions and illnesses that residents suffer from, as certain patients can require far more resources than others, and a large census of patients with complex conditions can have an impact on both staffing and patient care. Bariatric residents, for example, may require multiple staff to move, bathe, and dress the patient, while others require a single staff member.

By far, the most frequently heard complaint at the STJ facility concerned the quality of food. The Dietary Manager was interviewed, and stated that before coming to STJ, he had worked as a cook and assistant manager at Barre Gardens, which is a long-term care facility in Barre whose food service is provided by the same vendor that the STJ facility utilizes. Upon his arrival at STJ, he was immediately installed as manager, without the benefit of a proper transition or training for the position. He was forced to rely upon a combination of on the job training and assistance from other managers, particularly the Dietary Manager from Berlin. Although the Dietary Manager was justifiably concerned about his ability to successfully perform, his efforts to feed the residents in these circumstances demonstrated a commendable commitment to them, and a sense of responsibility that is often lacking. We will follow up on this issue when we visit the facility.

B. Administrator’s Comments

Ross Farnsworth has been the Administrator of the St. Johnsbury facility since April 8, 2021. He stated that he was previously the Administrator of the Genesis Burlington facility from December 2019 through his transfer to St. Johnsbury.

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The administrator identified his direct supervisor is Ryan Wisner, Regional Director for Priority. He also has reporting requirements to the Regional Clinical Director for Genesis. He estimates he has 10 direct reports who are department heads or assistants although those in Dietary and Housekeeping are through contracts with Healthcare Services Group.

On the day of his interview, Mr. Farnworth reported that a surveyor was at the facility from the Vermont Division of Licensing and Protection doing a follow-up survey on the Plan of Correction related to deficiencies cited on 4/28/21 and 5/10/21 which resulted from complaint investigations. Those complaints alleged that residents' rights had been violated when a resident was discharged with medications belonging to another resident and several incidents of a resident being "unclothed" and in sight of windows, hallways and other residents. .

Mr. Farnsworth stated that the surveyor walked through the kitchen in May but no issues were identified and he does frequent walk-throughs himself. On a scale of 1-10 he describes the condition and cleanliness of the facility in general as a 7. He states he does not believe there are any major or system issues that would affect the health or safety of residents or employees but that he gives the 7 score based on the contracted housekeeping staff and feels they could do a better job and be better trained by the contracted agency. Last month the Housekeeping Manager from the contracted agency left. One of the housekeepers volunteered to step into the position as there was no one else available.

The facility has a passenger bus dedicated to providing transportation for residents to/from appointments such as dialysis. A maintenance man has been trained as a driver and one of the aides handles the appointment schedules.

He would describe the quality of the food fed to the residents as a 7 and states it is difficult to manage a kitchen without a budget. He states the facility used to have a defined budged from Genesis but there is no dietary budget from Priority.

The administrator reported that neither he, nor any other managers, have access to a budget or participate in any budget development. As a result, he occasionally must address specific needs with Priority. He does not feel that residents go without because he and the managers "fight hard to get what they need".

He feels that the percentage of "travelers" has decreased significantly and about 75% of employees are their own staff. Travelers are mostly used in clinical positions. They basically use an agency called Career Staff for their traveling contracts but he believes that Career Staff gets travelers from other agencies as well. They do not use other contracted staff such as "per diem" staff but do have some of their own employees who function in a per diem capacity.

Mr. Farnsworth believes the on-boarding process for traveling staff is appropriate. He states they have a facility tour, are given a copy of the employee handbook, review general orientation modules in a classroom setting and shadow an employee. They are subjected to the same clinical competency evaluations as in-house staff.

He believes that, in general, they have sufficient clinical staff to meet the residents' needs but can always use more nurses and LNA's especially since they have about 55% of residents with behavior issues. They are able to meet the minimum regulatory staffing requirements. The

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current census is 70 with a capacity of 99. The empty beds are scattered throughout the facility because some of the residents with behavior issues could not have a roommate. Thus, the option of closing a unit to reduce costs is not practical.

There is an MDS Coordinator who is responsible for assuring that accurate information on patient care needs is collected and submitted. Because the facility's Medicaid per diem is almost $80 less than one of the other three facilities under review, he will examine if there is an opportunity to improve the capture of documentation.

Mr. Farnsworth believes the medical services are provided in a timely manner. Dr. Brinkley is the Medical Director and is the attending physician for 100% of the residents. He has a new Nurse Practitioner who started recently and is in-house 4-5 days per week. They have on-call arrangements for psychiatric services.

He believes their rehab services are adequate. They do not have a problem meeting residents' rehab needs. The facility has a newly started Social Worker but she is not totally new in that she has worked at the facility in the past. There is a new Activities Director and she has two fulltime and one parttime activity assistants.

Overall, the administrator believes staff morale is high. He does not think the loss of benefits during the transition from Genesis to Priority has remained an issue affecting morale, possibly because so many employees are new and wouldn't have been affected. I believes he is accessible to employees and participates in the daily "Huddles" which include the Administrator, DON and other department managers as needed.

Jason Caron is responsible for Human Resources and performs background, license and reference checks. Mr. Farnsworth is involved in interviewing any Department Heads and Department Heads interview their own staff. He doesn't feel he has had to settle for staff that is less qualified than he would like but said that new LPN grads do require more on-boarding and shadowing than someone who is experienced. He has also taken an aide and trained her as a scheduler.

New employees complete an orientation agenda. One-half day is spent in orientation with HR on employee policies and the employee handbook. Clinical orientation is done by the Center Nursing Executive. Competencies are completed by clinical staff prior to being allowed to independently perform tasks. He describes that much of the integration of new employees and particularly travelers is accomplished through the daily huddles involving the DON and NPE where new employees can learn about the needs of specific residents.

Mr. Farnsworth states he feels he has a good amount of oversight of clinical services as he participates in the daily huddles, clinical meetings, and has an opportunity to hear about discharge planning as part of the Utilization Review Committee. He also feels his participation in these meetings allows him the opportunity to address communication issues. He runs the QAPI meetings and therefore receives routine reports related to risk assessments, complaints, accidents and other issues falling under the purview of QAPI. The facility is restraint-free so there are no relevant reports or monitoring of residents in restraints.

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With regard to resident rights, he states that the rights are posted on each unit, the lobby and a copy is given to residents/families on admission. Ombudsman visits and Resident Council has restarted following the pandemic and he receives reports from both areas of identified issues.

The Patient Care Coordinator is in his facility about once per week. He sees her role as observation of residents and review of medical records to identify deficiencies that affect resident care. Following her visit she meets with himself and the DON to discuss any findings that she has and to provide a report.

Mr. Farnsworth identified the biggest challenges facing the facility as hiring in-house staff to replace the housekeeping and dietary staff contracted from Healthcare Group Services is high on his list since HGS pays bare minimum both to line staff and managers resulting in high turnover. He doesn't see this as possible until the sale to Priority is finalized because the HGS contract is held by Genesis. He also hopes that Priority will conduct a wage analysis and adjust the pay scale to improve the chances of hiring and keeping staff.

Conclusion and Next Steps

The Covid-19 pandemic has, without question, impacted the both the operation of these facilities, as well as our review of them. This review process was further complicated by the unanticipated sale of the facilities, and the complex nature of that transfer, which remains pending. The video interviews we conducted and the documents reviewed provide a limited insight into the homes, and because of that, we caution against making any final conclusions at this point. It is, however, apparent that each of the three facilities faces certain common challenges, the most significant being the hiring and retention of staff. The comprehensive solution to this problem is elusive, and extends beyond these facilities to the long term care industry as whole. Nevertheless, it is apparent that with strong executive leadership, differences among and between the facilities emerge. Leadership clearly makes a difference, and has a direct impact on every aspect of a facility's operations.

The sale of these homes represents yet another challenge that must be addressed. Certain changes related to budgeting may well be necessary for the new owners to introduce efficiencies while controlling costs. The impact of new budgeting procedures must be a focus of future reviews. What is clear, however, is that the uncertainty surrounding the sale of these facilities has introduced a level of anxiety that has only added a year of unprecedented anxiety already, and that anxiety will continue until the sale is finalized.

In focusing holistically upon the care the residents receive, these interviews are not intended to be simply another "survey" that forms part of each facility's extensive oversight. Rather, they are intended to provide a comprehensive overview of the quality of life for the residents of the home, and ultimately to improve the quality of the care they receive. During many interviews, staff thanked us for providing the opportunity to air their concerns. The staff at each facility includes a number of employees who have dedicated their careers to providing long term care, as well others

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who have only recently chosen that line of work. Those employees are the keys to each facility's success, and to the safety and care of its residents.

In order to complete this annual review, and assuming Covid-19 protocols permit, we intend to visit the facilities in September. We will issue a supplemental report following those visits which will incorporate the results of them.

We appreciate the opportunity to assist your office in the very important task.

Very truly yours,

Gerald J. Coyne
Managing Director
State Monitoring Services

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