This testimony is for the Public Hearing on Monday, Jan. 24, 2022 that will address Licensing of Nursing Facilities (216-RICR-40-10-1). My name is Susan Hodgin, and I've been a long-time advocate for the Essential Caregiver Bill.

While I understand and applaud the safeguards to protect nursing-home residents and am grateful for the extraordinary care that CNAs and nursing staff provide, isolated residents - *especially those suffering from dementia* – remain at risk. The policies put in place during March 2020 caused suffering and often confusion for countless residents. Even when visitation gradually returned, the residents needed more than a 30-minute, distanced "social visit" once per week. Before the pandemic, many spouses, other relatives, or friends were in nursing homes daily, assisting with care, supporting the hard-working staff and keeping their loved ones alert and stimulated. Without that direct engagement and advocacy, the seniors' mental and physical condition deteriorated at an alarming rate.

I know this because my father, who had dementia, died on May 24, 2020 at St. Elizabeth's Home in East Greenwich. He didn't have COVID, but I believe that the isolation and drop in the quality of his care were significant contributing factors. Prior to being locked out by the virus, I checked on him daily, assisting with fluids, feeding, range of motion, skin care, mental stimulation, and of course, love.

Rhode Island needs to care for our most vulnerable population with compassion and empathy. Thank you for your willingness to adopt the Essential Caregiver (EC) program!

Here are some *specific questions and concerns*:
In 1.15.6, section B states that an "individual with decision-making authority for the resident" may choose the EC. But section C, number 2 only states that the resident must be consulted. **Shouldn't the language be consistent? The first wording makes allowances for cases of dementia, apraxia of speech, and aphasia, but the second statement only names the resident.**

In section D (safety measures), number 1 says that facilities have 15 days after a declaration of a disaster emergency to put this into place. **Facilities should be ready to put the plan into place IMMEDIATELY.** It should be part of their operating system at ALL times, ready to spring into action

immediately when needed. All residents and new residents on should be asked to name their Essential Caregiver, and the EC training should be offered several times during the year. Also: **there should be language to allow Essential Caregivers continued full access when lockdowns are relaxed but visitation is still not back to "normal."** It was understandable that facilities needed time in March thru July of 2020 to navigate operations during the beginning of the pandemic, but the "surprise" has passed. Facilities should anticipate this need for any kind of emergency and be ready.

Page 51, Number 2 says that the essential caregiver does not have to be vaccinated. **If a vaccine is required of facility workers, the same requirement should be made of the ECs.** Protection of the residents is vital!

Also, on page 51, Number 5 states that facilities may lockdown for 30 days without allowing ECs inside. **That defeats the whole purpose of the bill and is extremely contradictory to the important strides in care that ECs can bring to their loved ones.**
Number 6A does the same thing. It seems to allow nursing homes to further restrict EC access by allowing additional requirements directly linked to a declaration of disaster emergency. But isn't that what the EC Bill is for? To ensure that each individual in a LTC facility has the human right to the personal care, connection, and love that is needed for a meaningful life? *The back-pedaling in Numbers 5 & 6 reek of insider industry lobbying.*

Please consider your own struggles the past 2 years without the ability to easily see loved ones. Then imagine you have dementia and don't understand why your family, whom you still recognize and need for the physical and mental care they provide, never visit.

Which road will the DOH and LTC facilities take?

1. repeat the isolation, struggle with shortages in staffing, watch helplessly as the virus infects residents when staff bring it in, cause emotional harm to countless families, witness the rapid decline of resident's health?
2. OR enact the Essential Caregiver Bill and allow the DOH and the care industry to carefully allow each resident a lifeline of care and love with their Essential Caregiver, a system practiced and in-place, ready to go, and safe for all.

Thank you for reading this and for your consideration of this important human right.

Sincerely,
Susan Hodgin
401-323-9183
108 Betsey Williams Dr
Cranston, RI 02905

It has been brought to my attention that certain elements of the Essential Caregiver Bill are being put in jeopardy as a result of some possible proposed changes.I specifically refer to Section 1.15.6 Essential Caregivers During a Declared Emergency. Item D.1 proposes that a facility be allowed up to 15 days to implement safety protocols for essential caregivers. Protocols should be ready to be put in place immediately. Item D.5 permits a facility to keep essential caregivers out during a lock-down phase for up to 30 days. That is also too long. Finally, E.7 allows a facility to replace an essential caregiver due to "necessary circumstances" without specifically defining what that would entail. Such language is inviting the possible removal of an essential caregiver unjustly.

I am part of a group that worked so hard for the passage of this bill. Please do not make changes that can destroy the heart and spirit of this bill. Its passage was too late for my mother who resided in the memory care unit of a long term care facility. Although her death certificate states she died of Covid, it was really the isolation and feeling of abandonment that killed her. We can not allow this to ever happen again. Thank you.

Barbara Tarczuk

Dear Ms. Pullano:

I am a healthcare professional and fully support the passing of the RI Essential Caregiver Bill. I am, however, concerned with Section D 5 *"In accordance with R.I. Gen. Laws § 23-17.5-37(b)(4), a facility that enters a lock down phase to establish safety measures for residents and essential caregivers shall not exceed a period of thirty (30) days. During the lock-down phase, essential caregivers are not permitted to enter."*

We suspected, and now know, poorer health outcomes were associated with visitation restrictions. I request this language be removed from the Bill. Forced isolation of those most vulnerable is deadly.

Thank you,
Dana R. Palka, RN

This testimony is in response to the Public Hearing on Monday, January 24, 2022 that addressed Licensing of Nursing Facilities (216-RICR-40-10-1). My name is Maria Renzulli, and I am writing for myself, my Mom Patricia Venagro, and the rest of our family. I have been a long- time advocate for the Essential Caregiver Bill.

We would like to begin by acknowledging and thanking the CNA's and nursing staff that provided extraordinary care under very difficult and unprecedented circumstances and continue to do so. While I appreciate the mandates that were put in place in March 2020, to protect the most vulnerable population, we do believe that isolated residents, especially those that suffer from dementia like my Dad, suffered needlessly in the days when visitation bans were gradually lifted. We believe different institutions like schools worked tirelessly to "think outside the box" and offer creative solutions for those vulnerable and suffering at home. In contrast, we believe that many administrations in nursing homes hid behind the Covid regulations issued by the state. One distanced 30-minute visit once per week was granted sporadically in the times of open visitation. Many residents, especially those on the dementia unit, had family and loved ones there daily helping and advocating for their care before the lockdown occurred. As dementia takes its hold, families of those suffering become their voice. Without engagement and advocacy by family members my dad along with the majority of others on his unit declined at an alarming rate.

We were not allowed to touch or comfort my very confused Dad for **a year,** we were allowed to return to his room in full PPE in March of 2021. My Dad, who was very healthy physically, survived Covid but died from a brain hemorrhage from a fall in his facility in April, one month later. My family strongly believes this fall was a result from the culmination of months of decline from living in a facility with no one to communicate for him, no one to advocate for all the things only his family would know he needed, and no one he loved to hug him and tell him they loved him.

The greatest tragedy of this Pandemic, to us, is the blatant disregard for the need to care for one of our most vulnerable populations; nursing home residents who sat in isolation in some instances for a year, with so little compassion and empathy. We are happy you see the need to adopt the Essential Caregiver

Program, but I have some specific questions and concerns about the changes that were talked about in the January public hearing,

1. In section D (safety measures) number one says that facilities have 15 days after a declaration of a disaster emergency to put this into place. I believe with the lessons learned from the Pandemic; these measures should be put in place **immediately.** I believe the wording needs to be specific, and it needs to be mandated that families will clearly be made aware of the essential care program when entering a facility and are allowed to name an essential care giver. Also, there should be clear language that allows essential caregivers full access even when lockdowns are relaxed but full visitation is not in place yet. We need to use what we have learned and apply it to help the residents in nursing homes that will be alone and isolated in light of another lock down.

2. Pg. 51 does not clearly state that all essential caregivers need to be vaccinated, if our goal is to keep residents safe and protect their mental health by allowing visitation, precautions should be taken by all parties. Everyone should be vaccinated

3. Pg 51, Number 5 states that facilities may lockdown without allowing ECs inside. This seems to move against the very point for which the bill was established. Again, language needs to be specific so facilities cannot hide behind the language in this bill. This same language is repeated in 6A, this section gives additional reasons to restrict access by essential caregivers. This contradicts the spirit in which the bill was created for. It denies us access to loved ones at a time when they need us the most. It is hard not see the hands of nursing home administration in the back-pedaling in these sections of the bill.

My family and I did not have a lot of choices when we placed our Dad in nursing care, it became necessary for my family, but we went every day. We knew and loved the staff on his floor and the other residents, and their families and we did our best to become part of this new community. Put one of your loved ones in my Dad's place and think about being locked out of that community completely,

knowing your loved ones have been locked in a small room for **a year** without physical, or in my Dad's case, because of his dementia, emotional contact. My family suffers guilt, grief and pain knowing that my Dad had to live the last year of his life in isolation from the people that he loved. I think the committee **must** create strong language in this bill, so this kind of pain and suffering does not happen to other residents of nursing homes or their families.

My Dad was a teacher in the Providence School System for 30 years and he believed in community and helping the people who were coming up behind him. He spent his life in service to others, when considering the language in this bill consider if he deserved to spend the last year of his life confused and afraid locked in a room with no one to speak or advocate for him, as his family fought to be let back in. As a family we are now begging you not to let this happen to any other family ever, do not repeat the isolation, struggle with shortages in staffing, and heartbreak that we suffered and will continue to suffer, enact a strong essential caregiver plan in memory of all those who suffered over the past two years. As a family we strongly believe this is the best first step forward.

Sincerely,

Maria Renzulli

401-644-4182

23 Haggarty Hill Rd

Saunderstown, RI 02874

This testimony is in response to the Public Hearing held on Monday, January 24, 2022 that addressed **Licensing of Nursing Facilities (216-RICR-40-10-1)**, specifically **Section 1.15.6 Essential Caregivers During a Declared Emergency**.

My name is Veronica Ferraro and I am an Essential Caregiver for my husband who was diagnosed with Alzheimer's Disease at the young age of 62. We have been on this 13-year journey together, the last 8 of which have been spent in long-term dementia care settings. Throughout this journey I have always been essential in guiding and contributing to my husband's care **and** ensuring the ***quality*** of his care once he transitioned out of our home due to a difficult mid-stage progression. As a result of these experiences, I have become a staunch advocate not only for him, but for anyone who suffers from dementia and resides in a dementia unit. The recent pandemic lockout has heightened the urgency for more advocacy.

I, along with other affected families, actively campaigned for and testified in support of the Essential Caregiver bill that was signed into law during the last session. We provided real life examples of the deleterious affects our loved ones with dementia suffered being locked away from our love, care, support, and most importantly OVERSIGHT of the quality of their care, which was severely compromised. We understood that some of the difficulties were situational, however key family caregivers do and could have contributed positively to offset some of the negative impacts due to the prolonged lockout. We now have the benefit of hindsight to see what needs to be done so this NEVER HAPPENS AGAIN!

Based on such hindsight and learnings, I have concerns regarding some provisions laid out in Section 1.15.6 regarding Essential Caregivers. Some of these specific provisions violate the original spirit and integrity of the law—that is to allow an Essential Caregiver access to their loved one during a declared emergency to continue to provide critical in-person care and emotional support.

Specifically, under Part D, #5—allows a lockdown of up to 30 days where not even Essential Caregivers are allowed in—THIS VIOLATES THE INTENT AND SPIRIT OF THE LAW. There should be NO lockout of Essential Caregivers. The facilities should have procedures and training in place on an ongoing basis for a smooth and immediate transition. Infection control is basic and should be in place regardless. Actually, the next part #6B, appears to negate #5.

Under Part C, Qualifications and Caregiver Designation, it does not address residents who have cognitive issues or who aren't capable of independently designating his or her Essential Caregiver.

Finally in Part D Safety Measures, #2 does not require vaccines for Essential Caregivers. This appears to work against the higher standards required for Essential Caregiver participation. I am fully vaccinated and boosted, as is my husband, and would hope others would do the same, if they don't have medical issues that would prohibit it.

What is missing from my testimony is my accounting of the experience both during the lockout and once I was able to regain entry close enough to observe the impact my absence had on my husband's condition BEYOND his Alzheimer's disease. Basic ADLs were obviously lacking over a prolonged period, enough for me to document my observations to RI-DOH. Through my resumption of supplementing his care, some issues were corrected, while others cannot be reversed, as the damage went on too long. Most of the other families in the unit lost their loved ones before the lockout ended, either from Covid or neglect/lack of key caregiver oversight. I guess I was one of the "lucky" ones.

If you are reading this and have limited to no "real life" experience with dementia or other debilitating diseases that dictate having your spouse or parent in a dementia unit or long-term congregate care setting, please consider our experiences carefully. Life happens when you are busy making other plans. Someday you may be thankful that others advocate for "doing the right thing"—we are, sadly, speaking from experience "on the front lines"—please listen.

Thank you for your consideration. Anything additional I can provide, please don't hesitate to contact me.

Veronica Ferraro

39 Valley Brook Dr.

East Greenwich, RI 02818

401-952-7982

TEXAS CAREGIVERS FOR COMPROMISE

BECAUSE ISOLATION KILLS, TOO!

January 26, 2022

Rhode Island Department of Health
3 Capitol Hill Room 410
Providence, RI 02908-5097

Attention: Paula Pullano

RE: Proposed adoption of rules and regulations regarding COVID-19 procedures, essential caregivers, and minimum staffing requirements

Texas has operated under essential caregiver guidelines since September 23, 2020, under an essential caregiver statute since September 1, 2021, and under an amendment to our Texas Constitution establishing essential caregivers as a resident right since November 2, 2021. There is little we have not seen, experienced, stumbled upon, and been required to address or correct due to trial and error. It is my fervent hope that Rhode Island will learn from Texas, enjoy our successes and not repeat the missteps we took that caused unnecessary inconvenience to providers and hardship on residents.

My suggested amendments to Section 1.15.6 as proposed come from working in a state of 120,000 long-term care residents in 1223 nursing homes, 2000 assisted living facilities and 738 intermediate care facilities where we held extensive monthly sessions regarding each facility type and extrapolated the thoughts, experiences, and input from providers, advocates, and families regarding both permanent and emergency essential caregiver guidelines.

SPECIFICALLY, Section A and D.1 appear to prohibit essential caregivers for the first fifteen days following the declaration of an emergency, the single most critical time when communication with family is necessary to help long-term care residents transition into new protocols in their facility. Two weeks is long enough for a resident to stop eating, sink into despondency, and begin an acceleration of dementia or other disease that cannot be reversed. The same arguments apply to Section D.5 which is twice as long, negates the purpose of an essential caregiver at all by permitting 30 days of quarantine and/or isolation, and puts a resident's life in jeopardy if a facility can lock essential caregivers out for a full thirty days.

Section D.2.c.(2) makes PPE and testing costs the responsibility of the essential caregiver and is potentially discriminatory against lower income families and a barrier to visitation especially if that facility receives grants or federal funding to offset those costs.

Section E.3. allows a facility to make an essential caregiver an ad-hoc employee and under E.4

remove that essential caregiver for failure to provide care according to agreed upon “duties” in that contract. This is in direct conflict with the 1987 Nursing Home Reform Act which allows 24/7 visitation without restriction or condition or qualification.

MISSING from these rules is any recourse for a suspended essential caregiver. There is no appeal or reinstatement process and there is an assumption built into these guidelines that every facility policy is sound and just enough to merit the removal of an essential caregiver for violation. This has historically not been the case with all facilities. Some facilities have been known to suspend essential caregivers for violation to a policy that itself violates essential caregiver guidelines, CMS guidelines, CDC guidelines, or state law.

None of these remarks are meant to generalize that all long-term care facilities are purposely non-compliant but many are and many will continue to be. While most facilities in Texas made genuine efforts to comply and provide residents access to their essential caregivers, many even today refuse admission of essential caregivers despite our statute and despite the constitutional amendment unless and until a family member complains to our Texas Department of Health and Human Services. Those families uninformed enough to make such a complaint go without visitation to the detriment of the resident.

Please consider each provision of these guidelines from the view of the resident and family member as well as the provider. Nobody has a more vested interest in keeping residents safe than their loved ones. Please do not adopt guidelines that treat loved ones like they, themselves, are the disease.

Mary Nichols
Texas Caregivers for Compromise

January 27, 2022

Rhode Island Department of Health
Attn: Paula Pullano
3 Capitol Hill Room 410
Providence, RI 02908-5097

Re: Proposed adoption of rules and regulations regarding COVID-19 procedures, essential caregivers, and minimum staffing requirements

Dear Ms. Pullano,

Florida has been following essential caregiver guidelines since September 1, 2020, when Governor Ron DeSantis issued an executive order allowing visitation. Since that time, we have seen zero uptick in cases being brought in to facilities by family. It is my hope that Rhode Island will learn from Florida and reduce the learning curve significantly so that you can avoid the problems that we have faced along the way.

My suggested changes to Section 1.15.6 as proposed come from working within Florida and several other states to create effective legislation. These are my recommendations:

Section A and D.1 appear to prohibit essential caregivers for the first fifteen days following the declaration of an emergency, the single most critical time when communication with family is necessary to help long-term care residents transition into new protocols in their facility. Two weeks is long enough for a resident to stop eating, sink into despondency, and begin an acceleration of dementia or other disease that cannot be reversed.

The same arguments apply to Section D.5 which is twice as long, negates the purpose of an essential caregiver at all by permitting 30 days of quarantine and/or isolation, and puts a resident's life in jeopardy if a facility can lock essential caregivers out for a full thirty days.

Section D.2.c.(2) makes PPE and testing costs the responsibility of the essential caregiver and is potentially discriminatory against lower income families and a barrier to visitation especially if that facility receives grants or federal funding to offset those costs.

Section E.3. allows a facility to make an essential caregiver an ad-hoc employee and under E.4 remove that essential caregiver for failure to provide care according to agreed upon "duties" in that contract. This is in direct conflict with the 1987 Nursing Home Reform Act which allows 24/7 visitation without restriction or condition or qualification.

Missing from these rules is any recourse for a suspended essential caregiver. There is no appeal or reinstatement process and there is an assumption built into these guidelines that every facility policy is sound and just enough to merit the removal of an essential caregiver for violation. This has historically not been the case with all facilities. Some facilities have been known to suspend essential caregivers for violation of a policy that itself violates essential caregiver guidelines, CMS guidelines, CDC guidelines, or state law.

None of these remarks are meant to generalize that all long-term care facilities are purposely non-compliant but many are and many will continue to be. While most facilities in Florida made genuine efforts to comply and provide residents access to their essential caregivers, but there are many, even today, that refuse admission of essential caregivers unless a family member complains to our Agency for Healthcare Administration. Those families uninformed enough to make such a complaint go without visitation to the detriment of the resident.

Please consider each provision of these guidelines from the view of the resident and family member as well as the provider. Nobody has a more vested interest in keeping residents safe than their loved ones. Please do not adopt guidelines that treat loved ones like they, themselves, are the disease.

Thank you so much for your consideration.

Mary Daniel
Founder, Caregivers for Compromise – because isolation kills too!

rihca
Rhode Island Health Care Association
57 KILVERT STREET, SUITE 200, WARWICK, RI 02886-1009 (401) 732-9333
FAX (401) 739-3103 www.rihca.com

January 24, 2022

I am submitting these written comments regarding proposed amendments to the Rules and Regulations for the Licensure of Nursing Facilities as contained in the RIDOH Public Notice of January 5, 2022 in my capacity as the President and CEO of the Rhode Island Health Care Association (RIHCA) on behalf of our sixty-four (64) member nursing facilities.

It is worth noting that key aspects of the proposed changes relate to key components of RI General Law 23-17.5-32 and 23-17.5-33 have been suspended by Governor McKee through his Executive Order 22-07 issued on January 21, 2022. The Executive Order stipulates that "any regulations scheduled to be promulgated by RIDOH for the enforcement of the provisions…are hereby suspended."

Minimum Staffing, Funding, Penalties.

RIHCA has strong objections to most all aspects of the proposed changes. While we acknowledge that the vast majority of these changes are the direct result of the enactment of the minimum staffing law passed last year by the General Assembly; however, we feel the need to detail the ramifications of this law and these Nursing Facility Regulation proposed changes.

Rhode Island nursing facilities are in the midst of an economic crisis resulting from the prolonged and ongoing COVID-19 pandemic. We are plagued with spiraling cost increases in most all areas of our operations including food, energy, medical supplies, etc.

Our biggest predicament, however, is the labor shortage impacting staffing in all areas of operation – direct care nursing, dietary, housekeeping and all other ancillary departments. In order to provide appropriate levels of staffing, we have increased wages, shift-differentials, bonuses and such for our existing staff and in an effort to recruit new staff. Temporary staffing agencies are being used at record levels to supplement our direct care staff, and we face price gouging by these agencies as the staffing crisis lingers.

The labor shortage has been further exacerbated by RIDOH's recent Covid-19 vaccine mandate on the healthcare industry which drove hundreds of staff out of the industry altogether. We are in the midst of an unprecedented labor crisis, and it shows no signs of easing anytime soon.

We are now facing the first phase of the implementation of the mandatory minimum staffing law with direct care targets that would have been challenging in a normal economic environment and that will be impossible given the extreme challenges we face. Again, key provisions of the minimum staffing statute are currently suspended by the Governor's Executive Order referenced above.

Dr. Nicole Alexander-Scott herself is on record with regard to necessary conditions for the successful implementation of the minimum staffing policy. In a letter dated July 13, 2020 written in support of the mandatory staffing legislation, Dr. Scott stated: "For minimum staffing standards to be successfully implemented, sufficient data must be available to establish meaningful metrics around minimum staffing, there must be a sustained pool of nursing staff (RNs, LPNs, CNAs) from which to hire, and appropriate financing must be made available to support them." Three conditions: sufficient data, a sustained pool of nursing staff and appropriate funding. Not one of these conditions apply for the proposed regulatory changes. Implementing a one-size-fits-all 3.58 HPPD unfunded staffing mandate in the midst of a prolonged pandemic during a grave and growing labor shortage will have dire consequences.

As a threshold matter, there are simply not enough willing clinical candidates to recruit in order to comply. Rhode Island nursing facilities are already seeking, with varying degrees of desperation, to hire more staff with very little success. According to the R.I. Department of Labor and Training, the largest number of open positions in Rhode Island – the two occupations with the highest number of advertised job openings in the state – are "Registered Nurses" and "Nursing Assistants" – the very staff we are required to hire to comply with the minimum staffing bill.[1]

Rhode Island's nursing facilities lack the financial resources to implement meaningful wage increases. The vast majority of nursing home reimbursement comes from governmental payers, primarily Medicaid. Revenues are limited by what the state pays, and facilities have no way to increase those payments.

We note that the General Assembly provided for a 0.5% labor add-on to become effective October 1, 2021; however, that increase has not yet been applied. We are told that it will be applied eventually, although we may not see the increase applied to our rates until February 2022 or later. Although the increase will be applied retroactive to October 1, it is not possible for us to begin to spend money on wage pass throughs in the fourth quarter of 2021 with money we hope to receive beginning in February 2022 or later.

Even once implemented, a 0.5% increase is woefully inadequate to achieve the FY 2022 minimum staffing targets. We estimate an FY 2022 direct care funding shortfall of $9.5 million as a result of the first phase of implementation. When fully implemented, funding will be $49 million short per year based on the staffing law alone.

These losses are on top of the already existing chronic underfunding of nursing facilities by the State of Rhode Island Medicaid program. Since the price-based system of reimbursement was implemented in 2013, our rates should have been increased under the funding formula by an average of 2.5% per year.[2] Due to sequential state budget cuts, however, we have received an average annual increase of just 1%, with at least four of the ten years with no increase at all.

Our association also has grave concerns regarding the draconian Medicaid claw backs, the withholding of Medicaid payments and the imposition of admissions freezes. Many nursing facilities throughout the State are already limiting admissions and keeping wings or units unoccupied. They simply can't attract the staff needed to increase their census even though they need to do so. This is and will have a growing impact on people's access to care at nursing facilities. RI nursing facilities are being required to do the impossible, and, once deemed to be out of compliance, fines estimated by RIDOH in their Benefit Cost Analysis of December 2021 estimates the additional cost to the industry to be $21,320,000.00for year one and penalties are estimated at $8,268,224.00. These costs and penalties will dramatically impact our members and will do absolutely nothing to enhance quality of care as was the original intent of the legislation. Instead, it will result in access issues and facility closures. Something's got to give! Thank you.

Respectfully Submitted,

John E. Gage, MBA, NHA
President & CEO

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[1] See DLT Chart at Exhibit A. Trailing the nurses and nursing assistants are customer service representatives, truck drivers, and retail salespersons. Data available at:
https://www.employri.org/vosnet/lmi/profiles/profileDetails.aspx?enc=Elzv7W1H4bwmL+k+/LJ5/SmAXTh9pSNHRcaHlwDOqS1LA/jKeQuGAazNf+diUCAtsdl780RE2MK9BwwSOHwUGCgikOICBzVFDw8s4o18UgQ=

[2] This is based on the ten-year average of the CMS Skilled Nursing Facility Market Basket Index.

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EMPLOYRI

Here are the occupations with the most job openings advertised online for Rhode Island.
Click on the occupation title in the table to see more information about that occupation

Rhode Island

Customize Report

For help click the information icon next to each s

Occupations by Advertised Jobs

This section shows the occupations with the highest number of job openings advertised online in Rhode Island on October 19, 2021 (Jobs De-duplication Level 3)

Click a column title to sort

Rank	Occupation	Job Openings
1	Registered Nurses	2,372
2	Nursing Assistants	785
3	Customer Service Representatives	661
4	Heavy and Tractor-Trailer Truck Drivers	650
5	Retail Salespersons	608
6	Licensed Practical and Licensed Vocational Nurses	594
7	Computer Programmers	547
8	First-Line Supervisors of Retail Sales Workers	539
9	Medical Assistants	527
10	Managers, All Other	521

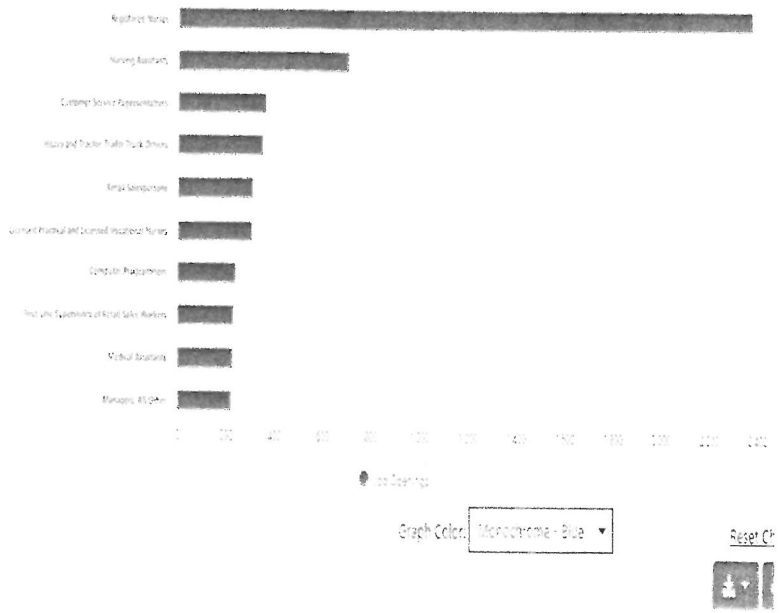

Exhibit A