

RESPONDING TO ALLEGATIONS OF ABUSE: ROLE AND RESPONSIBILITIES OF LONG-TERM CARE OMBUDSMEN

OVERVIEW

Provisions in the Older Americans Act (OAA) state that Long-Term Care Ombudsmen (LTCO) shall “identify, investigate and resolve complaints” regarding “action, inaction, or decisions that may adversely affect the health, safety, welfare or rights of the residents” made by, or on behalf of, residents.¹ Complaints may include, but are not limited to, allegations of abuse, gross neglect and exploitation. Long-Term Care Ombudsmen are resident-centered advocates, directed by resident goals for complaint resolution and federal disclosure requirements; therefore, the LTCO role in investigating allegations of abuse is unique and differs from other entities such as, adult protective services and state licensing and certification agencies. These disclosure requirements mean that information shared with or gathered by the LTCO is confidential unless consent is obtained as described below in the OAA provisions. Furthermore, LTCO programs receive complaints from a variety of individuals (e.g. residents, family members, facility staff, representatives of other agencies), but due to strict requirements in the OAA, LTCO may not disclose the identity of the resident or complainant without receiving permission from the resident or complainant (or their legal representative).

The purpose of this guide is to discuss how Ombudsmen can respond to allegations and observations of abuse, neglect and exploitation when the resident does not or cannot give consent to pursue the complaint. In the absence of resident consent, ombudsmen can take other actions to adhere to disclosure requirements and work to ensure the resident receives quality care and is protected from harm. This guide reviews the federal requirements regarding complaint investigations and disclosure, highlights statements from the Administration on Aging, and provides advocacy strategies and additional resources.²

Note: A few State Long-Term Care Ombudsman Programs (LTCOPs) receive allegations of abuse and investigate to substantiate the complaint (gather evidence to prove abuse occurred), but the primary focus of this resource is to discuss the role of the LTCOP in response to complaints according to the Older Americans Act and Administration on Aging technical assistance to states, not compare individual state LTCOP responsibilities.

KEY POINTS

What is abuse?

Since states have different definitions for abuse, neglect and exploitation, this guide will use the definitions provided in the National Ombudsman Reporting system (NORS) definitions of complaint codes and unless otherwise stated, we use the term “abuse” to include any willful act of “abuse, gross neglect and exploitation” throughout this resource.³

Older Americans Act Provisions

Under federal law, "the files and records" of the long-term care ombudsman program "may be disclosed only at the discretion of the [State] Ombudsman (or the person designated by the Ombudsman to disclose files and records)."⁴

¹ Older Americans Act of 1965. Section 712 (a)(3)(A)

² Examples for statewide LTCOPs are available in a supplemental resource titled, “Responding to Allegations of Abuse: Role and Responsibilities for Long-Term Care Ombudsmen- State Long-Term Care Ombudsman Program Policies, Procedures and Practices.”

³ Administration on Aging. Administration for Community Living. *Long-Term Care Ombudsman Program Complaint Codes*. OMB. NO. 0985-0005. Expiration Date: 07/31/2015. http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/docs/Complaint_Code2015.pdf

Furthermore, the "identity of any complainant or resident with respect to whom the [Ombudsman] Office maintains such files or records" cannot be disclosed without either consent from the complainant or resident, or from their legal representative, or pursuant to a court order.⁵ The State Ombudsman cannot authorize disclosure of the identities of complainants or residents without their consent, or the consent of their legal representatives, or pursuant to court order.

The Older Americans Act provisions regarding long-term care ombudsman disclosure are as follows:

(d) DISCLOSURE.—

(1) IN GENERAL.—The State agency shall establish procedures for the disclosure by the Ombudsman or local Ombudsman entities of files maintained by the program, including records described in subsection (b)(1) or (c).

(2) IDENTITY OF COMPLAINANT OR RESIDENT.—The procedures described in paragraph (1) shall—

(A) provide that, subject to subparagraph (B), the files and records described in paragraph (1) may be disclosed only at the discretion of the Ombudsman (or the person designated by the Ombudsman to disclose the files and records); and

(B) prohibit the disclosure of the identity of any complainant or resident with respect to whom the Office maintains such files or records unless—

(i) the complainant or resident, or the legal representative of the complainant or resident, consents to the disclosure and the consent is given in writing;

(ii) (I) the complainant or resident gives consent orally; and

(II) the consent is documented contemporaneously in a writing made by a representative of the Office in accordance with such requirements as the State agency shall establish; or

(iii) the disclosure is required by court order.

Administration on Aging Statements

In addition to the program requirements regarding disclosure and complaint investigation outlined in the Older Americans Act, the Administration on Aging has responded to questions regarding the role of the Office of the State LTCO in investigating allegations of abuse.

LTCO Role in Investigating Allegations of Abuse, Gross Neglect and Exploitation

The primary responsibility of the LTCOP is to investigate and resolve complaints on behalf of residents, but the LTCO program is unique in that its goal is to resolve the complaint to the "satisfaction of the resident or complainant" as opposed to seeking to "substantiate" a complaint by gathering evidence to prove the allegation occurred.⁶ This difference means that the LTCO program does not have the same standard of evidence required for complaint investigation and resolution as other entities, such as Adult Protective Services, state survey agency and law enforcement. The investigation by other entities seeks evidence to demonstrate that laws or regulations were broken. Since the LTCOP's primary goal is to resolve complaints to the satisfaction of the resident, the LTCO seeks resolution "on behalf of a resident regardless of whether violation of any law or regulation is at issue."⁷

State Laws Regarding Mandatory Reporting of Abuse

Most states have mandatory reporting laws that require certain individuals (e.g. facility staff, social workers) to report suspected elder abuse. However, "state law may not require reporting of suspected abuse, neglect or exploitation by the LTCO Program where such reporting violates the Federal requirement that an ombudsman is prohibited from the disclosure of the identity of a complainant or resident without appropriate consent pursuant to Section 712(d) of the

⁴ 42 U.S.C. 3058g(d)(2)(A)

⁵ 42 U.S.C. § 3058g(d)(2)(B)

⁶ Administration on Aging. Administration for Community Living. *Instructions for Completing State Long Term Care Ombudsman Program Reporting Form for the National Ombudsman Reporting System (NORS)*. OMB 0985-0005. Expiration Date 07/31/2015. p. 5

⁷ Administration on Aging. Letter to Director Nels Holmgren, Utah Division of Aging and Adult Services. October 31, 2011.

OAA.”⁸ Even if a LTCO carries a professional license and is considered a mandatory reporter under their professional license (e.g. a licensed social worker), the LTCO must adhere to the federal disclosure requirements when acting as a LTCO and cannot be required to report abuse without appropriate consent. The LTCOP is unique in that it was designed to ensure that “ombudsmen serve as the agent of *residents* and help residents to achieve what *residents* believe is in their best interest.”⁹

Additionally, facilities are required to protect residents from all forms of abuse and investigate reports of abuse. Due to the lack of federal regulations for assisted living (e.g. board and care, personal care homes) state laws vary by state, but information regarding the federal regulations for nursing homes is available in the “Resources” section.

WHAT CAN A LTC OMBUDSMAN DO IN THIS SITUATION?

Respecting resident confidentiality is critical not only to maintain compliance with program requirements, but also to adhere to the fundamental LTCO role as resident advocates, maintain the integrity of the LTCOP and foster trust between the LTCO and residents. However, maintaining confidentiality in response to complaints involving abuse is a challenging, complex situation.

The preamble to the proposed rules for the LTCOP states, “the Act [OAA] requires that Ombudsman programs both assist residents in protecting their health, safety, welfare and rights as well as to provide the resident with the option to consent to disclosure of information about his or her complaint.”¹⁰ Therefore, when a resident does not, or cannot, provide consent for a LTCO to pursue an allegation of abuse, there are advocacy strategies that the LTCO needs to consider to ensure the resident is protected from harm while upholding the disclosure requirements.

The LTCO advocacy strategies shared in the following section are not comprehensive, but are examples of successful LTCO advocacy in response to this delicate situation. As with all LTCO work, advocacy strategies in response to allegations of abuse vary depending on the situation (e.g. type of abuse allegation, type and size of long-term care setting, identity of the perpetrator- family member, facility staff or another resident). For example, a LTCO’s approach in response to an allegation of abuse in a small personal care home may differ from their approach in response to a similar allegation in a large nursing home. These approaches were adapted from feedback received from state and local LTCO and from the Georgia Long-Term Care Ombudsman Program Policies and Procedures manual (see the “Long-Term Care Ombudsman Policies and Procedures” and “Resources” sections below for additional information).

Fear of retaliation is one of the most common reasons residents do not want to pursue a complaint and disclose their identity. Since residents live in the facility and rely on staff for their basic needs their fear of retaliation cannot be overemphasized. It is critical that LTCO understand how fear of retaliation influences a resident’s, or another complainant’s, choices regarding complaint reporting and resolution. Materials providing additional information and advocacy strategies regarding fear of retaliation are available in the “Resources” section.

Note: Due to the primary focus of this guide the advocacy strategies were developed for individual case advocacy, but that does not negate the importance of systemic advocacy to improve the general responsiveness of other entities to allegations of abuse. Information regarding systems advocacy related to abuse and communication and information sharing with other entities is available in the “Resources” section.

⁸ AoA. Letter to Director Holmgren. op.cit.

⁹ The National Long-Term Care Ombudsman Resource Center (NORC). *Best Practices: Confidentiality*. December 2000.

¹⁰ Federal Register. Notice of Proposed Rulemaking. State Long-Term Care Ombudsman Program. A Proposed Rule by the Aging Administration on June 18, 2013. <https://www.federalregister.gov/articles/2013/06/18/2013-14325/state-long-term-care-ombudsman-program>

LTCO ADVOCACY STRATEGIES

Complaints received by the LTCOP are often more complicated than the examples below; however, the purpose of this guide is to provide advocacy strategies and best practices to consider when responding to situations involving abuse, neglect and exploitation. In addition to the advocacy strategies discussed in this section, LTCO should communicate with their supervisor when they receive an allegation of abuse (e.g. a volunteer LTCO consults with their staff LTCO) and follow applicable state LTCO program policies and procedures regarding consultation and communication.

Situation #1: A resident informs the LTCO of an allegation of abuse or financial exploitation, but does not give the ombudsman permission to pursue the complaint.

Ombudsmen must employ other advocacy strategies when responding to allegations of abuse, where consent is not given, in order to protect resident confidentiality and do their best to ensure resident safety.¹¹ When responding to allegations of abuse, LTCO should exhaust all possible advocacy strategies for the safety not only of the complainant resident, but for the safety of all residents. Below are some suggested practices for responding to this situation:¹²

- Explore the reason for the resident's reluctance to pursue the allegation of abuse, explain residents' rights and the LTCO role and responsibilities in supporting residents. Inform the resident of the complaint process, including how not disclosing their identity may impact complaint investigation and resolution, the potential risks of consenting to disclosure as well as risks for not pursuing allegations of abuse. Offer to investigate the complaint without disclosing her name (e.g. reporting the time and dates the incidents occurred without disclosing her name or identifying information). If possible, visit the resident frequently, see if she is interested in seeking supportive services (e.g. counseling) and encourage her to give permission to report the abuse. Take care to ensure that the resident does not feel that you are pressuring her to give permission to report.
- Ask the resident if she has shared this information with anyone else or if there is someone she trusts to share it with, such as a family member, friend or another staff person and if so, ask if you can talk to that person.
- See if there are other residents with the same issue who are willing to pursue it to resolution. By resolving the issue for others, you might be able to resolve it for the resident who does not want you to proceed on her behalf.¹³ Be careful to avoid revealing the identity of the previous resident and to avoid elevating anxiety levels among other residents with whom you speak.
- Investigate to gather information regarding the allegation. If you gain information supporting the allegation, share the information with the facility administrator if it is possible to do so without identifying the resident(s) involved (e.g. "here is information we gathered supporting allegations that the nurse aide, Jackie, on the evening shift is..."). The LTCO should not recommend that the facility take any specific action against the accused employee, but rather remind the administrator of the facility's responsibility to investigate and report allegations of abuse. If the facility administrator asks the LTCO for advice the LTCO could suggest that they consult the regulations for guidance and contact the state survey agency with questions about how to proceed.
- For complainants other than the resident, inform them of the role of the LTCO program and refer them to the appropriate investigative entity (e.g. state licensing and certification agency, adult protective services, law enforcement). Then speak with the resident regarding the complaint and their options including the advocacy strategies listed above.

¹¹ NORC. *The Problem-Solving Process: Investigation. Resource Material for the NORC Curriculum.* April 2006. p. 9.

<http://www.ltombudsman.org/sites/default/files/ombudsmen-support/training/Local-Investigation-Curri-cResource-Material.pdf>

¹² These approaches were adapted from the Georgia Long-Term Care Ombudsman Program Policies and Procedures and from discussions with state and local LTCO. See the "Long-Term Care Ombudsman Policies and Procedures" and "Resources" sections for additional information.

¹³ NORC. *The Problem-Solving Process: Investigation. Resource Material for the NORC Curriculum.* April 2006.

<http://www.ltombudsman.org/sites/default/files/ombudsmen-support/training/Local-Investigation-Curri-cResource-Material.pdf>

Situation #2: A facility staff person shares an allegation of abuse with the LTCO, but the resident involved does not give the ombudsman permission to pursue the complaint.

In addition to using the advocacy strategies listed in response to Situation #1, the LTCO should consider the following since the initial allegation of abuse was received from a facility staff person:

- Remind the individual of their responsibility (per state and/or federal regulations) to report the allegation of abuse to the appropriate entity (e.g. state licensing and certification agency, adult protective services, law enforcement).¹⁴
- Without revealing the resident's identity or identifying information, contact the appropriate investigative entity (e.g. state licensing and certification agency, Adult Protective Services) to inquire whether an allegation of abuse from the facility staff was received. Per state and federal regulations facilities are required to protect residents from abuse, report suspected abuse and investigate allegations of abuse. By contacting the appropriate investigative entity, the LTCO inquires whether the facility reported the allegation and the investigative entity is made aware of the allegation and will proceed accordingly. Contacting the investigative entity without revealing confidential information and the resident identity can be challenging, but it is an important step to take when responding to allegations of abuse.
 - If the investigative entity informs the LTCO that they have not received an allegation of abuse from the facility and the LTCO cannot disclose any identifying information since the resident did not provide consent, at least the investigative agency is aware that an incident of abuse may have occurred and the LTCO can provide non-identifying information relevant to the allegation (e.g. when the alleged incident occurred).

Situation #3: During a facility visit, the LTCO witnesses resident physical or verbal abuse.

Currently, the Older Americans Act (OAA) does not address this specific situation and the Administration on Aging (AoA) has not provided specific program guidance regarding whether LTCO can report abuse they witness without resident consent.¹⁵ This creates a difficult conflict for the Ombudsman and requires an evaluation of many factors to determine an approach that aims to ensure that all residents are free from abuse. If you witness physical or verbal abuse there is often no time to stop and ask questions of consent as stopping the abuse from happening is the immediate priority and this often involves notifying staff to assist the resident who has been harmed.

If you witness abuse:¹⁶

- Stop what you are doing, remain calm and call attention to the situation. If it is a physical altercation, don't physically intervene, but capture the attention of the abuser, the victim and others. Calling attention to the attack may stop it and attract staff.
- Pay close attention to details (e.g. what did you see and hear, what is the room number, who are the individuals involved). Identify other witnesses, especially facility staff since they are mandatory reporters of abuse.
- Get help. Find a staff supervisor or the facility administrator as they are required to report to the appropriate investigative entity, conduct an internal investigation and ensure the safety of the resident.

¹⁴ The following memo applies to long-term care facilities as defined by CMS (e.g. nursing homes). Department of Health and Human Services. Centers for Medicare & Medicaid Services. Center for Medicaid, CHIP and Survey & Certification Group. Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 1150B of the Social Security Act. June 17, 2011. http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter11_30.pdf

¹⁵ The AoA issued proposed rules for the State Long-Term Care Program in a Notice of Proposed Rulemaking (NPRM) on June 18, 2013. The rules are not finalized, but they do include guidance for LTCO that witness abuse and do not have resident consent to report the abuse. (April 2014) <https://www.federalregister.gov/articles/2013/06/18/2013-14325/state-long-term-care-ombudsman-program>

¹⁶ Adapted from Washington State LTCO Certification Manual.

- Speak with the resident about the incident, ask the resident if he/she wants you to report the incident to the investigative agency and inform the resident of the facility staff's responsibility to report the incident and conduct an internal investigation.
 - If the resident does not want to report to the investigative entity the LTCO should explore the resident's concerns, address any fear of retaliation and discuss what steps can be taken to keep the resident safe (e.g. the advocacy strategies in above scenarios in which the resident does not provide consent).
 - If the resident cannot provide consent, in addition to documenting everything and consulting with your supervising LTCO:
 - Find out if the resident has a representative (e.g. family member, power of attorney, guardian) who can speak on behalf of the resident. Inform the representative of the need to involve outside individuals, such as facility staff or the investigative agency and the role of the LTCO program. Work with the individual to develop a plan of action for resolution of the complaint.
 - If the resident does not have a representative, or the representative cannot be reached, or the representative is not acting in the best interest of the resident and the resolution goal is for action by the state licensing and certification agency, adult protective services and/or law enforcement, then the LTCO should obtain approval from the State LTCO and disclose the identity of the resident to appropriate facility staff and the appropriate investigative agency.¹⁷
- Document everything and contact your supervising LTCO to report the incident, to debrief and for support.
- Ask the facility staff to work with the resident to develop a plan to maintain their safety, meet their needs after the incident (e.g. counseling) and prevent future incidents. For example, if this was a physical assault by another resident there are two issues to address immediately, first, how to ensure the safety of the victim of abuse and second, how the facility will ensure the other resident is properly supervised and will not harm anyone else.

The difference between this scenario (in which the ombudsman witnesses the abuse and is the complainant) and the others (where the complainant is someone else) is that if the ombudsman witnesses the abuse, they are able to report first hand knowledge and information, rather than having to rely on someone else's account and does not put the victim in the position of naming the abuser.

Situation #4: A LTCO receives a complaint regarding abuse or gross neglect and the resident cannot provide consent to pursue the complaint.

- Find out if the resident has a representative (e.g. family member, power of attorney, guardian) who can speak on behalf of the resident. Inform the representative of the need to involve outside individuals, such as facility staff or the investigative agency and the role of the LTCO program. Work with the individual to develop a plan of action for resolution of the complaint.
- If the resident does not have a representative, or the representative cannot be reached, or the representative is not acting in the best interest of the resident and the resolution goal is for action by the state licensing and certification agency, adult protective services and/or law enforcement, then the LTCO should obtain approval from the State LTCO and disclose the identity of the resident to appropriate facility staff and the appropriate investigative agency.¹⁸

¹⁷ Federal Register. Notice of Proposed Rulemaking. State Long-Term Care Ombudsman Program. A Proposed Rule by the Aging Administration on June 18, 2013. <https://www.federalregister.gov/articles/2013/06/18/2013-14325/state-long-term-care-ombudsman-program>

¹⁸ Federal Register. Notice of Proposed Rulemaking. State Long-Term Care Ombudsman Program. op.cit.

Situation #5: A LTCO receives a complaint regarding abuse via email or phone call from an individual other than the resident.

As stated earlier, LTCO do not investigate complaints (including allegations of abuse) to determine if a law or regulation was violated or to enforce a penalty; therefore, LTCO are not generally considered the primary entity to investigate allegations of resident abuse.¹⁹

- Since LTCO are not primary investigators the LTCO should inform the complainant of the role of the LTCOP and provide contact information for the appropriate entity that does investigate to substantiate allegations of abuse (in most states the state licensing agency or adult protective services).
- Then the LTCO should visit the resident who may be at risk. For an example regarding appropriate complaint response time, see Table III-A titled, “Complaint Response” from Georgia’s Long-Term Care Ombudsman Program Policies and Procedures.²⁰
 - If the resident does not give the LTCO permission to pursue the complaint the LTCO should consider other advocacy strategies such as those mentioned in response to Situation #1.
- See additional advocacy strategies listed under Situation #2 regarding communication with the investigative entity.

Regardless of how the complaint is received (e.g. via email, mail, phone or in-person) the LTCO should follow the fundamental LTCO complaint investigation process for every complaint and always seek resident permission before pursuing the complaint and then proceed accordingly. For example, the LTCO should not forward a complaint received via email directly to the investigating entity before visiting the resident since LTCO work is always resident-directed, even in cases involving allegations of abuse.

Whether or not a resident chooses to pursue a complaint regarding abuse, a LTCO should support the resident as much as the resident wants them to be involved. For example, if a resident says she was abused and wants to file a complaint with the agency that serves as the state’s “official finder of fact” (e.g. state licensing and certification agency), the LTCO should support the resident during that agency’s investigation in order to “assist the resident in voicing and realizing his or her goals.” The LTCO could support the resident by following up with the resident and making sure she is aware of available support services (e.g. facility social worker, victims’ services, counseling).

For additional advocacy strategies and tips for effective communication in response to a variety of complaints (including allegations of abuse by a family member) consult the NORC guide and webinar titled, *Working with Families: Tips for Effective Communication and Strategies for Challenging Situations*.²¹

SHARE YOUR EXPERIENCE

The examples of LTCO practices and advocacy strategies provided in this guide are not comprehensive. We invite and encourage you to share your policies, practices, training and activities regarding this topic by sending an email to ombudcenter@theconsumervoice.org.

¹⁹ There are a few state LTCOPs that investigate allegations of abuse for the purpose of substantiating the abuse.

²⁰ Georgia Long-Term Care Ombudsman Program Policies and Procedures.
http://www.odis.dhr.state.ga.us/5000_agi/Aging%20Directives%20Index.htm

²¹ Working with Families: Tips for Effective Communication and Strategies for Challenging Situations. NORC.
<http://www.ltombudsman.org/ombudsman-support/training/conference-calls/family-members>

RESOURCES

Abuse, Neglect and Exploitation

NORC Elder Abuse/Elder Justice Issue Page

<http://www.ltombudsman.org/issues/elder-abuse-elder-justice>

Training Programs and In-Services (includes materials regarding abuse)

http://www.ltombudsman.org/ombudsman-support/training#Training_Programs_and_In-services

National Center on Elder Abuse

<http://www.ncea.aoa.gov>

State Abuse Reporting Guidance

http://www.ncea.aoa.gov/Stop_Abuse/Get_Help/State/index.aspx

Addressing Fear of Retaliation and Empowering Residents

Voices Speak Out Against Retaliation (CT LTCOP)

Training video and Instructor's Guide to discuss the reality of residents' fear of retaliation and how to help reduce that fear <http://www.ct.gov/ltcop/cwp/view.asp?Q=473774&A=3821>

Nursing Homes: Getting Good Care There Training Manual and PowerPoint (under "Advocacy")

<http://www.ltombudsman.org/ombudsman-support/training>

Complaint Investigation

Equipping Long-Term Care Ombudsmen for Effective Advocacy: A Basic Curriculum (NORC Curriculum)

See "The Problem-Solving Process: Investigation and Resolution" modules

<http://www.ltombudsman.org/ombudsman-support/training#Curriculum>

Quick Reference Guide: Ethical Guide for Long-Term Care Ombudsmen

<http://www.ltombudsman.org/sites/default/files/ombudsmen-support/program-management/Quick-Reference-Guide-Ethics.pdf>

Working with Families: Tips for Effective Communication and Strategies for Challenging Situations

<http://www.ltombudsman.org/ombudsman-support/training/conference-calls/family-members>

Confidentiality and Information Sharing

Best Practices Confidentiality. NORC. (2000)

<http://www.ltombudsman.org/sites/default/files/Best-Practices-Confidentiality.pdf>

CMS and AoA Discussion with State LTC Ombudsmen and State Survey Agencies

http://www.ltombudsman.org/ombudsman-support/program-management#Confidentiality_Information_Sharing

Coordination Between Long-Term Care Ombudsman and Adult Protective Services Programs and Related Issues

<http://www.ltombudsman.org/sites/default/files/LTCO-and-Adult-Protective-Services.pdf>

NORC Confidentiality and Information Sharing Resource Page

http://www.ltombudsman.org/ombudsman-support/program-management#Confidentiality_Information_Sharing

Resource Brief: Ombudsman Program Memoranda of Understanding

<http://www.nasuad.org/documentation/ombudsman/RBOmbudsmanProgramMemorandumofUnderstanding.pdf>

Federal Nursing Facility Regulations

Code of Federal Regulations

Title 42: Public Health, Chapter IV, Subchapter G, Part 483 Requirements for States and Long-Term Care Facilities

http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr483_main_02.tpl

CMS Survey & Certification Letter. Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 1150B of the Social Security Act. June 17, 2011.

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter11_30.pdf

CMS State Operations Manual (SOM)

See Chapter 5, Chapter 7, Appendix P, Appendix PP

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html>

The Interpretive Guidelines: A Tool for Advocacy (Consumer Voice, 2012)

<http://www.ltombudsman.org/sites/default/files/norc/the-interpretive-guidelines.pdf>

Systems Advocacy

NORC Systemic Advocacy Resource Page

<http://www.ltombudsman.org/ombudsman-support/systemic-advocacy>

Victim Services and Supports

My Body, My Rights (Nursing Home Ombudsman Agency of the Bluegrass brochure regarding sexual assault in nursing homes)

<http://www.ltombudsman.org/sites/default/files/norc/KY-MyBodyMyRightsBrochure.pdf>

The Prevention and Detection of Sexual Assault in Nursing Homes (Nursing Home Ombudsman Agency of the Bluegrass and Bluegrass Rape Crisis Center)

<http://www.ltombudsman.org/sites/default/files/norc/ky-manual.pdf>

Office for Victims of Crime (information for victims of crime including victim advocacy, search for local/state resources, victims compensation fund)

<http://www.crimevictims.gov/crime.html>

Office for Violence Against Women (information and search for local resources and supports)

<http://www.ovw.usdoj.gov/index.html>

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