State Long-Term Care Ombudsman

Initial Certification Training

State Long-term Care Ombudsman Program
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Ombudsman Certification Training

INTRODUCTION

Welcome to the Long-term Care Ombudsman Program

Thank you for choosing to serve as a Long-term Care Ombudsman. Long-term Care Ombudsmen serve as resident-directed advocates in nursing homes and assisted living facilities. Some residents may need help to improve their quality of life and care. As an ombudsman, you provide assistance and advocacy so everyone receives respectful and competent care.

What does an ombudsman do?

Ombudsmen investigate complaints, report findings, and help achieve resolutions. They can help one person resolve a problem, address issues that affect several residents, or work to change a systemic problem.

Ombudsmen serve residents of nursing homes and assisted living facilities in the following ways:

Handle complaints and problem-solve
An ombudsman supports residents and families to resolve any complaints by defining concerns, explaining rights, and identifying possible courses of action. In all situations, confidentiality is maintained and no information is released without permission of the resident or decision-maker.

Provide information and assistance
An ombudsman is a good source of information about selecting a long-term care facility, residents' rights, and how long-term care facilities operate.

Advocate for system and legislative changes
State and local ombudsman programs work cooperatively to recommend regulatory and legislative changes that affect older Texans.

Training Requirements:

Ombudsmen must complete a 36-hour certification training which includes:

- at least 12 hours of classroom training;
- at least 2 in-facility training sessions (provided through on-the-job training called shadow visits);
- maximum of 20 hours of self-study assignments; and
- volunteers complete a three month internship.

Other Requirements

- A sincere interest in promoting the well-being and protecting the rights of people in long-term care facilities
- An ability to work cooperatively with the people who live in nursing homes and assisted living facilities, local staff ombudsmen, and long-term care providers

- Ability to discover facts, work to resolve complaints, and impartially and objectively determine whether complaints are verified or not
- Acceptance of, and adherence to, the Texas Long-term Care Ombudsman Program (LTCOP) Code of Ethics
- Successful completion of Texas LTCOP training program and approval of the local Managing Local Ombudsman (MLO) and the State Ombudsman.
- Free of any conflict of interest

What will I learn in training?

Certification training prepares you to serve as an ombudsman. It includes information about the history of the program, laws and rules that direct ombudsman work, and the process of receiving, investigating, and resolving complaints made by, or on behalf of, residents of nursing homes and assisted living facilities.

How do I get certified?

After criminal history and conflict of interest screening, a person who applies to be a volunteer ombudsman is called an intern. After completing all training, a three-month internship, and demonstrating the ability to apply ombudsman fundamentals, an MLO may recommend an intern to be certified. The State Ombudsman makes the final decision.

Let's get started!

Opening Exercise: Get Acquainted

Use the following introductory questions to familiarize class members with one another. Depending on the number of participants, the class may break into groups to complete the exercise. Take turns asking each other these questions:

What is your name? _____

Why are you interested in being an ombudsman? _____

_____

Have you visited a nursing home? _____ Yes (Y) or No (N)

Have you visited an assisted living facility? _____ Yes (Y) or No (N)

What were your impressions of the last one visited? _____

_____

Training Manual - Icons Key

Questions about the reading above

Exercise

Ask the Trainer – Discussion

Ombudsman Tip

Very Important Information!

Link to a website such as YouTube or Facebook

Consultation Required

Movie or Video Clip

Acronyms

Acronyms	Terms
AAA	Area Agency on Aging
ADL	Activity of Daily Living
ADON	Assistant Director of Nursing
ALF	Assisted Living Facility
ANE	Abuse, Neglect, and Exploitation
APS	Adult Protective Services
CMS	Centers for Medicare and Medicaid Services
CNA	Certified Nurse Assistant
DON	Director of Nursing
DPOA	Durable Power of Attorney
HIPAA	Health Insurance Portability and Accountability Act
HSC	Health and Safety Code
LAR	Legally Authorized Representative, such as a guardian, a parent, managing conservator of a minor, or an agent authorized under a power of attorney
LIDDA	Local Intellectual and Developmental Disability Authority
LTC	Long-Term Care
LMHA	Local Mental Health Authority
LTCOP	Long-Term Care Ombudsman Program, i.e., a local ombudsman entity
MCO	Managed Care Organization
MFP	Money Follows the Person
MLO	Managing Local Ombudsman; is also a Certified Ombudsman
MOU	Memorandum of Understanding
MPOA	Medical Power of Attorney
NF	Nursing Facility
OAA	Older Americans Act
PASRR	Preadmission Screening and Resident Review
POA	Power of Attorney
QMP	Quality Monitoring Program
QRS	Quality Reporting System
RP	Responsible Party
RS	Regulatory Services
SLTCO	State Long-Term Care Ombudsman
STAR+PLUS	Texas Medicaid Managed Care program (for people who have disabilities or are age 65 or older)
TAC	Texas Administrative Code
TMF	TMF Health Quality Institute
VA	Veteran Administration

Ombudsman Certification Training

CHAPTER 1: Long-term Care Ombudsman Programs

Long-term Care Ombudsman Programs

Chapter 1 provides an understanding of the Texas Long-term Care Ombudsman Program, its purpose, unique aspects, and history.

Learning Objectives

- Develop an understanding of the history and uniqueness of long-term care ombudsman programs
- Review and follow the long-term care ombudsman responsibilities
- Learn why residents need advocates and how ombudsmen can respond

Contents

- How Long-term Care Ombudsman Programs Began
- Long-term Care Ombudsman Role
- Why Do Residents Need Advocacy?
- Unique Aspects of Long-term Care Ombudsman Program
- Long-term Care Ombudsman Responsibilities

DVD(s), Supplements, Forms

- DVD: Advocates for Resident Rights: The Older Americans Act Long-term Care Ombudsman Program
- Supplement 1-A: Ombudsman Program Milestones
- Supplement 1-B: Statutory and Rule References

How Long-term Care Ombudsman Programs Began

In 1965, Congress added Title XVIII - Medicare and Title XIX - Medicaid to the Social Security Act. These programs laid the groundwork to regulate and reimburse the nursing home industry, and the number of nursing homes grew tremendously. Before, the government provided no public money as an incentive for private owners to build facilities. President Lyndon B. Johnson signed the Older Americans Act into law, which set objectives to maintain the dignity and welfare of older adults and to create the aging network for organizing, coordinating, and providing aging services.

In the late 1960s and early 1970s, the government received reports of abuse, neglect, and substandard conditions in nursing homes. Congressional committees convened to hear testimonies, compile data, and propose reforms. Publicity attesting to poor care and personal profit for owners created a climate to enact specific federal regulations for standards of care.

In 1971, Dr. Arthur S. Flemming, U. S. Commissioner on Aging to President Nixon, developed the idea for the ombudsman program and envisioned it as an advocacy program for residents. He pitched the idea to the President on a trip on Air Force One. In 1978, long-term care ombudsman programs were established in the Older Americans Act. Supplement 1-A provides a timeline of long-term care ombudsman programs.

The Older Americans Act requires all state units on aging to establish an ombudsman program to:

- investigate and resolve residents' complaints;
- promote the development of citizens' organizations and train volunteers;
- identify problems and work to resolve them;
- monitor development and implementation of federal, state, and local long-term care laws and policies;
- gain access to nursing homes and assisted living facilities and to residents' records; and
- protect confidentiality of residents' records, complainants' identities, and ombudsman files.

Each state has an office of the state long-term care ombudsman headed by a full-time state long-term care ombudsman. In Texas, the office is an independent unit within a state health and human services agency. Patty Ducayet is the Texas State Long-term Care Ombudsman.

The Managing Local Ombudsman is: _____. Phone Number: _____

My supervising staff ombudsman is _____. Phone Number: _____

The State contracts with 28 area agencies on aging (AAAs). Twenty-six AAAs operate local ombudsman programs and two AAAs subcontract the ombudsman program: Dallas County through The Senior Source and Harris County through the University of Texas Health Sciences Center.

The Older Americans Act connects advocacy services for individual residents with the responsibility to publicly represent the needs of residents. Ombudsmen work to effect change in laws, regulations, and policies, using individual complaints as the basis for changing systems.

Long-term Care Ombudsman Role

Understanding the history, development, and unique aspects of long-term care ombudsman programs provides a foundation to understand the role of ombudsmen.

Long-term care ombudsmen:

- Advocate for residents of nursing homes and assisted living facilities;
- Work with the families and friends of residents as well as facility staff who make a complaint on behalf of a resident, even though 'resident' is used throughout this manual;
- Provide information about how to select a facility and how to get quality care;
- Identify, investigate, and resolve problems;
- Represent the resident perspective in monitoring laws, regulations, and policies, and make recommendations about needed change; and
- Prevent abuse and neglect by educating residents and supporting them if they need to report it.

As required by the federal Older Americans Act, long-term care ombudsman programs operate in 50 states, the District of Columbia, Puerto Rico, and Guam. Many states, including Texas, use staff and volunteer ombudsmen to advocate for residents.

Ombudsman Mission Statement

The Texas Long-term Care Ombudsman Program advocates for optimal quality of life and quality of care for residents in nursing homes and assisted living facilities. Residents and their families are served by developing and using the talents of specially trained volunteers and paid staff to represent the interests of residents who live in nursing homes and assisted living facilities.

Ombudsman Philosophy

People who are unable to care for themselves are entitled to dependable and consistent care. Ombudsmen advocate for residents to enjoy quality of life and receive high quality care.

Regulations pertaining to assisted living facilities do not directly address quality of life or care. However, Texas Nursing Facility Requirements (NFR) provide a definition of quality of life and care, based on federal law, and summarized below.

Quality of Life - NFR §19.701

The nursing home must care for its residents in a manner and environment to maintain or enhance each resident's quality of life. Four quality of life aspects addressed are:

1. Dignity and respect that fully recognize each resident's individuality.
2. Self-determination and participation to:
   - choose activities, schedules, and health care consistent with the resident's interests, assessments, and plans of care;
   - interact with members of the community both inside and outside; and
   - make choices that are significant to him or her.
3. Participation in social, religious, and community activities that do not interfere with the rights of other residents.
4. Residence and services that reasonably accommodate individual needs and preferences, except when health or safety of the individual or other residents would be endangered.

Quality of Care - NFR §19.901

Each resident receives and the nursing home provides care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive assessment and plan of care. Unique medical and developmental needs of children should be met. Care and services to be addressed include aspects such as activities of daily living, pressure sores, urinary incontinence, mental and psychosocial functioning, accidents, nutrition, and medications.

The Texas Long-term Care Ombudsman Program advocates for quality of _____ and quality of _____ for people who live in nursing homes and _____ _____ facilities.

As advocates, ombudsmen educate, support, and encourage residents to engage in self-advocacy and to represent themselves. A resident's direction is the basis for every action taken by an ombudsman. This applies to volunteer ombudsmen, staff ombudsmen, and the state ombudsman.

Ombudsmen also respond to and work to resolve complaints from family, friends, and facility staff - as long as the complaint pertains to residents. However, we always seek the resident's consent and take action based on resident direction, so resident wishes supersede another complainant's. Ombudsmen use a problem-solving process to analyze and resolve complaints. Chapter 10 describes the five-step problem-solving process in detail.

The next page provides a table with long-term care ombudsman responsibilities. Using the table, determine whether each statement is True (T) or False (F).

_____ Certified volunteer and staff ombudsmen, and the state office, have a role in ensuring residents have regular and timely access to an ombudsman.

_____ When acting as an ombudsman, volunteers and staff may comment on proposed laws in coordination with the Texas State Long-term Care Ombudsman.

_____ All staff and volunteers in the ombudsman program help to protect resident rights.

_____ Ombudsmen protect the confidentiality of all residents.

_____ Ombudsmen interns do not identify, investigate, and resolve complaints made by, or on behalf of, residents.

Long-term Care Ombudsman Responsibilities

Review the chart to see distinctions among the state long-term care ombudsman (SLTCO), certified staff, certified volunteer, and ombudsman interns. Chapter 6 has more information on ombudsman intern activities.

	SLTCO	Certified Staff	Certified Volunteer	Intern
Provide information to and visit residents; protect the confidentiality of all residents	✓	✓	✓	✓
Promote the Ombudsman Program	✓	✓	✓	
Provide technical support to develop resident and family councils	✓	✓ *	✓ *	
Provide residents with regular and timely access to ombudsman services	✓	✓	✓	
Assist residents to protect their rights and express a complaint pertaining to their health, safety, welfare, and rights within a facility	✓	✓	✓	
Identify, investigate, and resolve complaints made by, or on behalf of, residents	✓	✓	✓	
Seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of residents	✓	✓	✓	
Analyze, comment on, and monitor development and implementation of federal, state, and local laws, regulations, and other government policies and actions on behalf of residents; make recommendations about policies and laws to improve the system	✓	✓ *	✓ *	
The State Ombudsman prepares and submits an annual report describing program activities, noting problems residents' experience, and making recommendations to improve quality of care and life. The State Ombudsman also makes recommendations in laws, regulations, and policies to solve identified problems and protect resident welfare.	✓	**	**	

* Activities completed in accordance with the Older Americans Act and under direction of the SLTCO. Technical assistance to councils and commenting on laws, regulations, and policies requires coordination with the SLTCO to ensure the person's activities are consistent with statewide policies.

** The SLTCO report is comprised of reports made by volunteers, staff, and state office staff.

Advocates for Resident Rights: The Older Americans Act Long-term Care Ombudsman Program

Run Time: 15 min 15 sec

Watch the video, Advocates for Residents' Rights: The Older Americans Act Long-term Care Ombudsman Program. Describe what you learned below.

1. How does the Older Americans Act describe the long-term care ombudsman role?

_____

_____

2. What is the purpose of the long-term care ombudsman program?

_____

_____

3. What are some functions of a long-term care ombudsman?

_____

_____

4. What are some complaints ombudsmen work to resolve?

_____

_____

What questions do you have about being an ombudsman?

_____

_____

Why Do Residents Need Advocacy?

Advocacy is action by, or on the behalf of, individuals and groups. This action ensures benefits and services are received, rights are protected, and laws are enforced.

The Texas Long-term Care Ombudsman Program serves as advocates for all individuals who live in the 1,232 nursing homes and 1,821assisted living facilities in Texas. These licensed facilities have an average occupancy rate between 64% and 69%; therefore, approximately 134,000 individuals are our clients.

Because people are living longer and many families live far away, residents may have few visitors other than long-term care ombudsmen.

SOURCE: Regulatory Licensing and Certification July 2015

How many people live in a nursing home or assisted living facility in Texas? _____

How many nursing homes are in Texas? _____

How many assisted living facilities are in Texas? _____

With over 600 certified volunteer ombudsmen and the full-time equivalent of 68 certified staff ombudsmen, the Texas Long-term Care Ombudsman Program has an integral role in the long-term care system. Certified ombudsmen, as advocates for residents, protect residents' rights and the health, safety, and welfare of residents.

When people live and work together, differences of opinion and preferences are normal parts of life. Routines and rules develop for facility convenience and efficiency. Facility operations can conflict with the needs of individual residents. Moreover, many residents are unable to express their needs or exercise their rights without help from others.

What is advocacy?

_____

_____

Why do you think residents in nursing homes and assisted living facilities need advocates?

_____

_____

Barriers to Self-Advocacy

Physical and cognitive barriers	Lack of information about
• Cognitive impairment • Effects of medications • Loss of hearing, speech, sight • Loss of physical strength • Inability to get services, care, or attention because of physical or communication problems	• Alternative living options • Authority within the facility • How to improve their situation • Legal services • Rights

Personal feelings	Other barriers
• Believes this is the best it can be • Fear of being labeled a "complainer" • Fear of retaliation • Sense of isolation • Sense of hopelessness or despair • Loneliness • Reluctance to question authority	• Insufficient medical or nursing care • Lack of privacy • Physical or verbal abuse • Lack of experience being assertive

List two physical and cognitive barriers to self-advocacy

1. _____
2. _____

Two personal feelings that are barriers to self-advocacy are:

1. _____
2. _____

Unique Aspects of the Long-term Care Ombudsman Program

Many organizations, companies, and agencies have ombudsmen. They act in the classical sense of being neutral and impartial. Long-term care ombudsmen are impartial and objective while investigating a complaint, but become an advocate and represent the interests of the resident when working to resolve a problem.

This is an important distinction. A long-term care ombudsman makes this distinction clear to families and facility staff. While we seek to find resolution that is satisfactory to all parties, resident wishes guide the actions of an ombudsman. As a resident advocate, our presence and role helps balance the difference of power in a nursing home or assisted living facility.

The long-term care ombudsman program's history and development set it apart from other programs and roles in the long-term care system. It is very important to have a clear understanding of the ombudsman role based on the Older Americans Act because it is a frequent source of misunderstanding and tension when ombudsmen interact with others. Explaining and clarifying ombudsman responsibilities to others is a routine part of an ombudsman's work.

The long-term care ombudsman is a resident advocate.

Long-term care ombudsmen are impartial and objective while investigating a complaint, but become an _____ and represent the interests of the _____ when working to resolve a problem.

Classical Ombudsman vs. Long-term Care (Advocate) Ombudsman

Classical Ombudsman

Purpose:	Impartial mediator, who receives complaints, determines pertinent facts, and seeks resolution
Setting:	Many settings, both public and private
Focus:	Neutral; makes sure the system works as it was designed to work
Scope	Varies, but usually within one organization

Long-term Care Ombudsman

Purpose:	Impartial in investigation to: • determine pertinent facts; and • gather sufficient information to understand the problem in order to represent a resident's interests; once facts are gathered, advocates for a resident-focused solution
Setting:	Nursing homes and assisted living facilities
Focus:	Seeks a resident-directed resolution and works to overcome bureaucratic barriers
Scope	Seeks resolution for individual and systemic issues

Ombudsmen help residents with resolution strategies that may include:

- persuading or negotiating with facility staff;
- filing a complaint on behalf of the resident;
- working with a resident council;
- getting a group of residents with similar concerns together to solve a problem; or
- bringing problems to the attention of outside systems, such as the Medicaid agency or regulatory services.

Sometimes residents want an ombudsman to speak on their behalf. This may occur when:

- a resident is unable to communicate wishes and has no one else to call upon for help;
- family conflicts complicate the issue;
- legal services are needed;
- resources within a facility or community are uncertain; or
- a resident fears causing tension between resident and staff relationships.

Ethical Issues

Ombudsmen must act ethically in behavior and decision-making because:

- ombudsman work is filled with ambiguity regarding how to proceed;
- ombudsmen typically encounter issues that are not clearly right or wrong; and
- one ombudsman's actions can impact the credibility of the statewide program.

While many programs wrestle with ethical and confidentiality issues, long-term care ombudsman programs have a few unique elements.

- Jurisdiction is the *interest* of the resident.

- Resolution standard is to *resolve to the resident's satisfaction* — or in absence of an identified resident, the complainant's.
- Ombudsmen are mandated to *advocate on behalf of the broad interests of residents*, including public policy. This is often referred to as systems advocacy.
- Ombudsmen *promote the development of groups* such as citizen organizations to work with the ombudsman program and support for resident and family councils.

Atypical Mandates

The ombudsman program has some atypical mandates. Much of the ombudsman program structure and operation is specified in the Older Americans Act and federal rule.

Separate Office

A separate office of the state long-term care ombudsman is headed by a state long-term care ombudsman who is responsible for the statewide program.

Legal Coordination

The program can pursue administrative, legal, and other appropriate remedies on behalf of residents through in-house legal counsel or through coordination with other legal advocacy services such as Texas Legal Services Center, Disability Rights Texas, and Legal Aid.

Confidentiality

The Older Americans Act requires strict protection of the identity of residents and complainants, and information obtained about residents and complainants, during the course of ombudsman duties. To maintain confidentiality, ombudsmen must:

- not identify residents or complainants without their consent;
- not take action on behalf of a resident without the resident's consent;
- not disclose confidential information about a resident or complainant; and
- explain our confidentiality requirements to facility staff and other agencies who may expect that case information can be shared.

Surrogate Voice for Residents

The program is clearly directed to represent residents and act as a surrogate voice for residents. Regardless of the source of a complaint, an ombudsman serves the resident and is resident-directed.

Not Mandatory Reporters

Federal rules clearly define an ombudsman's role and responsibilities regarding abuse, neglect, and exploitation (ANE). An ombudsman *must* obtain consent from a resident before reporting any complaint or taking any action, including reporting complaints involving ANE. Special considerations apply if a resident is unable to provide consent. Chapters 3 and 4 provide detailed information about

consent and the ombudsman role and responsibility related to allegations of ANE.

Reporting suspected abuse while abiding by the Older Americans Act requires ombudsmen to carefully analyze the situation and listen to the wishes of the resident.

Willful Interference

Program representatives are protected from willful interference. Interference with ombudsmen performing their duties is a class B misdemeanor, according to the Texas Human Resources Code (§101A.264):

- A person commits an offense if the person:
  - intentionally interferes with an ombudsman attempting to perform official duties; or
  - commits or attempts to commit an act of retaliation or reprisal against any resident or employee of a long-term care facility for filing a complaint or providing information to an ombudsman.

Legal Counsel Must be Provided to Representatives of the Program

- If acting in good faith in performing ombudsman duties, representatives of the program, including interns and volunteers, are not liable for civil damages or subject to criminal prosecution.
- Texas Human Resources Code Chapter §101A.256 says, “The department shall ensure the Office receives adequate legal advice and representation. The attorney general shall represent the ombudsman or a representative if a suit or other legal action is brought or threatened to be brought against that person in connection with the person's performance of the official duties of the Office.”

Conflict of Interest Provisions

The program has specific conflict of interest provisions for organizational placement of the state and local programs and for individuals representing the program.

- Requirements underscore the importance of maximizing the long-term care ombudsman’s ability to adequately and independently represent residents on all levels.
- Ombudsmen need to speak honestly and publicly about conditions experienced by residents and the impact of actions, policies, and laws on residents.

- In addition to prohibiting any direct or indirect financial gain in the course of ombudsman duties, state conflict of interest policies include three dimensions:

  Loyalty - Judgment and objectivity is eroded if ombudsmen act as facility consultants, serve as board members of a facility or management company, work as case managers to help individuals move into facilities, or serve in a facility where they previously worked.

  Commitment - Issues of time and attention can interfere with an ombudsman's ability to respond to the needs of residents; therefore, being a voice for residents takes precedence over being a voice for a sponsoring agency.

  Control – Program independence creates a shield from administrative or political forces interfering with an ombudsman's ability to act without fear of retaliation.

Accountability

Ombudsmen hold themselves accountable and continually seek input to determine if their advocacy makes a difference for residents. The program maintains accountability through documentation and reporting of ombudsman work.

Ombudsmen must submit monthly reports to their local program office. These reports document ombudsman activities and casework on behalf of residents and serve as the basis for a statewide annual report. See Chapter 11 for details on reporting.

Summary

By law, long-term care ombudsman programs provide an independent program of advocacy services for residents and their representatives. They support volunteer services and citizen action.

Supervising staff ombudsmen and state ombudsmen are to be good managers, communicators, and negotiators. All ombudsmen strive for these characteristics:

- Accessibility
- Civility
- Humility
- Adaptability
- Courage
- Patience
- Professionalism
- Tolerance

Citizens have high expectations for long-term care ombudsman programs to fulfill their mandated responsibilities. Ombudsmen serve a unique and necessary role as resident advocates.

Supplement 1-A: Ombudsman Program Milestones

1972 To implement President Nixon's 1971 eight-point initiative to improve nursing home care, the Health Services and Mental Health Administration funded nursing home ombudsman demonstration projects in Idaho, Pennsylvania, South Carolina, Wisconsin and Michigan to "respond in a responsible and constructive way to complaints made by, or on behalf of, individual nursing home patients."

1973 Additional demonstration projects started in Massachusetts and Oregon. The Ombudsman Program transferred to the U.S. Administration on Aging (AoA).

1975 Amendments to the Older Americans Act authorized funding for state ombudsman programs.

Following an assessment of the findings and accomplishments of the seven demonstration projects, former Commissioner on Aging Arthur S. Flemming invited all State Units on Aging to submit proposals "to enable the State Agencies to develop the capabilities of the Area Agencies on Aging to promote, coordinate, monitor, and assess nursing home ombudsman activities within their services areas." All states except Nebraska and Oklahoma applied for and received one-year grants ranging from $18,000 for most states to $57,900 for New York, which was then the state with the largest elderly population. Total funding was about one million dollars.

The Texas Governor's Committee on Aging received its first grant for an ombudsman program.

1976 Dr. Flemming issued the first ombudsman program guidance, which said the program would be judged in the first year solely based on the number of community-based ombudsman programs launched and their effectiveness in receiving and resolving complaints.

In explaining this goal, he stated, "Our nation has been conducting investigations, passing new laws and issuing new regulations relative to nursing homes at a rapid rate during the past few years. All of this activity will be of little avail unless our communities organize in such a manner that new laws and new regulations deal with the individual complaints of older persons who are living in nursing homes. The individual in the nursing home is powerless. If the laws and regulations are not being applied to her or to him, they might just as well not have been passed or issued." (AoA Technical Assistance Memo 76-24)

The nationwide program relied on volunteer, rather than paid, ombudsmen.

1977 The AoA funded the National Paralegal Institute to provide the first training program for state ombudsmen, who were called "ombudsman developmental specialists."

In June, the AoA Advocacy Assistance grant program provided additional help for state ombudsman and legal services programs to focus on both individual and systems advocacy. Grants ranged from $50,000 for most states to $135,390 for California, which by then had the largest elderly population. To support the state and area agencies, AoA awarded contracts in 1979 and 1980 for 5 Bi-Regional Advocacy Assistance Resource Centers.

Older Americans Act amendments required every state to have an Ombudsman Program and specifically defined ombudsman functions and responsibilities.

1979 AoA awarded a grant to the newly formed National Citizens Coalition for Nursing Home Reform (now Consumer Voice) to promote citizen involvement to improve the quality of life for nursing home residents and strengthen linkages with the ombudsman network, including providing training and technical assistance.

1980 The Texas Nursing Home Program became operational in October.

1981 Older Americans Act amendments expanded ombudsman program coverage to include board and care homes, known as assisted living facilities in Texas. To reflect this expansion, the name Nursing Home Ombudsman changed to Long-term Care Ombudsman. Other duties remained substantially the same.

AoA issued a program instruction (AoA-PI-81-8) which provided substantial guidance and direction to the states in the implementation of the ombudsman provisions in the Older Americans Act.

1983-84 AoA issued a series of twenty-two papers, which constituted chapters of an Ombudsman Technical Assistance Manual.
The number of local programs and complaints and the amount of program funding increased substantially; and the number of state and local paid staff and volunteers increased 50% from 1982 levels.

1987 Older Americans Act amendments made substantive changes. They required states to provide:

- ombudsman access to residents and resident records;
- immunity for the good faith performance of ombudsman duties; and
- prohibitions against willful interference with official ombudsman duties and/or retaliation against an ombudsman, resident, or other individual for helping ombudsman representatives perform their duties.

1988 AoA funded the National Association of State Units on Aging (now National Association of States United for Aging and Disabilities) to operate the National Center for State Long-term Care Ombudsman Resources, in conjunction with the Consumer Voice.

1989 The 71st Texas Legislature passed state enabling legislation for the Texas Department on Aging Ombudsman Program, effective September 1, 1989.

1992 Older Americans Act amendments strengthened the ombudsman program and transferred it to a new Title VII Vulnerable Elder Rights Protection Activities, which also included:

- programs for the prevention of elder abuse, neglect, and exploitation;
- state elder rights and legal assistance development programs; and
- outreach, counseling and assistance programs.

1993 The Consumer Voice received an AoA grant to operate the National Long-term Care Ombudsman Resource Center (NORC), in conjunction with the National Association of State United for Aging and Disabilities. NORC continues to operate under the same structure and provides support to all 53 long-term care ombudsman programs.

1994 AoA regional offices conducted on-site assessments of the state ombudsman programs, issuing their reports in January 1995.

AoA held four training conferences, issued program instructions, and proposed regulations on the new Title VII. AoA also held a major symposium on coordination between Long-term Care Ombudsmen and Adult Protective Services programs and related issues.

1995 AoA implemented the National Ombudsman Reporting System (NORS) that provided substantial state and national data on ombudsman cases, complaints, and program activities.

AoA convened a task force to discuss and develop ways to document the impact of the ombudsman program. The group issued a meeting report “An Approach to Measuring the Outcomes of the Long-term Care Ombudsman Program.”

California, Florida, Illinois, New York, and Texas ombudsman programs participated in Operation Restore Trust, a federal pilot Medicare and Medicaid anti-fraud and abuse effort. For every $1 spent, $23 returned to the Medicare Trust Fund. In 1997, it expanded to all states as the Senior Medicare Patrol, which now operates separately from the Texas Long-Term Care Ombudsman Program.

2000 The Older Americans Act was reauthorized. Amendments retained and updated ombudsman provisions in Titles II, III, and VII.

2003 Over 1,000 paid ombudsmen and 8,400 volunteers provide services to the 2.8 million residents in over 63,000 facilities. For complaints handled, 32% involve resident rights, 30% resident care, and 21% quality of life.

Following 2008, work groups focused on systems advocacy and “charting the ombudsman role in a modernized long-term care system,” AoA built substantive Title VII

and ombudsman content into state plan guidance. They trained staff on Title VII programs, including the Long-term Care Ombudsman Program. In July, the National Association of State Ombudsman Programs (NASOP) released a white paper describing systems advocacy limits and restrictions placed on state ombudsmen.

Assistant Secretary on Aging Kathy Greenlee created a new position, National Director of Long-Term Care Ombudsman Programs. Assistant Secretary Greenlee hired Becky Kurtz, former Georgia State Long-term Care Ombudsman and former president of NASOP.

NASOP developed and approved aspirational standards to address all areas of program implementation. Standards align with ombudsman authority granted by the Older Americans Act.

2011 National Director of LTC Ombudsman Programs, Becky Kurtz, hired Louise Ryan, former Washington State LTC Ombudsman, as Aging Specialist for the LTC Ombudsman Program at the AOA.

2013 and 2015 The 83rd Texas Legislature granted State funds for the express purpose of long-term care ombudsmen expanding services to residents of assisted living facilities. Funding is ongoing.

Supplement 1-B: Statutory and Rule References

Texas Long-term Care Ombudsman Program

Older Americans Act

As Amended In 2006 (Public Law 109-365)

(*FEDERAL LEGISLATION*)

TITLE VII, Chapter 2
http://www.aoa.acl.gov/AoA_Programs/OAA/oaa_full.asp#_Toc153957785

Code of Federal Regulations

State Long-term Care Ombudsman Programs (February 11, 2015)

(*FEDERAL RULES)*

Title 45 - Public Welfare
Subtitle B - Regulations Relating to Public Welfare
Chapter Xiii - OFFICE OF HUMAN DEVELOPMENT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES
Subchapter C – ADMINISTRATION ON AGING, OLDER AMERICANS PROGRAMS
Part 1321 - GRANTS TO STATE AND COMMUNITY PROGRAMS ON AGING
Subpart B – State Agency Responsibilities
§1321.11 - State Agency Policies
http://www.ecfr.gov/cgi-bin/text-idx?tpl=/ecfrbrowse/Title45/45cfr1321_main_02.tpl

Part 1327 - ALLOTMENTS FOR VULNERABLE ELDER RIGHTS PROTECTION ACTIVITIES
Subpart A - State Long-Term Care Ombudsman Program
http://www.ecfr.gov/cgi-bin/text-idx?mc=true&node=20150211y1.13

Human Resources Code

(*STATE LEGISLATION*)

TITLE 6. Services for the Elderly
CHAPTER 101A. State Services for the Aging
SUBCHAPTER F. Office of Long–term Care Ombudsman (§101A.255 – §101A.264)
http://www.statutes.legis.state.tx.us/Docs/HR/htm/HR.101A.htm#F

Texas Administrative Code

(*STATE RULES*)

Implementation of Older Americans Act – Long-term Care Ombudsman Program

TITLE 40. Social Services and Assistance
PART 1. Department of Aging and Disability Services
Chapter 85. Implementation of the Older Americans Act
Subchapter A. Definitions
RULE §85.2 Definitions
Subchapter E. Long-Term Care Ombudsman Program
§85.401 Long-Term Care Ombudsman Program
http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=40&pt=1&ch=85&rl=401

Nursing Facility Requirements

TITLE 40. Social Services and Assistance
PART 1. Texas Department of Human Services
CHAPTER 19. Nursing Facility Requirements for Licensure and Medicaid Certification
Handbook: http://www.dads.state.tx.us/handbooks/nfr-lmc

Licensing Standards for Assisted Living Facilities

TITLE 40. Social Services and Assistance
PART 1. Texas Department of Human Services
CHAPTER 92. Licensing Standards for Assisted Living Facilities (92.801)
Handbook: http://www.dads.state.tx.us/handbooks/ls-alf/

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OLDER AMERICANS ACT of 1965 as Amended in 2006 (Public Law 109-365)

TITLE 42 – The Public Health and Welfare
CHAPTER 35 – Programs for Older Americans
SUBCHAPTER XI – Allotments for Vulnerable Elder Rights Protection Activities
CHAPTER 2 – Ombudsman Programs

Section 711. DEFINITIONS.

As used in this chapter:

(1) OFFICE. — The term ‘‘Office’’ means the office established in section 712(a)(1)(A).
(2) OMBUDSMAN. — The term ‘‘Ombudsman’’ means the individual described in section 712(a)(2).
(3) LOCAL OMBUDSMAN ENTITY.— The term ‘‘local Ombudsman entity’’ means an entity designated under section 712(a)(5)(A) to carry out the duties described in section 712(a)(5)(B) with respect to a planning and service area or other substate area.
(4) PROGRAM. — The term ‘‘program’’ means the State Long-Term Care Ombudsman Program established in section 712(a)(1)(B).
(5) REPRESENTATIVE. — The term ‘‘representative’’ includes an employee or volunteer who represents an entity designated under section 712(a)(5)(A) and who is individually designated by the Ombudsman.
(6) RESIDENT. — The term ‘‘resident’’ means an older individual who resides in a long-term care facility.

(42 U.S.C. 3058f)

Section 712. STATE LONG-TERM CARE OMBUDSMAN PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL. —In order to be eligible to receive an allotment under section 703 from funds appropriated under section 702 and made available to carry out this chapter, a State agency shall, in accordance with this section—
    (A) establish and operate an Office of the State Long-Term Care Ombudsman; and
    (B) carry out through the Office a State Long-Term Care Ombudsman Program.
(2) OMBUDSMAN.— The Office shall be headed by an individual, to be known as the State Long-Term Care Ombudsman, who shall be selected from among individuals with expertise and experience in the fields of long-term care and advocacy.
(3) FUNCTIONS. — The Ombudsman shall serve on a fulltime basis, and shall, personally or through representatives of the Office—
    (A) identify, investigate, and resolve complaints that—
        (i) are made by, or on behalf of, residents; and
        (ii) relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the residents (including the welfare and rights of the residents with respect to the appointment and activities of guardians and representative payees), of—
            (I) providers, or representatives of providers, of long-term care services;
            (II) public agencies; or
            (III) health and social service agencies;
    (B) provide services to assist the residents in protecting the health, safety, welfare, and rights of the residents;

(C) inform the residents about means of obtaining services provided by providers or agencies described in subparagraph (A)(ii) or services described in subparagraph (B);
(D) ensure that the residents have regular and timely access to the services provided through the Office and that the residents and complainants receive timely responses from representatives of the Office to complaints;
(E) represent the interests of the residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;
(F) provide administrative and technical assistance to entities designated under paragraph (5) to assist the entities in participating in the program;
(G)
(i) analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other governmental policies and actions, that pertain to the health, safety, welfare, and rights of the residents, with respect to the adequacy of long-term care facilities and services in the State;
(ii) recommend any changes in such laws, regulations, policies, and actions as the Office determines to be appropriate; and
(iii) facilitate public comment on the laws, regulations, policies, and actions;
(H)
(i) provide for training representatives of the Office;
(ii) promote the development of citizen organizations, to participate in the program; and
(iii) provide technical support for the development of resident and family councils to protect the well-being and rights of residents; and
(iv) carry out such other activities as the Assistant Secretary determines to be appropriate.
(4) CONTRACTS AND ARRANGEMENTS.—
(A) IN GENERAL.— Except as provided in subparagraph (B) the State agency may establish and operate the Office, and carry out the program, directly, or by contract or other arrangement with any public agency or nonprofit private organization.
(B) LICENSING AND CERTIFICATION ORGANIZATIONS; ASSOCIATIONS.— The State agency may not enter into the contract or other arrangement described in subparagraph (A) with—
(i) an agency or organization that is responsible for licensing or certifying long-term care services in the State; or
(ii) an association (or an affiliate of such an association) of long-term care facilities, or of any other residential facilities for older individuals.
(5) DESIGNATION OF LOCAL OMBUDSMAN ENTITIES AND REPRESENTATIVES. —
(A) DESIGNATION.— In carrying out the duties of the Office, the Ombudsman may designate an entity as a local Ombudsman entity, and may designate an employee or volunteer to represent the entity.
(B) DUTIES.— An individual so designated shall, in accordance with the policies and procedures established by the Office and the State agency —
(i) provide services to protect the health, safety, welfare and rights of residents;
(ii) ensure that residents in the service area of the entity have regular, timely access to representatives of the program and timely responses to complaints and requests for assistance;
(iii) identify, investigate, and resolve complaints made by or on behalf of residents that relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the residents;

(iv) represent the interests of residents before government agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;

(v) (I) review, and if necessary, comment on any existing and proposed laws, regulations, and other government policies and actions, that pertain to the rights and well-being of residents; and

(II) facilitate the ability of the public to comment on the laws, regulations, policies, and actions;

(vi) support the development of resident and family councils; and

(vii) carry out other activities that the Ombudsman determines to be appropriate.

(C) ELIGIBILITY FOR DESIGNATION.— Entities eligible to be designated as local Ombudsman entities, and individuals eligible to be designated as representatives of such entities, shall—

(i) have demonstrated capability to carry out the responsibilities of the Office;

(ii) be free of conflicts of interest and not stand to gain financially through an action or potential action brought on behalf of individuals the Ombudsman serves;

(iii) in the case of the entities, be public or nonprofit private entities; and

(iv) meet such additional requirements as the Ombudsman may specify.

(D) POLICIES AND PROCEDURES.—

(i) IN GENERAL.— The State agency shall establish, in accordance with the Office, policies and procedures for monitoring local Ombudsman entities designated to carry out the duties of the Office.

(ii) POLICIES.— In a case in which the entities are grantees, or the representatives are employees, of area agencies on aging, the State agency shall develop the policies in consultation with the area agencies on aging. The policies shall provide for participation and comment by the agencies and for resolution of concerns with respect to case activity.

(iii) CONFIDENTIALITY AND DISCLOSURE.— The State agency shall develop the policies and procedures in accordance with all provisions of this subtitle regarding confidentiality and conflict of interest.

(b) PROCEDURES FOR ACCESS.—

(1) IN GENERAL. — The State shall ensure that representatives of the Office shall have—

(A) access to long-term care facilities and residents;

(B)(i) appropriate access to review the medical and social records of a resident, if—

(I) the representative has the permission of the resident, or the legal representative of the resident; or

(II) the resident is unable to consent to the review and has no legal representative; or

(ii) access to the records as is necessary to investigate a complaint if—

(I) a legal guardian of the resident refuses to give the permission;

(II) a representative of the Office has reasonable cause to believe that the guardian is not acting in the best interests of the resident; and

(III) the representative obtains the approval of the Ombudsman;

(C) access to the administrative records, policies, and documents, to which the residents have, or the general public has access, of long-term care facilities; and

(D) access to and, on request, copies of all licensing and certification records maintained by the State with respect to long-term care facilities.

(2) PROCEDURES.— The State agency shall establish procedures to ensure the access described in paragraph (1).

(c) REPORTING SYSTEM. — The State agency shall establish a statewide uniform reporting system to —

(1) collect and analyze data relating to complaints and conditions in long-term care facilities and to residents for the purpose of identifying and resolving significant problems; and

(2) submit the data, on a regular basis, to —

(A) the agency of the State responsible for licensing or certifying long-term care facilities in the State;

(B) other State and Federal entities that the Ombudsman determines to be appropriate;

(C) the Assistant Secretary; and

(D) the National Ombudsman Resource Center established in section 202(a)(21).

(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.

(e) CONSULTATION. — In planning and operating the program, the State agency shall consider the views of area agencies on aging, older individuals, and providers of long-term care.

(f) CONFLICT OF INTEREST. — The State agency shall —

(1) ensure that no individual, or member of the immediate family of an individual, involved in the designation of the Ombudsman (whether by appointment or otherwise) or the designation of an entity designated under subsection (a)(5), is subject to a conflict of interest;

(2) ensure that no officer or employee of the Office, representative of a local Ombudsman entity, or member of the immediate family of the officer, employee, or representative, is subject to a conflict of interest;

(3) ensure that the Ombudsman —

(A) does not have a direct involvement in the licensing or certification of a long-term care facility or of a provider of a long-term care service;

(B) does not have an ownership or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility or a long-term care service;

(C) is not employed by, or participating in the management of, a long-term care facility; and

(D) does not receive, or have the right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility; and

(4) establish, and specify in writing, mechanisms to identify and remove conflicts of interest referred to in paragraphs (1) and (2), and to identify and eliminate the relationships described in subparagraphs (A) through (D) of paragraph (3), including such mechanisms as —

(A) the methods by which the State agency will examine individuals, and immediate family members, to identify the conflicts; and

(B) the actions that the State agency will require the individuals and such family members to take to remove such conflicts.

(g) LEGAL COUNSEL.— The State agency shall ensure that—

(1)(A) adequate legal counsel is available, and is able, without conflict of interest, to —

(i) provide advice and consultation needed to protect the health, safety, welfare, and rights of residents; and

(ii) assist the Ombudsman and representatives of the Office in the performance of the official duties of the Ombudsman and representatives; and

(B) legal representation is provided to any representative of the Office against whom suit or other legal action is brought or threatened to be brought in connection with the performance of the official duties of the Ombudsman or such a representative; and

(2) the Office pursues administrative, legal, and other appropriate remedies on behalf of residents.

(h) ADMINISTRATION.— The State agency shall require the Office to —

(1) prepare an annual report —

(A) describing the activities carried out by the Office in the year for which the report is prepared;

(B) containing and analyzing the data collected under subsection (c);

(C) evaluating the problems experienced by, and the complaints made by or on behalf of, residents;

(D) containing recommendations for —

(i) improving quality of the care and life of the residents; and

(ii) protecting the health, safety, welfare, and rights of the residents;

(E)(i) analyzing the success of the program including success in providing services to residents of board and care facilities and other similar adult care facilities; and

(ii) identifying barriers that prevent the optimal operation of the program; and

(F) providing policy, regulatory, and legislative recommendations to solve identified problems, to resolve the complaints, to improve the quality of care and life of residents, to protect the health, safety, welfare, and rights of residents, and to remove the barriers;

(2) analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other government policies and actions that pertain to long-term care facilities and services, and to the health, safety, welfare, and rights of residents, in the State, and recommend any changes in such laws, regulations, and policies as the Office determines to be appropriate;

(3)(A) provide such information as the Office determines to be necessary to public and private agencies, legislators, and other persons, regarding —

(i) the problems and concerns of older individuals residing in long-term care facilities; and

(ii) recommendations related to the problems and concerns; and

(B) make available to the public, and submit to the Assistant Secretary, the chief executive officer of the State, the State legislature, the State agency responsible for licensing or certifying long-term care facilities, and other appropriate governmental entities, each report prepared under paragraph (1);

(4) not later than 1 year after the date of the enactment of this title, establish procedures for the training of the representatives of the Office, including unpaid volunteers, based on model standards established by the Director of the Office of Long-Term Care Ombudsman Programs, in consultation with representatives of citizen groups, long-term care providers, and the Office, that —
   (A) specify a minimum number of hours of initial training;
   (B) specify the content of the training, including training relating to —
      (i) Federal, State, and local laws, regulations, and policies, with respect to long-term care facilities in the State;
      (ii) investigative techniques; and
      (iii) such other matters as the State determines to be appropriate; and
   (C) specify an annual number of hours of in-service training for all designated representatives;

(5) prohibit any representative of the Office (other than the Ombudsman) from carrying out any activity described in subparagraphs (A) through (G) of subsection (a)(3) unless the representative —
   (A) has received the training required under paragraph (4); and
   (B) has been approved by the Ombudsman as qualified to carry out the activity on behalf of the Office;

(6) coordinate ombudsman services with the protection and advocacy systems for individuals with developmental disabilities and mental illnesses established under —
   (A) subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000[; and
   (B) the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 et seq.);

(7) coordinate, to the greatest extent possible, ombudsman services with legal assistance provided under section 306(a)(2)(C), through adoption of memoranda of understanding and other means;

(8) coordinate services with State and local law enforcement agencies and courts of competent jurisdiction; and

(9) permit any local Ombudsman entity to carry out the responsibilities described in paragraph (1), (2), (3), (6), or (7).

(i) LIABILITY.— The State shall ensure that no representative of the Office will be liable under State law for the good faith performance of official duties.

(j) NONINTERFERENCE.— The State shall —

(1) ensure that willful interference with representatives of the Office in the performance of the official duties of the representatives (as defined by the Assistant Secretary) shall be unlawful;

(2) prohibit retaliation and reprisals by a long-term care facility or other entity with respect to any resident, employee, or other person for filing a complaint with, providing information to, or otherwise cooperating with any representative of, the Office; and

(3) provide for appropriate sanctions with respect to the interference, retaliation, and reprisals.

(42 U.S.C. 3058g)

Code of Federal Regulations

Title 45 - Public Welfare
Subtitle B - Regulations Relating to Public Welfare
Chapter Xiii - OFFICE OF HUMAN DEVELOPMENT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES
Subchapter C – ADMINISTRATION ON AGING, OLDER AMERICANS PROGRAMS

Part 1321 - GRANTS TO STATE AND COMMUNITY PROGRAMS ON AGING
Subpart B – State Agency Responsibilities

§ 1321.11 - **State agency policies.**

(b) The policies developed by the State agency shall address the manner in which the State agency will monitor the performance of all programs and activities initiated under this part for quality and effectiveness. The State Long-Term Care Ombudsman shall be responsible for monitoring the files, records and other information maintained by the Ombudsman program. Such monitoring may be conducted by a designee of the Ombudsman. Neither the Ombudsman nor a designee shall disclose identifying information of any complainant or long-term care facility resident to individuals outside of the Ombudsman program, except as otherwise specifically provided in §1327.11(e)(3) of this chapter.

Part 1327 - ALLOTMENTS FOR VULNERABLE ELDER RIGHTS PROTECTION ACTIVITIES
Subpart A - State Long-Term Care Ombudsman Program

§ 1327.1 Definitions.

The following definitions apply to this part:

Immediate family, pertaining to conflicts of interest as used in section 712 of the Act, means a member of the household or a relative with whom there is a close personal or significant financial relationship.

Office of the State Long-Term Care Ombudsman, as used in sections 711 and 712 of the Act, means the organizational unit in a State or territory which is headed by a State Long-Term Care Ombudsman.

Representatives of the Office of the State Long-Term Care Ombudsman, as used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in § 1327.19(a), whether personnel supervision is provided by the Ombudsman or his or her designees or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.

Resident representative means any of the following:

(1) An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;

(2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;

(3) Legal representative, as used in section 712 of the Act; or

(4) The court-appointed guardian or conservator of a resident.

(5) Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

State Long-Term Care Ombudsman, or Ombudsman, as used in sections 711 and 712 of the Act, means the individual who heads the Office and is responsible to personally, or through representatives of the Office, fulfill the functions, responsibilities and duties set forth in §§ 1327.13 and 1327.19.

State Long-Term Care Ombudsman program, Ombudsman program, or program, as used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.

Willful interference means actions or inactions taken by an individual in an attempt to intentionally prevent, interfere with, or attempt to impede the Ombudsman from performing any of the functions or responsibilities set forth in § 1327.13, or the Ombudsman or a representative of the Office from performing any of the duties set forth in § 1327.19.

§ 1327.11 Establishment of the Office of the State Long-Term Care Ombudsman.

(a) The Office of the State Long-Term Care Ombudsman shall be an entity which shall be headed by the State Long-Term Care Ombudsman, who shall carry out all of the functions and responsibilities set forth in § 1327.13 and shall carry out, directly and/or through local Ombudsman entities, the duties set forth in § 1327.19.

(b) The State agency shall establish the Office and, thereby carry out the Long-Term Care Ombudsman program in any of the following ways:

(1) The Office is a distinct entity, separately identifiable, and located within or connected to the State agency; or

(2) The State agency enters into a contract or other arrangement with any public agency or nonprofit organization which shall establish a separately identifiable, distinct entity as the Office.

(c) The State agency shall require that the Ombudsman serve on a full-time basis. In providing leadership and management of the Office, the functions, responsibilities, and duties, as set forth in §§ 1327.13 and 1327.19 are to constitute the entirety of the Ombudsman's work. The State agency or other agency carrying out the Office shall not require or request the Ombudsman to be responsible for leading, managing or performing the work of non-ombudsman services or programs except on a time-limited, intermittent basis.

(1) This provision does not limit the authority of the Ombudsman program to provide ombudsman services to populations other than residents of long-term care facilities so long as the appropriations under the Act are utilized to serve residents of long-term care facilities, as authorized by the Act.

(2) [Reserved]

(d) The State agency, and other entity selecting the Ombudsman, if applicable, shall ensure that the Ombudsman meets minimum qualifications which shall include, but not be limited to, demonstrated expertise in:

(1) Long-term services and supports or other direct services for older persons or individuals with disabilities;

(2) Consumer-oriented public policy advocacy;

(3) Leadership and program management skills; and

(4) Negotiation and problem resolution skills.

(e) *Policies and procedures.* Where the Ombudsman has the legal authority to do so, he or she shall establish policies and procedures, in consultation with the State agency, to carry out the Ombudsman program in accordance with the Act. Where State law does not provide the Ombudsman with legal authority to establish policies and procedures, the Ombudsman shall recommend policies and procedures to the State agency or other agency in which the Office is organizationally located, and such agency shall establish Ombudsman program policies and procedures. Where local Ombudsman entities are designated within area agencies on aging or other entities, the Ombudsman and/or appropriate agency shall develop such policies and procedures in consultation with the agencies hosting local Ombudsman entities and with representatives of the Office. The policies and procedures must address the matters within this subsection.

(1) *Program administration.* Policies and procedures regarding program administration must include, but not be limited to:

(i) A requirement that the agency in which the Office is organizationally located must not have personnel policies or practices which prohibit the Ombudsman from performing the functions and responsibilities of the Ombudsman, as set forth in § 1327.13, or from adhering to the requirements of section 712 of the Act. Nothing in this provision shall prohibit such agency from requiring that the Ombudsman, or other employees or volunteers of the Office, adhere to the personnel policies and procedures of the entity which are otherwise lawful.

(ii) A requirement that an agency hosting a local Ombudsman entity must not have personnel policies or practices which prohibit a representative of the Office from performing the duties of the Ombudsman program or from adhering to the requirements of section 712 of the Act. Nothing in this provision shall prohibit such agency from requiring that representatives of the Office adhere to the personnel policies and procedures of the host agency which are otherwise lawful.

(iii) A requirement that the Ombudsman shall monitor the performance of local Ombudsman entities which the Ombudsman has designated to carry out the duties of the Office.

(iv) A description of the process by which the agencies hosting local Ombudsman entities will coordinate with the Ombudsman in the employment or appointment of representatives of the Office.

(v) Standards to assure prompt response to complaints by the Office and/or local Ombudsman entities which prioritize abuse, neglect, exploitation and time-sensitive complaints and which consider the severity of the risk to the resident, the imminence of the threat of harm to the resident, and the opportunity for mitigating harm to the resident through provision of Ombudsman program services.

(vi) Procedures that clarify appropriate fiscal responsibilities of the local Ombudsman entity, including but not limited to clarifications regarding access to programmatic fiscal information by appropriate representatives of the Office.

(2) *Procedures for access.* Policies and procedures regarding timely access to facilities, residents, and appropriate records (regardless of format and including, upon request, copies of such records) by the Ombudsman and representatives of the Office must include, but not be limited to:

(i) Access to enter all long-term care facilities at any time during a facility's regular business hours or regular visiting hours, and at any other time when access may be required by the circumstances to be investigated;

(ii) Access to all residents to perform the functions and duties set forth in §§ 1327.13 and 1327.19;

(iii) Access to the name and contact information of the resident representative, if any, where needed to perform the functions and duties set forth in §§ 1327.13 and 1327.19;

(iv) Access to review the medical, social and other records relating to a resident, if—

(A) The resident or resident representative communicates informed consent to the access and the consent is given in writing or through the use of auxiliary aids and services;

(B) The resident or resident representative communicates informed consent orally, visually, or through the use of auxiliary aids and services, and such consent is documented contemporaneously by a representative of the Office in accordance with such procedures; and

(C) Access is necessary in order to investigate a complaint, the resident representative refuses to consent to the access, a representative of the Office has reasonable cause to believe that the resident representative is not acting in the best interests of the resident, and the representative of the Office obtains the approval of the Ombudsman;

(v) Access to the administrative records, policies, and documents, to which the residents have, or the general public has access, of long-term care facilities;

(vi) Access of the Ombudsman to, and, upon request, copies of all licensing and certification records maintained by the State with respect to long-term care facilities; and

(vii) Reaffirmation that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, 45 CFR part 160 and 45 CFR part 164, subparts A and E, does not preclude release by covered entities of resident private health information or other resident identifying information to the Ombudsman program, including but not limited to residents' medical, social, or other records, a list of resident names and room numbers, or information collected in the course of a State or Federal survey or inspection process.

(3) *Disclosure.* Policies and procedures regarding disclosure of files, records and other information maintained by the Ombudsman program must include, but not be limited to:

(i) Provision that the files, records, and information maintained by the Ombudsman program may be disclosed only at the discretion of the Ombudsman or designee of the Ombudsman for such purpose and in accordance with the criteria developed by the Ombudsman, as required by § 1327.13(e);

(ii) Prohibition of the disclosure of identifying information of any resident with respect to whom the Ombudsman program maintains files, records, or information, except as otherwise provided by § 1327.19(b)(5) through (8), unless:

(A) The resident or the resident representative communicates informed consent to the disclosure and the consent is given in writing or through the use of auxiliary aids and services;

(B) The resident or resident representative communicates informed consent orally, visually, or through the use of auxiliary aids and services and such consent is documented contemporaneously by a representative of the Office in accordance with such procedures; or

(C) The disclosure is required by court order;

(iii) Prohibition of the disclosure of identifying information of any complainant with respect to whom the Ombudsman program maintains files, records, or information, unless:

(A) The complainant communicates informed consent to the disclosure and the consent is given in writing or through the use of auxiliary aids and services;

(B) The complainant communicates informed consent orally, visually, or through the use of auxiliary aids and services and such consent is documented contemporaneously by a representative of the Office in accordance with such procedures; or

(C) The disclosure is required by court order;

(iv) Exclusion of the Ombudsman and representatives of the Office from abuse reporting requirements, including when such reporting would disclose identifying information of a complainant or resident without appropriate consent or court order, except as otherwise provided in § 1327.19(b)(5) through (8); and

(v) Adherence to the provisions of paragraph (e)(3) of this section, regardless of the source of the request for information or the source of funding for the services of the Ombudsman program, notwithstanding section 705(a)(6)(c) of the Act.

(4) *Conflicts of interest.* Policies and procedures regarding conflicts of interest must establish mechanisms to identify and remove or remedy conflicts of interest as provided in § 1327.21, including:

(i) Ensuring that no individual, or member of the immediate family of an individual, involved in the employment or appointment of the Ombudsman is subject to a conflict of interest;

(ii) Requiring that other agencies in which the Office or local Ombudsman entities are organizationally located have policies in place to prohibit the employment or appointment of an Ombudsman or representatives of the Office with a conflict that cannot be adequately removed or remedied;

(iii) Requiring that the Ombudsman take reasonable steps to refuse, suspend or remove designation of an individual who has a conflict of interest, or who has a member of the immediate family with a conflict of interest, which cannot be adequately removed or remedied;

(iv) Establishing the methods by which the Office and/or State agency will periodically review and identify conflicts of the Ombudsman and representatives of the Office; and

(v) Establishing the actions the Office and/or State agency will require the Ombudsman or representatives of the Office to take in order to remedy or remove such conflicts.

(5) *Systems advocacy.* Policies and procedures related to systems advocacy must assure that the Office is required and has sufficient authority to carry out its responsibility to analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other government policies and actions that pertain to long-term care facilities and services and to the health, safety, welfare, and rights of residents, and to recommend any changes in such laws, regulations, and policies as the Office determines to be appropriate.

(i) Such procedures must exclude the Ombudsman and representatives of the Office from any State lobbying prohibitions to the extent that such requirements are inconsistent with section 712 of the Act.

(ii) Nothing in this part shall prohibit the Ombudsman or the State agency or other agency in which the Office is organizationally located from establishing policies which promote consultation regarding the determinations of the Office related to recommended changes in laws, regulations, and policies. However, such a policy shall not require a right to review or pre-approve positions or communications of the Office.

(6) *Designation.* Policies and procedures related to designation must establish the criteria and process by which the Ombudsman shall designate and refuse, suspend or remove designation of local Ombudsman entities and representatives of the Office.

(i) Such criteria should include, but not be limited to, the authority to refuse, suspend or remove designation a local Ombudsman entity or representative of the Office in situations in which an identified conflict of interest cannot be adequately removed or remedied as set forth in § 1327.21.

(ii) [Reserved]

(7) *Grievance process.* Policies and procedures related to grievances must establish a grievance process for the receipt and review of grievances regarding the determinations or actions of the Ombudsman and representatives of the Office.

(i) Such process shall include an opportunity for reconsideration of the Ombudsman decision to refuse, suspend, or remove designation of a local Ombudsman entity or

representative of the Office. Notwithstanding the grievance process, the Ombudsman shall make the final determination to designate or to refuse, suspend, or remove designation of a local Ombudsman entity or representative of the Office.

(ii) [Reserved]

(8) *Determinations of the Office.* Policies and procedures related to the determinations of the Office must ensure that the Ombudsman, as head of the Office, shall be able to independently make determinations and establish positions of the Office, without necessarily representing the determinations or positions of the State agency or other agency in which the Office is organizationally located, regarding:

(i) Disclosure of information maintained by the Ombudsman program within the limitations set forth in section 712(d) of the Act;

(ii) Recommendations to changes in Federal, State and local laws, regulations, policies and actions pertaining to the health, safety, welfare, and rights of residents; and

(iii) Provision of information to public and private agencies, legislators, the media, and other persons, regarding the problems and concerns of residents and recommendations related to the problems and concerns.

§ 1327.13 Functions and responsibilities of the State Long-Term Care Ombudsman.

The Ombudsman, as head of the Office, shall have responsibility for the leadership and management of the Office in coordination with the State agency, and, where applicable, any other agency carrying out the Ombudsman program, as follows.

(a) *Functions.* The Ombudsman shall, personally or through representatives of the Office—

(1) Identify, investigate, and resolve complaints that—

(i) Are made by, or on behalf of, residents; and

(ii) Relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of residents (including the welfare and rights of residents with respect to the appointment and activities of resident representatives) of—

(A) Providers, or representatives of providers, of long-term care;

(B) Public agencies; or

(C) Health and social service agencies.

(2) Provide services to protect the health, safety, welfare, and rights of the residents;

(3) Inform residents about means of obtaining services provided by the Ombudsman program;

(4) Ensure that residents have regular and timely access to the services provided through the Ombudsman program and that residents and complainants receive timely responses from representatives of the Office to requests for information and complaints;

(5) Represent the interests of residents before governmental agencies, assure that individual residents have access to, and pursue (as the Ombudsman determines as necessary and consistent with resident interests) administrative, legal, and other remedies to protect the health, safety, welfare, and rights of residents;

(6) Provide administrative and technical assistance to representatives of the Office and agencies hosting local Ombudsman entities;

(7)(i) Analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other governmental policies and actions, that pertain to the health, safety, welfare, and rights of the residents, with respect to the adequacy of long-term care facilities and services in the State;

(ii) Recommend any changes in such laws, regulations, policies, and actions as the Office determines to be appropriate; and

(iii) Facilitate public comment on the laws, regulations, policies, and actions;

(iv) Provide leadership to statewide systems advocacy efforts of the Office on behalf of long-term care facility residents, including coordination of systems advocacy efforts carried out by representatives of the Office; and

(v) Provide information to public and private agencies, legislators, the media, and other persons, regarding the problems and concerns of residents and recommendations related to the problems and concerns.

(vi) Such determinations and positions shall be those of the Office and shall not necessarily represent the determinations or positions of the State agency or other agency in which the Office is organizationally located.

(vii) In carrying out systems advocacy efforts of the Office on behalf of long-term care facility residents and pursuant to the receipt of grant funds under the Act, the provision of information, recommendations of changes of laws to legislators, and recommendations of changes of regulations and policies to government agencies by the Ombudsman or representatives of the Office do not constitute lobbying activities as defined by 45 CFR part 93.

(8) Coordinate with and promote the development of citizen organizations consistent with the interests of residents; and

(9) Promote, provide technical support for the development of, and provide ongoing support as requested by resident and family councils to protect the well-being and rights of residents; and

(b) The Ombudsman shall be the head of a unified statewide program and shall:

(1) Establish or recommend policies, procedures and standards for administration of the Ombudsman program pursuant to § 1327.11(e);

(2) Require representatives of the Office to fulfill the duties set forth in § 1327.19 in accordance with Ombudsman program policies and procedures.

(c) *Designation.* The Ombudsman shall determine designation, and refusal, suspension, or removal of designation, of local Ombudsman entities and representatives of the Office pursuant to section 712(a)(5) of the Act and the policies and procedures set forth in § 1327.11(e)(6).

(1) Where an Ombudsman chooses to designate local Ombudsman entities, the Ombudsman shall:

(i) Designate local Ombudsman entities to be organizationally located within public or non-profit private entities;

(ii) Review and approve plans or contracts governing local Ombudsman entity operations, including, where applicable, through area agency on aging plans, in coordination with the State agency; and

(iii) Monitor, on a regular basis, the Ombudsman program performance of local Ombudsman entities.

(2) *Training requirements.* The Ombudsman shall establish procedures for training for certification and continuing education of the representatives of the Office, based on model standards established by the Director of the Office of Long-Term Care Ombudsman Programs as described in section 201(d) of the Act, in consultation with residents, resident representatives, citizen organizations, long-term care providers, and the State agency, that—

(i) Specify a minimum number of hours of initial training;

(ii) Specify the content of the training, including training relating to Federal, State, and local laws, regulations, and policies, with respect to long-term care facilities in the State; investigative and resolution techniques; and such other matters as the Office determines to be appropriate; and

(iii) Specify an annual number of hours of in-service training for all representatives of the Office;

(3) Prohibit any representative of the Office from carrying out the duties described in § 1327.19 unless the representative—

(i) Has received the training required under paragraph (c)(2) of this section or is performing such duties under supervision of the Ombudsman or a designated representative of the Office as part of certification training requirements; and

(ii) Has been approved by the Ombudsman as qualified to carry out the activity on behalf of the Office;

(4) The Ombudsman shall investigate allegations of misconduct by representatives of the Office in the performance of Ombudsman program duties and, as applicable, coordinate such investigations with the State agency in which the Office is organizationally located, agency hosting the local Ombudsman entity and/or the local Ombudsman entity.

(5) Policies, procedures, or practices which the Ombudsman determines to be in conflict with the laws, policies, or procedures governing the Ombudsman program shall be sufficient grounds for refusal, suspension, or removal of designation of the representative of the Office and/or the local Ombudsman entity.

(d) *Ombudsman program information.* The Ombudsman shall manage the files, records, and other information of the Ombudsman program, whether in physical, electronic, or other formats, including information maintained by representatives of the Office and local Ombudsman entities pertaining to the cases and activities of the Ombudsman program. Such files, records, and other information are the property of the Office. Nothing in this provision shall prohibit a representative of the Office or a local Ombudsman entity from maintaining such information in accordance with Ombudsman program requirements.

(e) *Disclosure.* In making determinations regarding the disclosure of files, records and other information maintained by the Ombudsman program, the Ombudsman shall:

(1) Have the sole authority to make or delegate determinations concerning the disclosure of the files, records, and other information maintained by the Ombudsman program. The Ombudsman shall comply with section 712(d) of the Act in responding to requests for disclosure of files, records, and other information, regardless of the format of such file, record, or other information, the source of the request, and the sources of funding to the Ombudsman program;

(2) Develop and adhere to criteria to guide the Ombudsman's discretion in determining whether to disclose the files, records or other information of the Office; and

(3) Develop and adhere to a process for the appropriate disclosure of information maintained by the Office, including:

(i) Classification of at least the following types of files, records, and information: medical, social and other records of residents; administrative records, policies, and documents of long-term care facilities; licensing and certification records maintained by the State with respect to long-term care facilities; and data collected in the Ombudsman program reporting system; and

(ii) Identification of the appropriate individual designee or category of designee, if other than the Ombudsman, authorized to determine the disclosure of specific categories of information in accordance with the criteria described in paragraph (e) of this section.

(f) *Fiscal management.* The Ombudsman shall determine the use of the fiscal resources appropriated or otherwise available for the operation of the Office. Where local Ombudsman entities are designated, the Ombudsman shall approve the allocations of Federal and State funds provided to such entities, subject to applicable Federal and State laws and policies. The Ombudsman shall determine that program budgets and expenditures of the Office and local Ombudsman entities are consistent with laws, policies and procedures governing the Ombudsman program.

(g) *Annual report.* The Ombudsman shall independently develop and provide final approval of an annual report as set forth in section 712(h)(1) of the Act and as otherwise required by the Assistant Secretary.

(1) Such report shall:

(i) Describe the activities carried out by the Office in the year for which the report is prepared;

(ii) Contain analysis of Ombudsman program data;

(iii) Describe evaluation of the problems experienced by, and the complaints made by or on behalf of, residents;

(iv) Contain policy, regulatory, and/or legislative recommendations for improving quality of the care and life of the residents; protecting the health, safety, welfare, and rights of the residents; and resolving resident complaints and identified problems or barriers;

(v) Contain analysis of the success of the Ombudsman program, including success in providing services to residents of, assisted living, board and care facilities and other similar adult care facilities; and

(vi) Describe barriers that prevent the optimal operation of the Ombudsman program.

(2) The Ombudsman shall make such report available to the public and submit it to the Assistant Secretary, the chief executive officer of the State, the State legislature, the State agency responsible for licensing or certifying long-term care facilities, and other appropriate governmental entities.

(h) Through adoption of memoranda of understanding and other means, the Ombudsman shall lead state-level coordination, and support appropriate local Ombudsman entity coordination, between the Ombudsman program and other entities with responsibilities relevant to the health, safety, well-being or rights of residents of long-term care facilities including, but not limited to:

(1) Area agency on aging programs;

(2) Aging and disability resource centers;

(3) Adult protective services programs;

(4) Protection and advocacy systems, as designated by the State, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 *et seq.*);

(5) Facility and long-term care provider licensure and certification programs;

(6) The State Medicaid fraud control unit, as defined in section 1903(q) of the Social Security Act (42 U.S.C. 1396b(q));

(7) Victim assistance programs;

(8) State and local law enforcement agencies;

(9) Courts of competent jurisdiction; and

(10) The State legal assistance developer and legal assistance programs, including those provided under section 306(a)(2)(C) of the Act.

(i) The Ombudsman shall carry out such other activities as the Assistant Secretary determines to be appropriate.

§ 1327.15 State agency responsibilities related to the Ombudsman program.

(a) In addition to the responsibilities set forth in part 1321 of this chapter, the State agency shall ensure that the Ombudsman complies with the relevant provisions of the Act and of this rule.

(b) The State agency shall ensure, through the development of policies, procedures, and other means, consistent with § 1327.11(e)(2), that the Ombudsman program has

sufficient authority and access to facilities, residents, and information needed to fully perform all of the functions, responsibilities, and duties of the Office.

(c) The State agency shall provide opportunities for training for the Ombudsman and representatives of the Office in order to maintain expertise to serve as effective advocates for residents. The State agency may utilize funds appropriated under Title III and/or Title VII of the Act designated for direct services in order to provide access to such training opportunities.

(d) The State agency shall provide personnel supervision and management for the Ombudsman and representatives of the Office who are employees of the State agency. Such management shall include an assessment of whether the Office is performing all of its functions under the Act.

(e) The State agency shall provide monitoring, as required by § 1321.11(b) of this chapter, including but not limited to fiscal monitoring, where the Office and/or local Ombudsman entity is organizationally located within an agency under contract or other arrangement with the State agency. Such monitoring shall include an assessment of whether the Ombudsman program is performing all of the functions, responsibilities and duties set forth in §§ 1327.13 and 1327.19. The State agency may make reasonable requests of reports, including aggregated data regarding Ombudsman program activities, to meet the requirements of this provision.

(f) The State agency shall ensure that any review of files, records or other information maintained by the Ombudsman program is consistent with the disclosure limitations set forth in §§ 1327.11(e)(3) and 1327.13(e).

(g) The State agency shall integrate the goals and objectives of the Office into the State plan and coordinate the goals and objectives of the Office with those of other programs established under Title VII of the Act and other State elder rights, disability rights, and elder justice programs, including, but not limited to, legal assistance programs provided under section 306(a)(2)(C) of the Act, to promote collaborative efforts and diminish duplicative efforts. Where applicable, the State agency shall require inclusion of goals and objectives of local Ombudsman entities into area plans on aging.

(h) The State agency shall provide elder rights leadership. In so doing, it shall require the coordination of Ombudsman program services with, the activities of other programs authorized by Title VII of the Act as well as other State and local entities with responsibilities relevant to the health, safety, well-being or rights of older adults, including residents of long-term care facilities as set forth in § 1327.13(h).

(i) *Interference, retaliation and reprisals.* The State agency shall:

(1) Ensure that it has mechanisms to prohibit and investigate allegations of interference, retaliation and reprisals:

(i) by a long-term care facility, other entity, or individual with respect to any resident, employee, or other person for filing a complaint with, providing information to, or otherwise cooperating with any representative of the Office; or

(ii) by a long-term care facility, other entity or individual against the Ombudsman or representatives of the Office for fulfillment of the functions, responsibilities, or duties enumerated at §§ 1327.13 and 1327.19; and

(2) Provide for appropriate sanctions with respect to interference, retaliation and reprisals.

(j) *Legal counsel.* (1) The State agency shall ensure that:

(i) Legal counsel for the Ombudsman program is adequate, available, has competencies relevant to the legal needs of the program and of residents, and is without conflict of interest (as defined by the State ethical standards governing the legal profession), in order to—

(A) Provide consultation and representation as needed in order for the Ombudsman program to protect the health, safety, welfare, and rights of residents; and

(B) Provide consultation and/or representation as needed to assist the Ombudsman and representatives of the Office in the performance of their official functions, responsibilities, and duties, including, but not limited to, complaint resolution and systems advocacy;

(ii) The Ombudsman and representatives of the Office assist residents in seeking administrative, legal, and other appropriate remedies. In so doing, the Ombudsman shall coordinate with the legal services developer, legal services providers, and victim assistance services to promote the availability of legal counsel to residents; and

(iii) Legal representation, arranged by or with the approval of the Ombudsman, is provided to the Ombudsman or any representative of the Office against whom suit or other legal action is brought or threatened to be brought in connection with the performance of the official duties.

(2) Such legal counsel may be provided by one or more entities, depending on the nature of the competencies and services needed and as necessary to avoid conflicts of interest (as defined by the State ethical standards governing the legal profession). However, at a minimum, the Office shall have access to an attorney knowledgeable about the Federal and State laws protecting the rights of residents and governing long-term care facilities.

(3) Legal representation of the Ombudsman program by the Ombudsman or representative of the Office who is a licensed attorney shall not by itself constitute sufficiently adequate legal counsel.

(4) The communications between the Ombudsman and legal counsel are subject to attorney-client privilege.

(k) The State agency shall require the Office to:

(1) Develop and provide final approval of an annual report as set forth in section 712(h)(1) of the Act and § 1327.13(g) and as otherwise required by the Assistant Secretary.

(2) Analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other government policies and actions that pertain to long-term care facilities and services, and to the health, safety, welfare, and rights of residents, in the State, and recommend any changes in such laws, regulations, and policies as the Office determines to be appropriate;

(3) Provide such information as the Office determines to be necessary to public and private agencies, legislators, the media, and other persons, regarding the problems and concerns of individuals residing in long-term care facilities; and recommendations related to such problems and concerns; and

(4) Establish procedures for the training of the representatives of the Office, as set forth in § 1327.13(c)(2).

(5) Coordinate Ombudsman program services with entities with responsibilities relevant to the health, safety, welfare, and rights of residents of long-term care facilities, as set forth in § 1327.13(h).

§ 1327.17 Responsibilities of agencies hosting local Ombudsman entities.

(a) The agency in which a local Ombudsman entity is organizationally located shall be responsible for the personnel management, but not the programmatic oversight, of representatives, including employee and volunteer representatives, of the Office.

(b) The agency in which a local Ombudsman entity is organizationally located shall not have personnel policies or practices which prohibit the representatives of the Office from performing the duties, or from adhering to the access, confidentiality and disclosure requirements of section 712 of the Act, as implemented through this rule and the policies and procedures of the Office.

(1) Policies, procedures and practices, including personnel management practices of the host agency, which the Ombudsman determines conflict with the laws or policies governing the Ombudsman program shall be sufficient grounds for the refusal, suspension, or removal of the designation of local Ombudsman entity by the Ombudsman.

(2) Nothing in this provision shall prohibit the host agency from requiring that the representatives of the Office adhere to the personnel policies and procedures of the agency which are otherwise lawful.

§ 1327.19 Duties of the representatives of the Office.

In carrying out the duties of the Office, the Ombudsman may designate an entity as a local Ombudsman entity and may designate an employee or volunteer of the local Ombudsman entity as a representative of the Office. Representatives of the Office may also be designated employees or volunteers within the Office.

(a) *Duties.* An individual so designated as a representative of the Office shall, in accordance with the policies and procedures established by the Office and the State agency:

(1) Identify, investigate, and resolve complaints made by or on behalf of residents that relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the residents;

(2) Provide services to protect the health, safety, welfare, and rights of residents;

(3) Ensure that residents in the service area of the local Ombudsman entity have regular and timely access to the services provided through the Ombudsman program and that residents and complainants receive timely responses to requests for information and complaints;

(4) Represent the interests of residents before government agencies and assure that individual residents have access to, and pursue (as the representative of the Office determines necessary and consistent with resident interest) administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;

(5)(i) Review, and if necessary, comment on any existing and proposed laws, regulations, and other government policies and actions, that pertain to the rights and well-being of residents; and

(ii) Facilitate the ability of the public to comment on the laws, regulations, policies, and actions;

(6) Promote, provide technical support for the development of, and provide ongoing support as requested by resident and family councils; and

(7) Carry out other activities that the Ombudsman determines to be appropriate.

(b) *Complaint processing.* (1) With respect to identifying, investigating and resolving complaints, and regardless of the source of the complaint (*i.e.* complainant), the Ombudsman and the representatives of the Office serve the resident of a long-term

care facility. The Ombudsman or representative of the Office shall investigate a complaint, including but not limited to a complaint related to abuse, neglect, or exploitation, for the purposes of resolving the complaint to the resident's satisfaction and of protecting the health, welfare, and rights of the resident. The Ombudsman or representative of the Office may identify, investigate and resolve a complaint impacting multiple residents or all residents of a facility.

(2) Regardless of the source of the complaint (*i.e.* the complainant), including when the source is the Ombudsman or representative of the Office, the Ombudsman or representative of the Office must support and maximize resident participation in the process of resolving the complaint as follows:

(i) The Ombudsman or representative of Office shall offer privacy to the resident for the purpose of confidentially providing information and hearing, investigating and resolving complaints.

(ii) The Ombudsman or representative of the Office shall personally discuss the complaint with the resident (and, if the resident is unable to communicate informed consent, the resident's representative) in order to:

(A) Determine the perspective of the resident (or resident representative, where applicable) of the complaint;

(B) Request the resident (or resident representative, where applicable) to communicate informed consent in order to investigate the complaint;

(C) Determine the wishes of the resident (or resident representative, where applicable) with respect to resolution of the complaint, including whether the allegations are to be reported and, if so, whether Ombudsman or representative of the Office may disclose resident identifying information or other relevant information to the facility and/or appropriate agencies. Such report and disclosure shall be consistent with paragraph (b)(3) of this section;

(D) Advise the resident (and resident representative, where applicable) of the resident's rights;

(E) Work with the resident (or resident representative, where applicable) to develop a plan of action for resolution of the complaint;

(F) Investigate the complaint to determine whether the complaint can be verified; and

(G) Determine whether the complaint is resolved to the satisfaction of the resident (or resident representative, where applicable).

(iii) Where the resident is unable to communicate informed consent, and has no resident representative, the Ombudsman or representative of the Office shall:

(A) Take appropriate steps to investigate and work to resolve the complaint in order to protect the health, safety, welfare and rights of the resident; and

(B) Determine whether the complaint was resolved to the satisfaction of the complainant.

(iv) In determining whether to rely upon a resident representative to communicate or make determinations on behalf of the resident related to complaint processing, the Ombudsman or representative of the Office shall ascertain the extent of the authority that has been granted to the resident representative under court order (in the case of a guardian or conservator), by power of attorney or other document by which the resident has granted authority to the representative, or under other applicable State or Federal law.

(3) The Ombudsman or representative of the Office may provide information regarding the complaint to another agency in order for such agency to substantiate the facts for regulatory, protective services, law enforcement, or other purposes so long as the Ombudsman or representative of the Office adheres to the disclosure requirements of section 712(d) of the Act and the procedures set forth in § 1327.11(e)(3).

(i) Where the goals of a resident or resident representative are for regulatory, protective services or law enforcement action, and the Ombudsman or representative of the Office determines that the resident or resident representative has communicated informed consent to the Office, the Office must assist the resident or resident representative in contacting the appropriate agency and/or disclose the information for which the resident has provided consent to the appropriate agency for such purposes.

(ii) Where the goals of a resident or resident representative can be served by disclosing information to a facility representative and/or referrals to an entity other than those referenced in paragraph (b)(3)(i) of this section, and the Ombudsman or representative of the Office determines that the resident or resident representative has communicated informed consent to the Ombudsman program, the Ombudsman or representative of the Office may assist the resident or resident representative in contacting the appropriate facility representative or the entity, provide information on how a resident or representative may obtain contact information of such facility representatives or entities, and/or disclose the information for which the resident has provided consent to an appropriate facility representative or entity, consistent with Ombudsman program procedures.

(iii) In order to comply with the wishes of the resident, (or, in the case where the resident is unable to communicate informed consent, the wishes of the resident representative), the Ombudsman and representatives of the Office shall not report suspected abuse, neglect or exploitation of a resident when a resident or resident representative has not communicated informed consent to such report except as set forth in paragraphs (b)(5) through (7) of this section, notwithstanding State laws to the contrary.

(4) For purposes of paragraphs (b)(1) through (3) of this section, communication of informed consent may be made in writing, including through the use of auxiliary aids and services. Alternatively, communication may be made orally or visually, including through the use of auxiliary aids and services, and such consent must be documented contemporaneously by the Ombudsman or a representative of the Office, in accordance with the procedures of the Office;

(5) For purposes of paragraphs (b)(1) paragraph (3) of this section, if a resident is unable to communicate his or her informed consent, or perspective on the extent to which the matter has been satisfactorily resolved, the Ombudsman or representative of the Office may rely on the communication of informed consent and/or perspective regarding the resolution of the complaint of a resident representative so long as the Ombudsman or representative of the Office has no reasonable cause to believe that the resident representative is not acting in the best interests of the resident.

(6) For purposes of paragraphs (b)(1) through (3) of this section, the procedures for disclosure, as required by § 1327.11(e)(3), shall provide that the Ombudsman or representative of the Office may refer the matter and disclose resident-identifying information to the appropriate agency or agencies for regulatory oversight; protective services; access to administrative, legal, or other remedies; and/or law enforcement action in the following circumstances:

(i) The resident is unable to communicate informed consent to the Ombudsman or representative of the Office;

(ii) The resident has no resident representative;

(iii) The Ombudsman or representative of the Office has reasonable cause to believe that an action, inaction or decision may adversely affect the health, safety, welfare, or rights of the resident;

(iv) The Ombudsman or representative of the Office has no evidence indicating that the resident would not wish a referral to be made;

(v) The Ombudsman or representative of the Office has reasonable cause to believe that it is in the best interest of the resident to make a referral; and

(vi) The representative of the Office obtains the approval of the Ombudsman or otherwise follows the policies and procedures of the Office described in paragraph (b)(9) of this section.

(7) For purposes of paragraphs (b)(1) through (3) of this section, the procedures for disclosure, as required by § 1327.11(e)(3), shall provide that, the Ombudsman or representative of the Office may refer the matter and disclose resident-identifying information to the appropriate agency or agencies for regulatory oversight; protective

services; access to administrative, legal, or other remedies; and/or law enforcement action in the following circumstances:

(i) The resident is unable to communicate informed consent to the Ombudsman or representative of the Office and has no resident representative, or the Ombudsman or representative of the Office has reasonable cause to believe that the resident representative has taken an action, inaction or decision that may adversely affect the health, safety, welfare, or rights of the resident;

(ii) The Ombudsman or representative of the Office has no evidence indicating that the resident would not wish a referral to be made;

(iii) The Ombudsman or representative of the Office has reasonable cause to believe that it is in the best interest of the resident to make a referral; and

(iv) The representative of the Ombudsman obtains the approval of the Ombudsman.

(8) The procedures for disclosure, as required by § 1327.11(e)(3), shall provide that, if the Ombudsman or representative of the Office personally witnesses suspected abuse, gross neglect, or exploitation of a resident, the Ombudsman or representative of the Office shall seek communication of informed consent from such resident to disclose resident-identifying information to appropriate agencies;

(i) Where such resident is able to communicate informed consent, or has a resident representative available to provide informed consent, the Ombudsman or representative of the Office shall follow the direction of the resident or resident representative as set forth paragraphs (b)(1) through (3) of this section; and

(ii) Where the resident is unable to communicate informed consent, and has no resident representative available to provide informed consent, the Ombudsman or representative of the Office shall open a case with the Ombudsman or representative of the Office as the complainant, follow the Ombudsman program's complaint resolution procedures, and shall refer the matter and disclose identifying information of the resident to the management of the facility in which the resident resides and/or to the appropriate agency or agencies for substantiation of abuse, gross neglect or exploitation in the following circumstances:

(A) The Ombudsman or representative of the Office has no evidence indicating that the resident would not wish a referral to be made;

(B) The Ombudsman or representative of the Office has reasonable cause to believe that disclosure would be in the best interest of the resident; and

(C) The representative of the Office obtains the approval of the Ombudsman or otherwise follows the policies and procedures of the Office described in paragraph (b)(9) of this section.

(iii) In addition, the Ombudsman or representative of the Office, following the policies and procedures of the Office described in paragraph (b)(9) of this section, may report the suspected abuse, gross neglect, or exploitation to other appropriate agencies for regulatory oversight; protective services; access to administrative, legal, or other remedies; and/or law enforcement action.

(9) Prior to disclosing resident-identifying information pursuant to paragraph (b)(6) or (8) of this section, a representative of the Office must obtain approval by the Ombudsman or, alternatively, follow policies and procedures of the Office which provide for such disclosure.

(i) Where the policies and procedures require Ombudsman approval, they shall include a time frame in which the Ombudsman is required to communicate approval or disapproval in order to assure that the representative of the Office has the ability to promptly take actions to protect the health, safety, welfare or rights of residents.

(ii) Where the policies and procedures do not require Ombudsman approval prior to disclosure, they shall require that the representative of the Office promptly notify the Ombudsman of any disclosure of resident-identifying information under the circumstances set forth in paragraph (b)(6) or (8) of this section.

(iii) Disclosure of resident-identifying information under paragraph (b)(7) of this section shall require Ombudsman approval.

§ 1327.21 Conflicts of interest.

The State agency and the Ombudsman shall consider both the organizational and individual conflicts of interest that may impact the effectiveness and credibility of the work of the Office. In so doing, both the State agency and the Ombudsman shall be responsible to identify actual and potential conflicts and, where a conflict has been identified, to remove or remedy such conflict as set forth in paragraphs (b) and (d) of this section.

(a) *Identification of organizational conflicts.* In identifying conflicts of interest pursuant to section 712(f) of the Act, the State agency and the Ombudsman shall consider the organizational conflicts that may impact the effectiveness and credibility of the work of the Office. Organizational conflicts of interest include, but are not limited to, placement of the Office, or requiring that an Ombudsman or representative of the Office perform conflicting activities, in an organization that:

(1) Is responsible for licensing, surveying, or certifying long-term care facilities;

(2) Is an association (or an affiliate of such an association) of long-term care facilities, or of any other residential facilities for older individuals or individuals with disabilities;

(3) Has any ownership or investment interest (represented by equity, debt, or other financial relationship) in, or receives grants or donations from, a long-term care facility;

(4) Has governing board members with any ownership, investment or employment interest in long-term care facilities;

(5) Provides long-term care to residents of long-term care facilities, including the provision of personnel for long-term care facilities or the operation of programs which control access to or services for long-term care facilities;

(6) Provides long-term care coordination or case management for residents of long-term care facilities;

(7) Sets reimbursement rates for long-term care facilities;

(8) Provides adult protective services;

(9) Is responsible for eligibility determinations regarding Medicaid or other public benefits for residents of long-term care facilities;

(10) Conducts preadmission screening for long-term care facility placements;

(11) Makes decisions regarding admission or discharge of individuals to or from long-term care facilities; or

(12) Provides guardianship, conservatorship or other fiduciary or surrogate decision-making services for residents of long-term care facilities.

(b) *Removing or remedying organizational conflicts.* The State agency and the Ombudsman shall identify and take steps to remove or remedy conflicts of interest between the Office and the State agency or other agency carrying out the Ombudsman program.

(1) The Ombudsman shall identify organizational conflicts of interest in the Ombudsman program and describe steps taken to remove or remedy conflicts within the annual report submitted to the Assistant Secretary through the National Ombudsman Reporting System.

(2) Where the Office is located within or otherwise organizationally attached to the State agency, the State agency shall:

(i) Take reasonable steps to avoid internal conflicts of interest;

(ii) Establish a process for review and identification of internal conflicts;

(iii) Take steps to remove or remedy conflicts;

(iv) Ensure that no individual, or member of the immediate family of an individual, involved in the designating, appointing, otherwise selecting or terminating the Ombudsman is subject to a conflict of interest; and

(v) Assure that the Ombudsman has disclosed such conflicts and described steps taken to remove or remedy conflicts within the annual report submitted to the Assistant Secretary through the National Ombudsman Reporting System.

(3) Where a State agency is unable to adequately remove or remedy a conflict, it shall carry out the Ombudsman program by contract or other arrangement with a public agency or nonprofit private organization, pursuant to section 712(a)(4) of the Act. The State agency may not enter into a contract or other arrangement to carry out the Ombudsman program if the other entity, and may not operate the Office directly if it:

(i) Is responsible for licensing, surveying, or certifying long-term care facilities;

(ii) Is an association (or an affiliate of such an association) of long-term care facilities, or of any other residential facilities for older individuals or individuals with disabilities; or

(iii) Has any ownership, operational, or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility.

(4) Where the State agency carries out the Ombudsman program by contract or other arrangement with a public agency or nonprofit private organization, pursuant to section 712(a)(4) of the Act, the State agency shall:

(i) Prior to contracting or making another arrangement, take reasonable steps to avoid conflicts of interest in such agency or organization which is to carry out the Ombudsman program and to avoid conflicts of interest in the State agency's oversight of the contract or arrangement;

(ii) Establish a process for periodic review and identification of conflicts;

(iii) Establish criteria for approval of steps taken by the agency or organization to remedy or remove conflicts;

(iv) Require that such agency or organization have a process in place to:

(A) Take reasonable steps to avoid conflicts of interest, and

(B) Disclose identified conflicts and steps taken to remove or remedy conflicts to the State agency for review and approval.

(5) Where an agency or organization carrying out the Ombudsman program by contract or other arrangement develops a conflict and is unable to adequately remove or remedy a conflict, the State agency shall either operate the Ombudsman program directly or by

contract or other arrangement with another public agency or nonprofit private organization. The State agency shall not enter into such contract or other arrangement with an agency or organization which is responsible for licensing or certifying long-term care facilities in the state or is an association (or affiliate of such an association) of long-term care facilities.

(6) Where local Ombudsman entities provide Ombudsman services, the Ombudsman shall:

(i) Prior to designating or renewing designation, take reasonable steps to avoid conflicts of interest in any agency which may host a local Ombudsman entity.

(ii) Establish a process for periodic review and identification of conflicts of interest with the local Ombudsman entity in any agencies hosting a local Ombudsman entity,

(iii) Require that such agencies disclose identified conflicts of interest with the local Ombudsman entity and steps taken to remove or remedy conflicts within such agency to the Ombudsman,

(iv) Establish criteria for approval of steps taken to remedy or remove conflicts in such agencies, and

(v) Establish a process for review of and criteria for approval of plans to remove or remedy conflicts with the local Ombudsman entity in such agencies.

(7) Failure of an agency hosting a local Ombudsman entity to disclose a conflict to the Office or inability to adequately remove or remedy a conflict shall constitute grounds for refusal, suspension or removal of designation of the local Ombudsman entity by the Ombudsman.

(c) *Identifying individual conflicts of interest.* (1) In identifying conflicts of interest pursuant to section 712(f) of the Act, the State agency and the Ombudsman shall consider individual conflicts that may impact the effectiveness and credibility of the work of the Office.

(2) Individual conflicts of interest for an Ombudsman, representatives of the Office, and members of their immediate family include, but are not limited to:

(i) Direct involvement in the licensing or certification of a long-term care facility;

(ii) Ownership, operational, or investment interest (represented by equity, debt, or other financial relationship) in an existing or proposed long-term care facility;

(iii) Employment of an individual by, or participation in the management of, a long-term care facility in the service area or by the owner or operator of any long-term care facility in the service area;

(iv) Receipt of, or right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility;

(v) Accepting gifts or gratuities of significant value from a long-term care facility or its management, a resident or a resident representative of a long-term care facility in which the Ombudsman or representative of the Office provides services (except where there is a personal relationship with a resident or resident representative which is separate from the individual's role as Ombudsman or representative of the Office);

(vi) Accepting money or any other consideration from anyone other than the Office, or an entity approved by the Ombudsman, for the performance of an act in the regular course of the duties of the Ombudsman or the representatives of the Office without Ombudsman approval;

(vii) Serving as guardian, conservator or in another fiduciary or surrogate decision-making capacity for a resident of a long-term care facility in which the Ombudsman or representative of the Office provides services; and

(viii) Serving residents of a facility in which an immediate family member resides.

(d) *Removing or remedying individual conflicts.* (1) The State agency or Ombudsman shall develop and implement policies and procedures, pursuant to § 1327.11(e)(4), to ensure that no Ombudsman or representatives of the Office are required or permitted to hold positions or perform duties that would constitute a conflict of interest as set forth in § 1327.21(c). This rule does not prohibit a State agency or Ombudsman from having policies or procedures that exceed these requirements.

(2) When considering the employment or appointment of an individual as the Ombudsman or as a representative of the Office, the State agency or other employing or appointing entity shall:

(i) Take reasonable steps to avoid employing or appointing an individual who has an unremedied conflict of interest or who has a member of the immediate family with an unremedied conflict of interest;

(ii) Take reasonable steps to avoid assigning an individual to perform duties which would constitute an unremedied conflict of interest;

(iii) Establish a process for periodic review and identification of conflicts of the Ombudsman and representatives of the Office, and

(iv) Take steps to remove or remedy conflicts.

(3) In no circumstance shall the entity, which appoints or employs the Ombudsman, appoint or employ an individual as the Ombudsman who:

(i) Has direct involvement in the licensing or certification of a long-term care facility;

(ii) Has an ownership or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility. Divestment within a reasonable period may be considered an adequate remedy to this conflict;

(iii) Has been employed by or participating in the management of a long-term care facility within the previous twelve months.

(iv) Receives, or has the right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility.

(4) In no circumstance shall the State agency, other agency which carries out the Office, or an agency hosting a local Ombudsman entity appoint or employ an individual, nor shall the Ombudsman designate an individual, as a representative of the Office who:

(i) Has direct involvement in the licensing or certification of a long-term care facility;

(ii) Has an ownership or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility. Divestment within a reasonable period may be considered an adequate remedy to this conflict;

(iii) Receives, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility; or

(iv) Is employed by, or participating in the management of, a long-term care facility.

(A) An agency which appoints or employs representatives of the Office shall make efforts to avoid appointing or employing an individual as a representative of the Office who has been employed by or participating in the management of a long-term care facility within the previous twelve months.

(B) Where such individual is appointed or employed, the agency shall take steps to remedy the conflict.

Subpart B—[Reserved]

HUMAN RESOURCES CODE
TITLE 6 - Services for the Elderly
CHAPTER 101A – State Services for the Aging
SUBCHAPTER F – Office of Long-Term Care Ombudsman

Sec. 101A.251. DEFINITIONS. In this subchapter:

(1) "Elderly resident" means a resident of a long-term care facility who is 60 years of age or older.

(2) "Long-term care facility" means a facility that serves persons who are 60 years of age or older and that is licensed or regulated or that is required to be licensed or regulated by the department under Chapter 242 or 247, Health and Safety Code.

(3) "Office" means the office of the state long-term care ombudsman.

(4) "Representative" means an employee or volunteer specifically designated by the office as a representative of the office.

(5) "State ombudsman" means the chief administrator of the office.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

Sec. 101A.252. OPERATION OF OFFICE.

(a) The department shall operate the office of the state long-term care ombudsman.

(b) The department may operate the office directly or by contract or memorandum of agreement with a public agency or other appropriate private nonprofit organization. The department may not use an agency or organization that is:

(1) responsible for licensing or certifying long-term care services; or

(2) an association of long-term care facilities or of any other residential facility that serves persons who are 60 years of age or older, or an affiliate of such an association.

(c) The department shall consider the views of elderly persons, provider organizations, advocacy groups, and area agencies on aging in planning and operating the office.

(d) The department shall ensure that a person involved in designating the state ombudsman or in designating an employee or representative of the office does not have a conflict of interest.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

Sec. 101A.253. ROLE OF OFFICE. The office and the ombudsman program shall operate in cooperation with any regulatory agency funded and mandated by the Older Americans Act of 1965 (42 U.S.C. Section 3001 et seq.) and state statute.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

Sec. 101A.254. POWERS AND DUTIES OF STATE OMBUDSMAN AND OFFICE.

(a) The state ombudsman and the office have the powers and duties required by state and federal law.

(b) The office may use appropriate administrative, legal, and other remedies to assist elderly residents as provided by department rules.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

Sec. 101A.255. OMBUDSMEN.

(a) The office shall recruit volunteers and citizen organizations to participate in the ombudsman program. A paid staff member of an area agency on aging network or a nonprofit social service agency may be an ombudsman. An ombudsman is a representative of the office.

(b) The office shall provide training to ombudsmen as required by this subchapter and federal law.

(c) The office shall coordinate ombudsman services with the protection and advocacy systems that exist for persons with developmental disabilities or mental illness.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

Sec. 101A.256. LEGAL ASSISTANCE. The department shall ensure that the office receives adequate legal advice and representation. The attorney general shall represent the ombudsman or a representative if a suit or other legal action is brought or threatened to be brought against that person in connection with the person's performance of the official duties of the office.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

Sec. 101A.257. INVESTIGATIONS.

(a) The office shall have access to elderly residents and shall investigate and resolve complaints made by or on behalf of elderly residents.

(b) The department shall ensure that each ombudsman who investigates complaints has received proper training and has been approved by the office as qualified to investigate complaints.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

Sec. 101A.258. ACCESS TO RECORDS AND CONFIDENTIALITY.

(a) The state ombudsman or the state ombudsman's designee, specifically identified by the commissioner, shall have access to patient care records of elderly residents of long-term care facilities as provided by Subsection (a-1). The executive commissioner by rule shall establish procedures for obtaining access to the records. All records and information to which the state ombudsman or the state ombudsman's designee obtains access remain confidential.

(a-1) The state ombudsman or the state ombudsman's designee, specifically identified by the commissioner, shall have access to patient care records of elderly residents of long-term care facilities if:

(1) the resident or the resident's legal representative consents to the access;

(2) the resident is unable to consent to the access and the resident has no legal representative; or

(3) access to the records is necessary to investigate a complaint and:

(A) a legal guardian of the resident refuses to consent to the access;

(B) the state ombudsman or the state ombudsman's designee has reasonable cause to believe that the guardian is not acting in the best interests of the resident; and

(C) the state ombudsman approves the access.

(b) The office shall ensure that the identity of a complainant or any facility resident may be disclosed only with the written consent of the person or the person's legal representative or on court order.

(c) The information in files maintained by the office may be disclosed only by the ombudsman who has authority over the disposition of the files.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

Sec. 101A.259. REPORTING SYSTEM. The office shall maintain a statewide ombudsman uniform reporting system to collect and analyze information relating to complaints and conditions in long-term care facilities as long as such system does not duplicate other state reporting systems. The office shall provide the information to the department and the Health and Human Services Commission.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

Sec. 101A.260. ANALYSIS OF LAWS. The office shall analyze and monitor the development and implementation of federal, state, and local laws, rules, regulations, and policies relating to long-term care facilities and services and shall recommend any changes the office considers necessary.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

Sec. 101A.261. PUBLIC INFORMATION. The office shall provide information to public agencies, legislators, and others that relates to the problems and concerns of elderly residents.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

Sec. 101A.262. ANNUAL REPORT.

(a) The office shall prepare an annual report that contains:

(1) information and findings relating to the problems and complaints of elderly residents; and

(2) policy, regulatory, and legislative recommendations to solve the problems, resolve the complaints, and improve the quality of the elderly residents' care and lives.

(b) The report must be submitted to the governor and the presiding officer of each house of the legislature not later than November 1 of each even-numbered year.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

Sec. 101A.263. LIMITATION OF LIABILITY. An ombudsman or a representative is not liable for civil damages or subject to criminal prosecution for performing official duties unless the ombudsman or representative acts in bad faith or with a malicious purpose.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

Sec. 101A.264. CRIMINAL PENALTY.

(a) A person commits an offense if the person:

(1) intentionally interferes with an ombudsman attempting to perform official duties; or

(2) commits or attempts to commit an act of retaliation or reprisal against any resident or employee of a long-term care facility for filing a complaint or providing information to an ombudsman.

(b) An offense under this section is a Class B misdemeanor.

(c) The department shall assure that criminal sanctions will be initiated only after all administrative procedures are exhausted.

Added by Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 4.361, eff. April 2, 2015.

TEXAS ADMINISTRATIVE CODE
TITLE 40 - Social Services and Assistance
PART 1 - Department of Aging and Disability Services
CHAPTER 85 - Implementation of the Older Americans Act

SUBCHAPTER A - DEFINITIONS

RULE §85.2 – Definitions

(6) Certified ombudsman--A certified staff ombudsman or a certified volunteer ombudsman.
(7) Certified staff ombudsman--A person who:
  (A) meets the qualifications described in §85.401(g)(1) of this chapter (relating to Long-Term Care Ombudsman Program);
  (B) is employed by or is contracting with a AAA or nonprofit organization designated in accordance with §85.401(b) of this chapter; and
  (C) performs activities for the AAA or designated nonprofit organization to implement the Long-Term Care Ombudsman Program.
(8) Certified volunteer ombudsman--A person who:
  (A) meets the qualifications described in §85.401(g)(1) of this chapter;
  (B) is not employed by or contracting with a AAA or nonprofit organization designated in accordance with §85.401(b) of this chapter; and
  (C) voluntarily performs activities for the AAA or designated nonprofit organization to implement the Long-Term Care Ombudsman Program.
(19) Friendly visitor--A volunteer for a AAA or nonprofit organization designated in accordance with §85.401(b) of this chapter who:
  (A) is not a certified ombudsman or ombudsman intern;
  (B) meets the qualifications described in §85.401(g)(2) of this chapter; and
  (C) performs activities to further the mission of the Long-Term Care Ombudsman Program such as visiting residents and coordinating social activities.
(21) Local ombudsman entity--A AAA or other entity designated by DADS to provide services in the Long-Term Care Ombudsman Program in accordance with the Older Americans Act, §712(a)(5)(A).
(22) LTC facility--Long-term care facility. A nursing facility licensed or required to be licensed in accordance with Texas Health and Safety Code, Chapter 242, and Chapter 19 of this title (relating to Nursing Facility Requirements for Licensure and Medicaid Certification) or an assisted living facility licensed or required to be licensed in accordance with Texas Health and Safety Code, Chapter 247, and Chapter 92 of this title (relating to Licensing Standards for Assisted Living Facilities).
(24) Office--The Office of the State Long-Term Care Ombudsman. A division of DADS established to oversee the statewide implementation of the Long-Term Care Ombudsman Program.
(26) Ombudsman intern--A person who is being trained to be a certified volunteer ombudsman in accordance with DADS Ombudsman Certification Training Manual but has not been approved by the Office to be a certified volunteer ombudsman.
(29) Resident--A person who resides in an LTC facility.
(34) State Long-Term Care Ombudsman--The person designated by DADS to be the administrator of the Office.

SUBCHAPTER E - Long-Term Care Ombudsman Program

RULE §85.401 - Long-Term Care Ombudsman Program

(a) Purpose. This section establishes the requirements of the Long-Term Care Ombudsman Program, a program established under the Older Americans Act, §712 and funded, in whole or in part, by DADS.

(b) Designation.
(1) DADS designates AAAs as local ombudsman entities.
(2) A AAA may contract with a nonprofit organization to perform the duties of the local ombudsman entity, as described in this section, in the AAA's planning and service area.
(3) The requirements of this section apply to a AAA in its role as the local ombudsman entity.

(c) Description of program. The Long-Term Care Ombudsman Program provides services to protect the health, safety, welfare, and rights of residents. Such services include investigating and resolving complaints made by or on behalf of such residents, providing assistance and information to persons in choosing an LTC facility, and promoting a variety of means to ensure that residents' rights are protected, including conducting training programs and supporting the development of resident and family councils that advise LTC facilities.

(d) Eligibility.
(1) Except as provided in paragraph (2) of this subsection, a AAA must ensure that a program participant who receives services from the Long-Term Care Ombudsman Program is a resident and 60 years of age or older.
(2) A AAA may respond to a complaint of a resident who is under 60 years of age if such response:
(A) benefits the residents of that facility or residents of other LTC facilities who are 60 years of age or older; and
(B) will not significantly diminish the effectiveness of the Long-Term Care Ombudsman Program in assisting residents who are 60 years of age or older.

(e) Managing local ombudsman. A AAA must appoint a certified staff ombudsman to act as a managing local ombudsman. The managing local ombudsman must:
(1) oversee the administration of the Long-Term Care Ombudsman Program in the AAA's planning and service area; and
(2) be the primary contact for the local ombudsman entity.

(f) Adequate number of certified ombudsman. In order to implement the Long-Term Care Ombudsman Program as described in this section, a AAA:
(1) must have an adequate number of certified ombudsmen; and
(2) may have friendly visitors.

(g) Qualifications for certified ombudsmen and friendly visitors.
(1) A person may be a certified ombudsman only if:
(A) the person has not been convicted of an offense listed under Texas Health and Safety Code, §250.006;
(B) the person successfully completes a certification training provided by the AAA in accordance with DADS Ombudsman Certification Training Manual;
(C) for a certified volunteer ombudsman, the person successfully completes an internship in accordance with DADS Ombudsman Policies and Procedures Manual;

(D) the AAA recommends to the Office, in writing, using DADS *Certified Ombudsman Application,* that the person be approved as a certified ombudsman;
(E) the Office signs the DADS *Certified Ombudsman Application* approving the person to be a certified ombudsman; and
(F) the person completes continuing education provided by the AAA in accordance with DADS Ombudsman Policies and Procedures Manual.

(2) A person may be a friendly visitor only if the person successfully completes an orientation provided by the AAA in accordance with DADS Ombudsman Policies and Procedures Manual.

(h) Access to residents and records.

(1) In accordance with §19.413 of this title (relating to Access and Visitation Rights) and §92.801 of this title (relating to Access to Residents and Records by the Long-Term Care Ombudsman Program), a representative of the Office, as described in subsection (r) of this section, is entitled to immediate access to a resident.

(2) In accordance with §19.413 of this title and §92.801 of this title a certified ombudsman and a staff person of the Office are entitled to access:

(A) the medical and social records of a resident, if the certified ombudsman or staff person of the Office has the consent of the resident or the legally authorized representative of the resident;

(B) the medical and social records of a resident 60 years of age or older, if such access is necessary to investigate a complaint made to the Long-Term Care Ombudsman Program and:

(i) the resident is unable to consent to access and has no legally authorized representative; or

(ii) the following circumstances occur:

(I) the legal guardian of the resident refuses to give consent for access to the records;

(II) the certified ombudsman or staff person of the Office has reasonable cause to believe that the guardian is not acting in the best interest of the resident; and

(III) the certified ombudsman or staff person of the Office obtains the approval of the State Long-Term Care Ombudsman to access the records without the guardian's consent; and

(C) to the administrative records, policies and documents of the LTC facility to which the residents or general public have access.

(i) Conflict of interest and identity of certain relationships.

(1) A AAA must ensure that a certified ombudsman, an ombudsman intern, and a member of the immediate family of the managing local ombudsman are not subject to a conflict of interest.

(2) A conflict of interest includes the following:

(A) having a direct involvement in the licensing or certification of an LTC facility or of a home and community support services agency (HCSSA) licensed to provide home health services or hospice services in accordance with Chapter 97 of this title (relating to Licensing Standards for Home and Community Support Services Agencies);

(B) having an ownership or investment interest (represented by equity, debt, or other financial relationship) in an LTC facility or a HCSSA licensed to provide home health services or hospice services in accordance with Chapter 97 of this title;

(C) being employed by, or participating in the management of, an LTC facility or a HCSSA licensed to provide home health services or hospice services in accordance with Chapter 97 of this title;
(D) receiving, or having the right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of an LTC facility or a HCSSA licensed to provide home health services or hospice services in accordance with Chapter 97 of this title; and
(E) a certified ombudsman or ombudsman intern having a relative who is a resident in or an employee of an LTC facility in which the certified ombudsman or ombudsman intern provides Long-Term Care Ombudsman Program services.

(3) a conflict of interest described in paragraph (2)(A) - (D) of this subsection exists only if an LTC facility is in a AAA's planning and service area or a HCSSA is providing services to an LTC facility in a AAA's planning and service area.

(4) A AAA must specify, in writing, the mechanisms to:
(A) identify and remove conflicts of interest; and
(B) identify and address, if necessary, a familial or personal relationship that a certified ombudsman or ombudsman intern has with:
(i) a staff person of an LTC facility in the AAA's planning and service area; or
(ii) a staff person of DADS.

(j) Complaints. A AAA must:

(1) ensure that a person is allowed to make a complaint about circumstances that may adversely affect the health, safety, welfare, or rights of a resident in the following ways:
(A) in writing, including by electronic mail;
(B) in person; and
(C) by telephone, either by:
(i) a toll-free telephone number established by the AAA; or
(ii) acceptance by the AAA of a collect telephone call;

(2) initiate a complaint if the AAA becomes aware of circumstances that may adversely affect the health, safety, welfare, or rights of a resident;

(3) unless a complaint is initiated by the AAA in accordance with paragraph (2) of this subsection, respond to the person who makes a complaint, within two business days after receipt of the complaint or sooner, if possible, if the complaint presents an emergency situation;

(4) require a certified ombudsman to initiate an investigation of a complaint as soon as practicable after receipt of the complaint;

(5) require a certified ombudsman to investigate and resolve a complaint in a fair and objective manner; and

(6) report information about complaints to DADS in accordance with instructions promulgated by the Office.

(k) Disclosure of information.

(1) For a resident for whom a AAA maintains files or records, the AAA may disclose confidential information, including the identity of the resident or information from the files or records, only if:
(A) the resident or legally authorized representative consents to the disclosure in writing;
(B) the resident or legally authorized representative consents to the disclosure orally and the consent is documented by a certified ombudsman, in writing, at the time the oral consent is given; or
(C) the disclosure is required by court order.

(2) A AAA may disclose the identity of a person who files a complaint only if:

(A) the complainant, or legally authorized representative of the complainant, consents to the disclosure in writing;
(B) the complainant, or legally authorized representative, consents to the disclosure orally and the consent is documented by a certified ombudsman, in writing, at the time the oral consent is given; or
(C) the disclosure is required by court order.

(3) A AAA must disclose Long-Term Care Ombudsman Program information, other than the information described in paragraphs (1) and (2) of this subsection, in accordance with Texas Government Code, Chapter 552 (the Public Information Act).

(l) Representation of residents. A AAA may represent the interests of a resident before government agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the resident, if requested by a resident or another person on behalf of the resident.

(m) Review of proposed laws, regulations, and policies. A AAA may review and comment on existing and proposed laws, regulations, and other government policies and actions that pertain to the rights and well-being of a resident; and facilitate the ability of the public to comment on the laws, regulations, policies, and actions.

(n) Community relations. A AAA must:

(1) ensure that the local Ombudsman entity is visible within a AAA's planning and service area;
(2) coordinate with public and private organizations to involve residents in the community;
(3) be a knowledgeable resource about:
(A) community services and supports for residents;
(B) LTC facilities (including having information about facility operations and Ombudsman complaint history) without recommending a specific facility;
(C) DADS regulatory system regarding LTC facilities; and
(D) resident-centered care (that is, care based on a resident's needs, choices, and preferences);
(4) provide training to LTC facility staff regarding quality of care provided to residents as requested by a facility;
(5) support the development of resident and family councils in LTC facilities; and
(6) coordinate with DADS Regulatory Services, at least quarterly, and the Department of Family and Protective Services, as needed, to resolve issues regarding LTC facility operations and the quality of care for and the quality of life of residents.

(o) Recruitment, supervision, and retention of certified volunteer ombudsmen. If a AAA determines that certified volunteer ombudsmen are needed, the AAA must:

(1) determine the number of certified volunteer ombudsmen needed to comply with DADS performance measures;
(2) make a good faith effort to recruit the number of certified volunteer ombudsmen needed;
(3) ensure that a certified volunteer ombudsman meets the qualifications described in subsection (g) of this section and is not subject to a conflict of interest as described in subsection (i) of this section;
(4) supervise and routinely communicate with a certified volunteer ombudsman to:
(A) monitor performance;
(B) support effective volunteer conduct; and
(C) identify training needs.
(5) promote retention of a certified volunteer ombudsman by:

(A) providing continuing education in accordance with subsection (g)(1)(F) of this section;
(B) providing recognition and motivational activities;
(C) conducting annual evaluations; and
(D) conducting exit evaluations for a certified volunteer ombudsman leaving volunteer service.

(**p**) **Grievance procedures for certified volunteer ombudsmen and friendly visitors**. A AAA must have a process that:
(1) allows a certified volunteer ombudsman or friendly visitor to file a grievance with the AAA regarding the Long-Term Care Ombudsman Program; and
(2) requires a staff person of the AAA to review and resolve the grievance.

(q) Compliance with documents of the Office. A AAA must comply with the following documents promulgated by the Office:
(1) DADS Ombudsman performance measures;
(2) DADS Ombudsman Policies and Procedures Manual;
(3) DADS Program Instructions; and
(4) DADS Ombudsman Certification Training Manual.

(r) Representatives of the Office. In accordance with Texas Human Resources Code, §101A.251(4), DADS designates the following persons as representatives of the Office:
(1) staff persons of the Office;
(2) certified ombudsmen; and
(3) ombudsman interns.

(s) Contractor compliance. If a AAA contracts with a nonprofit organization as described in subsection (b) of this section, the AAA must ensure that the organization complies with the requirements for a AAA described in this section.

(t) Ombudsman maintenance of effort.
(1) A AAA must comply with the Older Americans Act, §306(a)(9) regarding adequate expenditures for the Long-Term Care Ombudsman Program.
(2) A AAA may request, in writing, by September 30 of each year, that DADS waive the requirement described in paragraph (1) of this subsection for the next federal year.
(3) DADS may grant such a request if the AAA demonstrates adequate justification.

Source: *Provisions of §85.401 adopted to be effective September 1, 2008, 33*

Ombudsman References:

Excerpts from Nursing Facility Requirements for Licensure and Medicaid Certification

TEXAS ADMINISTRATIVE CODE
TITLE 40 - Social Services and Assistance
PART 1 - Department Of Aging and Disability Services
CHAPTER 19 - Nursing Facility Requirements for Licensure and Medicaid Certification

Subchapter B, Definitions

§19.101 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(92) Ombudsman — An advocate who is a certified representative, staff member, or volunteer, of the DADS Office of the State Long Term Care Ombudsman.

Subchapter E, Resident Rights

§19.403 Notice of Rights and Services

(a) The facility must inform the resident, the resident's next of kin or guardian, both orally and in writing, in a language that the resident understands, of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. This notification must be made prior to or upon admission and during the resident's stay if changed.

(b) The facility must also inform the resident, upon admission and during the stay, in a language the resident understands, of the following:

(4) a written description of the services available through the DADS Office of the State Long Term Care Ombudsman. This information must be made available to each facility by the ombudsman program. Facilities are responsible for reproducing this information and making it available to residents, their families, and legal representatives; and

§19.413 Access and Visitation Rights

(a) A resident has the right to have access to, and the facility must provide immediate access to a resident to, the following:

(4) a representative of the Office of the State Long Term Care Ombudsman (the Office), as described in §85.401(r) of this title (relating to Long-Term Care Ombudsman Program);

(b) A facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(c) A facility must allow a certified ombudsman, as defined in §85.2 of this title (relating to Definitions), and a staff person of the Office access:

(1) to the medical and social records of a resident, including an incident report involving the resident, if the certified ombudsman or staff person of the Office has the consent of the resident or the legally authorized representative of the resident;

(2) to the medical and social records of a resident 60 years of age or older, including an incident report involving the resident, in accordance with the Older Americans Act, §712(b); and
(3) to the administrative records, policies, and documents of the facility to which the facility residents or general public have access.

Subchapter F, Admission, Transfer, and Discharge Rights In Medicaid-Certified Facilities

§19.502 Transfer and Discharge in Medicaid-Certified Facilities

(f) Contents of the notice. For nursing facilities, the written notice specified in subsection (d) of this section must include the following:
(5) the name, address, and telephone number of the regional representative of the Office of the State Long Term Care Ombudsman, Texas Department on Aging, and of the toll-free number of the Texas Long Term Care Ombudsman, 1-800-252-2412;

Subchapter T, Administration

§19.1923 Incident or Accident Reporting

(e) The facility must make incident reports available for review, upon request and without prior notice, by representatives of DHS, the U.S. Department of Health and Human Services, if applicable; and the Texas Department of Protective and Regulatory Services. Reports related to specific incidents must be available to the designated regional staff ombudsman, Office of the State Long Term Care Ombudsman, Texas Department on Aging.

Subchapter U, Inspections, Surveys, and Visits

§19.2002 Procedural Requirements - Licensure Inspections and Surveys

(f) Persons authorized to receive advance information on unannounced inspections include:
(2) representatives of the Texas Department of Aging serving as ombudsmen or authorized to attend or participate in inspections;

(g) DHS will conduct at least two unannounced inspections during each licensing period of each institution licensed under Health and Safety Code, Chapter 242, except as provided for in this subsection.
(2) For at least two unannounced inspections each licensing period, DHS will invite to the inspections at least one person as a citizen advocate from the American Association of Retired Persons, the Texas Senior Citizen Association, the Texas Retired Federal Employees, the Texas Department on Aging Certified Long Term Care Ombudsman, or any other statewide organization for the elderly. DHS will provide to these organizations basic licensing information and requirements for the organizations' dissemination to their members whom they engage to attend the inspections. Advocates participating in the inspections must follow all protocols of DHS. Advocates will provide their own transportation. The schedule of inspections in this category will be arranged confidentially in advance with the organizations. Participation by the advocates is not a condition precedent to conducting the inspection.

Subchapter BB, Preadmission Screening and Resident Review

§19.2703 Definitions

(29)

PASRR determination — A decision made by DADS, DSHS, or their designee regarding an individual's need for nursing facility specialized services, LIDDA specialized services, and LMHA specialized services, based on information in the PE; and, in accordance with Subchapter Y of this chapter (relating to Medical Necessity Determinations), whether the individual requires the level of care provided in a nursing facility. A report documenting the determination is sent to the individual and LAR.

§19.2708 Educational and Informational Activities for Residents

A nursing facility must:

(1) allow access to residents by representatives of the Office of the State Long Term Care Ombudsman and Disability Rights Texas to educate and inform them of their rights and options related to PASRR;
(2) allow access to designated residents to support educational activities about community living options arranged by the LIDDA; and
(3) provide a designated resident with adequate notice and assistance to be prepared for and participate in scheduled community visits.

Excerpts from Licensing Standards for Assisted Living Facilities

TEXAS ADMINISTRATIVE CODE
TITLE 40 – Social Services and Assistance
PART 1 – Department of Aging and Disability Services
CHAPTER 92 - Licensing Standards for Assisted Living Facilities

§92.125 Resident's Bill of Rights and Provider Bill of Rights

(a) Resident's bill of rights.
(3) Each resident in the assisted living facility has the right to:
(AA) have access to the service of a representative of the State Long Term Care Ombudsman Program, Texas Department on Aging;

§92.127 Required Postings

Each facility must prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees, and visitors: (7) the telephone number of the Office of the State Long Term Care Ombudsman

Subchapter I, Access to Residents and Records by the Long-Term Care Ombudsman Program

§92.801 Access to Residents and Records by the Long-Term Care Ombudsman Program

(a) A resident has the right to be visited by, and a facility must provide immediate access to any resident to:
  (1) a staff person of the Office of the State Long-Term Care Ombudsman (the Office) employed by DADS;
  (2) a certified ombudsman; and
  (3) an ombudsman intern.

(b) A facility must allow a certified ombudsman and a staff person of the Office access:
  (1) to the medical and social records of a resident, if the certified ombudsman or the staff person has the consent of the resident or the legally authorized representative of the resident;
  (2) to the medical and social records of a resident 60 years of age or older, in accordance with the Older Americans Act, §712(b); and
  (3) to the administrative records, policies, and documents of the facility to which the facility residents or general public have access.

Notes

Ombudsman Certification Training

CHAPTER 2: Aging and Residents

Aging and Residents

Chapter 2 provides basic information about aging, demographic information, and dispels some myths and stereotypes about aging. Chapter 2 also provides training on person-centered care to people with dementia.

Learning Objectives

- Become aware of the continuous process of aging
- Discover your attitudes about aging
- Understand common myths and stereotypes as well as facts about residents and aging
- Prepare to take a person-centered approach in advocating for residents with dementia

Contents

- The Physical Aging Process
- Attitudes about Aging
- Demographic Information on Older Adults
- Fourteen Myths and Stereotypes about Older Adults

DVD(s), Supplements, Forms

- DVD: CMS Hand in Hand Training Module 1: Understanding the World of Dementia: The Person and the Disease

The Physical Aging Process

Aging is a complex natural process potentially involving every molecule, cell, and organ in the body. Gerontology, the study of aging, is a relatively new science. Gerontologists identify two main aging categories:

- Programmed – certain genes switch on and off over time; and
- Error – environmental damages to our body systems accumulate over time.

Over time, body organs and other systems make changes. These changes alter susceptibility to various diseases. Understanding these processes is important because many of the effects of aging are first noticed in our body systems. Review the following overview of how some body systems age.

- Heart: The heart muscle thickens with age as a response to the thickening of the arteries. This thicker heart has a lower maximum pumping rate, and the body's ability to extract oxygen from blood diminishes with age.
- Immune system: T cells take longer to replenish in older people and their ability to function declines.
- Arteries: Arteries usually stiffen with age. In turn, the older heart needs to supply more force to propel the blood forward through less elastic arteries.
- Lung: The maximum breathing (vital) capacity of the lungs may decrease as much as 40% between 20 – 70 years of age.
- Brain: As the brain ages, some connections between neurons seem to be reduced or less efficient. This is not yet well understood.
- Kidney: Kidneys gradually become less efficient at cleaning waste from the blood.
- Body fat: Body fat gradually increases until middle age and then in late life body weight tends to decrease. With age, body fat redistributes in the body, shifting from just beneath the skin to deeper organs.
- Muscle: Muscle tone declines about 22% by age 70. Exercise can slow this rate of loss.
- Bone: Bone mineral is lost and replaced throughout life. Around age 35, loss begins to outstrip replacement. Regular weight bearing exercise, such as walking, running, and strength training can slow bone loss.
- Sight: Starting in the 40s, difficulty focusing close up may begin. From age 50, susceptibility to glare, greater difficulty in seeing at low illumination levels, and more difficulty in detecting moving objects increases. Ability to distinguish fine details may begin to decline in the 70s.
- Hearing: It becomes more difficult to hear high frequencies. Even with good hearing, older adults may have difficulty understanding speech especially where there is background noise. Hearing declines more quickly in men than in women.

Describe one physical change associated with aging.

_____

If you met someone like …

> *Bess C. (60) has always lived in Austin. She was a hairdresser. After her stroke, she requires 24-hour care. However, she remains active in the community. She has a cell phone and likes to write. She uses her power wheelchair as a mobility device. To visit friends and her sister, as well as enjoy other activities, she uses the city's special transit service. She writes poetry and contributes to the nursing home newsletter. She self-advocates but doesn't hesitate to seek the ombudsman's help if needed. Her faith is very important to her.*

… Ask yourself, how would you build a relationship with Bess?

Attitudes about Aging

Aging is an ongoing process, but people see the value of aging differently at different points in the process. People anticipate some changes with joy, such as a baby's first tooth or first step. They greet other changes with a less positive response, such as pulling out their first gray hairs.

The American culture values youth. Americans mask signs of aging with face-lifts, wrinkle creams, and hair dyes. Physical maturation so eagerly anticipated in the first stages of life is often viewed negatively in later stages of life.

These prevailing attitudes lead to a denial of aging and can perpetuate stereotypes of aging and ignore positive aspects. At each stage of life, people perceive pros and cons. Some people think that in old age the balance tips to more negatives than positives, but this is not true for everyone.

Activity: Attitudes about Aging

True (T) or False (F)

__ 1. The majority of adults over 65 have memory loss, disorientation, or dementia.

__ 2. All five senses tend to decline in old age.

__ 3. Lung capacity tends to decline in old age.

__ 4. Physical strength tends to decline in old age.

__ 5. Older adults have no interest in sexual relations.

__ 6. Older drivers have fewer accidents per person than drivers under age 65.

__ 7. Older workers are less effective than younger workers.

__ 8. About 80% of older adults are healthy enough to carry out normal activities.

__ 9. Older adults are set in their ways and unable to change.

__ 10. Older adults usually take longer to learn something new.

__ 11. Most older adults' reaction time tends to be slower than younger adults.

__ 12. It is almost impossible for most older adults to learn new things.

__ 13. In general, most older adults are much alike.

__ 14. Older workers have fewer accidents than younger workers do.

__ 15. The majority of older adults are socially isolated and lonely.

__ 16. Over 20% of the U.S. population is now aged 65 or over.

__ 17. Most medical professionals tend to give low priority to older adults.

__ 18. The majority of older adults have incomes below the poverty level.

__ 19. The majority of older adults work or would like to do some kind of work, including volunteering.

__ 20. In the U.S., families provide about 80% of the care for older family members.

__ 21. People tend to become more religious as they age.

__ 22. Most American workers receive private pensions and Social Security when they retire.

Exercise: Choice or Restriction

List three morning activities you routinely do.

1. _____
2. _____
3. _____

How might you feel if others changed your routine? _____

_____

True (T) or False (F)**:**

___ 1. Nursing home staff must provide services and care in ways that help each resident live to his or her fullest potential physically, mentally, and emotionally.

___ 2. Supporting each resident's individuality is an important standard of care.

___ 3. Residents may experience disconnection and loss of identity.

___ 4. Staff should support each resident's life patterns.

___ 5. Facilities need rules that determine everyone's routines, such as when to go to bed, when to turn the TV off, when to take baths, and when visitors can come and go.

___ 6. A major loss to residents might be losing their daily routines.

___ 7. All residents are entitled to participate in planning their own care.

Give an example of what you believe privacy means in a facility setting.

_____

_____

Why should residents be able to control their lives after moving to an assisted living facility or nursing home? _____

_____

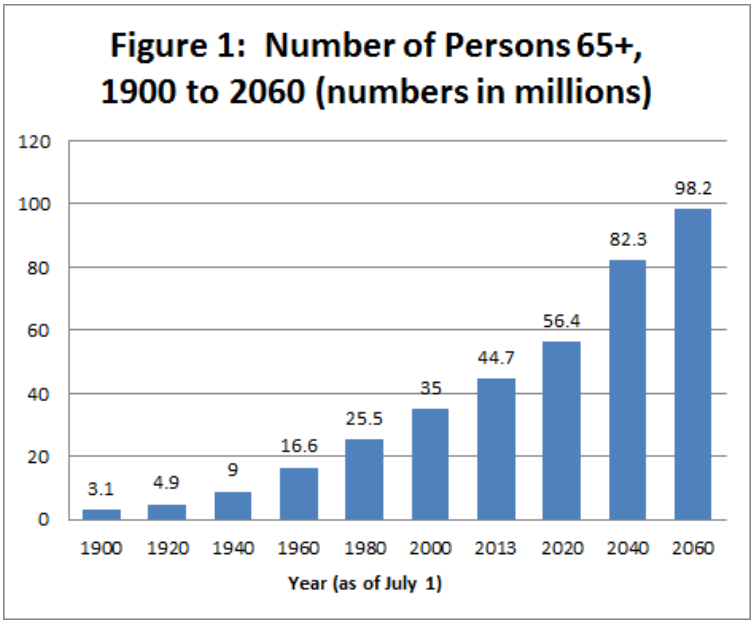
_____

If you met someone like …

> *Lora F (94), widow, diagnosed with dementia, needs help with all personal care. She has been hospitalized a few times with urinary tract infections due to poor hydration. She was a homemaker who operated a boarding house and a charter member of the local garden club. One son and four daughters live nearby and visit at different times – the son helps her with breakfast; the daughters come at lunch and on weekends. While there, they check on her roommate whose only daughter lives in California. Since Mrs. F cannot communicate, her roommate tells the family what happens between their visits.*
>
> *… Ask yourself, how you would build a relationship with Mrs. F and her roommate?*

Demographic Information on Older Adults

Knowing a person's chronological age tells you almost nothing about that person's feelings or abilities. Nevertheless, we tend to categorize individuals by chronological age. Some key statistics to describe the United States aged 65+ populations:



The 65+ population totaled 44.7 million in 2013.

- One person in every seven people is an older adult.

The 65+ population is projected to increase from 44.7 million in 2013 to 98.2 million in 2060.

- The 85+ population is projected to grow from 6 million in 2013 to 14.1 million in 2040.
- Minority populations are projected to increase from 9.5 million in 2013 to 21.1 million in 2030.

Average life expectancy after reaching age 65 is another 19.3 years.

- 20.5 years for females and 17.9 years for males.

In 2013, 25.1 million older women outnumber 19.6 million older men.

- 72% of older men are married, while 46% of older women are married.
- About 28% (8.8 million women, 3.8 million men) of older adults live alone.

Median income of older adults in 2013 was $29,327 for males and $16,301 for females. Their major sources of income in 2013 were:

- Social Security (86%)
- Income from assets (51%)
- Earnings (28%)
- Private pensions (27%)
- Government employee pensions (14%)

Over 4.2 million older adults (9.5%) were below the poverty level in 2013.

SOURCE: Administration on Aging prepared *A Profile of Older Americans 2014*

Nursing Homes and Assisted Living Facilities

While a small number (1.5 million) and percentage (3.4%) of the 65+ population lived in nursing homes in 2013, the percentage increases dramatically with age.

- 1.0% for people 65-74
- 3.0% for people 75-84
- 10.0% for people 85+

SOURCE: Administration on Aging prepared *A Profile of Older Americans 2014*

No national standards exist for assisted living services and settings. Limited national statistics about people living in assisted living are available in the 2010 Centers for Disease Control and Prevention, National Center for Health Statistics survey of residential care facilities.

In Texas, about 93,000 people live in nursing homes on any given day and about 41,000 people live in assisted living facilities.

SOURCE: Regulatory Licensing and Certification July 2015

What percentage of adults age 65+ live in nursing homes? _____

If you met someone like …

> *Jack K (76), a widower, had a stroke (medically known as CVA - cerebrovascular accident) with right side hemiplegia (paralysis on one side of the body) four months ago. He has expressive aphasia and cannot communicate his needs verbally so he gestures and uses a communication board. Living in a small town, he was an auto mechanic and his hobby was gardening. He was a leader in his church and loves to sing and hear gospel music. One son lives in a nearby town and visits once a week. Mr. K has fallen several times at night but not suffered any serious injury. Staff finds him on the floor near his bed. He prefers to use the bathroom without help.*

… Ask yourself, how would you start to build trust with Mr. K?

Fourteen Myths and Stereotypes about Older Adults

Many people, including older adults, think some generalizations about older adults are truths. Myths, stereotypes, and negative attitudes greatly influence our interactions with older adults. Paid and family caregivers are naturally influenced by these same myths and stereotypes, which can affect the way they treat older adults. As an ombudsman, it is important to recognize your biases and work to overcome them in order to be resident-directed and protect resident rights.

Myth 1: Older adults are disengaged. They live by themselves or with other older adults, lose interest in life, become more introspective and withdrawn, and do not want to associate with other people.

Reality: Opportunities to be with others may be limited. Physical disabilities, lack of transportation, lack of alternatives, and the death of a spouse or friends may cause older adults to appear disengaged. Other people may have chosen to stay away from them. Most older adults prefer to stay involved in their communities.

Myth 2: Older adults are sick. Disease and disability are automatic with advancing age.

Reality: Chronic conditions, such as arthritis and diabetes, usually begin in middle age and worsen with age. Disabilities have many causes and can be influenced by diet, exercise, and lifestyle. Older adults do not suddenly become sick just because they age.

Myth 3: “Once a man, twice a child.” Older adults become childish, return to a second childhood, and must be treated like children.

Reality: Adults remain adults and want to be treated as such.

Why might older adults disengage from their community?

_____

_____

Myth 4: Older adults are dependent. They need someone to take care of them.

Reality: Most older adults are independent, caring for themselves, and living in the community. Younger adults often try to do things for an older person because they lack patience to wait for the older adult to do it by himself or herself. Older adults can gradually become dependent on others because they received unnecessary assistance.

Myth 5: Older adults are unproductive.

Reality: The majority of older adults remain actively and productively involved in their community. However, opportunities for meaningful work, education, or leisure activities may be less available. Incapacity is directly linked to loss such as bereavement or loss of purpose in life, disease, and circumstance rather than aging. Sharing knowledge and reminiscing are important aspects of an older adult's productivity.

What is at risk if an older adult has someone do everyday tasks for them?

_____

Myth 6: Sexual function ceases in old age.

Reality: Sexual desire continues throughout life. Sexual function may change with advancing age, but it does not automatically cease. If people have been sexually active throughout adulthood, they are likely to be in later years.

Myth 7: Older people become senile. Eventually all older adults become forgetful, confused, and lose attention span.

Reality: "Senility" is one of the most misused words to describe older adults; it has little meaning. Similarly, "Alzheimer's" has become a general term used to

describe all types of memory loss that may have different causes and different intervention strategies. Dementia prevalence increases with age, from 5% of people aged 71–79 years to 37% of those aged 90 and older.

SOURCE: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2705925/, Neuroepidemiology, **Vol. 29, No. 1-2, 2007**

Myth 8: If people live long enough, they will end up in nursing homes.

Reality: About 5% of older adults live in a nursing home. About 25% of older adults will need nursing home care at some point in their lives. The vast majority of older adults live outside of nursing homes.

Myth 9: Serious health problems are unavoidable in older adulthood.

Reality: Three reasons make health deterioration or decline unavoidable:

1. New disease or condition, such as heart disease
2. Disease progression, such as the medicine for Parkinson's no longer works and the person loses mobility
3. Choosing to refuse treatment or care

One reason a person's decline in health might be unavoidable is if

_____.

Myth 10: Given their frail condition, movement for long-term care residents is not as important as it is for other adults. A decline in mobility is an inevitable part of aging.

Reality: The ability to move may change with physical and mental ability. Even older residents with frail bones keep their instinct for movement, just as they do for all basic needs. Nursing homes and assisted living facilities may fail to recognize — and encourage — movement as a basic human need, but the need to move is important to maintain physical and mental health.

Myth 11: Pressure ulcers are an unfortunate part of normal aging for nursing home residents.

Reality: A pressure ulcer, sometimes called a bed sore, is an injury caused primarily by unrelieved pressure that damages the skin and underlying tissue. They are painful. Pressure ulcers can require hospitalization or nursing home treatment and can cause death. People who are most at-risk of skin breakdown

have limited mobility, incontinence, diabetes, decreased mental capacity, and confusion. Pressure ulcers can be prevented. For some, pressure sores may be prevented by repositioning the body or by using an air mattress.

Another term for “bed sore” is pressure _____.

Myth 12: Involuntary loss of urine is a normal signal of advanced age. Once it occurs, nothing can be done except to keep clean and dry.

Reality: Incontinence is not a normal part of aging. Urinary incontinence is a symptom of a medical problem. Continence depends on many factors such as a well-functioning urinary tract, ability to reach the toilet on time, ability to remove clothing, cognitive function, and motivation.

Myth 13: Older adults tend to withdraw and become depressed. Depression is normal.

Reality: Depression is treatable and not a normal part of aging. A depressed mood may not be as noticeable a symptom as other symptoms, such as sleeplessness, sleeping too much, loss of appetite, lack of energy, and loss of enjoyment of normal life interests. The risk of depression among women is twice that of men. Older adults with depression are at risk of committing suicide; white men over age 80 are at greatest risk. Proper assessment, detection, and intervention are critical.

Myth 14: Older adults and individuals with disabilities need protection. Environmental risks must be minimized. Restraints can keep nursing home and assisted living facility residents safe.

Reality: Life is full of risks. Our willingness to live with risks is individualized. Care decisions made solely for a person’s safety should be carefully scrutinized. Residents’ rights need to be factored into each care decision. Restrained residents often try to get out of restraints. Physical restraints create new risks, including increased risk of death and serious injury. Physical and chemical restraints* also increase isolation and negatively affect an individual’s mood.

* A physical restraint is "any manual method or physical or mechanical device, material, or equipment attached *or adjacent to* the individual’s body that the individual cannot remove easily which restricts freedom of movement or normal access to one’s body." A chemical restraint is defined as “any drug that is used for discipline or convenience and not required to treat medical symptoms.” (SOM – CMS Appendix PP Guidance to Surveyors)

Using a restraint on a person puts them at risk of serious _____ and death.

If you met someone like …

William E (81), a Marine veteran of World War II, smoked most of his life but quit several years ago. He has lung cancer and was given six weeks to live. He was transferred from the hospital to the nursing home rather than to his home because his wife was not physically strong enough to care for him. While not happy with the choice, Mr. E accepted the situation and appreciates his wife being by his side almost 24/7.

… Ask yourself, how can I build trust while visiting this family?

Exercise: Your Perfect Long-term Care Home

If you became unable to care for yourself in your private home, describe the home in which you would want to live and how staff will care for you.

_____

_____

_____

_____

_____

_____

_____

_____

CMS Hand in Hand Training - Module 1: Understanding the World of Dementia: The Person and the Disease

Run Time: Approximately 1 hour to view video clips and discuss

Hand in Hand training was created by the Centers for Medicare and Medicaid Services (CMS) to provide long-term care providers training. It shows staff how to provide person-centered care to residents with dementia and how to prevent and report abuse.

Ombudsmen should keep in mind the information presented in Hand in Hand is created for facility staff, but the principles can be applied to ombudsman work. For ombudsmen, special considerations apply to allegations of abuse, neglect, and exploitation and these are addressed in Chapter 4.

Dementia is considered a late-life disease because it tends to develop mostly in older people. People in their 30s, 40s, or 50s can have dementia but it is less common. At Age 65, about 5-8% of people have some form of dementia; this number doubles every five years above that age. There are currently more than 5 million people in the U.S. living with Alzheimer's disease and other forms of dementia, and prevalence is expected to triple over the next 40 years.

SOURCES: Cleveland Clinic, *Types of Dementia, http://myclevelandclinic.org; and National Center for Biotechnology Information, Predicting Dementia: Role of Dementia Risk Indices, Deborah E. Barnes, PhD., MPH,* Christine Yaffe, MD; Future Neurol. Sep 1, 2009; 4(5): 555–560. doi: 10.2217/fnl.09.43

Dementia is a term that describes a wide range of symptoms associated with a decline in memory and at least one other thinking skill such as concentration, language, judgment, sequencing, visuospatial skills, and orientation. The actions and reactions of a resident with dementia are related to one or more of these challenges.

Answer the following questions about CMS *Hand in Hand Module 1, Understanding the World of Dementia: The Person and the Disease*

1. Define dementia: _____

   _____

2. Who gets dementia?

   _____

   _____

   _____

3. Identify three of the seven symptoms of dementia:

_____

_____

_____

4. Identify two irreversible types of dementia:

_____

_____

5. Identify two other conditions that might have symptoms that can look like dementia:

_____

_____

6. List three conditions that may worsen symptoms of dementia:

_____

_____

_____

Notes:

Notes:

Ombudsman Certification Training

CHAPTER 3: Communication and Consent

Communication and Consent

Chapter 3 is about communication, active listening, and consent. It has tips for communicating with people who have disabilities and provides a structured approach to communicate effectively with people who live in nursing homes and assisted living facilities. This chapter addresses important long-term care ombudsman consent requirements.

Learning Objectives

- Recognize the importance of active listening
- Understand the difference between empathy and sympathy
- Develop a protocol for communicating with residents
- Learn strategies for successful communication and observation during a facility visit
- Understand consent and confidentiality requirements for ombudsmen

Contents

- Communication Basics
- Communicating with Residents
- Consent

DVD(s), Supplements, Forms

- DVD: RSA Short: The Power of Empathy
- DVD: CMS Hand in Hand Training Module 3: Being with a Person with Dementia: Listening and Speaking

Communication Basics

Communication is a four step process.

- Message is sent.
- Message is received.
- Sender gets feedback.
- Another message is sent.

Communication includes verbal and nonverbal messages. To communicate effectively, it is important for the sender of the message to express him or herself in a way that the receiver knows what the message means. A mixed message is when verbal and nonverbal messages appear to contradict one another.

Verbal communication includes

- Tone of voice
- Word choice

Nonverbal communication (examples)

- Facial expressions
- Eye contact
- Touch
- Body language and gestures
- Spatial distance
- Silence
- Head nodding

Listening

Listening means comprehending what the other person is saying. It is one of the most neglected communication skills.

Active listening is the act of hearing what the other person is saying and responding both to the content and feeling of what is being said.

Goals for active listening are:

- Give the person your full attention.
- Be patient.
- Focus your energy on the conversation. Don’t let your thoughts stray.
- Be sincerely interested in what the other person is talking about.
- Listen for the intent and feeling of what is being said as well as the words.

- Restate what you heard the person say.
- Validate what the person said.
- Ask questions to clarify.
- Be aware of your own feelings and opinions.
- State your views only after you listen.
- Address inconsistencies in nonverbal and verbal messages.

Giving feedback is a good way to confirm the information you received is an accurate representation of what the sender intended. When you are unsure if the receiver understood your message, ask for feedback.

Active listening requires concentration and sincerity. One goal is to hear what the person says by listening for the intent and _____ of what is being said as well as the words.

Empathy

Empathy requires an ombudsman to not only understand residents' situations but also to relate to their feelings. Even if you are a naturally caring person, empathy can get lost in the process of "getting the job done," particularly when the focus is on facts, not emotions.

RSA Short - The Power of Empathy
Run Time: 2 min 51 sec

Watch the RSA Short – The Power of Empathy and answer the following questions.

1. What is the difference between empathy and sympathy? _____

   _____

2. What are three qualities of empathy?
   a) Ability to recognize the individual's perspective as his or her truth. _____
   b) _____
   c) _____

Listening Skills Assessment

Most people believe they are good listeners without considering the important differences between *hearing* and *listening*. Listening means paying attention and making a conscious effort to process what you hear. It is one of an ombudsman's most important skills. Are you a thoughtful, actively-engaged listener? Assess your listening skills using the exercise below.

Exercise: Rate Your Listening Skills

Take the listening skills assessment. It will give you an idea of which listening habits you might want to reshape. Think about how you listen and rank your behavior frequency in the list below with a 1, 2, 3, 4, or 5. Total the numbers for your score.

1 – Rarely 2 – Occasionally 3 - Neutral 4 - Fairly often 5 - Frequently

___ Talking too much, not giving the other person a chance to talk
___ Interrupting others when they are talking
___ Not looking at the person talking
___ Fidgeting with pencil and paper, tapping your legs, etc. when someone is talking
___ Having a "poker face," blank look, or manner which makes it difficult for another to know if you are listening
___ Trying to do other things while another is talking
___ Letting emotional-laden words arouse personal ill feelings
___ Daydreaming or thinking about other things while another is talking
___ Blaming the speaking habits or mannerisms of another
___ Finishing the other person's statements
___ Drawing conclusions about the subject before actually listening to it
___ Cleaning fingernails, glasses, etc. while the other person is talking
___ Listening only to the facts being said, not to emotional aspects
___ Sitting too close, being in another's personal space
___ Looking frequently at your watch or clock while another is talking
___ Letting your feelings get in the way while listening
___ Asking many questions while another is talking

____ ***Total score***

(The lower the score, the better listener you are. If your score is high, you need to work on your listening skills.)

How can you improve your listening skills? Practice. Start with the easiest habit to improve. For example, if you are prone to interrupting others, be slow to speak. Practice actively repeating what is being said to you as the speaker is speaking.

Communicating with Residents

Each individual who lives in an assisted living facility or a nursing home is unique in physical, mental, and psychosocial capacity. For an individual who has physical and mental challenges, communication can be difficult.

If you are unable to communicate with a resident for some reason, your supervising staff ombudsman is a good resource for information and ideas. Facility staff may also have helpful tips.

Ombudsmen strive to use “people first” language to avoid perpetuating stereotypes and creating barriers. For example, describing a person as an “individual with a disability” is considered more respectful than a “disabled person.” Watch and listen for descriptions of a person by the disability, such as “she’s a diabetic.” Ombudsmen can model respect by using more respectful language.

General Communication Etiquette

Focus on People First

- Think of the person first, not his or her disability or diagnosis.
- Assume the person has capacity to understand.
- Treat adults as adults.
- When other people are around, speak directly to the resident and not to the friend, companion, or interpreter who may be present.
- Avoid showing pity or being patronizing. Don’t pat hands or use endearments such as ‘honey’.
- Do not pet a service animal or make it the focus of conversation.
- Address people with disabilities by their first name only when extending the same familiarity to all others.
- Offer assistance completing forms or understanding written instructions and provide extra time for decision-making. Wait for the individual to accept the offer of assistance; do not "over-assist".

The Power of Attitude - Your Approach

- Approach residents from the front or within the line of vision.
- Before speaking, have the person’s attention.
- Smile and use a friendly voice and expression.

- Respect personal space.
- Be on the same level whenever possible.
- Respect all assistive devices such as canes, wheelchairs, crutches, and communication boards as personal property. Unless given permission, do not move, touch, or use them.
- If people have trouble shaking hands with the customary right hand, shake with your left or follow their lead on another greeting.
- Culture impacts communication too. Be aware of your cultural background, and the other person's, as you respond to verbal and nonverbal communication.

It is always a good idea to approach any resident from the _____.

Tips for Communicating with a Resident Who…

Appears Non-responsive

- Assume the individual has the capacity to understand and the ability to hear.
- Explain who you are and what an ombudsman is.
- Try to include the resident who appears non-responsive in the conversation, particularly if others are in the room.
- Use your "in plain sight" observational skills to determine if there are any environmental or care issues.

Appears Agitated

- Approach the resident from the front. It may startle and upset him if you touch him unexpectedly or approach him from behind.
- Act calmly; it can reduce agitation. Avoid quick, sudden, or erratic moves.
- Use short, clear, and concrete statements. Give step-by-step instructions.
- Never argue or try to reason with the person.
- Be alert for ways to gently change the subject, reduce the intensity of resident reaction, or remove yourself from the exchange.
- Ask staff for help to determine if the resident has an unmet need. The resident may be thirsty, tired, or in pain.
- Do not continue to try to calm a resident who is agitated. Ask staff for help.
- Keep out of striking distance. Never strike back.

Has Speech Impairments

- Be patient. Take as much time as necessary.
- Try to ask questions which require only short answers or a nod of the head.
- Concentrate on what the individual is saying.
- Do not speak for the individual or attempt to finish her or his sentences.
- If you do not understand something the individual says, do not pretend that you do. Ask the individual to repeat what he or she said and then repeat it back.
- Ask if the resident has a communication device.
- Consider writing as an alternative means of communicating, but first ask the individual if this is acceptable.

Aphasia is a communication disorder that results from damage or injury to language parts of the brain. It's more common in older adults, particularly those who have had a stroke.

Aphasia impairs a person's ability to use or understand words. Aphasia does not impair the person's intelligence. People who have aphasia may have difficulty speaking and finding the "right" words to complete their thoughts. They may also have problems understanding conversation, reading and comprehending written words, writing words, and using numbers.

Has Visual Impairments

- Speak to the resident when you approach.
- Identify yourself and anyone who accompanies you.
- If in a group, indicate whom you are addressing when you speak.
- Encourage and communicate using whatever vision remains.
- Leave things where they are unless the person asks you to move something.
- Allow the person to negotiate the surroundings, such as finding the door handle or locating a chair.
- You may offer assistance, but wait until your offer has been accepted. Then, ask for instructions on how you can help.
- Explain what you are doing as you are doing it.

Has Hearing Impairments

- Approach from the front or within the line of vision.
- Face the person. Maintain eye contact.
- Greet the person as you normally would.
- Lower the pitch of your voice and speak slowly.
- Speak normally. Do not shout or raise your voice unless asked to do so.
- Use simple, short sentences.
- Reduce or eliminate background noise.
- Be prepared to repeat what you say, orally or in writing. Consider writing messages.
- Minimize hand movements and keep your hands away from your face.

Visitors to nursing homes have a tendency to speak loudly when it is not needed. Ombudsmen should use a regular volume.

- Ask if the person reads lips, has a hearing device, has an assistive device, or prefers written communication.
- Use a picture or communication board.
- Use nonverbal communication and gestures.
- Seek help from an interpreter if the person signs.
- Don't interrupt or appear impatient.
- Help end the conversation if needed.

Who Does Not Speak English

- If you speak a resident's preferred language, use that language as much as possible.
- Learn a few words of the resident's native language, such as good morning, hello, and thank you. Address the resident by their proper name, such as Señora Chavez.
- Use gestures and nonverbal cues to help the person understand your meaning.
- Use a communication board or a free application on your phone, such as Google Translate or iTranslate.
- Ask the resident if there is someone on staff, a family member, or another resident that the resident trusts to translate for you.
- Have Spanish ombudsman cards and brochures available, and provide to residents whose preferred language is Spanish.

- Ask if the facility has a handheld translation device, and request to use it.
- Know your local resources for in-person and telephone language services.
- If options above are not sufficient, use a translator.
- When using a translator, direct questions to the resident. Make eye contact with the resident, observe the resident's nonverbal communication, and listen.

Has Limited Mobility

- If talking with people using a wheelchair for any length of time, try to place yourself at their eye level.
- Do not lean on a wheelchair or any other assistive device.
- Respect all assistive devices such as canes, wheelchairs, crutches, and communication boards as personal property.
- Never patronize people who use wheelchairs by patting them on the head or shoulder.
- You may offer to assist a person with a disability, but wait until your offer has been accepted. Then, ask for instructions on how you can best assist. For details on appropriate ombudsman activities, see Chapter 6.

In general, let a resident tell you if they need any help with their physical impairment. And, respect assistive devices as _____ _____.

Has Memory Loss

- Assume the person has the capacity to understand.
- Approach from the front and respect personal space.
- Avoid quick, sudden, or erratic moves.
- Face the person. Maintain eye contact. Smile.
- Greet the person as you normally would.
- Speak softly. Be calm and reassuring.
- Speak slowly. Ask simple "yes" or "no" questions.
- If you are in a public area with many distractions, consider moving to a quiet or private location.
- Take time to understand the individual and make sure the individual understands you.
- Don't correct mistakes made by the person. Be sensitive to the resident's reality and allow it to be what it is.
- Be patient, flexible, and supportive.

Dementia is a progressive decline in memory and at least one cognitive area such as abstract thinking, attention, personality, and judgment. Brain damage as a result of head injury or disease such as alcoholism, Alzheimer's disease, or Parkinson's disease may cause dementia.

Delirium is sudden severe confusion and rapid changes in brain function usually as a result of physical or mental illness. Symptoms include confusion, difficulties with short-term memory, wandering attention, physical restlessness, and changes in personality, sleep patterns, and alertness. Delirium is usually reversible.

CMS Hand in Hand Training - Module 3: Being with a Person with Dementia: Listening and Speaking

Run Time: Approximately 1 hour to view video clips and discuss

Just as staff experience frustration trying to understand what a resident with dementia is trying to communicate, the resident experiences frustration with their communication challenges.

Communicating with people with dementia involves more than words. It involves understanding the meaning and feeling behind what they are saying, so that we can respond to their emotions and fulfill their needs.

Answer the following questions about CMS Hand in Hand Module 3.

1. Because communication can be difficult for an individual with dementia, we have to learn to look for the meaning in _____ and nonverbal communication.

2. Identify three ways memory loss affects how an individual with dementia communicates:

   (1) _____

   (2) _____

   (3) _____

3. In *Good Morning Video Clip 1*, what did you notice about Mrs. Caputo's

communication?

_____

_____

4. In *Good Morning Video Clip 1*, what did you notice about how Jane communicated with Mrs. Caputo?

_____

_____

5. In *Good Morning Video Clip 2*, what did you notice about Mrs. Caputo's communication? How was she communicating?

_____

_____

_____

6. In *Good Morning Video Clip 2*, what did you notice about how Heather communicated with Mrs. Caputo? How did Mrs. Caputo respond?

_____

_____

_____

Communication Methods

The following communication methods are tried and true and help build trusting relationships:

1. Always respect the rights and dignity of each resident.
2. Remember their room is their home.
   - Knock on doors and receive permission before entering.
   - Try to sit at eye level and sit where offered.
   - Respect privacy by offering to close the door.
   - Excuse yourself if care or services are needed and never interrupt a resident who is receiving care. Closed doors often signal that care is being provided.
3. Begin with a proper introduction, addressing residents as the adults they are.
   - Greet by Mr., Mrs., or other title and given name, unless they suggest another name.
   - Avoid using words that are too simple.

- Avoid using overly complicated words and acronyms.
- Adapt your conversation to the resident's level of understanding.

4. Make it clear who you are and why you are there.
   - "Hello, my name is _____ and I am your ombudsman. I work for you."
5. Request permission to talk.
   - "Is now a good time to talk?"
   - "Do you feel like talking?"

Exercise: Instructor Demonstrates an Introduction

Think about how you will introduce yourself when you meet a resident for the first time. Your instructor will demonstrate. Answer the following questions.

1. How did the ombudsman describe the role of the ombudsman?

   _____

   _____

2. What listening techniques were used?

   _____

   _____

3. What will you say when you introduce yourself to residents and staff? Create your own introduction. Practice introductions with your instructor and other trainees.

   _____

   _____

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6. Keep an open body posture. Open posture is often perceived as communicating a friendly and positive attitude (uncrossed arms and leg, head upright). Establish a level of verbal warmth and trust. Be attentive and let them know you are interested.
   - Do not be in a rush to discover issues; use small talk to establish rapport, such as "Are you from this area? What caused you to move here? Do you have family around here? Are these pictures of your family?"
   - Allow the conversation, whenever possible, to go where the resident wishes. Gently look for openings to address potential issues. Don't rush!
   - Let residents set the pace of the conversations.

- Resist the impulse to talk rather than listen.

7. Be mindful about your personal reactions and feelings.
    - Be honest and professional.
    - Act from the residents' values; do not impose your values on them.
    - Be aware of your communication to ensure you are not inserting your opinions.

One of the most helpful things an ombudsman can do is listen without judgment and without imposing values on the resident.

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8. Discover residents' support systems.
    - Ask about contacts with family, friends, and other visitors.
9. Explore their personal history.
    - Without prying, discover residents' personal interests and life history.
    - Mention interests you have in common to build rapport.
10. Discuss the history of their stay.
    - After developing rapport, talk about their feelings about living in the nursing home or assisted living facility. (Gather information through conversation to find out what it's like to live there.)
    - Ask specific questions that may give clues to their feelings about where they live, such as "Does everyone here treat you well? Do you feel safe? Do you have family that visits? Do you ever feel lonely? How do staff members respond to your requests for help?"
    - If they express dissatisfaction about their life in the facility, probe for more information.
    - Listen carefully. Write down important information to remember. Ask permission to take notes or make notes later in a private place.
    - Observe residents. Are they nervous or shaking? Do they cry easily or get angry? Do they appear fearful of being overheard by staff?
    - Pursue concerns; do not ignore concerns that residents share.
11. Ask for permission before you talk to anyone about a complaint. This is also called "obtaining consent."
    - Explain the reason you want to talk with someone else and who it is.
12. Do not undermine your trusting relationship with a resident.

- Do not ask questions of facility staff or take action that is inconsistent with resident wishes.
- When you feel conflicted about your role, consult your supervising staff ombudsman.
- Maintaining confidentiality is the foundation of your integrity.

13. Respect confidentiality; protect resident identity if they ask you. Complaints can be investigated and resolved without using a resident's name. Some complaints affect several people in the facility.
14. Use residents as resources to resolve their problems. They can provide helpful information about whom you should approach and how you might attempt to resolve a problem.
    - Contact members of a resident council, such as the president of the council, as especially helpful resources.

Read how Resident Councils may be a good resource for resolving problems on behalf of residents in Chapter 7.

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15. Be honest and direct about your intentions. Explain any risks involved in any course of action.
16. Take resident concerns about retaliation seriously.
    - Respect confidentiality by visiting several residents and not identifying a resident as a complainant without consent to do so.
    - Refer to complainants as "resident or complainant" and avoid using identifying terms such as "he or she, resident's son, daughter, or wife."
    - Offer alternatives to residents about how you can investigate or work to resolve the problem without using their name.
    - Protect identities by visiting many residents before addressing a complaint or even returning another day to address a non-critical complaint.
17. Avoid making promises in general about what you will accomplish.
18. Be patient, dependable, and honest.

Communication During a Facility Visit

When you enter a facility:

- Let staff know you are there to visit residents.
- Wear your ombudsman badge and lanyard so that residents, residents' family, and staff can easily identify you as an ombudsman.
- Introduce yourself to new staff but keep your visit resident-focused.
- It is not a requirement for ombudsmen to sign the facility's visitor log at each visit. If you have questions about a facility's request that you sign-in at each visit, please consult your supervising staff ombudsman.
- Optional: Request the facility census (roster). You can request a list of residents by room number or by name. Ask if there are any new residents. As you visit with residents, place a check next to their name on the census to identify how many residents you visited. This is a confidential document that becomes an ombudsman record and must be safeguarded from release.

Visit with multiple residents

- If you are assigned a large facility with many residents, visit as many residents as time allows.
- Vary the residents you visit. Ensure all residents have access to the ombudsman.
- Make an effort to meet with new residents and families to share information concerning the ombudsman program and residents' rights.
- Offer residents privacy for confidentiality in communication.

See Chapter 6 *Facility Visit Guide* for more information on facility visits.

Consent

Consent is required from a resident or complainant to:

- work on a resident's behalf;
- reveal a resident's or complainant's name or identifying characteristics; or
- access a resident's record or other confidential information.

Regardless of the source of a complaint (*complainant)*, ombudsmen serve the resident. Offer privacy options to the resident for conversations involving complaints. Personally discuss the complaint with the resident to determine the resident's perspective and wishes regarding resolution. Before taking any action, communication of informed consent is required from the resident. Unless a court has ruled the resident is incapacitated, the resident speaks for himself or herself.

Informed Consent

Communication of informed consent (from a resident or others) means ombudsmen:

- explain the ombudsman role;
- clarify their understanding of the resident's problem or request;
- explain the resident's rights;
- describe what actions can be taken;
- discuss possible outcomes or consequences, as needed;
- get direction from the resident on how to proceed; and
- receive voluntary communication of consent.

Communication of Consent

Consent may be given in writing, orally, or visually, including through the use of auxiliary aids and services such as an interpreter or electronic communication device. For all situations where consent is obtained, permission applies to the immediate case or request and does not extend to future work. A resident may withdraw consent at any time and that stops the ombudsman's actions.

Consent is required for an ombudsman to work on a resident's _____, reveal a resident's or complainant's name, or access a resident's record or other _____ information.

Examples of how to ask for consent include:

- Would you like me to handle this concern or would you like to handle it on your own?
- Is it okay to use your name or would you prefer to be anonymous?

The ombudsman's role is not to determine a resident's capacity to make decisions. If you have concerns and are uncertain how much help you should give someone, consult your supervising staff ombudsman or MLO. Remember the resident keeps the right to make decisions unless a court has decided the person is incapacitated. Consult your supervising staff ombudsman if the resident:

- cannot remember you from visit to visit (you, not your name);
- has fixed, obsessional thoughts;
- is not able to understand, appreciate, and manipulate information; or
- displays unpredictable emotions.

The Ombudsman as the Complainant

If an ombudsman determines a concern impacts several residents, the ombudsman can open a complaint with the ombudsman as the complainant. In this case, the ombudsman does not identify specific residents. If an ombudsman plans to file a complaint contrary to the original resident's wishes, notify the resident of this decision and inform the resident that his or her identity will not be revealed.

If Resident is Unable to Communicate Consent

When a resident is unable to consent, an ombudsman seeks consent from a legally authorized representative (LAR) if one exists. An LAR may be a guardian or power of attorney.

If Resident is Unable to Communicate Consent and Has No LAR

If the resident is unable to consent and there is no LAR, a consultation with the SLTCO is required.

- The ombudsman consults with the supervising staff ombudsman or MLO. Staff or MLO consult the SLTCO.
- SLTCO approval is required before any action is taken or information is disclosed.
- The SLTCO considers information about a resident’s advanced directives or previously expressed wishes to make a decision. Both ombudsmen and facility staff need to know if advanced directives are on file at the facility or if the resident’s previously expressed wishes are contrary to the action under consideration.

Consent Documentation

Ombudsmen must document consent. Use release forms, case notes, or monthly reports to document consent. Your supervising staff ombudsman will provide these items. More information about consent forms, case notes, and monthly reports is provided in Chapters 11 and 12.

Guardian (of the Person)

Confirm with facility staff or the guardian that there are current letters of guardianship of the person in the medical records. Review the documents to determine scope of the guardian's authority. Work with the guardian, who speaks for the resident and may consent on the resident's behalf, per the court orders.

If a complainant is someone other than the guardian and the guardian does not consent, consider if the guardian is acting in the resident's best interest. Residents with a guardian may be a complainant too. If you believe the guardian is not acting in the person's best interests, an ombudsman must obtain approval from the State Long-term Care Ombudsman to take action on behalf of the resident.

An ombudsman may work with the guardian of the estate regarding financial issues.

Unless a court rules a resident is _____, a resident speaks for himself or herself.

Powers of Attorney

A medical power of attorney (MPOA) assigns an agent to exercise authority *only if the resident's attending physician certifies in writing that the resident is incapacitated*. The resident may revoke the MPOA at any time. Revocation is made by oral or written notification to the agent, the provider, or by any other act showing intent to revoke the MPOA. If a resident requests assistance or files a complaint, consider the resident as the client. Coordination or consultation with the MPOA is not required; for all circumstances, follow the resident’s direction.

A durable power of attorney (DPOA) takes effect in accordance with the terms of the DPOA document. Depending on how the document is written, the agent may exercise authority when the resident is able to make decisions, when the resident is incapacitated, or both. Determining the resident’s incapacity may be established in the language of the DPOA, but not always. Revocation of a DPOA is not addressed in law and if the DPOA document does not address revocation, the resident can revoke either orally or in writing as with an MPOA. Coordination or consultation with the DPOA is not required; follow the resident’s direction. More information on revocation of Powers of Attorney is detailed in Chapter 8: Care Planning.

Consent to Work on a Resident or Complainant's Behalf

A resident or complainant must provide consent for an ombudsman to work on the resident's behalf. If the complainant is not a resident, seek agreement from the resident to work on the issue.

If the resident declines consent, the resident's wishes supersede the complainant's and an ombudsman may:

- Advise the complainant of alternate resolution strategies. Options may include providing consultation to the complainant for self-advocacy with facility management, having the complainant work through a family council, or having the complainant follow the facility's grievance policy. If the complainant's concern involves a regulatory violation, provide information on how to file a complaint with Regulatory Services.
- Determine if the concern impacts other residents and file a complaint with facility management or Regulatory Services with the ombudsman as the complainant and no identification of specific residents. If an ombudsman plans to file a complaint contrary to the original resident's wishes, notify the resident of this decision and inform the resident that his or her identity will not be revealed.

If an ombudsman determines a problem affects other residents but the resident does not give consent, the ombudsman could take action with the ombudsman as the complainant, but must _____

_____.

Consent to Reveal Identity

For each case in which identity cannot be protected, the complainant must provide consent to disclose or the ombudsman clearly identifies him or herself as the complainant. All complainants, both residents and others, are afforded protection of identity in ombudsman laws and rules; therefore, protect the identity of non-resident complainants the same as residents.

In practice, a facility staff person may speculate about the identity of a resident or complainant. Without consent of the resident or complainant, do not confirm such speculation. Instead, redirect the conversation to information that is relevant and not confidential. If necessary, inform facility staff of the long-term care ombudsman program's confidentiality law or inform staff that the question arises from the ombudsman, rather than a resident or other complainant.

Ask the trainer. Discuss the following situations with your instructor.

1. Several younger residents engage in activities that intimidate older residents. Younger residents say they are exercising their choices and preferences. The older residents ask the ombudsman to represent them in making the younger residents change their behavior.

- How does the ombudsman decide whom to represent? _____

  _____

- What are some strategies to consider when residents have problems with other residents? _____

  _____

2. A resident with dementia has no legal representative. Some of her actions lead the ombudsman to wonder if her care plan needs updating.
   - What is the role of the ombudsman? _____
   - What authority, if any, does an ombudsman have to seek changes for a resident?

     _____

     _____

3. A facility asks the ombudsman what to do about a resident they are discharging.
   - What is appropriate for the ombudsman to say and do? _____

     _____

   - What should the ombudsman avoid doing? _____

     _____

   - How does the facility's request for help affect the ombudsman's actions? _____

     _____

   - Will the ombudsman instill trust in other residents if he or she helps facility staff in discharging the resident? _____

4. A resident tells you that her breakfast is always served with coffee, instead of hot tea which she has requested multiple times. You visit with the administrator about the resident's breakfast drink preference and will watch meal service several times during the next month. Did you have consent to work the complaint?

   _____ Yes (Y) or No (N)

Facility staff might guess who lodged a complaint. Without the complainant's permission, do not confirm.

Consent to Access Confidential Information

Access to records and the information within a record is all confidential. Facility staff members have an obligation to protect each resident's record from inappropriate access. Not only do laws pertaining to nursing homes and assisted living facilities protect privacy of a resident's record, the Health Insurance Portability and Accountability Act (HIPAA) establishes standards to protect individual medical records and personal health information.

HIPAA protects patient information from being released without the person's consent. HIPAA directs a facility to take certain precautions before releasing records. However, an ombudsman accesses confidential information in accordance with the Older Americans Act.

Under the HIPAA Privacy Rule, a long-term care ombudsman program is a "health oversight agency." Therefore, it does not prevent releasing resident clinical records to ombudsmen. If an ombudsman has proper consent, facilities must share information. This action does not violate HIPAA.

In anticipation of any questions of your authority, be prepared with applicable law and rules. If facility staff denies access, consult your supervising staff ombudsman. Chapter 12 describes the process for obtaining consent to access a resident record. Consent to access confidential information may be documented. For more information, see Chapter 12 and Supplements 12-B Form 8624-O (oral) and 12-C Form 8624-W (written), Consent to Release records to the Certified Ombudsman.

Do not disclose (outside of the ombudsman program) any information about a resident unless you have the resident's consent. Treat the information you read in a written record the same as information you hear from a resident, medical professional, or other caregiver. Everything you read and hear about a resident and other complainants should be carefully guarded to protect the identity and privacy of a resident.

Information acquired within a record or disclosed orally is essentially the same. It is _____.

HIPAA applies to _____.

Older Americans Act applies to _____.

Notes:

Ombudsman Certification Training

CHAPTER 4: Abuse, Neglect, and Exploitation

Abuse, Neglect, Exploitation (ANE)

Chapter 4 provides an understanding of the Texas Long-term Care Ombudsman Program response to abuse, neglect, and exploitation. This chapter also reviews advocacy reporting policies and strategies.

Learning Objectives

- Define abuse, neglect, and exploitation (ANE)
- Learn to identify types of abuse
- Understand a long-term care ombudsman's reporting and advocacy responsibilities related to ANE

Contents

- Abuse, Neglect, Exploitation
- Facility Responsibilities
- Who Investigates ANE?
- ANE Guidelines for Ombudsmen

DVD(s), Supplements, Forms

- DVD: CMS Hand in Hand Training Module 2: What is Abuse?
- DVD: CMS Hand in Hand Training Module 5: Preventing Abuse

Overview

This chapter examines how to recognize abuse, neglect, and exploitation (ANE) and reviews an ombudsman's reporting responsibilities. Federal requirements related to ANE and disclosure are noted.

Every resident has a right to be free from ANE. As advocates, ombudsmen are part of the elder justice system to prevent abuse and help residents and others report ANE with consent from the resident.

Since ombudsmen are directed by resident goals for complaint resolution and federal disclosure requirements, their role in allegations of abuse is unique and differs from other agencies in Texas. Respecting resident confidentiality is critical not only to maintain compliance with program requirements, but also to adhere to the fundamental ombudsman role as a resident advocate. Respecting our confidentiality mandate also maintains the integrity of the ombudsman program and fosters trust between the ombudsman and residents. However, maintaining confidentiality in response to complaints involving abuse is a challenging, complex situation that requires careful analysis and consultation with your ombudsman supervisor.

Abuse, Neglect, and Exploitation

It is important for ombudsmen to know how to recognize and respond to allegations of ANE. Ombudsmen must have a thorough understanding of our responsibilities about when and how to report it. Ombudsmen do not determine whether ANE occurred, but act as an advocate for the resident by helping report, and ensuring the resident, and other residents, are protected from further harm. Regulatory Services determines if ANE occurred.

Ombudsmen do not determine whether abuse, _____, or exploitation happened. We act as an _____ for the resident by helping report, and ensuring the resident, and other residents, are protected from further harm.

Abuse

Abuse is the negligent or willful infliction of injury, unreasonable confinement, intimidation, or punishment that causes physical or emotional harm or pain to a resident; or sexual abuse. It includes involuntary seclusion, any type of physical punishment, sexual harassment or coercion, deprivation, and any oral, written, or gestured language that includes disparaging or derogatory terms, regardless of the person's ability to hear or comprehend.

Examples of abuse may include:

- An aide called a resident "the wicked witch."
- A charge nurse told a resident he will never see his family again if he doesn't comply with treatment.
- A staff person humiliated and reprimanded a resident who did not make it to the restroom in time.
- A nurse coerced a resident by pinching her arm.
- An aide jokingly used sexual innuendo with a male resident who is embarrassed but pretends to go along with her joke.

Neglect

Neglect is the failure to care for a person in a manner which would avoid physical or emotional harm or pain, or the failure to react to a situation which may be harmful. Neglect may or may not be intentional.

Examples of neglect may include:

- incorrect body positioning – which leads to limb contractures and skin breakdown;
- lack of toileting or changing of a disposable brief – which causes incontinence and results in a resident sitting in urine or feces, increased falls or agitation, indignity or skin breakdown;
- lack of assistance eating or drinking – which leads to malnutrition and dehydration;
- lack of assistance with walking – which leads to lack of mobility;
- poor hand washing techniques – which leads to infection;
- lack of assistance with participating in activities of interest – which leads to withdrawal and isolation; or
- ignoring call lights or cries for help.

Neglect is the failure to care for a person in a manner which would avoid _____ or emotional harm or pain, or the failure to react to a situation which may be harmful. Neglect may or may not be intentional.

Exploitation

Exploitation is the illegal or improper act or process of a caregiver, family member, or other individual who has an ongoing relationship with a resident using the resources (money, assets, property) of the resident (or an elderly or disabled person) for monetary or personal benefit, profit, or gain without the informed consent of the resident.

Exploitation is defined as the _____ or improper act or process of a caregiver using the resources, such as money, assets, or property, of an elderly or disabled person for _____ or personal benefit.

Types of Exploitation

Financial mistreatment of older adults or adults with disabilities may be committed by a person known to the victim or by a stranger.

- Misappropriation of income or assets – The perpetrator obtains access to social security checks, pension payments, checking or savings accounts, credit cards, or ATM cards, or withholds portions of checks cashed for a senior citizen.

  Example: An aide who provides care to a resident offers to go to the store to buy snacks for her. The resident gives the aide her debit card and personal identification number. The aide gets cash back for herself.
- Charging excessive fees for goods or services – A person charges excessive rent or unreasonable fees for basic care services such as transportation, food, or medicine.
- Obtaining money or property by undue influence, misrepresentation, or fraud – An individual, staff, or family member coerces (pressures, bullies, misrepresents state of finances) a resident into signing over investments, real estate, or other assets through the use of manipulation, intimidation, or threats.

- Improper or fraudulent use of power of attorney or fiduciary authority – A person improperly uses the power of attorney or other fiduciary authority to alter a will, borrow money using the victim's name, or dispose of assets or income.

CMS Hand in Hand Training - Module 2: What is Abuse?

Run Time: Approximate 1 hour to view video clips and discuss them

Ombudsmen should keep in mind the information presented in Hand in Hand is created for facility staff, but many of the principles can be applied to ombudsman work. For ombudsmen, special considerations apply to reporting allegations of ANE.

Different types of abuse can occur at the same time. Abuse can be the result of escalated situations between staff and residents. Many times abuse is not witnessed, but we might see signs that abuse has occurred. Knowing residents can help you recognize changes that indicate something is wrong.

Watch CMS *Hand in Hand Module 2.* Answer the following questions.

1. List three types of abuse:
   a) _____
   b) _____
   c) _____

2. An example of verbal abuse is:

   _____

3. An example of physical abuse is:

   _____

4. An example of involuntary seclusion is:

   _____

5. Misappropriation of property is commonly called _____, but also includes deliberately misplacing a resident's belongings or money and using a resident's belongings without his or her permission.

6. List some signs of abuse:
   - _____
   - _____
   - _____

Facility Responsibilities

Employee Screening

Every facility has a responsibility to protect residents. Before a nursing home or an assisted living facility hires an employee, the facility must search the employee misconduct registry (EMR) and nurse aide registry (NAR) to determine if the person is designated in either registry as unemployable. Both registries are accessed on the internet.

A facility is prohibited from hiring or continuing to employ a person who is listed in the EMR or NAR as unemployable. Additionally, a facility may not hire a person convicted of one of the permanent bars to employment. Examples of permanent bars to employment include criminal homicide, kidnapping, Medicaid fraud, sexual or aggravated assault, and indecency with a child.

Employee Training

As a condition of employment, an employee of a facility must sign a statement that says the employee may be criminally liable for failure to report abuse. ANE training for staff must include how to recognize and report incidents. Training must include what, when, and to whom within the facility the report should be made. Each facility must have a formal reporting system that is known to staff.

Resident Screening

The facility should assess any potential resident's needs and determine if their facility can meet those needs before a facility accepts a resident. Unmet needs can lead to abuse and neglect. Screening should include an assessment of the resident's functional, health, nutritional, and social status, as well as mental acuity and special needs.

Facility Incident Reporting

A nursing home or assisted living facility must immediately report allegations or suspicions of ANE to Regulatory Services. For some types of ANE allegations, they must also report to local law enforcement. Depending on reporting guidelines and facility rules, providers must report other incidents including:

1. Misappropriation of funds or resident property
2. Death of a resident that involves unusual circumstances
3. Missing resident – If a resident is not located during a search of the facility, facility grounds, and immediate vicinity, and circumstances place the resident's

health, safety or welfare at risk, a report must be made as soon as the facility becomes aware the resident is missing and cannot be located.

4. Drug diversions – The facility must make a report to the State if it has reason to believe that drugs were stolen. Staff must also notify the local police department.
5. Fires – State provider letters specify reportable fire related incidents for assisted living facilities and nursing homes.
6. Conditions that pose a threat to resident health and safety – Examples include bomb threats, floods, failure of the sprinkler system or fire alarm, and others.
7. Injuries of unknown source – In nursing homes, if no one saw the incident that resulted in the injury or the source of the injury could not be explained by the resident; and, the injury is suspicious because of the extent of the injury, the location of the injury, number of injuries observed at one point in time, or the number of injuries over time. Encourage assisted living facilities to self-report serious injuries that are suspicious (possible ANE), or that are from an unknown source.

Sources: Provider Letter 14-10 – Joint Investigation with Law Enforcement Agencies of Nursing Home Abuse
Provider Letter 14-13 – Abuse, Neglect, Exploitation and Other Incidents that Must Be Reported–NF
Provider Letter 14-18 – Joint Investigation with Law Enforcement Agencies of ANE Allegations - ALF
Provider Letter 14-22 – Guidelines for Reporting Incidents - ALF

Who Investigates ANE?

Facility

A facility must thoroughly investigate all allegations of ANE and start the facility investigation immediately. It is important for facility policies and procedures to clearly delineate roles for those responsible for investigating and to describe appropriate responses to ensure protection of the alleged victim and the integrity of the investigation. Facility responses might include suspending the alleged perpetrator, making a room or staffing change, or developing a resident treatment plan.

In nursing homes, the employee named as the abuse coordinator is responsible for conducting the investigation. In an assisted living facility, the manager or executive director is usually responsible for conducting ANE investigations.

Nursing homes and assisted living facilities must follow the rules for ANE allegations which are found in §19.601 and §92.102. Facilities:

- follow the facility's policies and procedures for investigations of ANE;
- investigate every report or allegation;
- take action to protect the resident during the investigation and develop an immediate corrective action plan;
- take action when ANE is confirmed; and
- report the ANE investigation determination to Regulatory Services.

The facility's investigation determination is based on the quality and quantity of evidence and whether or not it is sufficient to confirm the allegation. After the facility conducts the investigation, they must send a written report of the investigation to Regulatory Services no later than the fifth working day after the oral report was made.

Regulatory Services

Regulatory Services investigates allegations of abuse and neglect if the incident occurred while the resident was in the facility, the facility was responsible for the supervision of the resident when the incident occurred, and the alleged perpetrator is affiliated with the facility. Other complaints of abuse and neglect that do not meet the previous criteria are referred to Adult Protective Services (APS). Certain types of serious allegations require Regulatory Services and the facility to report those allegations to law enforcement for joint investigation.

Regulatory Services also investigates resident financial exploitation if the alleged perpetrator is affiliated with the facility (employee, contractor, or volunteer).

Adult Protective Services

APS investigates if an allegation of abuse or neglect states the incident occurred outside of the facility, the alleged perpetrator is a family member, caregiver or person with an on-going relationship with the resident (as determined by APS), and the facility was not responsible for supervision or service delivery at the time the incident occurred.

APS and local law enforcement investigate financial exploitation incidents that occur while the resident is in a nursing home or assisted living facility and the alleged perpetrator is family member, caregiver, or person with an on-going relationship with the resident, and is not an employee, contractor, or volunteer of the facility.

If the alleged perpetrator is unaffiliated with the facility and unrelated or unknown to the victim, neither Regulatory Services nor APS has the authority to intervene. In these cases, the responsibility goes to other state and local agencies. Local police is one option. A second option is The Office of the Attorney General, Consumer Protection Hotline (1-800-621-0508). The Consumer Protection Division works to identify and prosecute those who deceive older adults through scams or fraud.

See the Memorandum of Understanding between DFPS Adult Protective Service and Long-term Care Ombudsman Program in Chapter 13, Regulators and Resources, Supplement 13-B for more information.

Texas has mandatory reporting laws that require everyone to report suspected elder abuse. However, state law does not require an ombudsman to report suspected ANE where such reporting violates federal requirements. By federal law, an ombudsman is prohibited from the disclosure of the identity of a complainant or resident without appropriate consent.

Ombudsmen ANE Complaint Guidelines

As described in Chapter 3, consent mandates apply to complaints involving ANE. Regardless of the source of a complaint, ombudsmen serve the resident and must support resident participation in the process of resolving complaints involving ANE allegations.

If Resident is Able to Communicate Consent

Federal rules direct ombudsmen to personally discuss complaints with residents to determine their wishes concerning resolution of the complaint. This includes whether to report an ANE allegation, and, if so, whether the ombudsman may disclose identifying or other relevant information to the facility or another appropriate agency. In order to comply with the wishes of the resident, ombudsmen do not report suspected ANE if the resident did not communicate informed consent. If the resident consents, the ombudsman must help the person report if requested.

Even if an ombudsman carries a professional license (for example, a licensed social worker or nurse), the ombudsman must adhere to the federal disclosure requirements when acting as ombudsman and must not report abuse without appropriate consent or approval from the MLO and State Ombudsman.

If Resident is Unable to Communicate Consent

When a resident is unable to consent, an ombudsman seeks consent from a legally authorized representative (LAR). An LAR may be a guardian or power of attorney.

If Resident is Unable to Communicate Consent and Has No LAR

If a resident is unable to communicate consent with regards to a complaint involving ANE allegations and has no LAR, a consultation with the State Ombudsman is required. Ombudsmen contact their supervising staff ombudsman or MLO who will seek guidance from the State Ombudsman. Approval from the State Ombudsman must be obtained before any information is shared or any action is taken.

If Complainant is Someone Other than the Resident

Any allegation of ANE that names a resident requires the resident's consent before an ombudsman takes action. If allegations of ANE are reported to an ombudsman by someone other than the resident, encourage the person to report the allegation to Regulatory Services at 1-800-458-9858. It is preferable for the person to report ANE directly so the intake worker can collect firsthand details. If the person for any reason is unable or unwilling to report, an ombudsman must report for the person *if* the ombudsman has permission from the resident to do so or the allegation does not include any names of residents. Speak with any named resident about an allegation, their rights, options to report, and other advocacy options.

If ANE is brought to an ombudsman's attention by a facility, the ombudsman follows typical complaint procedures, remaining resident-directed. Follow-up with the facility to ensure they took action to investigate, report, and protect residents. Visit residents and watch for other signs of ANE. If directed by a resident, take appropriate action.

ANE Witnessed by an Ombudsman

If an ombudsman personally witnesses ANE of a resident, the ombudsman must obtain the resident's consent prior to disclosing resident-identifying information to the facility or another agency. The ombudsman follows the direction of the resident or resident's LAR if the resident is unable to consent. Ombudsmen do not report witnessed suspected ANE of a resident when a resident (or resident's LAR when applicable) does not communicate informed consent.

Consultation Required

If a resident is unable to consent and has no LAR, immediately consult with your supervising staff ombudsman. Approval from the State Ombudsman is required before taking any action outside the ombudsman program.

If the ombudsman does not have resident consent but assesses the situation and believes there is an immediate threat to the health, safety, or welfare of a resident, immediately contact the supervising staff ombudsman. The MLO is responsible for immediately notifying the state office. A staff person at the state office will determine if reporting to facility management is in the best interest of residents, and may approve releasing confidential information for purposes of an ANE report.

Within two hours of witnessing the incident, create an ombudsman record that documents what you witnessed. Do not release any document without approval from the State Ombudsman.

Other Advocacy Strategies When Consent is Withheld

This section applies when a resident is capable of giving consent, but has not given it to the ombudsman. Sometimes it is necessary to employ other advocacy strategies when responding to allegations of abuse, where consent is not given, in order to protect resident confidentiality and ensure resident safety. Other advocacy strategies may include:

- Explore the reason for the resident's reluctance to pursue the allegation of ANE.
- Offer to investigate without disclosing a name or identifying information.
- Determine whether other residents with the same issue are willing to pursue it to resolution. This strategy must be carefully executed to avoid revealing who the initial complainant was and to avoid elevating anxiety levels among other residents.
- Ask the resident if there is a friend or family member with whom this information was shared. Ask if you can talk to this person.
- Determine if the resident will consent to you reporting to a specific staff person they trust, or with you by their side.

Case Examples

Case 1: A resident tells you he was injured by someone who works at the assisted living facility where he lives. He tells you he didn't want to shower and the shower aide tried to force him. He does not give you consent to report the ANE nor to disclose any identifying information.

Ombudsman Response: If consent is withheld, the ombudsman does not report the ANE allegation. Determine if other residents may be affected. Consider other advocacy options.

Ask the trainer. What other advocacy options might be used?

_____

_____

Case 2: A facility staff person shares an allegation of abuse with you.

Ombudsman Response: Remind the staff person that employees of long-term care facilities are mandatory reporters and are obligated to report their suspicions, whether or not they can prove them. Contact Regulatory Services to inquire whether an allegation of abuse from the facility staff was received. Do not reveal confidential information or information that might be used to identify the resident or complainant.

Ask the trainer. You personally witness abuse. What should you do?

During a facility visit, you see and hear an altercation between a nurse and a resident during a birthday party. The resident is crying and holding her arms up in front of her face as if to protect herself. Four residents and two aides are also in the room where the verbal confrontation is occurring. What should you do?

_____

_____

_____

_____

CMS Hand in Hand Training - Module 5: Preventing Abuse (Begin with Lesson 2): Actions and Reactions

Run Time: Approximately 1 hour to view video clips and discuss

Abuse situations are sometimes the result of a series of actions and reactions that escalate. This chain of events is often preventable. There are many reasons why residents might act the way they do. Understanding 'why' will help caregivers, and ombudsmen, find a better approach to a situation and prevent a series of events that might lead to abuse.

Watch CMS Hand-in-Hand Training - Module 5*:* Fill in the blanks below.

1. Abuse sometimes results of a series of actions and _____ that could have been prevented.

2. Identify several ways to respond to a resident's actions that might prevent abuse.
   - _____
   - _____
   - _____

3. _____ True (T) or False (F)?

   A nursing home is required by federal regulation to report alleged violations of mistreatment, neglect, or abuse to the state survey agency.

4. Facility staff must report suspicion of a crime within _____ hours, if the events result in serious bodily injury to a resident.

SOURCES: The National Long-Term Care Ombudsman Resource Center, TA Guide: Technical Assistance for LTCO Practice, *Responding to Allegations of Abuse: Role and Responsibilities of Long-term Care Ombudsmen and Long-Term Care Ombudsman, The National Long-term Care Ombudsman Resource Center, Final Regulations Overview;* CMS *Hand in Hand Training* Modules 1-6

Notes:

Ombudsman Certification Training

CHAPTER 5: Residents' Rights

Residents' Rights

Chapter 5 is about understanding residents' rights and the ombudsman role to support residents in exercising their rights.

Learning Objectives

- Become familiar with the scope of residents' rights
- Recognize the importance of empowering residents rather than creating dependency
- Connect resident rights to applicable complaints
- Experience a facility visit

Contents

- Overview of Residents' Rights
- Empowerment
- Ombudsman Role
- Residents' Rights Themes
- Residents' Rights under Law
- Incapacitated Residents
- Shadow Visit Overview
- Facility Contact Sheet

DVD(s), Supplements, Forms

- DVD: Residents Speak Out Against Retaliation
- YouTube Video: Nursing Home Transfer and Discharge Procedures
- Supplement 5-A: Nursing Home Resident Rights
- Supplement 5-B: Assisted Living Facility Resident Bill of Rights

When asked what they consider most important to the quality of their lives, residents say:

"Give me kind, caring staff who respect my dignity and privacy and treat me as a person. Recognize I am an adult and let me make choices in all areas of my life."

Overview of Residents' Rights

Long-term care ombudsmen have a responsibility to:

- provide information about residents' rights; and
- help residents to exercise their rights.

Understanding rights and an ombudsman's role to support residents in exercising their rights is essential. The ombudsman process and approach is much the same regardless of whether a resident lives in a nursing home or assisted living facility. Laws and regulations are different in these settings.

Ombudsmen use laws and regulations as advocacy tools. Some regulations referenced in this chapter apply only to nursing homes that accept Medicaid or Medicare. Rely on state laws and regulations for people who live in assisted living facilities and licensed-only nursing homes.

You have daily routines and preferences.

- How and when do you wake up?
- What is your usual bathroom routine?
- How do you get ready for bed?
- When, what, where, and how do you like to eat?

If you were a resident,

- What must staff know about you to have a good relationship?
- How would you feel if you had to change your routines?

How might individual routines impact residents' rights?

_____

_____

Empowerment

Empowerment means to take power for oneself or give your power to another. This concept can be applied to help a disadvantaged person or group to self-advocate.

Empowerment is a foundation of ombudsman work. As a primary way of relating to residents, ombudsmen always encourage residents to:

- speak on their own behalf; and
- have direct, open communication with other residents, family, and staff.

Everyone has their own way of expressing personality, participating in groups, and dealing with problems. How we express ourselves depends on how we see and exercise our power in a given situation. Many factors affect a person's way of living in a facility. Personal factors may include:

- Individual's history or life experience
- Current health
- Current support system
- Facility size, culture, and physical environment

Living in a facility can diminish a person's sense of self and capabilities. Residents are thrust into a new environment with new rules and new social standards.

Living in a facility can "disempower" residents. Residents may not want to upset caregivers. They may not have the health, mobility, or energy to figure out how to get help. Conversations and interactions with people they know, that can strengthen a sense of self, may be infrequent. This can lead to feeling powerless, disoriented, or despondent. Generational, gender, and ethnic differences can affect a person's sense of empowerment. Individuals may have:

- used indirect or direct approaches to work out problems;
- depended traditionally on others to speak for them; or
- accepted the status quo.

Describe Empowerment. _____

_____

_____

Once disempowered, a person may feel powerless,

_____ or _____.

Residents may not choose to fully exercise their rights because they:

- Feel intimidated by the idea of appearing critical
- Lack information about rights or not think about concerns as rights
- Prefer to choose battles and put up with daily limitations of their dignity and individuality because:
    - It requires too much strength to challenge.

    - They may be labeled a troublemaker.
    - They depend on caregivers to provide for their basic care.
    - They feel defeated.
- Accept that their rights are limited as a part of the daily routine and stop seeing these limits as a problem
- Have physical, emotional, psychological, social, and cognitive disabilities that make it difficult to voice concerns
- Fear they may be discharged if they speak up

What are some reasons residents might not complain when their rights are violated?

_____

_____

_____

_____

Ombudsman Role

Residents can regain personal power and voice. If a resident:

- finds it easy to speak up, an ombudsman can point them in the right direction and reassure them of their rights;
- needs more support, an ombudsman can be present as the resident expresses the need or speak on the resident's behalf; or
- is severely impaired or unable to communicate needs, an ombudsman may need to carry more of the load.

First, get to know residents as individuals. With that connection, residents may share concerns about their experiences. How you respond and work with these concerns can go a long way to empower residents and restore their sense of self. Relate honestly and authentically to the resident and to the situation.

Voices Speak Out Against Retaliation

Run Time: 14 min

Five people tell stories about their lives, the changes when they moved into a nursing home, and their fears. Then they share how they found their voices and became empowered to live life to its fullest. Listen to Helen, Kramer, Mary, Rich, and Ronnie speak in their own words.

Answer the following questions:

When speaking about fear of retaliation, what did the residents tell you?

_____

_____

_____

What can you do as an ombudsman to reduce fear of retaliation?

_____

_____

_____

Resident-Directed

Take residents' experiences and viewpoints seriously. Proceed at their pace and in the direction they choose. Promote an environment in which residents, families, and staff can talk with each other to make life work well for residents living and staff working in the facility. In this environment, ombudsmen can address problems at the earliest stages before they become major problems.

Empowering residents takes patience and persistence. Control the urge to take over and problem solve. Take the lead from residents and with their permission, help carry their message. This helps residents maintain control over their own lives. Encourage residents to communicate with the staff who can resolve problems. If residents feel they can tell their problems to staff and have those problems addressed, residents are truly empowered.

Resident direction is the key to an ombudsman helping to empower residents because…

_____

_____

Possible Obstacles to Implementing Resident Rights

- Residents who assert their rights may face resistance from every level. Staff may discourage them or create barriers to residents' efforts.
- Many residents do not have social supports inside or outside to encourage or help them to exercise their rights.
- Resident councils may not receive the leadership development needed to function effectively.
- Some facilities are run as strictly controlled institutions with little room for individuality, choice, free expression, or personal autonomy.
- Staff is not always sufficiently trained and may not understand residents' rights.
- Short staffing prevents staff from taking the time to treat residents respectfully.
- Staff is expected to provide care and may not know how to empower residents to care for themselves.
- It takes longer to help residents do some things for themselves than to do it for them.
- Staff may sense residents' concerns and recommendations as another demand on their work schedule.
- Many staff and others see residents' impairments instead of abilities.
- Residents may fear the unknown.

SOURCE: Consumer Voice, Nursing Home Resident Rights Project

How can short staffing negatively affect resident rights? Short staffing prevents staff from taking the time to:

_____

_____

_____

Residents' Rights Themes

One way to consider residents' rights is to categorize them into four themes.

1. Communication
2. Choice
3. Decision-making
4. Participation

1. Communication

Effective, ongoing communication between residents and facility staff is essential. The facility must communicate with residents in languages they understand. This includes information about their rights, health status, plan of care, activities, and other aspects of life in the nursing home and assisted living facility.

A resident may say, "I don't want this food." What does it really mean? It could be:

- a way to say she dislikes the food because it is cold, bland, or she never liked it;
- the resident is refusing a special diet; or
- a different, unrelated meaning behind refusing the food.

When residents exercise their right to say "No," staff should ask questions and observe until they fully understand what the resident is really expressing. Residents who have cognitive impairment can also express choice and need to be asked.

2. Choice

State and federal law challenges each facility to focus on meeting the needs and desires of each individual resident, not on maintaining the customary routines of an institution. Residents make choices based on various reasons such as culture, ethnicity, health, and religion.

Exercising choice is a continual process.

- Making a choice is not a time-limited event.

  For example, if a resident does not care what clothes she wears one day, her choice does not mean she will never have a preference about her clothes.
- An individual's choices and preferences may change.

  For example, after a person has lived in the facility awhile, or if her condition changes, she may make different choices than previous ones.
- An individual's choices and preferences may remain constant.

  For example, if a person holds specific religious beliefs, he wants his diet to continue to adhere to that faith.

Ask the Trainer: Meal times

A nursing home changed breakfast time from 8:00 to 7:00 a.m., but a group of residents don't want to get up that early.

Do residents have a say in this policy? _____

How would you approach this problem as the ombudsman? _____

_____

_____

3. Decision-Making

Unless a court determines a person is incapacitated (unable to make decisions), he or she exercises all of his or her personal rights. To exercise decision-making, a person needs two things:

- Full information. To make an informed decision, a person needs accurate information about alternatives and short- and long-term consequences about the decisions being considered.
- An encouraging and supportive environment. Residents should feel free to make decisions without fear of being declared incapacitated or discharged if their decisions differ from what professionals recommend or their family wants.

4. Participation

Residents are encouraged by law to participate in:

- Planning their care and treatment;
- Care plan meetings;
- Resident groups such as a resident council if they choose;
- Social, religious, and community activities; and
- The survey process.

If residents want to move out of nursing homes, they participate in making decisions about the transition. Medicaid-eligible residents can work with the Money Follows the Person program or through their Medicaid managed care service coordinator. More details about this program are in Chapter 13 Regulators and Resources and Chapter 15 Systems Advocacy.

Residents with cognitive impairment or other disabilities can participate in planning care and exercising choice. If staff cannot honor resident preferences, they need to problem solve with the resident to find a solution as close as possible to what the resident wants.

Resident Rights under Law

The United States Constitution sets forth certain rights for all citizens. People do not lose these rights when they move to an assisted living facility or nursing home. In fact, federal and state laws guarantee additional rights specific to their status as nursing home residents and state law protects rights specific to assisted living facility residents.

Federal

- Nursing Home Reform Law: Omnibus Budget Reconciliation Act of 1987 (OBRA '87), as amended, Medicaid Provisions §1396r and Medicare Provisions §1395i-3
- Regulation: Medicare and Medicaid Requirements for Long Term Care Facilities, 42 U.S. Code of Federal Regulations, §483

State of Texas

- Laws: Health & Safety Code
  - Chapter 242 Convalescent and Nursing Homes
  - Chapter 247 Assisted Living Facilities (see also Chapter 102 of the Texas Human Resources Code, Rights of the Elderly)
- Regulations: Texas Administrative Code, Title 40, Part 1
  - Chapter 19 Nursing Facility Requirements
  - Chapter 92 Licensing Standards for Assisted Living Facilities

Foundation of nursing home resident rights

Quality of care: provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care.

Quality of life: care for residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

Ask the Trainer: Late Night Television

A resident wants to watch television in the living room of his assisted living facility in the late hours of the evening. The manager said the TV must be off at 8:00 p.m. because it keeps other residents awake.

- Whose rights need to be protected, the complainant or those who go to bed at 8:00? _____
- Are there differences in resident rights in an assisted living facility as opposed to a similar situation in a nursing home? _____

Specific Rights

Resident rights safeguard and promote dignity, choice, and self-determination.

Nursing homes must comply with the Nursing Facility Requirements and assisted living facilities must comply with the Licensing Standards for Assisted Living Facilities. Both sets of rules include resident rights provisions.

Resident rights may be restricted only to the extent necessary to protect the resident or other residents, or to protect the rights of others, particularly rights relating to privacy and confidentiality. The following list of rights applies to nursing home and assisted living facility residents. An asterisk (*) identifies rights that only apply to nursing home residents.

Dignity and Respect

Residents have the right to:

- Live in safe, decent, and clean conditions
- Be free from abuse, neglect, and exploitation
- Be treated with dignity, courtesy, consideration, and respect
- Be free from discrimination based on age, race, religion, sex, nationality, disability, marital status, or source of payment
- Practice their own religious beliefs
- Keep and use personal property, secure from theft or loss
- Choose and wear their own clothes
- Be free from any physical or chemical restraints used for discipline or convenience and not required to treat medical symptoms
- Receive visitors

Freedom of Choice

Residents have the right to:

- Make choices regarding personal affairs, care, benefits, and services
- Choose their physician at their own expense or through a health care plan
- Manage personal financial affairs in the least restrictive method, or delegate that responsibility to another person
- *Access money and property deposited with the facility and have an accounting of that money and property and of all financial transactions made with or on their behalf
- Participate in activities inside and outside the facility
- Place in their room an electronic monitoring device that is owned and operated by them or provided by their guardian or legal representative
- Refuse to perform services for the person or facility providing services
- Use advance directives as in Health and Safety Code §166.002
- Designate a guardian or representative to ensure quality stewardship of their affairs, if protective measures are required

---

Residents can leave their nursing home for visits and can stay overnight.

_____ True (T) or False (F)

Residents have the right to determine their personal care schedule, such as activities, bathing, and bedtime. _____ True (T) or False (F)

Residents have the right to keep money in their room.

_____ True (T) or False (F)

Ask the Trainer: Love and Marriage

A nursing home administrator told marriage-bound residents, “You can get married, as long as your children give permission. I’m not sure you’ll be able to share a room.”

- Do residents need permission to marry? _____
- Will the newlyweds be entitled to their own room? What if a couple is not married, can they room together? _____

Privacy and Confidentiality

Residents have the right to:

- Privacy, including during visits, phone calls, and attending to personal needs
- Have facility information about them maintained as confidential
- Send and receive unopened mail and receive help in reading or writing correspondence

---

Residents have the right to receive their mail unopened, including government benefit checks that will pay for their care at the facility. _____ True (T) or False (F)

Facility staff may monitor resident visits with a long-term care Ombudsman. _____ True (T) or False (F)

Participation in Care

Residents have the right to:

- Receive all care necessary to have the highest possible level of health
- Participate in developing a care or service plan
- Refuse treatment, care, or services
- *Receive information about prescribed psychoactive medication from the person who prescribes the medication or that person's designee
- Have psychoactive medications prescribed and administered in a responsible manner and refuse to consent to the prescription of psychoactive medications
- Access personal and clinical records, which will be maintained as confidential and may not be released without their consent
- Communicate in native languages to get or receive treatment, care, or services

---

Residents *do not* have the right to communicate in their native language to get or receive treatment, care, or services. _____ True (T) or False (F)

Residents have the right to refuse food, medicine, therapy, and other services. _____ True (T) or False (F)

Transfers and Discharges

Residents have the right to:

- Not be relocated within the facility, except in accordance with rules
- Discharge themselves unless a court determines a person is incapacitated
- Not be discharged from the facility, except as provided in regulations
- Receive a 30-day written notice sent to them and a legally authorized representative or family member
- *Appeal a discharge within 10 days of receiving notice in a Medicaid facility in order to stay in the facility until an appeal decision is made or up to 90 days to file an appeal otherwise
- *Be readmitted to the facility as provided by regulations
- Notice of immediate discharge in the event the resident becomes a threat to the health and safety of himself or others
- *Right to notice of bed hold policy

Residents should receive a _____ - day notice of a home's intent to discharge them. It must be in _____. The resident has _____ days to appeal in order to stay in the facility until an appeal decision is made, but up to 90 days to appeal.

For more information about transfer and discharge procedures, please watch the recorded webinar, Nursing Home Transfer and Discharge Procedures, which can be found on the Texas Long-term Care Ombudsman YouTube channel or follow this link:

http://www.youtube.com/watch?v=UIQVmySJR4Y
Run Time: 14 min 45 sec

Information

Residents have the right to:

- Receive a written statement or admission agreement describing services provided by the facility and related charges
- Be informed of Medicare or Medicaid benefits
- Receive a Statement of Resident Rights and be informed of revisions
- Be informed in a language they understand about total medical condition, recommended treatment and expected results (including reasonably expected effects and risks), and be notified when their condition significantly changes

Complaints

Residents have the right to:

- Complain about care or treatment without fear of reprisal or discrimination
- Receive a prompt response to resolve complaints from the facility
- Organize or participate in any group that presents residents' concerns to the administrator of the facility

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Exercise: Residents Have Rights

Residents have a right to complain only about situations that directly affect them.

_____ True (T) or False (F)

Only approved residents have the right to attend and participate in resident council meetings. _____ True (T) or False (F)

Use Supplement 5-A or 5-B to choose the nursing home and assisted living facility resident right to help resolve the complaint.

1. My doctor won't listen to me. He is always in a rush. I want to see another doctor.

   _____

   _____

2. No one will tell me why I have to take so many pills every day.

   _____

   _____

3. Tomorrow they are moving me to another hallway. I don't want to move.

   _____

   _____

4. My mother is very frail and I don't want her to fall. Yet they won't put side rails up on her bed at night.

   _____

_____

5. My friend is very critical of staff when she comes. The administrator says if she doesn't stop, she cannot visit any more.

_____

_____

6. The staff who feed my Dad shoves food into his mouth without care or attention.

_____

_____

7. My sister stopped eating and is losing weight. The doctor wants to insert a feeding tube, but my sister always said she didn't want one.

_____

_____

8. The activities are boring here … TV, bingo, or playing with paint like children!

_____

_____

9. My hearing aid is lost. They won't get me another.

_____

_____

10. Someone is spying on me. My mail is opened before I get it.

_____

_____

11. I told the nurse last week there's a sore on my leg. No one has checked it yet.

_____

_____

12. This place is like a prison. I want to go home and they won't let me.

    _____

    _____

13. The housekeeping staff always barges in when I'm undressed. No one ever knocks before they come into my room.

    _____

    _____

14. When I visit Dad, he's usually sitting in a soiled brief. When I tell the nurse, she says, "I'm busy now. I'll come as soon as I can," and then comes an hour later.

    _____

Rights of Families and Legal Representatives of Residents in Nursing Homes

Federal law provides family and legal representatives with certain rights related to information and participation. Legal representatives include guardians and individuals acting as agents, such as an agent authorized by a Medical Power of Attorney. Family, subject to the resident's direction, and legal representatives have the right to:

- Be notified:
  - within 24 hours of an accident resulting in injury, a significant change in the resident's physical, mental, or psychosocial status, a need to alter treatment significantly, or a decision to transfer the resident;
  - of appeal rights related to loss of benefits, services, or discharge;
  - promptly of a change in room, roommate, or in resident rights provisions; and
  - if the facility receives a waiver of licensed nurse staffing requirements;
- Participate:
  - in the care planning process; and
  - in a family council that may meet privately in space provided by the facility, and have a facility staff person serve as liaison to the council;
- Have immediate access to the resident, subject to the resident's rights to deny or withdraw consent at any time; and
- Make recommendations to the facility. The facility must listen to the views and act on grievances and recommendations by residents and families concerning

proposed policy and operational decisions affecting resident care and life in the facility.

For a resident in a nursing home, family has a right to be notified within 24 hours of an _____ or a significant change in the resident's physical, mental, or _____ status. Family also has a right to participate in the _____ planning process.

Incapacitated Residents

If a court determines a person is incapacitated, resident rights are exercised by the person appointed under Texas law to act on his or her behalf. Even with a guardian, an incapacitated person should be encouraged to make as many decisions as they are able. Frequently, family members and facility staff use the label of guardian incorrectly. Many family members are authorized as a medical or financial decision-maker by a power of attorney. Other family members act as decision-makers with no formal legal authority to do so.

Ombudsmen should not assume a person is a legal guardian of a resident unless a letter of guardianship, dated within the current year, is made available. Powers of attorney are important advance care planning documents, but as long as residents can speak for themselves, the resident's wishes supersede the agent's. Read Chapter 8 for more information about advance care planning.

Unless a court determines a resident is legally incapacitated, residents speak for themselves.

Enforcement of Resident Rights

The primary mechanism to enforce resident rights is the survey and certification process performed by Regulatory Services and described in Chapter 13. Having residents' rights as part of federal and state laws gives emphasis to the rights. However, a lack of understanding and sensitivity to residents' rights can hinder enforcement.

Residents' rights can be difficult to quantify compared with other regulations. Violations may be challenging to document and prove. Correction of the violation may not be black and white for the surveyor to monitor.

The primary method to discover resident rights violations is through resident interviews. To help surveyors, ombudsmen can give examples of violations and with resident permission, point surveyors to particular residents as sources for more information.

How Facilities Can Promote Rights

1. Educate residents and their families about rights (beyond the minimum requirement when a resident is admitted).
2. Educate and sensitize every level of staff about residents' rights; take time at each staff meeting to promote and describe at least one resident right.
3. Incorporate resident participation and self-determination into every aspect of services, such as resident advisory committees for food services, activities, and housekeeping.
4. Provide support to workers, such as sufficient staffing, training, supervision, mentoring, and increased salaries and benefits.
5. Take time to introduce staff to the residents they will work with.
6. Promote relationships between management and direct care staff.
7. Use the information and wisdom of residents and their representatives to help develop and conduct training programs for staff.
8. Help staff, residents, and families focus on empowerment. Residents need assistance, but the help received should strive to increase their ability to help themselves.
9. Establish a grievance committee comprised of residents, family, staff, and management.
10. Encourage and promote an open exchange of ideas, recommendations, and concerns throughout the facility.
11. Build more private rooms for individual residents and public rooms for private use by residents.
12. Promote a sense of community within the facility. Organize activities in different areas and design activities that promote interaction and intellectual stimulation.

SOURCE: Consumer Voice, Nursing Home Resident Rights Project

Supplement 5-A – Summary: Nursing Home Resident Rights

Residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States. They have the right to be free of interference, coercion, discrimination, and reprisal in exercising these rights as citizens of the United States.

Dignity and Respect

You have the right to:

- live in safe, decent, and clean conditions
- be free from abuse, neglect, and exploitation
- be treated with dignity, courtesy, consideration, and respect
- be free from discrimination based on age, race, religion, sex, nationality, disability, marital status, or source of payment
- practice your own religious beliefs
- keep and use personal property, secure from theft or loss
- choose and wear your own clothes
- be free from any physical or chemical restraints used for discipline or convenience and not required to treat your medical symptoms
- receive visitors

Freedom of Choice

You have the right to;

- make your own choices regarding personal affairs, care, benefits, and services
- choose your own physician at your own expense or through a health care plan
- manage your own financial affairs in the least restrictive method, or to delegate that responsibility to another person
- access money and property you have deposited with the facility and to have an accounting of your money and property that are deposited with the facility and of all financial transactions made with or on your behalf
- participate in activities inside and outside the facility
- place in your room an electronic monitoring device that is owned and operated by you or provided by your guardian or legal representative
- refuse to perform services for the person or facility providing services
- use advance directives as defined in the Texas Health and Safety Code, §166.002
- designate a guardian or representative to ensure quality stewardship of your affairs, if protective measures are required

Privacy and Confidentiality

You have the right to:

- privacy, including privacy during visits, phone calls and while attending to personal needs
- have facility information about you maintained as confidential
- send and receive unopened mail and to receive help in reading or writing correspondence

Participation in Your Care

You have the right to:

- receive all care necessary to have the highest possible level of health
- participate in developing a plan of care, to refuse treatment, and to refuse to participate in experimental research
- refuse treatment, care, or services
- receive information about prescribed psychoactive medication from the person who prescribes the medication or that person's designee
- have any psychoactive medications prescribed and administered in a responsible manner as mandated by the Texas Health and Safety Code, §242.505, and to refuse to consent to the prescription of psychoactive medications
- access personal and clinical records, which will be maintained as confidential and may not be released without your consent
- communicate in your native language to acquire or to receive treatment, care, or services

Transfers and Discharges

You have the right to:

- not be relocated within the facility, except in accordance with nursing facility regulations
- discharge yourself from the facility unless you have been adjudicated mentally incompetent
- not be discharged from the facility, except as provided in the nursing facility regulations
- receive a 30-day written notice sent to you, your legally authorized representative, or a family member
- appeal the discharge within 10 days of receiving notice in a Medicaid facility
- be readmitted to the facility as provided by nursing facility regulations

Information

You have the right to:

- receive a written statement or admission agreement describing the services provided by the facility and the related charges

- be informed of Medicare or Medicaid benefits
- receive a copy of the Statement of Resident Rights and to be informed of revisions
- be informed in a language you understand about your total medical condition, recommended treatment and expected results (including reasonably expected effects, side effects and associated risks), and be notified whenever there is a significant change in your condition.

Complaints

You have the right to:

- complain about care or treatment and receive a prompt response to resolve the complaint without fear of reprisal or discrimination
- organize or participate in any group that presents residents' concerns to the administrator of the facility

Your rights may be restricted only to the extent necessary to protect you or others, or to protect the rights of others, particularly those rights relating to privacy and confidentiality.

These described rights are in addition to other rights or remedies an individual may be entitled to, according to rules and under the law.

SOURCE: This list of rights is based on the Nursing Facility Requirements for Licensure and Medicaid Certification Handbook, Subchapter E

Supplement 5-B - Summary: Assisted Living Facility Resident Rights

A resident has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where lawfully restricted. The resident has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights.

Dignity and Respect

You have the right to:

- be free from physical and mental abuse, including punishment or physical and chemical restraints not required to treat medical symptoms
- be treated with respect, consideration, and recognition of dignity and individuality, without regard to race, religion, national origin, gender, age, disability, marital status, or source of payment. This means that you have the right to:
    - make choices regarding personal affairs, care, benefits, and services
    - be free from abuse, neglect, and exploitation and
    - designate a guardian or representative to ensure the right to quality stewardship of your affairs
- achieve the highest level of independence, autonomy, and interaction with the community
- a safe and decent living environment
- communicate in your native language with residents or employees
- complain about care or treatment. The complaint may be made anonymously or communicated by a person you designate. The provider must:
    - promptly respond to resolve the complaint
    - not discriminate or take other punitive action against a resident who makes a complaint
- participate in a behavior modification program involving restraints with the consent of the person's guardian, as described in TAC § 92.125

Privacy and Confidentiality

You have the right to:

- receive and send unopened mail, and have mail sent and delivered promptly
- access to a telephone
- privacy while attending to personal needs and receiving medical treatment
- a private place for receiving visitors or associating with other residents, including written communications, telephone conversations, meeting with family, and access to a resident council or group
- share a room with a spouse receiving similar services
- unrestricted communication, including visits with family members, representatives of advocacy groups and community service organizations, and other visitors at any reasonable hour

- have access to a representative of the Office of the State Long-term Care Ombudsman

Freedom of Choice

You have the right to:

- participate in activities of social, religious, or community groups and practice religion of your choice
- manage financial affairs, including written authorization of another person to manage your money. You may choose how your money is managed, including a money management program, a representative payee program, a financial power of attorney, a trust, or similar method, and may choose the least restrictive of these methods
- if the facility accepts written delegation to manage any portion of a resident's finances, the resident must be given, upon request and at least quarterly, an accounting of financial transactions made on the resident's behalf
- retain and use personal possessions, including clothing and furnishings. The number of personal possessions may be limited only for the health and safety of other residents
- choose dress, hair style, and other personal effects according to individual preference; the resident is responsible for maintaining personal hygiene
- retain and use personal property in your immediate living quarters and to have an individual locked area to keep personal property
- refuse to perform services for the facility, except as contracted for by the resident and operator
- have access to a representative of the State Long Term Care Ombudsman Program

Participation in Your Care

You have the right to:

- choose and retain a personal physician
- participate in developing an individual service plan that describes your medical and psychological needs and how the needs will be met
- access to personal records, which are confidential and may not be released without your consent, except:
    - to another provider, if the resident transfers residence or
    - if the release is required by another law
- refuse medical treatment or services after:
    - being advised by the person providing services of the possible consequences of refusing treatment or services and
    - acknowledging that you understand the consequences of refusing treatment or services

- execute an advance directive, under Chapter 166 of the Health and Safety Code, or designate a guardian in advance of need to make decisions regarding your health care

Information

You have the right to:

- be informed by the provider no later than the 30th day after admission:
  - whether the resident is entitled to benefits under Medicare or Medicaid and
  - which items and services are covered by these benefits, including items or services for which the resident may not be charged
- be fully informed in advance about treatment or care that may affect the resident's well-being

Transfer and Discharge

You have the right to:

- leave the facility temporarily or permanently, subject to contractual or financial obligations
- not be transferred or discharged unless:
  - the transfer is for the resident's welfare, and the resident's needs cannot be met by the facility
  - the resident's health is improved sufficiently so that services are no longer needed
  - the resident's health and safety or the health and safety of another resident would be endangered if the transfer or discharge was not made
  - the provider ceases to operate or to participate in the program that reimburses for the resident's treatment or care or
  - the resident fails, after reasonable and appropriate notice, to pay for services
- not be transferred or discharged, except in an emergency, until the 30th day after the date the facility provides written notice to the resident, the resident's legal representative, or a member of the resident's family, stating:
  - the facility intends to transfer or discharge the resident
  - the reason for the transfer or discharge
  - the effective date of the transfer or discharge
  - the location to which the resident will be transferred and
  - any appeal rights available to the resident

SOURCE: This list of rights is based on the Licensing Standards for Assisted Living Facilities, Residents Bill of Rights §92.125

Notes:

Ombudsman Certification Training

CHAPTER 6: Facilities

Facilities

Chapter 6 is about assisted living facilities and nursing homes. People who live in either type of facility have a right to our services. Assisted living facilities and nursing homes are two living options in a continuum of long-term services and supports in Texas.

Learning Objectives

- Develop a general understanding of long-term services and supports
- Understand the long-term care ombudsman roles and responsibilities associated with facilities and helping people choose them
- Understand how most residents pay for assisted living or nursing home care
- Become familiar with long-term care management, operations, and staffing
- Identify alternatives to nursing home care
- Understand your role as a resident advocate and maintain healthy boundaries

Contents

- Long-term Services and Supports
- Ombudsman Role and Access
- Assisted Living Facilities
- Nursing Homes
- Walk the Fine Line
- Facility Visits – Intern Shadow Visits
- Ombudsman Activities
- Facility Visit Guide – Things to Look for During Visits

DVD(s), Supplements, Forms

- Walk the Fine Line
- Supplement 6-A: Managed Care Toolkit

Long-term Services and Supports

Long-term services and supports is a term to describe a range of services that can be provided in a variety of settings. Supports include home delivered meals, service coordination, financial planning and money management, home health care, assisted living facilities, continuing care retirement communities, nursing homes, and hospice.

Ombudsmen give information (never recommendations) on nursing homes and assisted living facilities based on a person's needs and preferences. National and state resources, such as the options below, can also be shared.

How to choose a facility:

- A Consumer Guide to Choosing a Nursing Home by National Consumer Voice for Quality Care, www.ltcombudsman.org
- Guide to Choosing a Nursing Home by Centers for Medicare and Medicaid Services, www.cms.gov
- Guide to Choosing an Assisted Living Community by Assisted Living Federation of America , www.alfa.org

Quality of facilities:

- Nursing Home Compare by Centers for Medicare and Medicaid Services, https://www.medicare.gov/nursinghomecompare/search.html
- Quality Reporting System for assisted living facilities, nursing homes, home health care, and adult day care by the State of Texas at: http://facilityquality.dads.state.tx.us/qrs/public/qrs.do

Home Health and Hospice Agencies

The State of Texas licenses home health and hospice agencies as Home and Community Support Services Agencies (HCSSAs). People receive services in private homes, hospice facilities, assisted living facilities, or nursing homes. Medicare, Medicaid, and other insurance may reimburse providers for services to eligible individuals.

Home health agencies provide services such as:

- nursing, including blood pressure monitoring, and diabetes treatment;
- physical, occupational, speech, or respiratory therapy; and
- medical equipment and supplies.

Hospice agency services include:

- services provided by unlicensed personnel under the delegation of a registered nurse or physical therapist;

- palliative care (to soothe or relieve pain) for terminally ill clients; and
- support services for clients and their families that are available 24 hours a day, 7 days a week, during final stages of illness, death, and bereavement.

Ombudsman Tip: Nursing homes choose whether to offer hospice services. A contract between the facility and a hospice agency is required by state law. Staff in each provider type must define and practice their respective responsibilities. If issues occur, the contract can provide answers. Assisted living facility residents directly contract with home health and hospice agencies. While facilities and agencies coordinate care and services, the assisted living facilities hold overall responsibility.

Ombudsman Role and Access

In a facility, long-term care ombudsmen:

- advocate for residents;
- provide information about how to select a facility;
- provide information on how to get quality care;
- identify problems in facilities and work to resolve them; and
- investigate and resolve complaints made by a resident or by another complainant on behalf of a resident.

In Texas, ombudsman services are available to people living in nursing homes and assisted living facilities that are licensed and regulated by Regulatory Services. Ombudsmen have access to long-term care facilities, residents, and resident records if a resident gives consent. State rules describing this authority include:

- Texas Administrative Code
  - Chapter 85, Subchapter E Long-term Care Ombudsman Program
  - Chapter 19, Subchapter E Residents Rights Access and Visitation Rights
  - Chapter 92, Subchapter I Access to Residents and Records by the Long-term Care Ombudsman Program

In Texas, Ombudsmen do not provide oversight to Personal Care Homes*, Adult Day Care Facilities, and Intermediate Care Facilities Serving Persons with Intellectual or Developmental Disabilities.

* Personal care homes in Texas are private residences that offer personal care services, assistance, and supervision to four or more persons. If the care home provides personal care to four or more persons, unrelated to the owner, the home must be licensed under state licensure requirements.

Assisted Living Facilities

Assisted living as it exists today emerged in the 1990s as an alternative for people who do not need 24-hour skilled nursing care provided by a nursing home but independent living is no longer appropriate. Assisted living facilities provide individualized health and personal care assistance in a homelike setting with an emphasis on personal dignity, autonomy, independence, and privacy. Facilities can be large apartment-like settings or private residences with a few bedrooms. Services include meals, bathing, dressing, toileting, and administering or supervising medication. In Texas, a licensed assisted living facility is an establishment that:

- furnishes, in one or more facilities, food and shelter to four or more persons who are unrelated to the proprietor of the establishment;
- provides personal care services; and
- may provide help with or supervision of the medication administration.

The State of Texas considers one or more facilities to be part of the same establishment and, therefore, subject to licensure, based on the following factors:

- common ownership;
- shared services, personnel, or equipment in any part of the facilities' operations;
- physical proximity; and
- any public appearance of joint operations or a relationship between the facilities.

Laws and Rules

There is no national definition of an assisted living facility. Each state determines a description of care that does not meet requirements for nursing home licensure. More than two-thirds of the states use the term "assisted living." Other states use terms such as personal care homes, board and care, adult family homes, and residential care homes.

Regulatory Services licenses and regulates assisted living facilities in Texas.

- Texas law - Health and Safety Code, Title 4, Chapter 247, Assisted Living Facilities
- Texas rule – Licensing Standards for Assisted Living Facilities, Texas Administrative Code (TAC) Title 40, Part I, Chapter 92

Typical Resident

General characteristics of an assisted living resident is a woman in her mid-eighties who is mobile, but needs assistance with approximately two to three activities of daily living (ADLs).

Resident statistics:

- Female (±74%)
- Non-Hispanic white (±91%)
- Receive dressing assistance (±52%)
- Assistances with some ADLs (over 66%)
- Alzheimer's disease or other dementias (± 40%)
- Divorced, separated or widowed (over 69%)
- Age 85 or older (±50%)
- Help transferring (±26%)
- Receive bathing assistance (±72%)

Source: Centers for Disease Control and Prevention's National Center for Health Statistics (NCHS), Long-term Care Services in the United States: 2013 Overview
http://www.cdc.gov/nchs/data/nsltcp/long_term_care_services_2013.pdf

Types of Licenses

Texas licenses assisted living facilities based on residents' physical and mental ability to evacuate the facility in an emergency and whether nighttime attendance is necessary. An assisted living facility must be licensed as Type A, B, or C. The ability of residents to evacuate, types of services provided, or both determine licensure type.

- Type A. In a Type A facility, night shift staff in a small facility must be immediately available. In a large facility, the staff must be immediately available and awake. In addition, a resident:
  - must be physically and mentally capable of evacuating the facility without physical assistance from staff, which may include an individual who is mobile, although non-ambulatory, such as an individual who uses a wheelchair or an electric chair, and has the capacity to transfer and evacuate him- or herself in an emergency;
  - does not require routine attendance during nighttime sleeping hours;
  - must be capable of following directions under emergency conditions; and
  - must be able to demonstrate to Regulatory Services they can travel from their living unit to a centralized space, such as lobby, living or dining room on the level of discharge within a 13-minute period without continuous staff assistance. Elevators cannot be used as an evacuation route.
- Type B. In a Type B facility, night shift staff must be immediately available and awake, regardless of the number of licensed beds. In addition, a resident may:
  - require staff assistance to evacuate;
  - require attendance during nighttime sleeping hours;
  - be incapable of following directions under emergency conditions; and
  - require assistance in transferring to and from a wheelchair, but must not be permanently bedfast.

- Type C. A Type C facility is a four-bed facility that:
    - has an active contract with the State to provide adult foster care services; and
    - must be contracted with the State to provide adult foster care services before it can be licensed.

As of July 2015, Texas has 1,821 assisted living facilities: 569 Type A, 1,213 Type B, and 39 Type C. Assisted living is further categorized as large or small as determined by the licensed bed capacity. If fewer than 17 beds, Type A and B facilities are designated as small; if 17 or more beds, facilities are designated as large.

Management and Operation

Each assisted living facility is unique. The organizational structure differs from one property to another. Corporations with boards of directors own some facilities and hire managers. Depending on size, a small facility may operate with a manager and attendants while a large facility may have a variety of departments. Many assisted living facilities are small, privately-owned homes with one or two staff typically on the premises.

Assisted Living Facility Manager

- Has authority over all operational and financial aspects;
- Abides by rules described in Licensing Standards for Assisted Living Facilities §92.41(a)(1); and
- Ensures state regulations are met, develops policies and procedures, and hires, trains, and terminates staff.

Attendants

- Full-time attendants must be at least 18 years old or a high-school graduate.
- An attendant must be in the facility at all times when residents are in the facility.
- Attendants may perform other functions as required by the facility.
- Attendants are not required to be certified or licensed.

Financing Assisted Living Care

Personal

- Assisted living care is generally paid for with a person's private funds.
- Long-term care insurance can provide coverage to pay for assisted living facilities. Each insurance policy differs in what services and what amounts can be paid.

Government

- Medicaid-waiver - A facility can choose to accept residents who are eligible for Medicaid-waiver services called STAR+PLUS. These services require a contract with the State and include contractual requirements that create additional oversight and enforcement options to the assisted living facility license. When an assisted living has a Medicaid-waiver contract, the Medicaid-eligible resident pays part of the cost, known as “co-pay,” and Medicaid pays the remainder of the costs. Because STAR+PLUS is a waiver program (Medicaid managed care), the managed care company pays the assisted living facility provider.
- Veterans’ Administration (VA) - Some assisted living facilities contract with the VA and accept the VA Aid and Attendance benefit to pay for all or a portion of a resident’s assistance with activities of daily living such as grooming, showering, eating, medication management, and toileting. The Aid and Attendance benefit is for veterans age 65 and older who served during war time. It is also available to their surviving spouses. It is a tax-free benefit and is awarded by the Department of Veterans Affairs.
- Home health care paid by Medicare, Medicaid, or other insurance may provide services to a resident who lives in an assisted living facility. A physician prescribes the home care and the agency arranges care for the resident. While the assisted living facility staff maintains authority for the resident’s total care, a home health agency provides medical care.

1. Most assisted living staff is not _____ or _____.
2. In Texas, assisted living services emerged in what decade? _____
3. Assisted living can only be paid for with private funds (not Medicaid). _____ True (T) or False (F)
4. Since residents can require help to evacuate, the highest level of care available is in a Type _____.

Comparing Assisted Living Facilities

Each licensed facility must complete an Assisted Living Disclosure Statement using Form 3647 and make it available to anyone who requests it. The disclosure statement gives prospective residents and their families consistent categories of information from which they can compare facilities, policies and services. Sections include:

- Basic facility information
- Pre-admission process
- Admission process
- Discharge and transfer

- Aging in place
- Planning and implementation of care
- Change in condition issues
- Staff training
- Physical environment
- Staffing patterns
- Residents' rights

Ombudsman tip: The assisted living facility disclosure statement, in addition to the agreement or contract signed at admission, is an important document for ombudsmen to be familiar with and to encourage residents and family to use as they work on resolving complaints.

Aging in Place

Over time, the appropriateness of placement of a resident in a particular facility can change due to the resident's change in condition, needed services, or ability to evacuate. According to the aging in place rule, a resident may be allowed to remain in his or her environment if the facility agrees, if certain procedures are followed, and if their health and safety needs can be met. The Assisted Living Disclosure Statement Form 3647 includes a brief statement from the facility about its general policies related to aging in place.

Inappropriately Placed Residents

All residents must be appropriate for the facility's licensure type when admitted to an assisted living facility, but residents may become inappropriately placed over time due to a change in condition.

The resident or his or her representative may prefer to remain in the facility if the resident's condition changes. The aging in place process applies only to residents who are already residents of a facility, and were originally appropriately placed into that facility. Assisted living facilities are not required to keep a resident who is no longer appropriately placed. Inappropriate placement is defined differently for each assisted living facility license type.

A facility will determine its ability to accommodate a resident and decide if it will apply for a waiver request on a case by case basis. Some of the required paperwork for a waiver includes a physician's assessment, a resident's request to stay, a facility's agreement for the resident to stay, and an evacuation waiver.

Waiver requirements are defined in the rules about inappropriately placed residents and may be found in the Licensing Standards for Assisted Living Facilities in 40 Texas Administrative Code Chapter 92, Subchapter 92.41(f).

Nursing Homes

Nursing homes are facilities that provide health care and must be licensed. For Medicaid and Medicare to reimburse for care provided to eligible residents, nursing homes must also be *certified*.

All nursing homes must be licensed by the State of Texas. If they choose to participate in government reimbursement programs as a certified nursing facility, skilled nursing facility, or both, state and federal requirements must be met.

- If they participate in the Medicaid program, they are nursing facilities.
- If participating in Medicare, they are skilled nursing facilities (free standing or hospital-based).
- If they choose not to participate in government reimbursement, they are called licensed only (or private pay).

As of July 2015, Texas has 1,232 nursing homes. Most are licensed and certified for Medicaid and Medicare reimbursement. Forty-six homes are certified only for Medicare reimbursement. Medicare certification allows the home to bill for “skilled nursing” services and the facility is referred to as a SNF. Ten homes are licensed-only, meaning they only receive private pay and private insurance to pay for services. There are 24 hospital-based skilled nursing facilities, usually rehabilitation units within a hospital. Services are paid for by Medicare and private insurance.

Regulatory Services licenses, certifies, and monitors compliance of each of these license and certification types. Chapter 13 has more information about regulators and an ombudsman’s relationship to their work.

Nursing homes are residences where people live who are rehabilitating from illness or injury, or who have chronic disabilities, and can receive services for their medical, social, and psychosocial needs. Businesses operate as either for-profit or not-for-profit. Building owners and operations managers may be different business entities.

Residents require 24-hour nursing care and have significant needs with activities of daily living such as personal hygiene, dressing, and medicine administration. Whether old or young, they have physical or cognitive disabilities, and often both. A nursing home must meet additional requirements if children live there. In a Medicare-certified home, residents requiring skilled nursing services receive additional rehabilitative therapies to recover and regain functioning following an accident, injury, or illness.

A commonly held myth is that people go to nursing homes to die.

- Most move to a nursing home because their ability to care for themselves has deteriorated and they require 24-hour nursing care.
- Needs vary with a wide range of cognitive impairments, mental illnesses, and physical disabilities.

- Many residents live for years in a nursing home, while others may only live there for days or weeks.
- Some go for therapy following surgery. After rehabilitation, they return home.
- Others go for respite care, staying temporarily while caregivers rest or recover.

Residents have different care needs and different care outcomes. Through the care planning process, staff and residents individualize goals of care and direct how staff will care for the person. Details on care planning are discussed in Chapter 8 of this manual.

When admitted, residents sign admission agreements that detail what residents pay and what nursing homes provide, such as room, board, and specific services. Costs vary based on level of care, setting, and location. At admission, residents also receive information about eligibility for Medicaid and Medicare benefits and rights, including a description of the long-term care ombudsman program.

Ombudsman tip: When meeting new residents and families, ask if they understood information in their admission packet, including bed-hold policy and the Medicaid application process. Admission paperwork can be daunting; few people remember everything they sign and receive. As a reminder about our services, ombudsmen can explain their role in-person to new residents and families. Ombudsmen can review admission agreements for policies that appear inappropriate or misleading. Watch for requirements in admission agreements that assign a family member or other person to act as a “third-party pay source” for a resident. It is illegal for the facility to require such arrangement, and the family can seek legal advice about how to handle it.

Before admission, residents are also screened using the Preadmission Screening and Resident Review (PASRR) process. PASRR is a federal requirement to help ensure that people are not inappropriately placed in nursing homes for long-term care. It requires that all applicants, prior to admission to Medicaid-certified nursing homes, be given a preliminary assessment to determine whether they might have a mental illness or an intellectual or developmental disability. More information on PASRR can be found in Chapter 13 Regulators and Resources.

Exercise: Introduction to a Nursing Home Administrator

A staff ombudsman goes with an ombudsman intern to a nursing home. After the staff ombudsman introduces the intern, the administrator says, “You know we haven’t needed an ombudsman for a long time. Regulatory Services surveys us and thinks we’re doing a great job. You probably won’t have much to do here.”

Questions about scenario:

1. Why do you think the administrator made the statement above?

   _____

2. What are some positive aspects of the program you would stress to the administrator? _____

   _____

Laws and Rules

- United States: Code of Federal Regulations, Title 42 Chapter IV, Part 483 Requirements for States and Long Term Care Facilities
- Texas law: Health and Safety Code, Title 4 Chapter 242 Convalescent and Nursing Homes and Related Institutions
- Texas rule: Nursing Facility Requirements for Licensure and Medicaid Certification

Typical Resident

- Majority of residents are female (±67%) who are age 85 or older (±38%) and are non-Hispanic white (±69%) [Non-Hispanic black (±13%); Hispanic (±17%)]
- Over half of residents have Alzheimer’s disease or other dementias (±55%)
- The majority need assistance with the majority of activities of daily living (±97% require assistance bathing; ±90% require assistance with dressing; ±86% require assistance with toileting; and ±61% require assistance with eating)
- Most common diagnosis at admission is heart disease, followed by cognitive impairment or mental disorders
- Takes 11 or more medications daily including over the counter medications

SOURCES: CMS Nursing Home Data Compendium 2013 Edition, CDC National Nursing Home Survey 2004 and Centers for Disease Control and Prevention’s National Center for Health Statistics (NCHS), Long-term Care Services in the United States: 2013 Overview

Management and Operation

While meeting the physical, mental, and psychosocial needs of residents, the nursing home also operates as a business. Typical management positions and direct care staff positions are described on the next few pages.

Board of directors

- A board governs most facilities, either as a for-profit or not-for-profit home.
- In corporations, the board typically hires regional staff to ensure administrators and facility staff adheres to corporate policy. These regional managers are another level of management for an ombudsman to work with to resolve problems on behalf of residents.

Administrator

- The board of directors or regional director hires a licensed administrator. The State of Texas oversees the credentialing of administrators.
- Administrator responsibilities include ensuring state and federal regulations are met, developing policies and procedures, and hiring, training, and terminating staff. He or she is responsible for all operational and financial aspects.
- Administrators have a high turnover rate; the average stay is 1½ years.

Ombudsman tip: Learn how the administrator wants you to communicate concerns, such as bring complaints and concerns directly to him or her, or give complaints to the matching department, such as food complaints to dietary or nursing complaints to nursing. Facilities must have a process to receive written complaints, so ombudsmen may use the written grievance policy as a more formal method to bring attention to some concerns.

Medical Services

Medical Director

- A physician, licensed by the Texas Medical Board, hired by the nursing home to assist in and advise regarding the provision of nursing and health care.
- Residents may select their own physician, who may or may not be the facility's Medical Director.

Physician

- A resident or responsible party designates an attending physician to have primary responsibility for treatment and care.

- The physician signs all orders relating to resident care, such as medications and treatments.
- Physicians must see residents at least once every 30 days for the first 90 days after admission, and once every 60 days thereafter in Medicaid- and Medicare-certified facilities. Private pay residents must have a medical examination annually by their physicians.

Pharmacist

- An individual, licensed by the Texas State Board of Pharmacy to practice pharmacy, prepares and dispenses medications prescribed by a physician, dentist, or podiatrist.
- Based on size of the facility and other factors, the facility may employ a pharmacist or enter into a contract for services. Contracts are more common.

Nursing Services

Director of Nursing (DON)

- The DON must be a Registered Nurse (RN). He or she:
  - Ensures nursing services are provided
  - Has administrative and personnel duties
  - Sets the nursing tone of the facility
  - Has a high turnover rate and stay on average 1½ years.

Licensed Vocational Nurse (LVN) / charge nurse

- A nurse currently licensed by the Texas Board of Nursing as a licensed vocational nurse.
- A charge nurse (an RN or LVN) is in charge of an area of the home; each shift must have a nurse who is in charge.

Ombudsman tip: Build professional working relationships with the DON and charge nurses since you will often bring care issues to that person's attention for resolution.

Certified Nurse Aide (CNA or aide)

- An individual who provides nursing or nursing-related services to residents under the supervision of a licensed nurse. CNAs are not authorized to provide nursing

and/or nursing-related services for which a license or registration is required under state law.

- CNAs provide a majority of direct resident care.
- CNAs have a very high turnover rate and stay on average 6 months. They often work in more than one facility or care setting.

Medication Aide

- An individual permitted by the State of Texas to administer medications to residents.
- Medication aides must comply with CNA requirements.
- A medication aide holds a current permit and acts under the authority of a person whose license authorizes him or her to administer medication.

Ombudsman tip: CNAs can provide immediate help to residents and provide insight into a person's needs and preferences. Some view the CNA as the hardest-working staff. Many CNAs appreciate praise for a job well done. "Walk the Fine Line" in Chapter 6: *Facilities* provides ideas on how to give praise without crossing limits with facility staff.

Other Services

Business Office Manager (BOM)

- A person who handles the bookkeeping and billing for each resident.
- He or she maintains demographic information of residents, including their payment source and location in the building.
- The BOM sometimes helps residents complete their Medicaid application or file long-term care insurance claims.

Ombudsman tip: Visit the business office once a month for a list of residents, their rooms, and to learn of new residents, residents who were discharged or residents who are in the hospital.

Admissions Director

- A person who oversees the admissions process in a nursing home. He or she is a resource for admissions materials.
- Sometimes the admissions director also serves as the facility social worker.

Social worker / social services director

- A qualified social worker is licensed, or provisionally licensed, by the Texas State Board of Social Work Examiners. Some staff who fill this role are not licensed but must be seeking licensure and operate under the supervision of a licensed social worker.
- Social services staff is often responsible for meeting psychosocial needs of residents and responding to family issues related to residents. Facilities with more than 120 beds must employ a full-time social worker. Those with 120 beds or fewer may contract or employ a part-time social worker.
- Social workers should be advocates for individualized resident needs. They may be an important link for an ombudsman between the home and resident.
- Social workers may also be the admissions coordinator or marketing director.
- The social worker frequently:
    - Functions as the staff liaison to the family council;
    - Serves as primary point of contact for making medical (including vision, hearing, and dental) appointments; and
    - Organizes and schedules care plan meetings.

Ombudsman tip: The social worker may be a resource for you to learn about newly admitted residents or those who may benefit from your visit.

Dietary Supervisor

- The person who supervises cooks, helpers, and dishwashers.
- The dietary supervisor works with corporate dieticians to ensure dietary compliance and specialty diets for residents.

Activity Director

- A qualified individual appointed by the facility who directs the activities program as described in Nursing Facility Requirements §19.702. This position may also be called Life Enrichment Director or similar title.
- An activity director provides an ongoing program of activities to meet the interests and abilities of each resident. Activities should include more than the 3

B's - birthday, bible, and bingo. This area of nursing home life should take its cue from resident direction and address each resident's individual needs.

- The activity director or assistant is often a staff liaison to the resident council.

Housekeeping

- The housekeeping staff oversees many environmental factors in the building related to resident rooms, cleaning, and laundry.

Maintenance

- Staff who are responsible for the interior and exterior of the physical plant including call lights operation; electrical outlets and lighting; air conditioning and heating; hallway railings and grab bars; physical condition of the walls, ceilings, and floors; ventilation; and other requirements.

Contracted Services

Facilities enter into contracts with agencies or professionals to provide specific services. These may include the following:

- Dentist
- Pharmacist
- Psychologist
- Podiatrist
- Pest Control
- Psychiatrist
- Ophthalmologist
- Therapist: Physical, Occupational, and Speech
- Hospice
- Managed Care Organizations

Exercise: Help! – Identify the Right Person

Identify the best person to help solve each problem. Assume you obtained consent from the resident in order to take action.

Activities director	Charge nurse	Dietary staff	Medical director
Administrator	Certified nurse aide	Family member	Social worker
Business office staff	Director of nursing	Housekeeping staff	Staff ombudsman

1. Mrs. Ortiz speaks Spanish, and you need an interpreter to communicate with her. _____
2. You notice Mr. Smith's drinking water container is empty. _____
3. Mrs. McMillan reports that she lost a sweater. _____
4. Mr. Jones appears to be uncharacteristically depressed. _____
5. There is something sticky on the floor of the main entrance. _____

6. Several call bells are answered slowly and some not at all. _____
7. Mr. Jenkins is worried about his bills. _____
8. A resident tells you the aide named “Mary” hit her. _____
9. Mrs. Nelson tells you she does not get her personal needs allowance.

   _____
10. A number of residents tell you they have not seen the doctor this month.

    _____
11. The social worker asks if you can help with a resident’s Power of Attorney who is not paying the nursing home bill. _____
12. After speaking several times with the Director of Food Services, you find that complaints are not getting resolved. _____
13. You notice a resident is sliding out of a chair. _____
14. Mr. Sims appears lonely and bored. _____
15. Two roommates are arguing with each other. _____

Financing Nursing Home Care

Personal

- Private pay: individuals or legal representatives use the residents’ personal funds
- Insurance: some companies allow clients to use life insurance policies to pay for long-term care. Some Medicare-eligible individuals may have a supplemental insurance policy to pay costs beyond the basic Medicare skilled nursing benefit. Each policy is different so nursing homes must work with an insurance agent to understand the scope of coverage.
- Long-term care insurance: this insurance can provide coverage to pay for care in nursing homes and some assisted living facilities. A policy may include skilled and non-skilled care. Each policy is different, so nursing homes must work with the insurance company to bill for reimbursement.

Government

Medicare

- An insurance program for people who are 65 years old, disabled, or people with end stage renal disease

- Beneficiaries share costs through deductibles and monthly premiums that help cover inpatient care in hospitals, skilled nursing services, hospice, and home health care
- Pays for skilled care of residents who were admitted to a hospital (not just under observation) for at least 72 hours prior to nursing home admission. Pays 100% for 1-20 days, then 80% for 21-100 days; if the person is also Medicaid-eligible, the remaining 20% of the cost is paid by Medicaid

Medicaid

- Assistance program covers low-income people regardless of age
- To be eligible, a resident must have some form of monthly income
- Has no monthly insurance fee
- Paid by state and federal taxes
- A majority of nursing home residents are on Medicaid
- Once a resident is on Medicaid, they choose a Managed Care Organization (MCO). See Supplement 6-A.

Veterans' Administration (VA)

- VA benefits vary by military branch, service-connected disability, and war-time service.
  - The Texas Veterans Land Board General Land Office operates Texas state veterans homes
  - VA contracts with other nursing homes to provide services to veterans
  - Some spouses and former spouses of veterans are also eligible for benefits.

Medicaid eligibility has many terms associated with the process. Ombudsmen need to understand these basics:

- About 70% of residents are eligible for Medicaid to pay for their care. Though many nursing homes will help, the person is responsible for completing paperwork to determine financial and medical eligibility.
- A Medicaid eligibility worker in the Health and Human Services Commission (HHSC) determines financial eligibility. Workers conduct their work by phone and mail. Financial eligibility is based on criteria set for a person's maximum allowed monthly income and resources. The Medicaid Eligibility for Persons with Disabilities Handbook provides details on financial eligibility determination.
- Texas Medicaid & Healthcare Partnership (TMHP) to evaluate assessment information determines medical eligibility. To be eligible, a resident needs to meet state criteria for "medical necessity." TMHP bases the determination on a resident's Resident Assessment Instrument and sets a Resource Utilization Group (RUG) reimbursement rate. That rate is the amount Medicaid reimburses a nursing home each day it delivers care to that resident.
- Medicaid eligible residents pay the nursing home each month with their monthly income, usually a social security check, which is called "applied income." Sixty

dollars per month is reserved to pay for incidental items. The remainder of the cost of the resident's care is paid for by Medicaid, which includes 60% federal funds and 40% state funds. Medicaid is considered a state program, even though the federal government provides matching funds. The 60 dollars a resident receives each month is called *Personal Needs Allowance*.

- Once a resident is eligible for Medicaid, a managed care organization (MCO) is chosen. The MCO will handle Medicaid payments to the nursing home. The MCO will also provide care authorizations and service coordination. For more information on managed care, see Supplement 6-A Ombudsman Managed Care Toolkit at the end of this chapter.
- Humans determine eligibility, and as such, may make mistakes. A frequent problem is incomplete paperwork that does not sufficiently describe a resident's medical needs or a failure to provide necessary financial documentation. Ombudsmen can help by reminding parties to submit complete information and persuading facility staff to communicate with HHSC and TMHP. If barriers are found in the system, ombudsmen can help identify state resources to overcome problems.

Medicaid Services

Nursing home care – meeting medical, nursing, and psychosocial needs of each client, to include room and board, social services, administration of medications, medical supplies and equipment, and personal needs items;

Rehabilitative services - physical, occupational, and speech therapy to eligible residents who are recovering from an acute illness or an injury; if a Medicaid-eligible resident needs skilled nursing facility (SNF) services, Medicaid pays for the remaining costs not covered by Medicare;

Hospice services - palliative care of medical, social, and support services for a person with a terminal illness diagnosis of six months or less to live;

Emergency dental services - reimbursement for emergency dental services; routine dental services (such as cleaning or dentures) may be paid for using the resident's monthly income as an incurred medical expense; and

Specialized services - therapies and restorative nursing services to residents determined to need these services in the Pre-admission Screening and Resident Review (PASRR) process.

Ombudsman tip: When a resident is away for more than 72 hours, the nursing home temporarily stops receiving Medicaid reimbursement until the resident returns. For example, lengthy hospital stays place the facility in situations of empty beds and that impacts revenue. Federal law requires a nursing home to provide written information about the resident right to pay for a "bed-hold." The hold reserves a resident's bed in the nursing home. Learn the bed-hold policy in your assigned facility and share any concerns with your supervising staff ombudsman.

Resident Trust Funds

- Residents whose care is paid for with Medicaid by a MCO receive $60 per month. With authorization from the resident or legal representative, the facility must hold, safeguard, manage, and account for the personal funds in a trust fund account.
- The facility must deposit funds:
  - in excess of $50 in an interest bearing account that is separate from the facility's account; and
  - less than $50 in a non-interest bearing account, interest bearing account, or petty cash fund.
- To remain Medicaid-eligible, an individual resident's resources must not exceed $2000. If savings are reaching the $2000 mark, the resident has an opportunity to buy something needed or wanted, like clothing, a phone, or other technology. Purchases are the property of the resident. The facility must not make charges to resident's funds for items or services paid for by Medicare or Medicaid, such as bath soaps, deodorants, moisturizing lotions, tissues, and incontinent supplies, unless the resident authorizes it and the resident prefers to purchase a specific brand of supplies.

Access to Personal Funds

If the facility is holding a resident's personal funds, these funds are available to the resident during normal working hours on regular business days. Upon a resident's request, transfer, or discharge, the nursing home must return the full balance of his or her personal funds within 30 days. The facility must respond to requests received after hours immediately at the beginning of the next day normal business hours.

On average, how many nursing home residents pay with Medicaid?

_____%

A person using Medicaid to pay for nursing home care keeps $_____

each month. This is called a personal needs _____.

What is "applied income?" _____ _____

The State of Texas contracts with TMHP to determine a resident's

_____.

Alternatives to Nursing Home Care

A range of options exist for long-term services and supports. Financing those options is critical to any decision. Texas has a policy and initiative, called Money Follows the Person. It allows funding for Medicaid-eligible nursing home residents to be used in settings other than nursing homes. If residents wish to exercise this option, they use a Medicaid waiver to relocate.

The federal government approves waivers to use the money that would be paid to nursing homes to instead pay for services in other settings tend to be less costly. For Medicaid-eligible people who are elderly, have a long-lasting illness, or have a disability, Texas uses the STAR+PLUS waiver. STAR+PLUS offers health care and long-term care services and supports provided through a health plan (also called a managed care organization or MCO).

Residents can use these waivers in private homes or in assisted living facilities under contract with the State of Texas to provide such services. Relatively few assisted living facilities have a contract to provide waiver services, so a majority of people live in apartments or houses. They may have family living with them, other roommates, or live alone. The waiver program can pay for nursing services, attendant care for getting a bath, meal preparation, housekeeping services, and for help getting in and out of a bed or chair.

In Texas, Medicaid-financed alternatives to nursing home care are most easily accessed by moving into a nursing home first, bypassing a waiver interest list, and then relocating to an independent setting. During the process, individuals can lose housing and other natural supports.

Federal and state governments appear motivated to “balance” the Medicaid payment system. Rebalancing refers to changing government policies biased towards institutional care to policies that allow individual choice to direct where a person lives.

It is likely there will always be a need for nursing homes, but changes in the overall system and more options appear to be on the horizon. Chapter 15 describes systems advocacy and offers guidance to ombudsmen on how to affect change for residents to live in settings other than a nursing home.

Ombudsman tip: Provide information to residents who indicate they want to move out of the nursing home. Tell them how to contact their managed care service coordinator or facility social worker.

Walk the Fine Line

Ombudsman Role with Residents, Families, and Facility Staff

Based on long-term care ombudsman experiences, Jana Tiefenwerth, former East Texas staff ombudsman, created “Walk the Fine Line.” This perspective helps create positive working relationships that lead to successful advocacy.

During the presentation, think about how ombudsmen can achieve the following:

- Walk the fine line between residents and staff in a way that increases their trust in an ombudsman.
- Help residents see an ombudsman as a resident advocate, but do not cross the line and create a dependent relationship.
- Develop relationships with staff that improves quality of life and care for residents, without crossing a boundary with staff.

Exercise: During the presentation, consider the following questions:

How can an ombudsman ‘walk the fine line’ between residents and staff in a way that increases residents’ trust?

_____

How can an ombudsman help residents see an ombudsman as a resident advocate, but not cross the line and create a dependent relationship?

_____

How can an ombudsman develop relationships with staff that improves quality of life and care for residents, without crossing a boundary with staff?

_____

Give an example of an ombudsman being pro-facility:

_____

Facility Visits - Intern Shadow Visits

Job shadowing, or a “shadow visit”, is a training technique used for new staff and interns. Essentially, it involves spending a period of time (two hours is recommended) with a seasoned certified ombudsman, watch the person as a facility visit is made. A shadow visit allows an intern to see how an ombudsman approaches residents and staff, and what is involved in performing the tasks associated with ombudsman work.

Interns must complete Chapters 1-6 of the initial certification manual, have a verified criminal history check, and have no unremedied conflicts of interest on file prior to entering a facility and interacting with residents. Interns are required to wear their ‘intern identification badge’ while participating in shadow visits. See *Ombudsman Activities (Dos and Don’ts)* later in this chapter for more information. A minimum of two shadow visits are required before certification can be recommended to the State Ombudsman.

Things to observe about the trainer during a shadow visit:

- Physical appearance
- Items carried into each facility
- Note taking
- Communication with staff
- Obtaining consent from residents and other complainants
- How the ombudsman takes direction from residents
- Not taking action on any request
- The first actions the ombudsman takes upon entering a facility

Things to ask the trainer in a private setting:

- How many residents do you usually visit?
- Do you have a protocol at the start of each facility visit?
- How do you decide which staff to talk to about a complaint
- How do you make sure all residents are visited over time?
- What support documents and materials do you keep with you or in your car?
- How do you decide whether to “go up the chain of command” on a complaint?
- How should I protect my confidential records?
- When is my monthly report due?

Ombudsman Activities

The internship provides opportunity for interns to become acquainted with residents and form trusting relationships. Ombudsman interns are restricted from certain activities while they practice the most fundamental skills of a resident advocate.

DOs

- Attend ombudsman training
- Be friendly and professional
- Be dependable by visiting on a regular basis; wear your badge
- Respect the confidentiality of all residents
- Focus your time and attention on residents
- Respect resident dignity, choice, and self-determination
- Be a good listener and communicator
- Knock before entering each resident room and introduce yourself
- Learn about resident and family council activities
- Visit all residents, including residents who cannot speak with you
- Immediately report safety concerns to the facility administrator and your supervising staff ombudsman
- Report visits each month to the local office and consult staff when needed
- Follow guidelines established by the Texas LTCOP

DON'Ts

- Do not provide physical assistance or nursing care to residents
- Do not act as an inspector in the facility
- Do not make promises you are unable to keep
- Do not treat residents as children or talk down to them
- Do not advise residents on business or legal matters
- Do not enter rooms where active treatment is being provided, such as rooms with the door closed
- Do not solicit or accept any form of gift, loan, or gratuity from anyone in any capacity while associated with the Texas Long-term Care Ombudsman Program
- *Interns do not visit or enter kitchen or medication rooms
- **Interns do not investigate complaints; immediately refer complaints to your supervising staff ombudsman

* This is only applicable to interns. A certified ombudsman (CO) accesses areas where residents live and receive services. In general, areas restricted to residents are restricted to a CO, such as kitchens, medicine storage closets, and electrical and utility rooms. If invited to view a restricted area under facility staff supervision or depending upon a specific complaint or inquiry, access is appropriate.

** This is only applicable to interns. Once certified, ombudsmen investigate and work to resolve complaints.

Facility Visit Guide - Things to Look for During Visits

The regular presence of staff and volunteer ombudsmen improves resident care and quality of life. Remember these, "Things to look for…," during your facility visits to help you focus on residents.

Things to look for in residents Are residents: • Clean and dressed? • Participating in regular activities? • Receiving meals and snacks? • Asked about individual preferences? • Inhibited by physical or chemical restraints*****? • Treated with kindness and respect? • Are residents comfortable? Observe positioning in chairs. • Encouraged to personalize their living space? **Read more about restraints in Chapter 5, Residents' rights and Chapter 15, Systems Advocacy*	**Things to look for in staff** Do staff: • Make eye contact and smile with residents and with you? • Know the residents by name? • Respond quickly to call lights? • Knock on doors before entering a resident's room? • Treat residents with respect, courtesy, and dignity? • Ensure residents are covered for privacy when being moved in the hallway for a bath and while providing care? • Wear name badges?
Things to look for in the physical environment • Are there odors in the rooms and halls? • Do residents have outside spaces to enjoy? • Are there private areas for conversations and phone calls? • Are there safety features such as door alarms on exits, smoke alarms and detectors, and warning signs displaying wet floors? • Do residents have ample access to water in their rooms and in public areas access to water, coffee, and other fluids? • Are public restrooms and other public areas accessible to residents? • Does the facility have security that restricts residents' access to the outdoors? • Are doors to hazardous areas properly secured?	**Things to look for in management** • Are resident rights posted? • Is the ombudsman poster visible? • Are visiting hours enforced against resident wishes and family schedules? • Are resident policies fair and within resident rights? • Is the menu posted and followed? • Do residents help direct menu choices? • Are resident menu preferences followed? • Are there flexible dining hours? • Is the activity calendar posted and followed? • Are activities varied, meaningful, and connected with the outside community? • Are Regulatory Services survey results accessible?

Facility Contact Sheet

Facility Name _____ ID# _____

Owner _____

Administrator or Manager _____

Medical Director _____

Director of Nursing _____

Social Worker _____

Activity Director _____

Housekeeping / Laundry _____

Resident Council Contact _____

Family Council Contact _____

Specialized Services _____

_____

Community Involvement _____

Ombudsman tip: Be aware of changes in ownership or key personnel. Keep your staff ombudsman updated through your monthly activity report.

The most recent survey was conducted on _____.

Once a year, ask for a copy of the admissions packet given to residents. Review it and check that it is easy to understand and complete with the required notices:

- Resident rights;
- Current information about the ombudsman program; and
- Current policies about safety and resident responsibilities.

Inform your supervising staff ombudsman of any concerns.

Observed and prepared by:

_____ _____

Ombudsman Date

Supplement 6-A – Ombudsman Managed Care Toolkit

an ombudsman guide...

to managed care in nursing facilities.

Introduction

Managed care is part of Medicaid in Texas nursing facilities.

Remember that nursing facilities still have to provide good care, and they receive a daily rate payment for each resident who is on Medicaid.

Though nursing facilities are still responsible for a resident's care, people who have Medicaid have an additional company that is part of their care - managed care organizations.

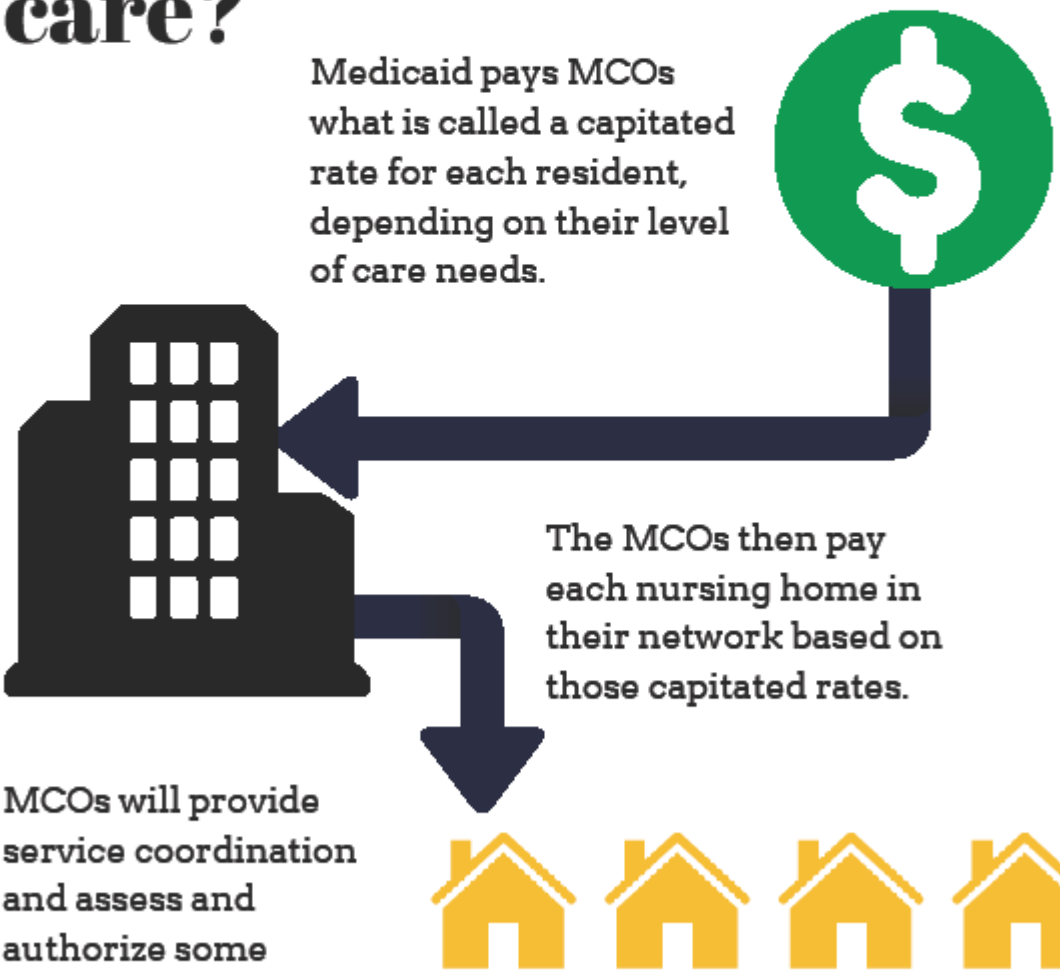
Ombudsmen help all residents, regardless of who pays for their care. For us, MCOs are simply another organization we may need to work with to fulfill our role as resident advocates.

This guide is designed to help you understand the process.

Introduction

So... What is managed care?

Medicaid pays MCOs what is called a capitated rate for each resident, depending on their level of care needs.



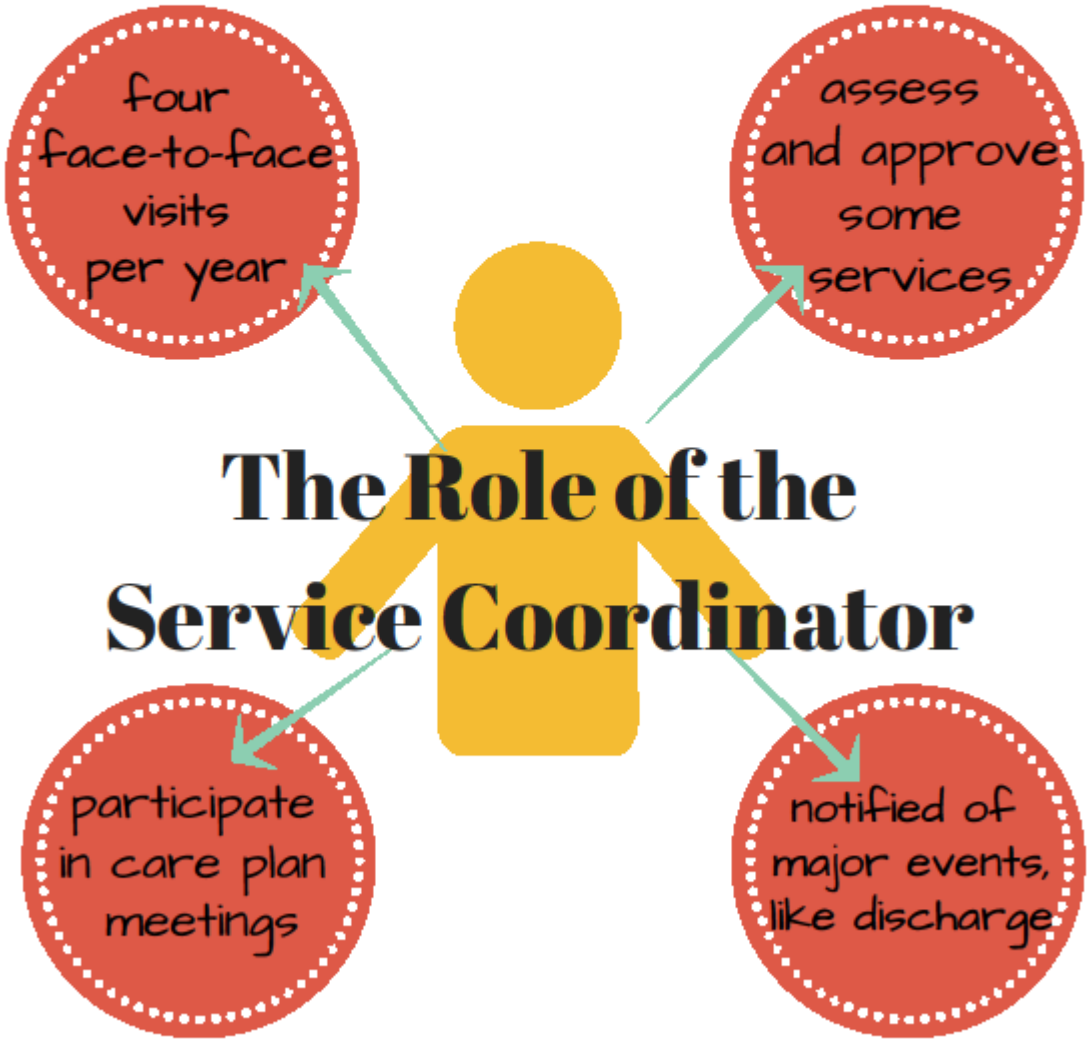
The MCOs then pay each nursing home in their network based on those capitated rates.

MCOs will provide service coordination and assess and authorize some services.

Service Coordination

Service coordinators are responsible for managing overall resident care, regardless of where they live. Each MCO will have one service coordinator per facility. This is an overview of service coordination in nursing homes.

NOTE: Service coordination services vary depending on the setting (e.g. nursing home vs. assisted living).



TIP: Try calling the service coordinator with MCO-related issues before filing a complaint.

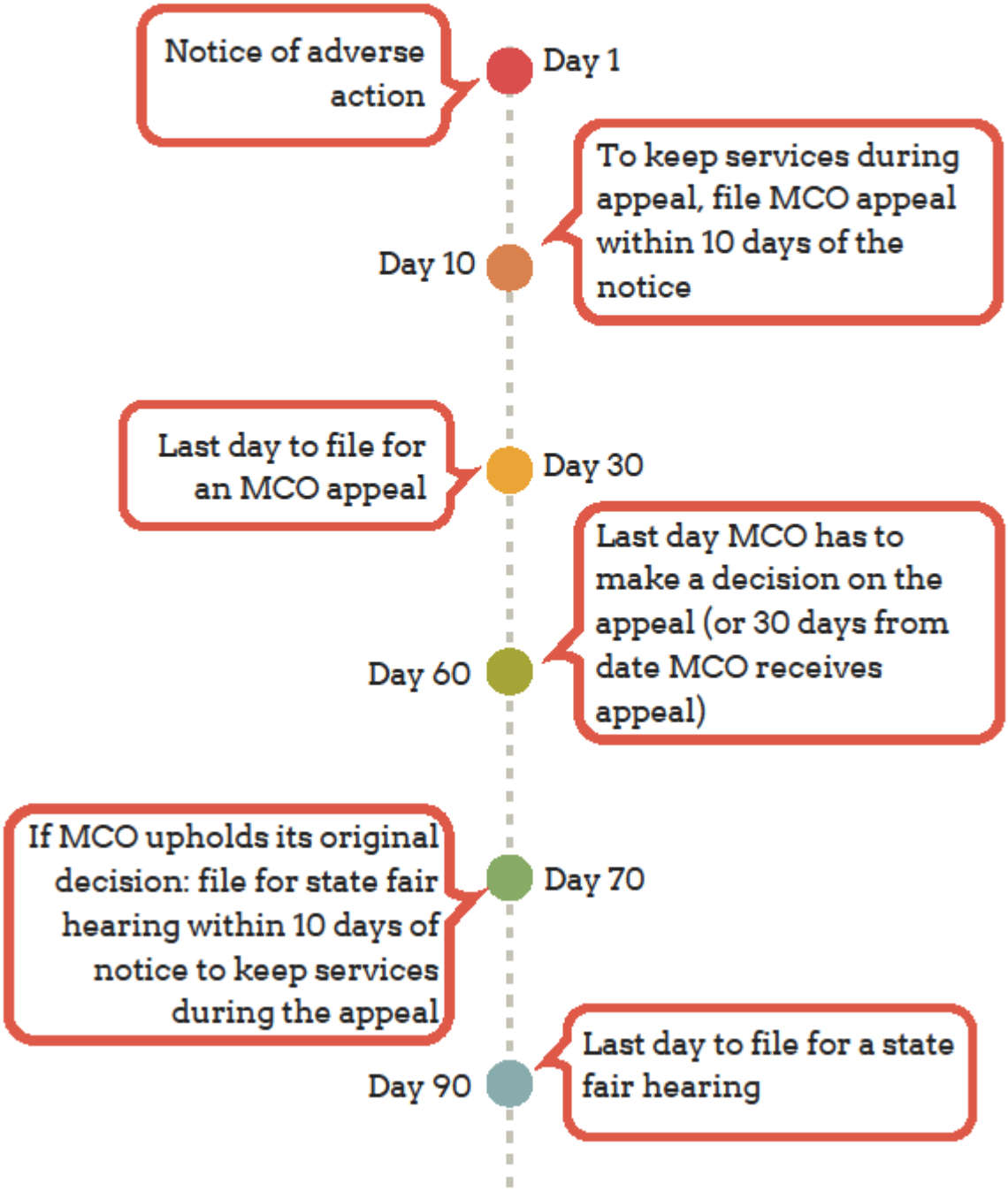
Complaints & Appeals

In managed care, complaints and appeals mean two different things.

Complaint	vs.	Appeal
Definition: An expression of dissatisfaction, either orally or in writing.		Definition: Formal challenge of an MCO action to deny, reduce, or terminate services.
Residents can complain about things like quality of services provided, rude employees, or failure to respect rights.		To keep services during an appeal, residents must submit within 10 days.
Submit complaints through the MCO hotline number. The MCO must resolve them within 30 days.		Residents can choose to appeal through the MCO, through the state fair hearing, or both. Find more MCO appeal information on the next page.

Complaints & Appeals

If an MCO denies, reduces, or terminates a resident's services (things like occupational therapy or a customized wheelchair), the resident can use both the MCO appeal and the state fair hearing. This appeal process does not apply to discharge.



Eligibility & Enrollment

All residents who have Medicaid will have a managed care organization. Residents will enroll in managed care AFTER their Medicaid application is accepted.

1 Introduction Letter

The resident will receive a managed care introduction letter. This letter will explain managed care and talk about they need to do next.

2 Information Packet

Soon after, the resident will get an enrollment packet. It contains information on each plan, lists of doctors and extra services, and information on how to enroll.

3 Enrollment Process

Maximus is the name of the company Texas uses for managed care enrollment. Residents will enroll by either mailing or faxing the form in, or they can call Maximus and enroll over the phone.

Eligibility & Enrollment

things to remember...

- Residents with Medicaid only (not dual eligible) should check and see whether their doctors and specialists are with the health plan they want. If the doctor they prefer is not listed, they will either need to talk to that doctor about joining or choose a new doctor in the health plan's network.

- Residents will become eligible for managed care AFTER they are accepted into Medicaid. The initial Medicaid eligibility and application process will remain the same.

- Residents can switch to a different MCO at any time, as long as it's an MCO that operates in their area.

for information on managed care issues

Medicaid Managed Care Helpline: 1-866-566-8989

for general Medicaid questions

HHSC Ombudsman: 1-877-787-8999

for enrollment in an MCO

MAXIMUS: 1-877-782-6440

References

1. **Medicaid Managed Care Initiatives Website**
http://www.hhsc.state.tx.us/medicaid/managed-care/mmc.shtml

2. **Health and Human Services Ombudsman:**
http://www.hhsc.state.tx.us/ombudsman/

3. **National Long-term Care Ombudsman Resource Center (NORC), on Managed Long-term Services and Supports (MLTSS)**
http://www.ltcombudsman.org/issues/medicare-and-medicaid#mltss

4. **Justice in Aging (formerly NSCLC), on Managed Long-term Services and Supports (MLTSS)**
http://justiceinaging.org/resources-for-advocates/mltss-in-managed-care-toolkit/

Notes:

Notes:

Ombudsman Certification Training

CHAPTER 7: Resident and Family Councils

Resident and Family Councils

Chapter 7 describes resident and family councils and their purpose. It provides an understanding of the ombudsman role with both council types and in similar group meetings.

Learning Objectives

- Become familiar with resident and family council requirements.
- Understand the typical roles and responsibilities of resident and family council members.
- Distinguish between an ombudsman's and facility staff's responsibilities with councils.

Contents

- Resident and Family Councils
- Ombudsman Role with Resident and Family Councils
- State and National Advocacy Organizations for Family Members
- References in Texas Administrative Code for Resident Groups and Family Councils

DVD(s), Supplements, Forms

- DVD: Strength in Numbers: The Importance of Nursing Home Family Councils
- Supplement 7-A: Agenda Template for Resident or Family Council Meetings
- Supplement 7-B: Sample Council Meeting Minutes
- Supplement 7-C: Sample Resident or Family Council Bylaws

Resident and Family Councils

Resident and family councils can impact quality of life and care for residents. It is a constitutional right for any private citizen to organize. In nursing homes, laws and regulations support the residents' right to meet as a group and the families' right to form a council. A resident right to meet privately is supported by rules §19.706 and §92.125.

Fear of retaliation is one of the most significant barriers to residents and family members voicing their concerns. Meetings and councils can help individuals find strength in numbers and overcome that fear. Some councils plan joint meetings in a larger geographic area to share information, talk about challenges and successes, and address systemic problems.

Residents and families communicate and keep in touch by traditional communication such as phone calls, newsletters, and mail but they may explore social networking such as e-mail lists, Facebook, and Google groups.

Residents have the right to prompt efforts by the facility to resolve grievances. During annual and complaint surveys, Regulatory Services surveyors may review minutes of resident and family council meetings. Surveyors examine how facility staff handled grievances and kept residents and families apprised of efforts. Well documented grievances can help alert surveyors to concerns and how they were addressed.

At the end of the chapter, sample materials are supplements to share with resident and family councils who request ombudsman assistance. Note Supplement 7-B: Sample Council Meeting Minutes provides specifics on concerns and any response by management.

Resident Council

A resident council is a group of residents with a purpose. These residents, with or without the help of staff, identify a common need or request and take action. Resident councils have potential to evolve into any number of types and adopt any combination of functions, any of which are correct if desired by residents. Above all else, resident councils are about residents. The needs and desires of residents should drive council activity.

Nursing homes are not legally required to have a resident council, but they must ensure:

- residents have the opportunity to meet as a group or council;
- no interference occurs with council activities;
- residents are afforded privacy during meetings;
- group and individual complaints are responded to; and
- services and activities are based on the individual needs of residents.

A resident council is a practical way to obtain resident input in a variety of services, such as meal planning, social activities, and policies affecting residents. In management terms, a council might enhance a facility by offering to residents and staff the benefits of problem-solving; facility, resident, and staff communications; and empowerment for residents through opportunities to make decisions.

When successfully implemented, the benefits of a resident council far outweigh any administrative costs. The resources spent on a council are investments that provide short-term gains and long-term dividends in the residents' well-being.

Councils provide a forum for residents to:

- Voice concerns directly to staff
- Hold a facility accountable for its promises
- Identify problems and solutions from the residents' perspective
- Recognize staff they feel deserve it
- Discuss topics of interest
- Contribute and shape their world

Since residents are different, councils are different too. A strong resident council has:

- broad participation;
- agenda set by residents;
- freely expressed concerns and suggestions; and
- staff who are responsive to residents' concerns.

Source: Resident Councils of Washington, 2001

Ask the Trainer: Resident Council

What is the key to success of a resident council?

_____

_____

How do I learn when the council meets in the home where I am assigned?

_____

_____

Ombudsman Role with Resident Councils

Ombudsmen can help start new councils or support existing resident councils and other resident groups. Councils can bring grievances to the attention of management, thus providing another option to solve problems at the facility level.

Ombudsman tip: Watch for facility staff who appear to control the council agenda or who limit resident input. Be an advocate for the group by letting your staff ombudsman know about any concerns.

As a new ombudsman, seek out the following information:

- Does the facility have an active council?
- How often and when does it meet?
- Who is the president?
- Who did the facility designate as staff support to the council?
- About how many residents attend?
- Are meetings resident-directed?

Building a relationship with the council president is an important first step to make. Ombudsmen may ask for an invitation to attend a council meeting and attend when invited. Offer to introduce yourself to the council and to describe your ombudsman role.

As ombudsmen develop relationships with councils, promote the idea of the council bringing group concerns to management as a means of problem-solving. Share information as requested, but be aware the ombudsman presence changes the group dynamic. Since a resident council is for residents, respect this concept and avoid attending council meetings every time they are scheduled. Taking the role of the council seriously models for residents and facility staff to take it seriously too.

If requested, ombudsmen help council leaders develop skills to make meetings productive and structures to generate and maintain interest and involvement. In the chapter Supplements, see samples of an agenda, minutes, and bylaws.

Ombudsman tip: Be a source of information on specific laws, rights, services, and health issues. Search your community for resources to share. Ask your staff ombudsman for help if needed.

Ombudsmen can encourage residents to attend council meetings and talk about the meetings with residents. Encourage them to bring concerns to the council to determine if others have the same concerns. If they are reluctant, find out why. While protecting resident confidentiality, share feedback with the president of any identified barrier that should be addressed to help councils meet the needs of all residents who want to participate.

More ombudsman tips:

- Occasionally attend council meetings (if invited). After suggesting that councils can be a means to solve problems, tell residents you can attend with their permission. Some residents will welcome this support.
- Come early. Arrive about 30 minutes before the meeting. Visit residents who said they would like to attend, as they may need a reminder. If staff has not helped residents get to the meeting, your presence can be a needed prompt.
- Suggest writing concerns down. Some residents might write concerns and issues before the meeting. At the meeting, they have their concerns ready to share.
- Offer information about residents' rights and regulations.

Ombudsmen attend council meetings if _____.

A facility must assign a _____ _____ to support council needs. Appropriate ways ombudsmen support councils (Mark the ones that apply):

__ Encourage residents to attend

__ Explain the ombudsman program at a meeting

__ Create and distribute minutes

__ Attend every month

A new ombudsman should make contact with the _____.

Family Council

A family council is an organized group consisting of family members, legal guardians, and friends of residents in a nursing home or assisted living facility. The council usually governs itself, but a facility must provide some support and assistance. Not all facilities have family councils.

With the exception of laws and rules that are specific to resident groups, family councils function in a similar way and serve similar purposes to resident councils. The role of the ombudsman is also essentially the same.

Family councils:

- Help link the facility to the local community
- Support facility operations through suggestions and activity support
- Bring complaints on behalf of residents or members to management

One barrier to an active family council is time. Family members and friends may not have time to visit the residents and attend a meeting.

Family councils can provide needed validation for complaints and support and education to family and friends.

Family members may believe they are the only ones who experience a problem. But in the meeting, they may learn others experience similar problems. When a council submits complaints, the administrator is less likely to ignore the problem and more likely to take action.

Ombudsman tip: The greatest benefit of attending meetings for some family members is the opportunity to build friendships and support. When family cannot visit, they can ask others to look in on their relatives or friends. This “looking out” for each other contributes to a feeling that residents are safe and secure even when family cannot visit.

Some facilities hold information sharing sessions, support groups, or host evening meetings for families. These events can be a starting point for a family council to evolve. But, family councils are groups run by family and friends with support from staff. Staff and other people, like ombudsmen, attend by invitation only.

Strength in Numbers: The Importance of Nursing Home Family Councils

Run Time: 24 min

Family councils led by families benefit residents, family members, and facility staff alike. This video gives an overview of the focus, techniques, and strategies to develop effective councils. It shows how families and friends become empowered to improve the quality of care. Watch the video and answer the questions that follow.

1. On a scale from 1-10, how well do you think the administrator _____ and staff _____ would receive a family council in your assigned home?

2. How could the council recruit more family members? _____

   _____

   _____

3. What guidelines might help a first meeting be successful?

   _____

   _____

   _____

4. Do you have any concerns about the family council at your assigned home?

   _____

   _____

5. Identify a barrier to starting a family council _____

   _____

   _____

6. Identify a facility staff that supports a family council _____

   _____

Ombudsman Role with Family Councils

The ombudsman role with family councils is similar to resident councils.

- Encourage family, guardians, and friends of residents to attend.
- Occasionally attend council meetings (if invited).
- Come early. Arrive about 30 minutes before the meeting and greet people. Introduce yourself to members you have not met.
- Help members understand what is productive to discuss in a group forum and what might be better handled individually.
- Offer information about residents' rights and regulations.

As a new ombudsman, find out if the facility has a family council, who serves as president, and who serves as the facility support staff. Seek out the president and ask:

- How often does the council meet?
- How well attended are the meetings?

- What are typical agenda items?
- How do families and friends learn about the council?
- How can an ombudsman help support the council?

If the facility does not have a family council, but there is a group of people who want to start one, an ombudsman can help. Encourage creation of a council that:

- Meets at a time convenient for a majority of members
- Has structure, including designated leadership and a grievance procedure
- Focuses on improving the quality of care and life for residents
- Educates members on topics of interest
- Creates opportunities for dialogue between staff and council members
- Provides a forum for family members to voice concerns

Members will likely participate only if the council seems worthwhile. Councils may benefit from help to develop their organization and elect leadership. Ombudsmen help members stay involved after the initial energy wanes. Work on particular issues so they see the value of their continued involvement.

Often families focus on personal situations without a greater understanding of how the facility and system work. Help them distinguish between personal concerns and:

- concerns of others;
- general issues about the facility; and
- issues affecting many residents or families.

Ombudsman tip: Encourage family council participation as a means to resolve problems. For example, a family member is concerned facility staff is not meeting her relative's needs. Root causes may include under-staffing, lack of staff training, or insufficient management. Educate families about possible underlying causes to consider and help them recognize the benefit of working with the family council.

State and National Advocacy Organizations

Some family members may want to connect to advocacy organizations with state or federal scope. The Consumer Voice for Quality Long-term Care is a national membership organization for residents, family members, long-term care ombudsmen, and other advocates. Many resources are available free on their website and help is available by telephone. Refer family members to this organization as a start to connecting with national resources. Ombudsmen can become members too. http://theconsumervoice.org/

Another good national resource for specific quality improvement tools is the campaign for Advancing Excellence in America's Nursing Homes. Residents, family members, ombudsmen, and others can join the campaign as a consumer for free. Their website has tools to promote consistent assignment of caregivers to residents, measure resident and family satisfaction, and implement change based on the results, as well as ideas to improve clinical outcomes. https://www.nhqualitycampaign.org/

Some family members find the Texas Advocates for Nursing Home Residents (TANHR) to be a helpful resource. TANHR headquarters is in Desoto, Texas but they take calls from family members statewide. It is a nonprofit organization that advocates for improvement in Texas nursing homes. http://tanhr.net/pages/home.

References in the Texas Administrative Code – Resident and Family Councils

Nursing Facility Requirements for Licensure and Certification

- In nursing homes, residents and families have the right to assemble.

§19.706 Resident Group and Family Council

(a) A resident has the right to organize and participate in resident groups in a facility.
(b) A facility must assist residents who require assistance to attend resident group meetings.
(c) A resident's family has the right to meet in the facility with the families of other residents in the facility and organize a family council. A family council may:
  (1) make recommendations to the facility proposing policy and operational decisions affecting resident care and quality of life; and
  (2) promote educational programs and projects intended to promote the health and happiness of residents.
(d) If a resident group or family council exists, a facility must:
  (1) listen to and consider the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility;
  (2) provide a resident group or family council with private space;
  (3) provide a designated staff person responsible for providing assistance and responding to written requests that result from resident group and family council meetings; and
  (4) allow staff or visitors to attend meetings at the resident group's or family council's invitation.
(e) If a family council exists, a facility must:
  (1) upon written request, allow the family council to meet in a common meeting room of the facility at least once a month during hours mutually agreed upon by the family council and the facility;

(2) provide the family council with adequate space on a prominent bulletin board to post notices and other information;
(3) designate a staff person to act as the family council's liaison to the facility;
(4) respond in writing to written requests by the family council within five working days;
(5) include information about the existence of the family council in a mailing that occurs at least semiannually; and
(6) permit a representative of the family council to discuss concerns with an individual conducting an inspection or survey of the facility.

(f) Unless the resident objects, a family council member may authorize, in writing, another member to visit and observe a resident represented by the authorizing member.

(g) A facility must not limit the rights of a resident, a resident's family member, or a family council member to meet with an outside person, including:
(1) an employee of the facility during the employee's nonworking hours if the employee agrees; or
(2) a member of a nonprofit or government organization.

(h) A facility must not:
(1) terminate an existing family council;
(2) prevent or interfere with the family council from receiving outside correspondence addressed to the family council or open family council mail; or
(3) willfully interfere with the formation, maintenance, or operation of a family council, including interfering by:
(A) denying a family council the opportunity to accept help from an outside person;
(B) discriminating or retaliating against a family council participant; or
(C) willfully scheduling events in conflict with previously scheduled family council meetings, if the facility has other scheduling options.

Licensing Standards for Assisted Living Facilities

- In assisted living facilities, residents' right to assemble and residents' right to access to resident councils is addressed in rule.

§92.125 Resident's Bill of Rights and Provider Bill of Rights (Excerpt)

(a) Resident's bill of rights.
(3) Each resident in the assisted living facility has the right to:
(J) unrestricted communication, including personal visitation with any person of the resident's choice, including family members and representatives of advocacy groups and community service organizations, at any reasonable hour; and

(R) privacy, while attending to personal needs and a private place for receiving visitors or associating with other residents, unless providing privacy would infringe on the rights of other residents. This right applies to medical treatment, written communications, telephone conversations, meeting with family, and access to resident councils. If a resident is married and the spouse is receiving similar services, the couple may share a room.

Supplement 7-A: Agenda Template for Resident or Family Council Meetings

Date
Time (beginning and ending)
Location

I. *Welcome and Introductions*
   a. *Members*
   b. *Guests (facility staff, ombudsman, other)*

II. *Minutes and Correspondence*
   a. *Review minutes from the previous meeting*
   b. *Review any correspondence from or to the council since the last meeting*

III. *Officer or Committee Reports (as applicable)*

IV. *Report from Facility Support Staff or Administrator*

V. *Old Business*

VI. *New Business*

VII. *Guest Speaker / Program*

VIII. *Concerns (includes status of issues submitted by the council to management and new concerns)*

IX. *Adjourn*
   a. *Announce date, time, and location of next meeting*
   b. *Reminder of other upcoming council events*

X. Social Time

Adapted from the Resident Council Handbook, Resident Councils of Washington and Nursing Home Family Council Manual, Texas Advocates for Nursing Home Resident

Supplement 7-B: Sample Council Meeting Minutes

Name of Council
Date
Time
Location of meeting

Welcome and Introductions

The meeting was called to order by [name and time].
Present: list the names of attendees; identify titles of officers and guests

Minutes and Correspondence

[Example] The December minutes were approved as distributed. Correspondence included a letter from Happy Elementary thanking the resident council for their donation of decorations for the school's annual carnival and a letter inviting our resident council to participate in Senior Days in our community.

Officer and Committee Reports

[Example] President Davis reported she was invited to participate in Happy Elementary board of directors meeting scheduled February 5 to provide ideas on how the school and nursing home can plan meaningful activities for the residents and students. The list of ideas was discussed, additional ideas were included, and all ideas were prioritized by the council.

Treasurer Smith reported the barbeque fundraiser earned $211 for the activities department.

The Welcoming Committee reported we have 6 new residents since the last meeting. There will be a write-up in our newsletter next month about them. They were introduced to the council board.

The Dietary Committee is pleased to announce the Dietitian will be a guest speaker at our next meeting and we have made progress with residents choosing when they prefer to eat breakfast with more menu options.

The Sunshine Committee announced that Mr. Sound is better and returned from the hospital. Mrs. Valley is still in the hospital and a card is being sent.

Report from Facility Support Staff or Administrator

Old Business

[Example] Building remodeling continues. The Bluebonnet hallway is being gutted and flooring, furniture, and fixtures will be replaced. Administrator Montana reports staff moved all the residents and personal items to their temporary rooms on Monday according to the contractor's schedule, and he is shopping for an aquarium for the sitting room. See concern listed below.

The idea generated from the last meeting regarding a suggestion box is being pursued by the maintenance department as to size and location. We suggested the box is placed at chair height for easy access.

New Business

[Example] Campaigning for mid-term elections will be starting soon. The council decided to invite candidates to our home on September 1 for dialogue. We discussed inviting residents from nearby nursing homes to join us. The activity director and President Davis will extend an invitation.

Guest Speaker / Program

[Example] John Willis was introduced as our guest speaker. Mr. Willis is Executive Director of the local Alzheimer's organization. A copy of his presentation is available at the front desk and highlights will be published in the next newsletter.

Concerns

[Example] Concerns included:

- *People on Bluebonnet hallway were not given enough notice about being relocated. Staff told them Friday that they would be moved to other rooms on Monday.*
- *Weekend access to management staff. If a serious problem occurred on the weekend, we are unsure how to reach the administrator and regional director. President Davis agreed to speak with the administrator about this concern and get everyone access to phone numbers for emergencies.*

Adjournment

The meeting was adjourned at 2:30 p.m.

Respectfully submitted,
[Name], title

Supplement 7-C: Sample Resident or Family Council Bylaws

I. Name

The name of our council shall be _____.

II. Purpose

The purpose of our council is: [Example] to provide a tool from which residents can communicate their needs and interests in the affairs of their home.

III. Membership

Every resident is a member of the _____ resident council. Each resident can vote. In the case of a family council, specify who can serve on the council.

IV. Officers and their duties

Officers of the council shall be:

- *President (Chair) – presides over all meetings*
- *Vice President (Vice Chair) – presides in the absence of the president*
- *Secretary – takes minutes and writes correspondence as directed by the council*
- *Treasurer – responsible for all financial business of the council*

[Recruiting for officer positions can be a challenge. Members might be willing to serve as co-chairs to share the leadership role. Using a standard agenda each month will make it easy to update and use.]

V. Committees

The council shall have the following committees as needed:

- *Executive (officers and committee chairs)*
  Purpose: to give direction and organization to the council
- *Food*
  Purpose: to serve as a liaison between dietary services and the residents for suggestions and improvements.
- *Grievance*
  Purpose: to serve as a sounding board for grievances and to follow up on complaints with administrator or ombudsman
- *Program*
  Purpose: to coordinate guest speakers and refreshments for meetings
- *Sunshine*
  Purpose: to prepare cards for residents in the hospital, for birthdays and other important events
- *Volunteer*
  Purpose: to enlist members to organize and volunteer for special projects in the community and to improve quality of life in the facility
- *Welcoming*
  Purpose: to greet new members, orient them to the facility, and encourage participation in the council

Elections

Elections of officers and other representatives will be held every _____ (date, month).

VI. Meetings

Meetings will be held every _____ (day, time and location). If committees will meet, include these dates as well.

VII. Amendments

Amendments may be made to the bylaws at any regular or special meeting of the council by vote. Amendments are announced at least one month prior to a vote.

VIII. Rules of Order

Each meeting will be conducted according to a written agenda. [Rules could also follow Robert's Rules of Order or be determined by the group.]

Notes:

Ombudsman Certification Training

CHAPTER 8: Care Planning

Care Planning

Chapter 8 is about the care planning process for individuals in nursing homes and assisted living facilities and about advance care planning. Individual care planning includes assessments, care or service plan meetings, and care or service plan documents. Advance care planning is about making decisions to direct future health care decisions should a person have physical or mental incapacity.

Learning Objectives

- Understand the care (nursing home) and service (assisted living facility) planning process
- Know the advance care planning concept and documents to communicate future health care wishes
- Understand who may serve as a surrogate decision maker and under what circumstances

Contents

- Individual Care Planning
- Comparison of Nursing Home and Assisted Living Facility Regulations
- Advance Care Planning
- Ombudsman Role in Advance Care Planning

DVD(s), Supplements, Forms

- DVD: CMS Hand in Hand Training Module 6: Being with a Person with Dementia: Making A Difference
- Supplement 8-A: I Want to Tell You about My Mother
- Supplement 8-B: Agonizing Schiavo Case Shows Need to Put Medical Wishes in Writing

Individualized Care Planning

According to federal and state laws, each nursing home must “provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which … is initially prepared, with participation to the extent practicable, of the resident, the resident’s family, or legal representative.” A person should not decline in health or wellbeing because of the way a nursing home provides care.

According to state licensing standards, a written plan of care in an assisted living facility (ALF) has special significance. The plan, known as a service plan, is the basis for providing services required to meet the needs of the resident.

The Ombudsman Role

An ombudsman is not responsible for creating a resident’s care or service plan; however, an ombudsman may use the care planning process to solve problems. Ombudsmen must be knowledgeable about person-directed care practices in order to incorporate this in their conversations with residents, families, and providers and in their advocacy. Ombudsmen only attend a care or service plan when invited by the resident or resident’s LAR if the resident is unable to make the request.

Assessment

To give good care, staff must assess each resident and plan care and services to support each person's life-long patterns, current interests, strengths, and needs. Resident and family involvement gives staff information to assure residents get good care.

Assessments gather information about how well residents can take care of themselves and when they need help in functional abilities, such as walking, talking, eating, dressing, bathing, seeing, hearing, communicating, understanding, and remembering. Staff should ask and learn about habits, activities, and relationships to help residents live more comfortably and feel more at home. Assessments help staff look for what causes a problem. Assessments should also pay attention to strengths.

In both assisted living facilities and nursing homes, assessments must be completed within 14 days of admission. In nursing homes, assessments must be reviewed at least once a year with reviews every three months (quarterly), and when a resident's physical or mental condition changes. In assisted living, the service plan must be updated annually or upon a significant change in condition, based upon an assessment of the resident.

Plan of care

A care plan for nursing home residents must be developed within seven days after an assessment. It describes a strategy for how staff will help a resident and what each staff will do and when it will happen, such as, “The nurse aide will help me walk to each meal to build my strength.” Staff should be familiar with all care plans, document services provided according to them, and revise as needed.

In assisted living, a service plan must be developed within 14 days of a resident’s admission to the facility.

Meeting to develop the plan

Staff, residents, and families talk about life in the nursing home or assisted living facility, including meals, activities, therapies, personal schedule, health care, and emotional needs. Residents and families bring up problems, ask questions, and offer information to help staff provide care. All staff who works with a resident should be involved such as nurse aides, nurses, physician, social worker, activities staff, dietician, and therapists.

To the degree possible, residents should talk about what they need and how they feel. They can ask questions about care, daily routines, food, activities, interests, staff, personal care, and medications. They should be persistent about concerns and choices. Staff must discuss treatment and only do what a resident agrees to.

Ombudsman Tip: Ombudsmen attend care meetings at the invitation of a resident or legal representative. Ombudsmen can help residents and family prepare for a meeting by giving information on how a meeting typically works and helping them practice discussing specific comments, questions, or concerns. Staff generally leads a care conference, but residents, family, and ombudsmen can direct discussion of issues most important to the resident. Ombudsmen may also suggest a care plan meeting as a strategy for resolving a problem.

Participation

Residents have the right to make choices about care, services, and daily life and be involved in the care-planning meeting.

Before the meeting, residents can:

- Tell staff their concerns, needs, and goals.
- Ask the doctor or staff who know about their condition, care, and treatment.
- Ask to meet when family can come, if they want them there.

During the meeting, residents can:

- Discuss options for treatment and for meeting needs and preferences.
- Ask for terms and procedures to be explained if needed.
- Decide if they agree with the plan and feel it meets their needs.
- Ask for a copy.
- Get the name of a person to talk to if they want changes.

After the meeting, residents can:

- Monitor how the plan is followed.
- Talk with nurse aides, other staff, or their doctor about it.

Good care or service plans:

- Are specific, individualized, and written in common language
- Reflect resident concerns and support well-being, functioning, and rights
- Do not label resident choices or needs as "problem behaviors"
- Use a multi-disciplinary team approach and use outside referrals as needed
- Are re-evaluated and revised routinely (watch for care plans that never change)

Adapted from a Consumer Voice fact sheet, http://theconsumervoice.org/uploads/files/family-member/assessment-and-care-planning.pdf

A care plan may include:

- What kind of services are needed
- What type of health care professional should provide the services
- How often the services are needed
- What kind of equipment or supplies are needed (like a wheelchair or feeding tube)
- If a special diet is required
- Health goal (or goals), and how the care plan will help the resident reach this goal

https://www.medicare.gov/what-medicare-covers/part-a/care-plan-in-snf.html

Comparison: Nursing Home and Assisted Living Facility Regulations

The State of Texas requires nursing homes to develop care plans and assisted living facilities to develop service plans. Compare the requirements in the following sections.

Nursing Facility Requirements §19.801 Resident Assessment

A facility must conduct initially and periodically a comprehensive accurate, standardized, reproducible assessment of each resident's functional capacity. The facility must electronically transmit admission, annual, quarterly and significant change assessments to the State of Texas.

(1) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

(2) Comprehensive assessments.

- (A) A facility must make a comprehensive assessment of a resident's needs, using the Resident Assessment Instrument, including the Minimum Data Set (MDS).
- (B) The assessment must include at least the following information:
  - (i) identification and demographic information;
  - (ii) customary routine;
  - (iii) cognitive patterns;
  - (iv) communication;
  - (v) vision;
  - (vi) mood and behavior patterns;
  - (vii) psychosocial well-being;
  - (viii) physical functioning and structural problems;
  - (ix) continence;
  - (x) disease diagnoses and health conditions;
  - (xi) dental and nutritional status;
  - (xii) skin condition;
  - (xiii) activity pursuit;
  - (xiv) medications;
  - (xv) special treatments and procedures;
  - (xvi) discharge potential;
  - (xvii) documentation of summary information regarding the additional assessment performed through the resident assessment protocols;
  - (xviii) documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.
- (C) A facility must conduct a resident comprehensive assessment as follows:
  - (i) within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.
  - (ii) within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff

or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.

(iii) not less often than once every 12 months.

Nursing Facility Requirements §19.802 Comprehensive Care Plans

(a) A facility must develop a comprehensive care plan for each resident that includes measurable short-term and long-term objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment. The plan must describe:
  (1) the services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being as required under §19.901; and
  (2) any services that would otherwise be required under §19.901 but are not provided due to the resident's exercise of rights, including the right to refuse treatment under §19.402(g).

(b) The comprehensive care plan must be:
  (1) developed within 7 days after completion of the comprehensive assessment;
  (2) prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by resident needs, and, to the extent practicable, with the participation of resident, resident's family, or legal representative;
  (3) periodically reviewed and revised by a team of qualified persons after each assessment; and
  (4) for a resident under 22 years of age, annually reviewed at a comprehensive care plan meeting between the facility and the resident's LAR.

(c) A comprehensive care plan must include:
  (1) for a resident under 18 years of age, activities, services, and supports when provided or facilitated by the facility will enable the resident to live with a family; or
  (2) for a resident 18-22 years of age, the activities, supports, and services that when provided or facilitated by the facility will result in the resident having a consistent and nurturing environment in the least restrictive setting, as defined by the resident and LAR.

(d) A comprehensive care plan may include a palliative plan of care. It may be developed only at the request of resident, surrogate decision maker, or legal representative for residents with terminal conditions, end stage diseases, or other conditions for which curative medical interventions are not appropriate. It must have goals that focus on maintaining a safe, comfortable, supportive environment in providing care to a resident at the end of life.

(e) For a resident under 22 years of age, facility must provide written notice to the LAR of a meeting to conduct an annual review of the resident's comprehensive care plan no later than 21 days before the meeting date and request a response from the LAR.

(f) The services provided or arranged by the facility must:

(1) meet professional standards of quality; and
(2) be provided by qualified persons in accordance with each resident's written plan of care.

(g) Comprehensive care plan must be made available to all direct care staff.

Licensing Standards for Assisted Living Facilities §92.41(c) Resident assessment

Within 14 days of admission, a resident comprehensive assessment and an individual service plan for providing care, based on the comprehensive assessment, must be completed. The assessment must be completed by appropriate staff and documented on a form developed by the facility. When a facility is unable to obtain required information, the facility should document its attempts to obtain the information.

(1) The comprehensive assessment must include:
- (A) location from which resident was admitted;
- (B) primary language;
- (C) sleep-cycle issues;
- (D) behavioral symptoms;
- (E) psychosocial issues;
- (F) Alzheimer's/dementia history;
- (G) activities of daily living patterns;
- (H) involvement patterns and preferred activity pursuits;
- (I) cognitive skills for daily decision-making;
- (J) communication;
- (K) physical functioning;
- (L) continence status;
- (M) nutritional status;
- (N) oral/dental status;
- (O) diagnoses;
- (P) medications;
- (Q) health conditions/ possible medication side effects;
- (R) special treatments and procedures;
- (S) hospital admissions within the past 6 months or since last assessment; and
- (T) preventive health needs.

(2) The service plan must be approved and signed by the resident or a person responsible for the resident's health care decisions. The facility must provide care according to the service plan. The service plan must be updated annually and upon a significant change in condition, based upon an assessment of the resident.

(3) For respite clients, the facility may keep a service plan for six months from the date on which it is developed. During that period, the facility may admit the individual as frequently as needed.

(4) Emergency admissions must be assessed and a service plan developed for them.

Basics of Individualized Quality Care

Traditionally, care plans are developed using a medical model. They are written from a staff perspective rather than a resident perspective. This model is not suited to individualized care. Individualized plans provide care and service that support quality of life for each resident.

Example: Fred is an 84-year old man with osteoarthritis. He is very pleasant and social, frequently visiting staff and residents. He ambulates with minimal assistance or moves independently in a wheelchair. His wife was a resident. They were happily married for 61 years and did not have children. They shared a room until she died six months ago. He is now in a private room. Recently he began acting out sexually (grabbing at staff and residents). He is alert and aware of his surroundings, has minimal cognitive impairment, and is hearing impaired.

Traditional Care Plan

Problem	Goal	Approaches
Inappropriate sexual behavior	Resident will not touch staff or residents against their wishes.	• 15-minute checks to monitor location. • Praise appropriate behavior. • Re-direct and allow time alone in room when sexual behavior occurs. • Private room.

Individualized Care Plan

Needs	Goal	Approaches
I need companionship.	I will choose a roommate by next resident care plan meeting.	• I prefer to have a roommate. • When I'm in my room, I like to watch action movies. Share any action DVDs you have with me. • I like to read books. • I look up words in my dictionary. • I enjoy wild birds. I have a bird feeder outside my window. Leave shades open and ensure I have birdseed so I can fill the feeder. • When I'm out of my room, I enjoy eating in the dining room. • Offer opportunities to be around staff and other residents. I may not talk a lot, but I like company. • Speak clearly and directly to me, hearing is difficult. • Introduce me to single women who are seeking companionship and friendship.

SOURCE: Susan Misiorski and Lynn MacLean, Apple Health Care Inc. Avon, CN

More information about individualized care plans can be found on the Consumer Voice website:
http://theconsumervoice.org/uploads/files/family-member/basics-of-individualized-quality-care.pdf

Exercise: Create Wilma's Care Plan

Wilma is an 88-year old woman with dementia. She has a short attention span and usually has a cheerful demeanor. Wilma likes to walk around the facility for most waking hours. She is unable to distinguish between areas she is allowed to enter and those that she should not. Her ambulation skills are excellent; she requires no assistance. Wilma disturbs some residents because she may enter their rooms against their wishes. She prefers to be with staff at all times; she does not tolerate being alone very well. She and her husband raised eleven children. They owned a hardware store and were respected business owners in town.

Traditional Care Plan

Problem	Goal	Approaches
Wanders due to dementia	Resident will not wander into other resident rooms through next resident care plan meeting.	Redirect resident to appropriate areas of facility. Praise for cooperation. Teach not to go into rooms with sashes across the door.
Short attention span	Resident will participate in one group program per week for 15 minutes through next care plan meeting.	Invite to group activities. Praise for participation.

Individualized Care Plan

Needs	Goal	Approaches

CMS Hand in Hand Training - Module 6: Being with a Person with Dementia: Making a Difference

Run Time: Approximately 1 hour to view video clips and discuss

Each person who lives, works, and volunteers in a nursing home or assisted living community makes a difference in the lives of everyone around him or her, staff as well as residents. While watching CMS Hand in Hand Module 6, think about how Mrs. Johnson's changing needs could be addressed in her care plan.

Answer the following questions about CMS *Hand in Hand Module 6*.

1. In the *Mrs. Johnson, Part I* video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?

- _____
- _____
- _____

2. In the *Mrs. Johnson, Part 2* video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?

- _____
- _____
- _____

3. In the *Mrs. Johnson, Part 3* video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?

- _____
- _____
- _____

4. In the *Mrs. Johnson, Part 4* video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?

- _____
- _____
- _____

5. In the *Mrs. Johnson, Part 5* video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?

- _____
- _____
- _____

6. Good dementia care involves fulfilling these basic human needs:

- _____
- _____
- _____

Advance Care Planning

Advances in health care and the growing number of Americans who are living longer create some challenges when people can no longer make decisions or express their needs. Sometimes when people are in accidents or have terminal illnesses, they are not able to talk or let others know how they feel. Directing how a person wants to be treated at the end of life, regardless of capacity, can be achieved through certain legal documents. Directions on what a person does or does not want can be included.

Advance care planning requires an individual to:

1. determine what wishes need to be shared;
2. direct choices about care if staying home, in a nursing home, or in a hospital;
3. talk with family and doctors about what treatment is desired and what is not;
4. document treatment wishes in the event of a serious accident, illness, or terminal condition; and
5. tell others what is decided.

Some advance care planning documents are legal forms. They may be completed with the help of an attorney, but an attorney is not required. The most common forms are:

Medical Power of Attorney —Authorizes, except to the extent a person states otherwise, a named agent to make any and all health care decisions in accordance with the person's wishes, including religious and moral beliefs, when a person is no longer capable to make them

Directive to Physicians and Family or Surrogates — Communicates wishes to doctors, family, and others about medical treatment at some time in the future when a person is unable to make wishes known because of illness or injury

Out-of-Hospital Do Not Resuscitate — Instructs emergency medical personnel and health care professionals to not attempt resuscitation and to allow natural

death; it does not affect receiving other emergency care and treatment including comfort care

Statutory Durable Power of Attorney — Designates an agent who is empowered to take certain actions regarding property and finances; it does not typically authorize anyone to make medical and other healthcare decisions

In a Medical Power of Attorney form, the named person (called an "agent") speaks for the individual when he or she is no longer able to. A Directive to Physicians or Medical Power of Attorney may include a person's written wishes about specific medical procedures. The documents can be updated by marking through an area and writing in current wishes or completing a new form and destroying the old one. It is the individual's responsibility to inform family members and doctors about any changes.

The person named in a Medical Power of Attorney to make decisions is called the _____.

Other advance care planning forms include:

Consent to Medical Treatment - This process can be used by hospitals, nursing homes, home health agencies, and hospice for a person who has not issued a directive and needs medical care. It does not include withholding or withdrawing life sustaining treatment.

Declaration for Mental Health Treatment - This form allows a person to make decisions in advance about mental health treatment and specifically three types of mental health treatment: psychoactive medication, convulsive therapy, and emergency mental health treatment. The instructions in this declaration will be followed only if a court believes a person is incapacitated to make treatment decisions. Otherwise, a person is considered able to give or withhold consent for the treatments.

Procedure When Person Has Not Executed or Issued a Directive and Is Incompetent or Incapable of Communication - This process can be used if an adult patient has not executed or issued a directive and is incapacitated, or mentally or physically incapable of communication. In that case, the attending physician and the resident's legal guardian or an agent under a medical power of attorney may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment from the resident.

If help is needed to understand advance care planning forms, facility and hospital staff can explain them. Benefits counselors at area agencies on aging are trained to help complete Medical Powers of Attorney. The Texas Legal Services Center can provide

information about legal forms and under some circumstances attorneys to assist in the completion of these documents.

Regulations pertaining to advance care planning:

- Nursing Facility Requirements §19.419
- Licensing Standards for Assisted Living Facilities §92.41(g)

Health care professionals cannot ignore the wishes expressed in an advance care planning document. If a doctor, nurse, hospital, assisted living facility, or nursing home is not able or willing to follow a person's instructions, they must transfer care for the person to someone who will.

Ask the Trainer: Family Members Disagree

The doctor told a resident there are no more treatments to improve her health and he recommends hospice care. One daughter agrees but the other wants aggressive treatments to continue.

- Whose wishes do you advocate for? _____
- What should an ombudsman do when family members disagree?

  _____

  _____

Consent for Medical Treatment

If a person can no longer make medical decisions and did not appoint an agent through an advance directive, a surrogate can consent to medical care. A surrogate is a substitute, or proxy, who acts on behalf of a person who needs medical care and decision-making.

Texas Health and Safety Code §313.004, Consent for Medical Treatment sets situations under which others make medical decisions for people unable to decide on their own. After two physicians certify in writing the person's incapacity to make medical decisions, the law allows the following people in order of priority to be surrogate decision makers:

1. patient's spouse;
2. adult child of the patient who has the waiver and consent of all other qualified adult children of the patient to act as the sole decision-maker;
3. majority of the patient's reasonably available adult children;

4. patient's parents; and
5. individual clearly identified to act for the patient by the patient before the patient became incapacitated, patient's nearest living relative, or a member of the clergy.

Surrogates can give informed consent for all medical decisions needed, except:

- voluntary inpatient mental health services;
- electro-convulsive treatment; and
- appointment of another surrogate decision-maker.

Surrogates try to make decisions based on what people would want by considering:

- Current diagnosis
- Prognosis
- Any preference expressed about the treatment
- Religious or personal beliefs
- Feeling about similar treatment for other people
- Expressed concerns about effects of illness and treatment on family or friends

If surrogates have no information about a person's wishes, they use the standard of best interest. They look at the benefits and burdens of treating and not treating, such as:

- Effects of treatment on the physical, emotional, and mental functions
- Pain suffered from the treatment
- Pain suffered without treatment
- Humiliation, loss of dignity, and dependency suffering because of the condition or would suffer because of the treatment
- Effect of the treatment on life expectancy
- Potential for recovery, with and without the treatment
- Risks, side effects, and benefits of the treatment
- Religious beliefs and values

Name one person who can be a surrogate decision maker?

_____

Ombudsman Role in Advance Care Planning

Ombudsmen should encourage residents to exercise their right to develop an advance care plan that directs their care when they are no longer able to make decisions for themselves. Ombudsmen support residents' decisions about their care and life.

If residents ask for help to create advance directives, direct them to the facility social worker or facility management for assistance. Ombudsmen may also coordinate with Texas Legal Services Center, AAA Benefits Counselors, and other public legal options for a resident who requires legal advice or representation. Some residents prefer to arrange for legal services on their own or may prefer to use a private attorney.

A resident may revoke an MPOA or DPOA at any time. If a resident raises questions about limits placed on their ability to exercise rights, an ombudsman's role is to educate, help the resident explore why those limitations exist, and work to overcome unnecessary limits.

If a resident requests help to revoke or change a power of attorney, first determine if the resident has a guardian of the person. If no guardianship exists, and with resident consent, the ombudsman obtains a copy of the resident's power of attorney. An ombudsman should carefully review the power of attorney and consult the state office if questions arise.

Whether a certified ombudsman directly helps a resident revoke a POA depends on the resident's capacity to understand the potential consequences of the decision to revoke. Refer to the ombudsman protocol provided by the state office.

It is a conflict of interest for an ombudsman to serve as a resident decision-maker, such as a guardian or agent in a Medical Power of Attorney. Decline any such request and explain our role as an advocate. This limit does not apply to an ombudsman serving as a decision-maker for a family member in a facility where the ombudsman does not serve residents. If you ever have any questions, speak with your supervising staff ombudsman or state ombudsman.

Unless specifically authorized by a court, or named by a resident as an agent in advance directives, family members and professional caregivers do not have legal authority to make decisions for residents. _____ True (T) or False (F)

Supplements 8-A and 8B provide two perspectives on end of life.

Supplement 8-A: *I Want to Tell You about My Mother*

Guide developed by Carter Catlett Williams, MSW, ACSW

Family members can give a variety of information to give staff at admission and anytime. Tell facts about your mother's:

- Birth date and place
- Number of sisters and brothers; her place in birth order; siblings still living
- Rural or urban childhood
- Your mother's ethnic community
- Schooling
- Marriage and date of marriage; Date of widowhood or divorce
- Children
- Employment outside of home before and after marriage
- Religious affiliation
- Hobbies
- Living arrangements during marriage and afterwards
- Reason for entering the nursing home

A person's story includes hopes, accomplishments, disappointments, losses, and things that didn't go so well. It includes his or her ways of handling the “ups and downs” of life.

Suggestions to help you think over your mother's life and tell her story:

- What she looked forward to in life: as a child, as a teenager
- How much she was able to realize her dreams
- If she had an outside career, what it meant to her; how she and her family coped with the Great Depression; how wars affected her life (World Wars I and II, Korean, and Vietnam)
- What she wanted for her children
- Her relationships with her family
- Was religious faith important and how does she express that: prayer; reading scripture; attending church, synagogue, or mosque; volunteer activity
- What she had, and now has, the most fun doing: cooking for family; hosting family gatherings; gardening; singing; reading; fishing; playing bingo; handwork; going to the movies; sports as a player or spectator; enjoying nature; seeing family and old friends
- Whether she likes to crack jokes or enjoys other's jokes
- How she handled money
- Whether she had pets and what they meant to her

- What angers her
- What pleases her
- What saddens her
- What comforts her
- Whether she generally has an optimistic attitude or sees the darker side of things
- Her major satisfactions and disappointments
- What she values most in life
- What you value most about her

To add further richness to your mother's story, collect photographs in an album for her room and take others to hang on her walls.

What makes a good day for your mother?

Daily schedule

- When she likes to get up and go to bed, times of rest and quiet
- How she prefers to spend her day
- What her mornings and evenings are like at home
- Times of her favorite radio and/or TV programs
- When and what she likes for snacks
- When and how often she likes to go outside
- Her usual bowel and bladder patterns
- Her patterns with: bathing, eating, and food preferences

Particular things that give her satisfaction and pleasure

- Particular foods at certain meals
- Careful grooming in the style she prefers
- The chance to be alone at least some part of each day
- Activities she enjoys: music, movies
- Attendance at worship service or other expression of her faith
- Where she prefers to place things in her room and at her bedside
- How she typically expresses affection and is comfortable receiving affection such as hugs, kisses, touching?

Remember no detail is too small if it's significant to your relative!

For your father, the same information is important. In addition, be sure activities and staff responses consider things from a man's perspective. The facility might need to offer more traditionally masculine pursuits for your father.

SOURCE: Nursing Homes Getting Good Care There, Appendix 4

Supplement 8-B: Agonizing Schiavo Case Shows Need to Put Medical Wishes in Writing

by Bruce Bower, Texas Legal Services Center

Love within families is a complex fabric woven from pride, tenderness and countless other shades of human emotion. It's a tough love, too, reinforced with unbreakable threads of trust and mutual responsibility. Most of us will do whatever it takes to avoid letting family down. So imagine the special sadness of failing them, not through betrayal or weakness, but omission.

The Terri Schiavo case in Florida epitomizes all that family caregivers dread. Ms. Schiavo had been in a coma since a 1990 heart attack. Husband Michael said, well before her heart attack, she told him to refuse offers of artificial life support if she ever became unable to make her own medical decisions. Nothing was ever put in writing, though.

Without taking sides, we can agree this is about Terri Schiavo and her right to direct her own health care. The trouble is, as she lay in her hospital bed with tubes nourishing a robust body that houses a lifeless cerebral cortex, there was little hope she could ever make those calls on her own.

The Legal Hotline for Texans urges all Texans to assure their loved ones never face such a snarl. If you're 60 or older, contact a AAA benefits counselor for free advice and access to legal documents that spell out all your preferences in advance:

- Whether you want emergency personnel to resuscitate you
- How far doctors should go to save or sustain your life
- Treatment or medication you don't want to receive
- Who will be your designated legal proxy or guardian if you become incapacitated

Most advanced planning documents can be prepared free of charge. Either way, it's a more than fair exchange for the power you have to assure someone who shares your personal value system is making medical decisions on your behalf.

Don't wait until the need arises; incapacitation often is sudden and unexpected. Worried that you'll change your mind after the papers are completed? Don't be. You can change the documents at any time.

Before calling the AAA, consult your physician who can discuss commonly used resuscitation techniques and life-sustaining treatments. This will help you make a more informed decision.

After you sign the legal documents, give copies to your physician to add to your medical records. Be sure to give copies to the person(s) you've named as decision-maker and agent. Keep the originals and at least one copy of each document.

Whom should you designate? Most typical are family members, friends, spouses, and attorneys. Just be sure the person knows you well enough to fully understand and be able to attest to your beliefs and preferences. (Important: never assume familiarity with your wishes guarantees willingness to carry them out.)

Procrastination can be forgivable, even endearing, in some life situations. But not when it brings pain and unnecessary stress to the people you love. Do right by them and specify in writing all of your life- and health-care preferences. Do it today.

Bruce Bower is an attorney for the Texas Legal Services Center that operates the Legal Hotline for Texans.

Notes:

Ombudsman Certification Training

CHAPTER 9: Recognizing, Receiving, and Investigating Complaints

Recognizing, Receiving, and Investigating Complaints

Chapter 9 describes an ombudsman's approach to recognizing, receiving, and investigating complaints on behalf of residents.

Learning Objectives

- Learn methods to recognize and receive complaints
- Identify basic investigation methods
- Learn how to collect evidence
- Recognize and employ good interview approaches

Contents

- Intake: Recognizing and Receiving Complaints
- Investigating Complaints
- Investigation Documentation

DVD(s), Supplements, Forms

- DVD: LTCO Casework: Advocacy and Communication Skills
- Supplement 9-A: Form 8619 Long-Term Care Ombudsman Case Record

Overview

To solve problems for residents, ombudsmen use basic investigation and problem-solving skills. Above all else, ombudsmen use common sense and stay resident-directed throughout the process.

Common sense is instinct, and enough of it is genius.

Henry Wheeler Shaw

Intake: Recognizing and Receiving Complaints

Ombudsmen receive complaints from a variety of sources including residents, residents' family, facility staff, and others acting on behalf of residents. Individuals who voice the complaint are called complainants. Complaints are received in-person, by phone, text, mail, and email. The rules of confidentiality and anonymity apply to all complainants, not just residents.

Listen carefully to what people say and note any concerns the person presents. Complaints are not always easily recognized. They may be made in an indirect manner and require you to probe for more information. For example, a resident tells you that he doesn't like facility staff to administer his medication. The resident implied he has a concern so this type of comment requires further exploration. Your task is to listen, observe, and ask questions in order to determine when an expression of dissatisfaction is a request for help.

While receiving a complaint:

> Involve the resident.
> Support and maximize the resident's participation in the complaint resolution process. Find a private place to meet with the resident to discuss the complaint and to determine the resident's perspective. If the complainant is not the resident, explain you are required to involve the resident and take action according to the resident's wishes.
>
> Gather information.
> Listen more than talk. Stay neutral and allow the complainant to tell his or her story without responding positively or negatively. Remember you are hearing only one side of the story. Be careful not to promise anything. Avoid judgmental statements like "That's horrible" or "That should not have happened."
>
> Direct the conversation if needed.
> The complainant may be overwhelmed by the situation, feel emotional, or

confused. In these cases, ombudsmen can help by taking the lead. Ask open-ended questions for someone who is not offering much detail; ask closed-ended questions and redirect for someone who is overly talkative or lacks focus. Do not hurry the process.

Sometimes ombudsmen identify complaints while making facility visits and are therefore the complainant. Complaint identification stems from an ombudsman's senses: sight, sound, smell, taste, and touch. For example, while making a facility visit you smell unpleasant odors, witness a problem with food service, and hear a resident continually crying out for assistance. All of these observations are potential complaints and need further investigation.

When receiving a complaint from anyone other than a resident, let that person know you take _____ according to the resident's wishes.

Investigating Complaints

Investigating is one step in the ombudsman problem-solving process. (More information on the five-step problem-solving process is described in Chapter 10.) Investigating is the process of gathering information to help explain what happened and to help those involved determine a suitable response.

Follow the investigative process outlined in *Ombudsman Policies and Procedures*.

The nature and scope of an investigation will depend on the circumstances of each case, resident requests, and any relevant statutory requirements that may apply. Not every complaint requires an in-depth investigation. Many concerns presented to ombudsmen can be resolved quickly and informally. These are, however, still complaints that must be reported.

Evaluate the complaint then determine what information is needed, what questions need to be answered, and the best way to obtain that information. Factors to take into account include whether the complaint:

- is a communication problem that can be resolved with explanation or discussion;
- is an issue with facility policies, procedures, or practices;
- involves conduct of individuals;
- is one of a series of complaints which may indicate a pattern or a widespread problem (systemic);
- is a significant issue for the complainant, resident, or the facility;
- needs to be referred to other agencies such as Regulatory Services, Adult Protective Services, or law enforcement.

An ombudsman does NOT conduct an investigation when:

- the complaint is about personnel issues with facility staff that do not affect residents;
- there is a conflict of interest, or the *perception* of a conflict of interest or impropriety;
- the complaint is an allegation of abuse, neglect, or exploitation (follow Chapter 4 *Ombudsman ANE Complaint Guidelines*); or
- there is no consent from the resident or complainant.

Gathering Evidence

Evidence is anything used to determine or demonstrate the truth of an assertion. It is a relevant fact which has the potential to assist in describing and explaining what occurred. An ombudsman's job is to collect the evidence (those relevant facts) that will verify a complaint.

Verified or Not Verified

An ombudsman verifies a complaint by determining after the work completed in an investigation (interviews, observations, record inspections, and other actions discussed in this chapter) that circumstances described in the complaint exist or are generally accurate.

Regardless of whether a complaint is verified, ombudsmen try to resolve any complaint made by a resident. When a complainant - especially a resident - tells an ombudsman something happened and there is no evidence to the contrary, take the complainant's word for it.

During an investigation, be open-minded. Don't draw conclusions. Don't offer opinions.

Three Methods of Evidence Collection

Ombudsmen use observation, interviews, and record review to collect facts or evidence during an investigation.

Observation

The ombudsman role as observer starts the moment you step into the facility. Skillful observation during unannounced visits will reveal important information. Observe the facility environment, staff and resident behaviors, as well as the facility's policies, procedures, and protocols.

Watch the YouTube video *The Monkey Business Illusion*

Follow this link: http://www.youtube.com/watch?v=IGQmdoK_ZfY
Run Time: 1 min 41 sec

In the video people are passing basketballs. One group is wearing white shirts; the other group is wearing black shirts.

Count the number of times the team in white shirts passes the basketball. Answer the questions posed in the video.

How many times did the team in the white shirts pass the basketball? _____

The video demonstrates selective observation: when you look too hard for one thing, you can miss an important piece of evidence. If you didn't see something unusual, watch the video again.

Tips for Observation

When observing conditions in a facility, be as impartial as possible. If you look for evidence that fits a preconceived theory, you risk misinterpreting evidence or missing other relevant evidence. Decide what observations will help you investigate a particular complaint.

For example, a resident, Mrs. Smith, tells you that staff are not responding promptly to her call light every day from 11a.m. to 1 p.m. By making a couple of unannounced visits to the facility between 11 a.m. and 1 p.m., you can observe staff response time to Mrs. Smith's call light. You can also observe the response time to other residents' call lights to see if there is a systemic issue.

Ombudsmen do not observe personal care being given to a resident. Evidence about inadequate or poor care must be gathered from other sources. In some cases, complaints about how care is delivered could be referred to Regulatory Services for investigation, if the resident consents.

Interview

An interview is a conversation with the purpose of gathering information. One tip to a successful interview is to regard the interview process as a discussion.

Take time to prepare for the interview. Try to find a setting that is comfortable, quiet, and private. Make sure you have the right amount of time allotted so the interview will not feel rushed. Before an interview, determine:

- whether you have permission to identify the resident, complainant, or other identifying information during the conversation;
- who you need to talk to; and
- what questions you need answered and what specific information you need.

Build rapport before you start to ask questions that address the problem. The relationship you develop at the beginning of the interview will affect what is said. It is a good strategy to confirm your role as an ombudsman, and the goals of the meeting, before starting the interview.

- Introduce yourself
- Shake hands
- Give your credentials
- Explain confidentiality
- Be clear about the purpose of the meeting

Don't provide too much information about what you are investigating because you might reveal identifying information such as the names of other witnesses. Ombudsman policy requires you to protect confidentiality of any resident or complainant.

The way you introduce yourself to an interviewee and what you say about the purpose of the interview may differ depending on the person's role. For example, you need to find out if staff respond to resident call lights in a timely manner. If you are talking to a family member, you might explain that you are trying to find out if staff meet the needs of the residents. If you are talking to the administrator, you might ask whether there has been a recent turnover of staff.

Order of Interviews

The order of who you interview can be important. Who do you interview first when you are conducting an investigation?

- First, interview the complainant. If this is not the resident, then interview the resident next.
- Second, interview any known witness in the case
- Third, conduct background interviews, such as:
    - Direct care staff (CNA)
    - Supervisors (charge nurses)
    - Director of Nurses
    - Executive Director or Administrator

Share very little information about yourself other than your role as an ombudsman. If your personal information is not consistent with the witness's value system, the witness might not want to develop rapport with you.

Interview Techniques:

Ask clear questions.

- If you aren't receiving answers, rephrase, and re-ask.
- Ask your supervising ombudsman to help if you are uncomfortable asking difficult questions.
- Be mindful of nonverbal cues; these can be evidence too.

An interview should be similar to a funnel. Start with "larger" open-ended questions then refine and channel information with close-ended questions. At the bottom of the funnel you ask close-ended questions meant to pinpoint and clearly define some facts.

Open-ended Questions

An open-ended question *cannot* be answered with “yes,” “no,” or “maybe.” Open-ended questions invite the witness to provide a lot of information. In general, it is the best kind of question to ask in an investigative interview. Formatting a question this way also helps to avoid asking leading questions which suggest the answer you want to hear.

Start an interview with open-ended questions. They help define the big picture and elicit the interviewee to describe or explain. Open-ended questions increase the chances of getting additional details and ensure a greater accuracy of the facts from the interviewee’s perspective.

Use open-ended questions to understand, rather than confirm, or use them to gather details from the interviewee’s perspective.

While conducting an interview, remember that only with permission of a resident or complainant may ombudsmen release confidential information. See *Ombudsman Policies and Procedures, Disclosure of Confidential Information, for detail.*

Close-ended Questions

A close-ended question *can* be answered with a “yes,” “no,” or “maybe.” Use close-ended questions to clarify or confirm. They can also be used to get specific times or dates.

Long-term Care Ombudsman Casework: Advocacy and Communication Skills
Run Time: 22 min - Scene 1 - Anne Walker 22 min 12 sec
YouTube: https://www.youtube.com/watch?v=Sm-8DsnDnxo&feature=youtu.be

Scenario #1: Anne Walker

INSTRUCTIONS: Watch the video and answer the following questions. Be prepared to discuss your responses with your trainer.
Note: Some questions seek specific examples from the scenarios so it may be helpful to review the questions before watching the video to understand what you will be asked to identify.

An ombudsman investigation should be _____, _____, and _____.

How did Gloria use her senses to gather evidence?

_____

_____

Why did Gloria visit during the morning shower time?

_____

_____

What challenges might an ombudsman encounter when visiting early mornings, nights or weekends?

_____

_____

Identify other ways Gloria could approach the investigation of this complaint.

_____

_____

When Ms. Walker expressed her concern about not wanting to be identified with this complaint and said residents have been discharged due to sharing their concerns, what else could Gloria have said in response to her statement?

_____

_____

What does Gloria do to protect Ms. Walker's confidentiality, and what are some other things she could do to ensure Ms. Walker isn't identified as the complainant unless she is ready?

_____

_____

What concerns did you hear Ms. Walker express in this scenario? Were all of them addressed?

_____

_____

Why didn't Gloria review Ms. Walker's care plan to check her preferences about showers?

_____

_____

For purposes of ombudsman visits and complaint investigations, make unannounced visits to facilities.

Effective Communication Skills

Gloria used both open-ended and close-ended questions during her complaint intake, investigation, and resolution process.

Exercise: Use the chart below to identify some of the open-ended and close-ended questions you heard Gloria ask and describe what information she was trying to obtain with those questions.

OPEN-ENDED	CLOSE-ENDED	INFORMATION GAINED

The Emotional or Uncooperative Witness

A successful interview is sometimes hampered by an emotional or uncooperative witness. Empathic listening is important and gives the person undivided attention which can make the interview more productive. Try to be nonjudgmental and acknowledge the person's feelings, not just the facts.

Think about potential emotional responses from witnesses and plan your response before it's needed. This can prepare you to de-escalate an emotional or uncooperative witness.

Ask the Trainer: Brainstorm appropriate responses to an emotional or uncooperative witness. In the table, list an approach for each emotional or uncooperative response.

Witness's Response	Ombudsman Approach
Crying	Acknowledge the witness's feelings and consider offering tissues
Pacing	
Slamming things	
Pointing fingers	
Eye rolling	
Lack of eye contact	
Screaming or yelling	
Folded arms or other body language	
Excessive talking	
Giving the same response to every question	
Sarcasm	
Cursing	
Blaming	
Avoiding	

Record Review

Review of relevant documentation may be necessary to thoroughly investigate a problem. Accessing a confidential resident record requires the resident's consent and is described in Chapter 12. Facility policies and admissions paperwork are public and available by request.

Documents most frequently reviewed are confidential resident records and public facility policies. Types of documents and records you might review include:

- Care or service plans
- Resident medical records
- Advanced directives
- Facility policies and procedures
- Ombudsman reports
- Powers of attorney
- Admission agreements, or contracts
- Grievance reports
- Resident council meeting minutes
- Resident or family journals
- Resident personal care logs
- Facility transfer sheets
- Police reports
- Incident reports regarding a specific resident

In general, a record review can help you learn:

- the condition of a resident before and after an incident;
- whether staff have assessed, care planned, implemented care, and evaluated the outcome of the care as specified by regulatory requirements; and
- how the facility documented their response to an incident and how the facility documented care delivered to a resident.

Review a facility's policies and procedures to determine if they are logical and consistent with requirements. An ombudsman might review the facility's policies and procedures to determine if the facility has adequate requirements for training employees, policies for protecting residents, or rules that limit resident rights.

Investigation Documentation

To document a case, ombudsmen use Form 8619, *Long-Term Care Ombudsman Case Record or* Form 8620, *Long-Term Care Ombudsman Activity Report.* Detailed information on ombudsman casework, documentation, and reporting is covered in Chapter 11.

Supplement 9-A: Form 8619 Long-Term Care Ombudsman Case Record

Texas Department of Aging
and Disability Services

Form 8619
September 2010

Long-Term Care Ombudsman Case Record

CONFIDENTIAL

Ombudsman	Reference Title for the Case	
Intake Date	First Action Date	Closed Date
Intake Summary Anonymity Requested? ☐ Yes ☐ No		
Consent Obtained to Work on Resident's Behalf ☐ Yes ☐ No	Consent to Review Records ☐ Yes ☐ No If yes, ☐ oral or ☐ written	

Complainant

Complainant Role	Complainant Name	
Agency/Company	Address	
Home Area Code and Telephone No.	Work Area Code and Telephone No.	
Cellular Area Code and Telephone No.	Fax Area Code and Telephone No.	E-mail Address

Facility

Type ☐ NF ☐ ALF	Name

Resident

Resident Name		
Legally Authorized Representative? ☐ Yes ☐ No	If Yes, Name	Type of Authority ☐ Legal Guardian ☐ DPoA ☐ MPoA

Complaints

Code (1 – 132)	Notes (describe the problem)	Verified?	Disposition
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

Actions (Journal)

CONFIDENTIAL

Notes:

Notes:

Ombudsman Certification Training

CHAPTER 10: Resolving Complaints

Resolving Complaints

Chapter 10 discusses the skills and strategies used to resolve complaints, including the five-step problem-solving process.

Learning Objectives

- Understand different complaint resolution skills
- Understand potential barriers to resolving conflict
- Learn how to apply the Five-Step Problem-Solving Process
- Practice using the Five-Step Problem-Solving Process

Contents

- Complaint Resolution Skills
- Potential Barriers to Resolving Conflict
- Putting it All Together: The Five-Step Problem-Solving Process
- Case Examples

DVD(s), Supplements, Forms

- DVD: LTCO Casework: Advocacy and Communication Skills

Overview

There are several skills ombudsmen use to help resolve complaints on behalf of residents in nursing homes and assisted living facilities. Chapter 10 discusses conflict resolution, self-advocacy, mediation, and negotiation. The entire five-step problem-solving process used to receive, investigate, and resolve complaints is described.

Complaint Resolution Skills

Conflict Resolution

Conflict arises from differences. It occurs whenever people disagree over their values, perceptions, ideas, or even care choices. Small conflicts can produce strong feelings. Everyone needs to feel safe and secure, to feel respected and valued, and to know their voice is heard.

Conflict resolution skills are the methods and processes people use to help bypass personal differences. They help parties involved to see possibilities and to search for solutions. A wide range of methods and processes for addressing conflict exist, including mediation and negotiation. Healthy responses to conflict are characterized by:

- the capacity to recognize and respond to important matters;
- a readiness to move forward;
- the ability to seek resolution (and avoid punishing); and
- a belief that resolution can support the interests and needs of both parties.

SOURCE; http://www.edcc.edu/counseling/documents/Conflict.pdf

Self-Advocacy

Self-advocacy is the ability to speak-up for yourself and the things that are important to you. It works for residents who are empowered. Encourage residents to advocate for themselves as much as they are able. They may prefer to work with an ombudsman for support or with the ombudsman taking the lead.

Residents who self-advocate are able to ask for what they need and want, and tell people about their thoughts and feelings. It also means they know their rights and responsibilities, they speak-up for their rights, and they are able to make choices and decisions that affect their lives.

Strategies to promote self-advocacy include:

- Educate a resident on residents' rights.
- Support a resident's participation in his or her care or service plan.
- Coach a resident in ways to negotiate with facility staff.

- Encourage a resident to bring his or her complaint to the resident council.
- Bring residents with similar concerns together to work on the problem.
- Encourage a resident to use the facility grievance process.

Mediation

Formal mediation requires a mediator to be impartial and all parties to have equal power. Mediators are not decision-makers; they help the parties agree to mutual resolution. Ombudsmen do not serve as mediators because:

- Ombudsman work is on behalf of residents. Although impartial in investigation, ombudsmen are resident advocates when resolving a problem.
- Parties are not usually equal in power. Mediation can be appropriate when two residents or two family members are the parties in conflict.

Ombudsman Tip. For ombudsmen to resolve conflicts, the problem and the parties need to fall within the scope of the ombudsman program.

If the conflict is not within the ombudsman scope of services, the involved parties could work with a mediation organization to help resolve the issues.

Negotiation

Negotiation is the complaint resolution skill most frequently used by ombudsmen. It is a dialogue between two or more people intended to reach an understanding, resolve points of difference, to gain advantage for an individual or collective, or to craft outcomes to satisfy various interests.

Negotiating is bargaining with the focus on *interests* rather than *positions*. Interests are what cause you to make decisions, such as “I want to be treated with dignity and respect.” Positions are things you decide upon, such as “That nurse cannot come into my room.” Some negotiation principles are especially relevant for ombudsmen to reach a “win-win” solution for the resident and the facility. When it comes to residents’ rights, *how* a resident right is met can be negotiated, but not *if* it is met.

- Focus on interests, not positions
  - Explore interests.
  - Each side may have multiple interests; try to find similar interests to form the basis of a win-win solution.
  - Avoid having a bottom line.

  For example, “We agree residents need the best care possible. Let’s discuss what Mr. Tanaka needs to feel safe and secure in his home.”

- Negotiate on the merits
  - Recognize people are problem-solvers.
  - Concentrate on achieving a wise outcome, reached efficiently and agreeably.
    - Focus on solving the problem.
    - Do not try to score debate points or outsmart the other party.

  For example when speaking to facility staff, “You have a huge responsibility and it is difficult to please everyone. However, having residents receive clothes that do not belong to them and are the wrong size is a problem. It can be solved if we work together.”

- Separate the people from the problem
  - Be soft on the people and hard on the problem.
  - Be aware the other person probably sees the situation differently.
  - Do not react to emotional outbursts; allow the other side to let off steam.
  - Phrase ideas in terms you think will solve a problem, not in terms of what someone should do.

  For example, “I know your facility strives to meet resident’s needs. However, trays left without giving help and removed without the resident being able to eat is a serious issue. Let’s focus on ways to avoid this. It could help if the aides were clear about which residents need help with eating and drinking, whose responsibility it is to help, and how to assist the residents.”

The difference between a position and an interest is: _____

_____

_____

- Look for options with mutual gain
  - Develop multiple options and decide later.
  - Look for solutions that allow both sides to gain something, in contrast to using compromises where both sides lose something.
  - Be open to different solutions.
  - Try to develop a win-win solution based on shared interest.

  For example, “Based on our discussion, we agree Mr. Dillard needs more opportunities to move around and to be outdoors. Can we brainstorm some ideas about how his needs can be met while considering his safety and need for supervision?”
- Insist on using objective criteria

- Try to reach a solution based on standards independent of will, such as laws, written rules, and outside experts.
- Reason and be open to reason (apply logic, establish and verify facts, and hear new or existing information).
- Yield to principle, not pressure.

For example, “I understand your concern that Mrs. Everett’s health will decline if she doesn’t take the medicine her doctor ordered. You have done an excellent job of explaining the consequences of her decision and offering other options. Nevertheless, residents have the legal right to refuse treatment.”

SOURCE: Getting to Yes: Negotiating Agreement without Giving In by Roger Fisher and William Ury

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When negotiating with management, separate the _____ from the problem.

Negotiation Styles

There are many ways to resolve a complaint. Each situation may require a different negotiation style and some may involve multiple ones over time. Review the appropriateness of your strategy and ask, “Is this the best method to resolve this problem with this person?” Negotiation styles include collaboration, competition, accommodation, compromise, and avoidance.

Collaboration

The collaboration style is characterized by assertiveness and willingness to cooperate. This is the primary style ombudsmen use in complaint resolution. It is solution-focused and can be time intensive. The ombudsman or resident emphasizes the resident’s position while also inviting other views.

Collaboration promotes open discussion about concerns and encourages both sides to explore solutions and resources to find a solution that works long-term for both parties. To be successful, the resident, staff, ombudsman, or others discuss concerns in a non-threatening way and think creatively. This style of negotiation builds trusting relationships, merges perspectives, and encourages high levels of cooperation.

Competition

A competitive approach is characterized by high levels of assertiveness with a reluctance to cooperate or compromise. It emphasizes achieving goals over maintaining smooth relationships. A competing style is one in which the concerns and the position of the opposition are ignored. If the ombudsman or resident uses this style, there is no concern about the facility, facility staff, or how they will live with the decisions.

The competition style is used when the goal is quick action or when there is little hope of consensus ever being reached. Competition is critical when you are certain that something is not negotiable and immediate compliance is required. An ombudsman might use this style if there is an emergency or the issue is vital to the resident's welfare.

A disadvantage of the competition style is that it may keep the others involved from voicing important concerns. If the resident or ombudsman wins, it may be at the expense of important information which could have altered the decision.

Accommodation

The accommodation style is characterized by a high degree of cooperativeness with low assertiveness. This style works to ensure goodwill among everyone involved and emphasizes meeting the needs of others. This approach focuses on preserving relationships.

Use this style when the issue is something of minimal importance to the resident but important to the facility. This technique can backfire if the ombudsman uses it all the time as it can earn the reputation of "not standing your ground." If residents feel their concerns are never acknowledged or their opinions are ignored, then the ombudsman may be too accommodating.

Compromise

The compromise style of negotiation is characterized by moderate levels of assertiveness and cooperativeness. It emphasizes flexibility and finding middle ground. Both parties give up part of what they want to settle the problem.

Ombudsmen should consult with the resident when using the compromise style. It's important to follow the resident's guidance and be careful to not give up something of great importance to the resident.

- Both parties may give away something important which leaves them feeling dissatisfied.
- Try to identify things that mean a lot to the other side but not as much to the resident. Give these up first.

Avoidance

The avoidance style of negotiation is characterized by low assertiveness and cooperativeness. This style is appropriate when the issues are not important to the resident or when more information is needed or forthcoming. It may also be appropriate if the resident or ombudsman is being pressured to negotiate a minor issue and there is a more important concern pending.

An avoiding style should be used sparingly and only when something is going to change: the resident, the other person, or the situation. For example, it's okay to avoid a conflict between the administrator and the resident if you already know the resident is planning to move soon.

SOURCE: http://www.dougsguides.com/

Potential Barriers to Resolving Conflict

Response to Authority Figures

Since ombudsmen encounter conflict on a routine basis, it is important to understand personal responses to authority figures that might present barriers to problem-solving.

Common responses include:

Intimidation
Feeling intimidated by a person in authority is not uncommon. Sometimes the professional title, expertise, or social status associated with a person can lead to feeling intimidated about personal training or capabilities.

Anger or fear
Working with authority figures who may not share the complainant's point of view can lead to feelings of anger or fear. Confronting authority figures who lack empathy can be stressful and take a toll on the person confronting the problem.

Avoidance
It is not uncommon for people to avoid directly confronting a problem. It can feel safer to avoid face-to-face communication to solve a problem, especially if a past experience was negative.

To most effectively work with authority figures, use the following strategies:

- Make an objective assessment of the person. Authority figures can be potential allies or opponents.
- Evaluate perceived prejudices, preferences, and decision-making patterns shown by authority figures. Study their personalities and adjust your responses to communicate better. For example, knowing four personality types known by terms such as controller, promoter, feeler, and thinker, you can build better relationships. If they are thinkers, give them facts; if they are feelers, share personal stories; and so on.
- Know the lines of communication. If a person in authority makes an unfavorable decision, find out who has higher authority, appeal rights, or opportunities.
- Be aware of policies, guidelines, rules, regulations, and laws that govern the authority figure. Know which ones the person has authority to control.
- Use residents' rights and other laws when they apply. Laws are powerful tools that ombudsmen must know and use. Refer to nursing home and assisted living facility rules cited in Chapter 1, Supplement 1-B: Statutory and Rule References.

Other Barriers to Resolving Conflict

Personal values and beliefs

- Everyone is influenced in varying degrees by the values of their family, culture, religion, education, and social group.

  For example, an ombudsman has a resident who has requested her assistance because he is being discharged for smoking in his room. She does not put much effort into helping him because smoking is bad for his health and she does not want to support his habit.
- Ask your supervising staff ombudsman for help if your values and beliefs inhibit your ability to be an effective advocate for a resident whose values and beliefs conflict with yours.

Emotional involvement

- Ombudsmen are human. Occasionally a resident's concern may touch an emotional note with an ombudsman.

  For example, residents who remind an ombudsman of one of his parents receives more attention to concerns than most residents.
- Ombudsmen should not become overly invested in the resident's issue. Check your personal boundaries to remain objective.
- Ask your supervising staff ombudsman for help or ask your staff ombudsman to take the case.

Friendly with facility staff

- It is important to establish a professional, friendly, yet firm, rapport with the facility staff.
- If ombudsmen become too familiar or friendly with staff, they may have difficulty being an effective advocate for residents. Review *Walk the Fine Line* from Chapter 6.
- Seek guidance from your supervising staff ombudsman or MLO if you have difficulty being an effective advocate in your assigned facility.

Long-term Care Ombudsman Casework: Advocacy and Communication Skills

Run Time: 13 min - Scene 2 - Brian Brashear 13 min
YouTube:
https://www.youtube.com/watch?v=BZJtzm_sA1Q&feature=youtu.be

INSTRUCTIONS: Watch the video and answer the following questions. Be prepared to discuss your responses with your trainer.

Note: Some questions seek specific examples from the scenarios so it may be helpful to review the questions before watching the video to understand what you will be asked to identify.

What concerns did you hear Mr. Brashear expressing in this scenario? Were all of them addressed?

_____

_____

_____

What is the PEP method? _____, _____,

_____.

How did Gloria address Mr. Brashear's concerns in relation to his rights and the other residents' rights when speaking with Mr. Cook? Was that effective? Explain your answer.

_____

_____

_____

How did Gloria ensure her complaint investigation was resident-directed while reminding Mr. Cook of the need for resident-directed care and quality of life? How did this impact her credibility with Mr. Brashear? With Mr. Cook?

_____

_____

_____

As it states in the video, the ombudsman needs to remain "calm, objective, and in control" at all times, especially when a situation has escalated. When speaking with Mr. Cook what techniques did Gloria use, both verbal and nonverbal, to maintain her professionalism and remain calm, but assertive?

_____

_____

_____

In the follow-up conversation with Mr. Brashear and Mr. Cook, how did Gloria demonstrate her support of Mr. Brashear when facilitating that conversation? Why was that important?

_____

_____

_____

Putting It All Together: The Five-Step Problem-Solving Process

Ombudsmen use a five-step problem-solving process to receive, investigate, and resolve complaints. This process is how an ombudsman works a case from start to finish. It includes working with a resident to support and maximize his or her participation in the complaint resolution process.

STEP 1 Identify the problem from the resident's perspective, investigate, and research statutory support.

Ombudsmen are resident-directed advocates. Therefore, when an ombudsman receives a complaint from someone other than a resident, the ombudsman must first consult with the resident who was identified prior to taking any actions. If the resident acknowledges the problem and gives the ombudsman permission to work to resolve it, the ombudsman investigates.

For each complaint, consider whether there are residents' rights involved and whether there is statutory support that will help resolve it.

Resident-directed advocacy means the ombudsman should:

_____

_____

STEP 2 Consider underlying causes and determine scope of the problem

A problem is more effectively resolved by finding its underlying or root cause. Once a complaint is investigated, analyze the information to determine the reason the problem occurred. It may reveal the root cause is not the problem that was originally reported.

Factors for ombudsmen to consider are:

- Was the problem an oversight or does it seem deliberate?
- Is the problem related to facility policies or procedures?
- Does the facility offer any justification for the problem?
- What role does staff have in the problem?
- What is the resident's role in the problem?
- What roles do family or visitors have in the problem?
- How many residents are affected by the problem?

Responsibility may rest with one or more of the following:

- facility staff failed to perform their duties properly;
- unclear regulations about the issue;
- services cannot be reimbursed;
- outside professionals gave unclear instructions; or
- resident or family contributed to the problem.

Scope refers to how many residents are affected by a complaint. The scope determines who needs to be involved in an investigation and may steer the approach an ombudsman takes towards resolution.

Finding the root cause of a problem is essential to a lasting solution.

STEP 3 Explore solutions and take action

Information gathered during an investigation is used to resolve the complaint. Before jumping to resolution, take time to analyze the information collected, explore resolution strategies, and make an action plan with the resident or complainant.

To identify possible solutions, ask yourself:

- What will resolve the problem?
- What will it take to keep the problem from reoccurring?
- What obstacles might be encountered with each solution?
- What are the resident's options regarding their medical and physical needs?

Sometimes there are several ways to resolve a problem. Options help ombudsmen be prepared with ideas for possible solutions, anticipate potential obstacles, and have suggestions ready to overcome obstacles to resolution.

Example: Exploring Solutions

A resident complains, "I pay a lot to live here but I can't have a baked potato for lunch." She asks the ombudsman for help.

Possible Solutions: Changing menu options
Potential Obstacles:
- Cost or supply issues
- No other similar requests have been made
- Resident preferences have not determined menu decisions in the past

Suggestions to Overcome Obstacles:
- Temporary use of another supplier or alternate purchase source
- Seeking assistance from the resident council
- Put concern in writing
- Create Dietary Council or Food Council

Possible Solutions: Updating the resident's food preferences
Potential Obstacles:
- Dietary manager unavailable
- Dietary manager unwilling
- Decision making is delegated to a family member

Suggestions to Overcome Obstacles:
- Speak with manager with authority over dietary manager
- Educate on resident rights

Possible Solutions: Changing dietary orders
Potential Obstacles:
- There is a medical reason potatoes are not provided
- The resident has an order for mechanically softened foods

Suggestions to Overcome Obstacles:
- Facilitate communication between resident and dietary staff
- Explore options with physician or dietitian

Possible Solutions: Staff training
Potential Obstacles:
- Time lag to next training
- Not all staff in attendance
- Staff turnover

Suggestions to Overcome Obstacles:
- Request interim training, ongoing training, and training across all shifts

Exercise: Brainstorm possible solutions, potential obstacles, and suggestions to overcome obstacles below.

Ms. Garcia wants to stay up late at night. An evening charge nurse knows her preference and will accommodate her. This nurse doesn't work every night. How can a lasting solution be reached?

Possible Solutions: _____

Potential Obstacles: _____

Suggestion to Overcome Obstacles: _____

_____

Possible Solutions: _____

Potential Obstacles: _____

Suggestion to Overcome Obstacles: _____

_____

Possible Solutions: _____

Potential Obstacles: _____

Suggestion to Overcome Obstacles: _____

_____

Possible Solutions: _____

Potential Obstacles: _____

Suggestion to Overcome Obstacles: _____

_____

Sometimes, ombudsmen develop a solution and suggest it to all parties. At other times, they bring people together to discover the best solution. Complaints can be resolved in a number of ways, but try to find a solution that addresses the root cause and supports the resident's wishes.

Individual care or service plans should be updated to meet a resident's needs. Ombudsmen can suggest a care or service plan meeting to resolve a variety of problems.

Check with the Resident

Once an ombudsman has investigated a complaint, identified the underlying problem, identified possible solutions, obstacles, and resolution strategies, it is time to pause and check with the resident. Reasons for this are to:

- share with the resident what the ombudsman learned;
- be sure the resident wants you to continue trying to resolve the problem;
- confirm the outcome the resident seeks;
- discuss ideas regarding how to resolve the problem;
- encourage the resident to participate in the resolution process;
- discuss potential consequences to the resident, if any;
- discuss possible outcomes; and
- determine what will satisfy the resident.

Before taking action to resolve, be sure you know what the _____ wants.

Take Action

To take action requires resident consent. Seek resident-directed resolutions. Once the resident is consulted and an approach is chosen, act to resolve. Be respectful, reasonable, confident, and have a good attitude. Not all complaints can be resolved using laws and rules. Some require persuasion which is dependent on an ombudsman's ability to identify the problem, listen, plan and prepare, and build credibility.

A meeting may be necessary to get the right parties in the same room to discuss a resolution. To prepare for a resolution meeting, have a plan of action:

- Investigate first
- Know what the resident wants

- Determine who needs to be involved and request their participation
- Establish who will lead the meeting
- Rehearse
    - Visualize what to do and say in the meeting
    - Be clear what your role is
    - Set the time and place and be sure parties are aware
    - Anticipate obstacles and have potential solutions ready
- Pay attention to others in the meeting. Note body language, eye contact, facial expressions, gestures, and tone of voice. Think about what negotiating style other parties may use. Do they appear submissive, assertive, or aggressive?
- Anticipate surprises
    - Do not agree to something under pressure if it does not fit with resident direction
    - Ask for time if needed
    - Trust your gut
    - Call all parties the day before to confirm

As you prepare for a meeting, visualize a cooperative environment where you serve as a guide toward resolution.

Ombudsmen take a complaint as far as possible to accomplish the resident's desired outcome. Some tools an ombudsman may use to work toward resolution include:

- care planning to focus attention on resident needs, routines, strengths, and preferences;
- resident and family councils;
- laws and rules that support the resident, especially residents' rights; or
- regulatory agencies which oversee health care facilities and use investigations, citations, and penalties to enforce laws and rules.

Ombudsmen should follow up with other agencies and the resident when a complaint is referred. Check back with the resident later if a complaint was withdrawn.

Other Resolution Strategies

If a complaint cannot be resolved by interventions at the facility, it may be necessary to use more adversarial strategies. Volunteer ombudsmen refer these complaints to the supervising staff ombudsman; he or she works with the managing local ombudsman

who coordinates with the State Ombudsman and serves as the lead in these strategies. These strategies might include:

- legal services – advice, litigation;
- courts – judgments, enforcement, recovery, damages;
- elected officials – add, edit, or delete laws and rules; and
- local media – publicity, news, opinions.

STEP 4 Check on progress and outcomes

The resident should always be an ombudsman's first source to check progress. This is often done in person, but also may be by phone. Other than in your confidential reports to the ombudsman program, be careful not to identify any resident as a complainant if he or she requested anonymity. A volunteer and staff ombudsman may work together to resolve and follow-up on a complaint.

If the complainant is someone other than a resident, ombudsmen have an obligation to inform the complainant of progress, according to the resident's direction. If a resident does not perceive the complaint as a problem, the ombudsman informs the complainant of the resident's perspective and provides options.

At any point while working towards a resolution, things may fall apart or there may be little to no progress. In such cases, investigate the cause and take action to restart the process or attempt a new strategy.

Resident communication styles and abilities guide follow-up strategy. Some residents do not hesitate to report to an ombudsman that the problem is getting worse or not improving. Others wait until an ombudsman visits or may hesitate to report bad news. An ombudsman listens, interprets nonverbal communication, redirects conversations, or probes for more information, depending on each resident's needs.

How often and how long you follow-up varies with each case. The facility's response, the complexity of the problem, and how quickly and successfully staff implemented changes may affect follow-up plans. Check back at least once or twice. For less complex cases, check back with the resident anywhere from several days to several weeks. If the problem was complex, check back in several weeks to several months to confirm the solution is lasting.

STEP 5 Determine resident or complainant satisfaction with outcome.

Once an ombudsman has done all the work they can toward resolution, identify an outcome for each complaint, and close the case. Ombudsmen call the outcome a disposition. The resident or complainant determines the outcome, so contact the person to check whether the problem was resolved to his or her satisfaction.

In the beginning, an ombudsman checks with the supervising staff ombudsman to determine when to close a case. With experience, ombudsmen often determine when to close a case on their own, but consulting the supervising staff ombudsman is always an option.

Close a case when you have done all the _____ you can reasonably do.

Ombudsmen report the disposition of a complaint or case, as follows:

- Resolved (include referred complaints with a resolved outcome)
- Partially resolved, part of the problem remains (include referred complaints that are partially resolved)
- Withdrawn
- Referred to another agency:
  - Disposition not obtained
  - Agency failed to act in accordance with policy
  - Agency did not substantiate
  - No action needed or appropriate
  - Not resolved
  - Cannot be resolved and requires regulatory or legislative action

If the complaint was referred to another agency to investigate, check with your supervising staff ombudsman on the status of investigation or action. If the problem continues, contact the agency again as necessary.

Remember two factors while working to resolve complaints:

1. Some complaints cannot be resolved. Sometimes a complaint can't be resolved even with thorough investigation, unquestionable verification, and wise and persistent efforts by the ombudsman.
2. Complaint resolution is not always clear-cut.

- A problem may go away and then reappear.
- Parts of the problem will be resolved but not others.
- The complainant will not be completely convinced the situation is as good as it should be.
- The complainant may say everything has been solved even if the ombudsman would prefer to continue pursuing the matter.

Case Example The Five-Step Problem-Solving Process

Complainant – Mr. Smith, Administrator of Golden Oaks Retirement

Resident - Mr. Flynn

Complaint – Mr. Smith tells you (the ombudsman) that Mr. Flynn will not bathe and he wears the same clothes every day. His body odor is unpleasant for his roommate, caregivers, and other residents. Mr. Smith says that the facility is concerned they can't meet Mr. Flynn's needs.

STEP 1 Identify the problem from the resident's perspective, investigate and research statutory support.

You consult with Mr. Flynn. Mr. Flynn acknowledges there is a problem and gives you permission to take action. You open a case and begin to collect information.

Mr. Flynn tells you he prefers to wear overalls. The pair he wears everyday fits well but he doesn't trust the facility laundry to wash them because they've lost or damaged several pairs in the past.

He also tells you that bathing is not something he looks forward to because the aides rush him, the shower water isn't hot enough, and aides don't let him wash himself.

With Mr. Flynn's consent, you interview some of his direct caregivers. They report he refuses a bath no matter what they try, including letting him bathe himself. They tell you at one time Mr. Flynn didn't mind taking showers, but the CNA that formerly helped him no longer works there. They tell you some residents complain of Mr. Flynn's odor but can't provide you with any specific names.

Statutory support for this case that is applicable:

- Residents have the right to refuse treatment and care.
- Residents have a right to a decent living environment.
- Residents have a right to have their choices and preferences respected and to secure their personal property from theft or loss.
- The facility must help maintain Mr. Flynn's highest practicable level of functioning, allow him to participate in his care plan, and maintain or enhance his quality of life.

STEP 2 Consider underlying causes and determine scope of the problem

Issues Mr. Flynn shared with you:

- The bathing environment is unpleasant.
- He needs some new clothes that are clearly labeled.
- Laundry sorting process does not ensure residents get their laundry returned.

Things that need further exploration by you:

- Is Mr. Flynn embarrassed by some part of the bathing process?
- Do the bathing times match his preferences?
- Do the caregivers know or respect Mr. Flynn's bathing preferences?
- Do the caregivers need additional training?

Scope: the problem primarily affects Mr. Flynn

STEP 3 Explore possible ways to resolve and take action

- Mr. Flynn identifies he wants to bathe in the afternoons and to have all the time he wants in the shower. He agrees to allow a CNA to check on him at regular intervals and to pull the call light when he is finished or if he needs help.
- Mr. Flynn agrees to the purchase of new overalls and shirts of the same brand and size, using his trust fund. He will allow the activity director to label his clothing. Laundry bags will be used to distinguish his clothes.
- You and Mr. Flynn meet with the social worker in Mr. Flynn's room. Mr. Flynn takes the lead with his requests. The social worker says the facility may need to set a limit on the shower time and Mr. Flynn agrees to 20 minutes.
- The social worker confirms the nursing home should replace any items lost in the laundry.

STEP 4 Check on progress and outcomes

The administrator brings Mr. Flynn his new clothes to approve.

- Mr. Flynn signs the receipts for the new overalls. He is satisfied.
- The overalls are clearly labeled with Mr. Flynn's name.
- The first day of Mr. Flynn's requested scheduled bath is successful. He has to persuade staff to allow him to bring his soiled clothes back to his room for the laundry, but this is also successful.
- The social worker writes down a procedure for bathing with his input and gives him a copy. She places a copy in his medical records and updates his care plan. His direct caregivers are briefed on the procedures.

STEP 5 Determine resident or complainant satisfaction with outcome

Mr. Flynn reports he is very satisfied with the outcome. If he encounters problems, he plans to speak with the social worker or administrator first, then the ombudsman if needed.

Exercise:
Case Discussion: "Show me the Money"

Ms. James lost several clothing items. Her sister Ms. Martin visits often. On the last visit, Ms. James was wearing clothes that did not belong to her. She told her sister some clothes had been taken out of her dresser. When Ms. Martin asked, the administrator said Ms. James is confused.

Ms. Martin heard that her sister should be able to keep some money out of her check each month. Ms. James doesn't know about this. Ms. Martin suggests the administrator use the money to buy a new dress for her sister. He says there isn't any money left after bills are paid each month. When Ms. Martin asked where the money was kept, staff replied that only the legal guardian could have that information.

Other residents report their funds are not accounted for. The administrator reports:

- Because of theft, personal needs allowances are given on an as-needed basis.
- At admission, every resident signs a form authorizing the facility to administer funds for security purposes. For residents who have a diagnosis of dementia, a family member is asked to agree to this procedure by signing the form.

Step 1: Identify the problem and research statutory support

_____

_____

Step 2: Consider causes and scope

_____

_____

Step 3: Explore ways to resolve and take action

_____

_____

The process continues in real cases…

Step 4: Check on progress and outcomes
Step 5: Determine satisfaction

Case Discussion: “Discharge – Unable to Meet Needs”

Lacey Dalton is married and 45 years old. Her husband lives in their home and she lives in a nursing home. The administrator issued her a 30-day discharge notice stating they cannot meet her needs.

The facility contacted Mr. Dalton numerous times to discuss his wife’s behaviors, but he changed his phone number and address. Mrs. Dalton reportedly gave her husband Power of Attorney when she was in the hospital, but the facility does not have a copy. The facility reports Mrs. Dalton is noncompliant with treatment and has placed her health at risk. Mrs. Dalton says her husband cannot take care of her. She calls the ombudsman to help her stay in the nursing home.

Step 1: Identify the problem and research statutory support

_____

_____

Step 2: Consider causes and scope

_____

_____

Step 3: Explore ways to resolve and take action

_____

_____

The process continues in real cases…
Step 4: Check on progress and outcomes
Step 5: Determine satisfaction

Case Discussion: “No Appropriate Food Choices”

Jerry Smith lives in Happy Hills Assisted Living. He recently shared his concern about the facility’s lack of food choices appropriate for a person with diabetes. Mr. Smith states he inquired about appropriate menus for diabetes before moving into Happy Hills. At that time, the executive director told Mr. Smith they always have two entrée choices at each meal and that he can choose the best option that serves his dietary needs.

Mr. Smith showed the monthly menu to the ombudsman. He highlighted the entrée choices which did not meet his dietary needs. Many lunches and dinners listed two high carbohydrate options such as chicken spaghetti and tuna noodle casserole. No sugar free desserts were indicated.

Mr. Smith said he recently told the executive director and the nurse about his dietary concerns. He shows you a copy of the facility disclosure statement which indicates no special diets are offered by his assisted living facility. He feels that meeting his needs requires a specialized diet and that the facility promised they would do so before he moved in. See below.

I. Pre-admission Process

A. Indicate services which are not offered by your facility:

- [ ] **Assistance in transferring to and from a wheelchair**
- [ ] **Bladder incontinence care**
- [ ] **Bowel incontinence care**
- [ ] **Medication injections**
- [ ] **Feeding residents**
- [ ] **Other:**
- [x] **Intravenous (IV) therapy**
- [ ] **Oxygen administration**
- [x] **Special diets**
- [ ] **Behavior management for verbal aggression**
- [x] **Behavior management for physical aggression**

Step 1: Identify the problem and research statutory support

_____

_____

Step 2: Consider causes and scope

_____

_____

Step 3: Explore ways to resolve and take action

_____

_____

The process continues in real cases…

Step 4: Check on progress and outcomes
Step 5: Determine satisfaction

Notes:

Ombudsman Certification Training

CHAPTER 11: Staying Connected

Staying Connected

Chapter 11 is about a certified ombudsman's communication with the Long-term Care Ombudsman Program and ways volunteers, local program staff, and the state office stay connected.

Learning Objectives

- Recognize the importance of strong communications among ombudsman volunteers and staff to stay connected
- Understand the conditions when consultation with the ombudsman program is required
- Recognize the methods used for volunteers, staff, and staff from the Office of the State Long-term Care Ombudsman to stay connected
- Learn how to complete and submit a monthly report to the ombudsman program office

Contents

- Communicating with the Ombudsman Program
- Ways to Stay Connected
- Consulting with Ombudsman Program Staff
- AoA Complaint Codes
- Reporting Ombudsman Work

DVD(s), Supplements, Forms

- AoA Ombudsman Complaint Codes (1-132)
- LTC Ombudsman Activity Report, Form 8620
- Instructions Form 8620 (Reporting Instructions Long-term Care Ombudsman Activity Report, Form 8620)
- Supplement 11-A - Researching Statutory Support
- Supplement 11-B – Consistency in Reporting Casework
- Supplement 11-C - Complaint Codes Descriptions - LTCOP

Staying Connected with the Ombudsman Program

Good communication between volunteers, local ombudsmen, and state office staff is essential to an effective ombudsman program. Staying connected and communicating ensures all ombudsmen feel supported and have access to help when needed. Good program communication also helps residents receive the advocacy they need, when they need it.

Ombudsman program communications are vital for effective advocacy. Ombudsmen stay connected through:

Consultations*

Ombudsmen should never feel alone. Call your supervising staff ombudsman for problem-solving ideas and for guidance about ombudsman procedures. Request a joint visit when needed.

Visits

A staff ombudsman makes periodic visits with a volunteer. Joint visits allow ombudsmen to learn from one another. Take advantage of these visits to ask questions, make observations, and exercise critical thinking skills while observing another ombudsman in action.

Training

In addition to training received for initial certification, every ombudsman must earn 12 hours of continuing education each year. Continuing education keeps ombudsmen informed of changes in the long-term care system and builds upon the foundation of initial training. Training in person with other ombudsmen is critical to staying connected.

Reporting

As a federally- and state-funded program, reporting is required. Reports communicate the real needs of residents and serve as the basis for legislative advocacy. To maintain certification, every ombudsman must report their activities monthly.

Evaluation

Annual feedback from program evaluations helps local programs plan continuing education for the coming year and identify program strengths and weaknesses. Personal evaluations recognize certified ombudsman performance and keep the program dialed into the needs and concerns of the ombudsman team.

Other

In addition to required forms of communication, programs may issue newsletters, send letters, and use social media and web communications. These efforts keep a strong connection among ombudsmen and improve the statewide program's effectiveness.

Like us on Facebook!
https://www.facebook.com/texasltcombudsman

* "Consultation" referenced in this chapter is not reported as providing information or consultation to residents.

Every certified ombudsman is required to earn ____ hours of continuing education each year.

Staff ombudsmen report daily and volunteers report every _____.

Consulting with Ombudsman Program Staff

Consultation provides all ombudsmen the support they need while ensuring ombudsmen follow procedures to protect residents' rights and the integrity of the ombudsman program. In some circumstances, consultation is advised. At other times, it is required.

Consultation is encouraged for many situations, including when ombudsmen:

- need information about possible resources;
- are unsure about laws and rules that may apply to a problem;
- have questions about ombudsman procedures;
- feel stuck on a case or problem; or
- suspect facility staff are not taking a complaint seriously.

Consultation is <u>required</u> when ombudsmen:

- feel uncomfortable helping a resident or have a personal belief that may interfere with their ability to assist a resident with a particular problem;
- have a conflict of interest related to any person associated with the facility where they serve;
- believe a person is interfering in the course of an ombudsman's official duties;
- are asked to disclose confidential information and consent from the resident, resident's LAR, or complainant cannot be obtained;
- need access to a resident's medical record and the resident cannot consent and has no LAR;
- suspect ANE of a resident and the resident is unable to consent to reporting and has no LAR;
- do not have consent to report ANE, but suspects other residents are at risk;
- feel a serious risk to resident health and safety exists in the facility where the ombudsman serves; and
- are directed to consult with their supervising staff ombudsman as described in this training manual or in other written procedures.

State Long-term Care Ombudsman approval is required in the following circumstances:

- access to confidential records without consent;
- ANE reporting without resident consent; and
- conflicts of interest.

Consultation provides all ombudsmen the support they need while ensuring they follow procedures to protect residents' rights and the _____ of the ombudsman program. Consultation is required when ombudsmen are asked to disclose confidential _____ and _____ from the resident, resident's LAR, or complainant cannot be obtained.

Reporting Ombudsman Work

On a daily basis, staff ombudsmen report their activities in a statewide reporting database. The database stores confidential information about ombudsman work and supports communication among ombudsman program representatives. The system protects all documentation from release to anyone other than an ombudsman involved in a case unless permission is given by the resident or by court order. The statewide database makes it possible for the state office and local ombudsman programs to analyze and report work in order to meet federal and state requirements.

The State Long-term Care Ombudsman creates a biennial report of program accomplishments for the Texas Legislature and Governor and reports annual program accomplishments. Reports are available on the Texas Long-term Care Ombudsman Program website. You can find a copy of these reports at http://www.dads.state.tx.us/news_info/ombudsman/annualreport.html

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Volunteers report their work monthly to the local ombudsman program using the Long-term Care Ombudsman Activity Report (Form 8620). Starting with the first month of visiting residents in a facility as an ombudsman intern, volunteers fill out this report to

describe activities completed on behalf of residents. Once an intern is certified, these reports are part of state and federal reporting of program work.

If a volunteer or staff ombudsman keeps visit or other work notes on a personal computer or other electronic device, it must be password protected to prevent access by others. The electronic record should be deleted after submitting the monthly report. Protection of information in hard copy is equally necessary.

The first step in reporting is to get familiar with codes that describe problems an ombudsman encounters. A list of codes is provided in this chapter, followed by a detailed description of each. To categorize each complaint, codes are organized into separate headings that include:

- Resident Rights,
- Resident Care,
- Quality of Life,
- Administration, and
- Problems with Outside Agency, System, or People.

Under the headings are subheadings indicated by letters A through Q and titled for additional guidance.

Example of a complaint subheading and complaints:

M. Staffing

096	Communication, language barrier
097	Shortage of staff
098	Staff: training, lack of screening
099	Staff: unresponsive, unavailable
100	Staff: unresponsive, unavailable
101	Supervision
102	Eating assistants

Exercise: Find the Best Complaint Code

Use the list of complaint codes to assign the best code to describe a complaint. Circle the complainant in each complaint. For detailed descriptions of each complaint code, refer to Supplement 11-C (Complaint Code Descriptions - LTCOP) at the end of this chapter. The complaint code descriptions will help you determine the best code to use.

Example: An ombudsman observed a resident with fingernails and hair that appeared dirty. The best complaint category and code is: F 45, personal hygiene.

____ 1. A resident tells you “A CNA is mean. I get nervous when she comes to my room.”

____ 2. A daughter reports the nursing home is moving her Mom to make room for a special rehabilitation unit. She has lived in the same room for two years and doesn’t want to move. She says, “The social worker is harassing us.”

____ 3. A resident says, “My roommate hollers out and keeps me up at night. I want him moved.”

____ 4. A facility staff tells you, “Breakfast looks awful. The pancakes are rubbery, the eggs are powdered, and the coffee is cold.” You ask residents and they agree.

____ 5. A resident reports the facility held her care plan meeting without her.

____ 6. The social worker reports, “Mr. Jones is going into resident rooms and stealing.”

____ 7. A resident reports, “Rehab has stopped physical therapy because they say I am no longer improving enough, but I know I can progress with more therapy.”

____ 8. The daughter said, “Mom called me very upset. The blouse and pants they put on her are not hers.”

____ 9. The ombudsman observes the bathroom in a resident’s room has feces, standing water, and live roaches.

____ 10. The ombudsman notices several call lights are not within residents’ reach in bed.

____ 11. The daughter of a resident says, “My mother is allergic to fish and she couldn’t eat what was served. No one told her she could order something else so she went to bed hungry.”

____ 12. The facility called the ombudsman for assistance. They report a resident wants to go home but the nursing home does not think he can live safely at home.

____ 13. An ombudsman is aware a resident is diagnosed with an anxiety disorder. The resident’s son calls and reports to the ombudsman that he was not informed his father’s doctor ordered two psychotropic drugs. The son is concerned after reading about serious side effects.

____ 14. The ombudsman notices the facility's living room smells of smoke. The smoking area is off the living room and has a large ashtray full of cigarette butts in the corner.

____ 15. A resident's daughter says, "Every time I visit my mother, she is sitting in the wheelchair in the hall staring at the walls."

____ 16. An ombudsman observes a resident looks very thin and does not eat lunch. The resident calls out for milk, but no one gets it for her.

____ 17. A resident reports, "My dentures got lost three months ago. I am still waiting for them to be replaced."

____ 18. The ombudsman learns a resident is Spanish speaking, but her caregivers don't speak or understand Spanish.

____ 19. A resident says, "I'm in terrible pain. The nurse is giving me Tylenol but it doesn't help. I told her but no one pays attention."

____ 20. A resident says, "Last evening I called the CNA to use the bathroom. The CNA said, "I'm busy now. Go in your diaper."

____ 21. A resident tells you she has left messages for her MCO service coordinator, but none of her calls are returned.

____ 22. A resident's customized power wheelchair is broken and the facility says the MCO will not agree to get it fixed.

AoA Ombudsman Complaint Codes

RESIDENTS' RIGHTS

A. Abuse, Gross Neglect, Exploitation

1. Abuse: physical (including corporal punishment)
2. Abuse: sexual
3. Abuse: verbal / psychological (including punishment, seclusion)
4. Financial exploitation (severe complaints)
5. Gross neglect (use categories F & G for non-willful forms of neglect)
6. Resident-to-resident physical or sexual abuse
7. Not used

B. Access to Information by Resident or Resident's Representative

8. Access: own records
9. Access by or to ombudsman / visitors
10. Access to facility survey, staffing reports, license
11. Information: advance directive
12. Information: medical condition, treatment and any changes
13. Information: rights, benefits, services, the resident's right to complain
14. Information communicated in understandable language
15. Not used

C. Admission, Transfer, Discharge, Eviction

16. Admission contract and/or procedure
17. Appeal process: absent, not followed
18. Bed hold: written notice, refusal to readmit
19. Discharge / eviction (including abandonment)
20. Admission discrimination: condition, disability
21. Admission discrimination: Medicaid status
22. Room assignment / change, intra-facility transfer
23. Not used

D. Autonomy, Choice, Preference, Exercise of Rights, Privacy

24. Choose personal physician, pharmacy, hospice, other health care provider
25. Confinement of facility against will (illegally)
26. Dignity, respect, staff attitudes
27. Exercise preference and choice and/or civil and religious rights, individual's right to smoke
28. Exercise right to refuse care / treatment
29. Language barrier in daily routine
30. Participate in care planning by resident and/or designated surrogate
31. Privacy: telephone, visitors, couples, mail
32. Privacy: treatment, confidentiality
33. Response to complaints
34. Reprisal, retaliation
35. Not used

E. Financial, Property (except for exploitation)

36. Billing and charges: notice, approval, questionable, accounting wrong or denied (includes overcharge of private pay residents)
37. Personal funds: mismanaged, access and information denied, deposits and other money not returned (report criminal-level misuse of personal funds under A.4)
38. Personal property lost, stolen, used by others, destroyed, withheld from resident
39. Not used

RESIDENT CARE

F. Care

40. Accidental or injury of unknown origin, falls, improper handling
41. Failure to respond to requests for assistance, call lights
42. Care plan / resident assessment: inadequate, failure to follow plan or physician orders
43. Contracture
44. Medications: administration, organization
45. Personal hygiene (includes nail care & oral hygiene) and adequacy of dressing & grooming
46. Physician services (including podiatrist)
47. Pressure sores, not turned
48. Symptoms unattended (including pain, pain not managed), no notice to others of changes in condition
49. Toileting, incontinent care
50. Tubes: neglect of catheter, gastric, NG tube
51. Wandering, failure to accommodate / monitor exit seeking behavior
52. Not used

G. Rehabilitation or Maintenance of Function

53. Assistive devices or equipment
54 Bowel and bladder training
55. Dental services
56. Mental health, psychosocial services
57. Range of motion, ambulation
58. Therapies: physical, occupational, speech
59. Vision and hearing
60. Not used

H. Restraints: Chemical and Physical

61. Physical restraint: assessment, use, monitoring
62. Psychoactive drugs: assessment, use, evaluation
63. Not used

QUALITY OF LIFE

I. Activities and Social Services

64. Activities: choice and appropriateness
65. Community interaction, transportation
66. Resident conflict (including roommates)
67. Social services: availability / appropriateness (use G.56 for mental health, psychosocial counseling / service)
68. Not used

J. Dietary

69. Assistance in eating or assistive devices
70. Fluid availability / hydration
71. Food service: quantity, quality, variation, choice, condiments, utensils, menu
72. Snacks, time between meals, late / missed meals
73. Temperature of food
74. Therapeutic diet
75. Weight loss due to inadequate nutrition
76. Not used

K. Environment / Safety

77. Air / environment: temperature and quality (heating, cooling, ventilation, water), noise
78. Cleanliness, pests, general housekeeping
79. Equipment / buildings: disrepair, hazard, poor lighting, fire safety, not secure
80. Furnishings, storage for residents
81. Infection control
82. Laundry: lost, condition
83. Odors
84. Space for activities, dining
85. Supplies and linens
86. Americans with Disabilities Act (ADA) accessibility

ADMINISTRATION

L. Policies, Procedures, Attitudes, Resources

87. Abuse investigation / reporting (including failure to report)
88. Administrator(s) unresponsive, unavailable
89. Grievance procedure (use C for transfer, discharge appeals)
90. Inappropriate or illegal policies, practices, record-keeping
91. Insufficient funds to operate
92. Operator inadequately trained
93. Offering inappropriate level of care (for ALFs)
94. Resident or family council interfered with, not supported
95. Not used

M. Staffing

96. Communication, language barrier
97. Shortage of staff
98. Staff training
99. Staff turn-over, over-use of nursing pools
100. Staff: unresponsive, unavailable
101. Supervision
102. Eating assistants

PROBLEMS WITH OUTSIDE AGENCY, SYSTEM, OR PEOPLE (not against the facility)

N. Certification / Licensing Agency

103. Access to information (including survey)
104. Complaint, response to
105. Decertification / closure
106. Sanction (including intermediate)
107. Survey process
108. Survey process: ombudsman participation
109. Transfer or eviction hearing
110. Not used

O. State Medicaid Agency and Managed Care

100134 MC – Enrollment
100135 MC – Service coordination
100138 MC – Value added
100140 MC – Appeals, denials
100142 MC – Dignity, respect, MC staff attitudes
100143 MC – Choice of provider or doctor
100144 MC – Add-on service (ACD, CPWC, CWC, DME, additional therapies)

111. Access to information, application
112. Denial of eligibility
113. Non-covered services
114. Personal Needs Allowance (PNA)
115. Services
116. Not used

P. System / Others

117. Abuse, neglect, abandonment by family member, friend, guardian or, while on visit out of facility, any other person
118. Bed shortage: placement
119. Facilities operating without a license
120. Family conflict; interference
121. Financial exploitation or neglect by family or other not affiliated with facility
122. Legal: guardianship, conservatorship, power of attorney, wills
123. Medicare
124. Mental health, developmental disabilities (including PASRR)
125. Problems with resident's physician / assistant
126. Protective Service agency
127. SSA, SSI, VA, other benefits / agencies
128. Request for less restrictive placement

Q. Complaints about services in settings other than long-term care facilities or by outside provider

129. Home care
130. Hospital or hospice
131. Public or other congregate housing not providing personal care
132. Services from outside provider
133. Not used

Exercise: Practice Completing a Monthly Report

Use the ombudsman's notes provided below to complete a May 2015 Ombudsman Activity Report. An activity report and instructions follows this exercise.

May 1 (2.5 hours)

- Ms. Green reports it is too noisy at night and she can't sleep. Reported to administrator and discussed changes in nighttime supervision.
- Mr. White says his roommate keeps his light on until midnight and it keeps him awake. His sheets have not been changed in a week. Housekeeping changes sheets while I am there. Visited 29 residents.

May 10 (2 hours)

- Mr. Mustard tells me, "I don't know why I am here, I want to go home." We speak with the social worker who calls the relocation contractor for an assessment.
- Ms. Scarlet reports never having a water pitcher and says she is thirsty. Three other rooms do not have water available and two hallways have only one CNA working.
- Attended Family Council meeting in p.m. Visited with 9 family members.

May 13 (1 hour)

- Ms. Brown wants to get outdoors but says everyone is too busy. Activities assistant helps her outside while I am there.
- Mr. White and I discuss his relationship with his roommate who was sent to the hospital last night. He reports several housekeeping staff quit. Trash cans are full and the restroom needs attention. Requested housekeeping services.

May 14

- Called Mr. White. Housekeeping cleaned his room yesterday afternoon.

May 21 (1.5 hours)

Followed up with all residents on complaints. Visited with 10 residents and 2 families.

- Ms. Green says nights are quieter. Other residents report the same. I reported to the administrator improvements and thanked her for intervention.
- Mr. Mustard hasn't seen the relocation contractor for an assessment. Asks me to call and find out the status of his request.

- Ms. Brown reports not getting outside since last week. Calendar includes no outdoor activities. Activity director is not available to talk; left a note for administrator to call me.
- Mr. White's roommate has returned from the hospital and is sleeping more. Room has been quiet at night, but he feels it is temporary.
- Observed water pitchers being distributed to each resident. Ms. Scarlet reports she has received water every day since I reported it. Close case, but watch for how often water is replenished and if solution lasts next month.
- Housekeeping still looks behind – beds not made at noon. Trash overflowing.

Ombudsman tip: Start your monthly report after your first visit of the month and add to it each time you visit. As soon as you make your last visit in the month, e-mail or mail it to your ombudsman program.

Texas Department of Aging
and Disability Services

Form 8620

Long-Term Care Ombudsman Activity Report

Ombudsman: _____ **Facility:** _____ **Month/Year:** _____

Visit Date	No. of Contacts			Time – Hrs:Mins		Mileage Optional
	Resident	Family/Other	Staff	On Site	Travel Optional	
Totals						

Date	Activity
	Family council
	Resident council
	Survey
	Care plan meeting

Notes

Cases and Complaints

Date Opened	Complainant	Resident / Complainant (name or description)	Consent		Complaints		Verified		Disposition	Date Closed
			Yes	No	(1-132)	Notes optional	Yes	No		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		

Complainant

1 Resident
2 Relative/friend
3 Guardian/legal rep
4 Ombudsman
5 Facility staff
6 Medical staff
7 Social/health agency
8 Unknown/anonymous
9 Banker, clergy, law

Disposition

a Govt./legislative
b Not resolved
c Withdrawn
d1 Referred: disposition not obtained
d2 Referred: failed to act on complaint
d3 Referred: complaint not substantiated
e No action needed
f Partially resolved
g Resolved

Date Opened	Complainant	Resident / Complainant (name or description)	Consent		Complaints		Verified		Disposition	Date Closed
			Yes	No	(1-132)	Notes optional	Yes	No		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
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			☐	☐			☐	☐		
			☐	☐			☐	☐		

Complainant

1	Resident	4	Ombudsman	7	Social/health agency
2	Relative/friend	5	Facility staff	8	Unknown/anonymous
3	Guardian/legal rep	6	Medical staff	9	Banker, clergy, law

Disposition

a	Govt./legislative	d1	Referred: disposition not obtained	e	No action needed
b	Not resolved	d2	Referred: failed to act on complaint	f	Partially resolved
c	Withdrawn	d3	Referred: complaint not substantiated	g	Resolved

Reporting Instructions for Activity Report

(Long-term Care Ombudsman Activity Report, Form 8620)

Long-term Care Ombudsman Activity Report

Certified volunteer ombudsmen are required to submit Form 8620, Activity Report, each month. The report can be submitted electronically or as a paper copy. Submit the report by the due date set by the local long-term care ombudsman program. Staff ombudsmen may use Form 8620 and then enter in OmbudsManager.

Instructions

Enter your name, assigned facility, and the report month and year.

Visits

Required: Enter dates and time spent on site.

- Your local program decides whether you are required to track number of contacts, travel time and mileage.
- Date – Enter each date you visited.
- No. of Contacts – Enter the number of separate contacts for resident, family/other (non-relative visitors) and staff. A contact consists of meaningful interaction and can be done by phone, e-mail, letter, or in person.
- Time On Site – Enter time spent in the facility and/or resolving complaints.
- Travel – Enter time spent traveling to and from the facility.
- Mileage – Enter miles traveled to and from the facility.

Note to the managing local ombudsman – Determine whether certified ombudsmen will report on the items listed above. When reporting donated hours of service, count time on site, travel time and mileage (if the volunteer is not reimbursed).

Activities

Enter a date you participated in an activity during the month or if you attended more than one, enter a number attended for each type of activity, as appropriate.

- Care plan meeting – Attendance at the invitation of a resident or legally authorized representative.
- Family council – Attendance at the invitation of a family council member.
- Resident council – Attendance at the invitation of a resident council member.
- Survey – Participation in any part of a Regulatory Services annual survey or complaint investigation; count only once per survey.

Notes

This section is optional. Enter information about other activities or, information such as referrals to legal services; facility staff changes; changes in overall quality; and requests for information and assistance or consultations you provided.

Cases and Complaints

- Date Opened – Enter the date you received or identified the first complaint within a case.
- Resident/Complainant – Complainant roles include:
    1 resident
    2 relative/friend of resident
    3 guardian/legal representative
    4 ombudsman
    5 facility staff or former staff
    6 medical physician/staff
    7 social/health agency representative
    8 unknown/anonymous
    9 bankers, clergy, law enforcement, public officials, etc.
- Consent – To show resident or complainant consent, mark Yes or No. With consent, work to resolve complaint(s). Without consent, seek guidance from supervising staff ombudsman or managing local ombudsman.
- Complaints (Codes 1-132) – Enter the code that best matches the complaint and/or enter information about the complaint in the Notes field. Your local long-term care ombudsman program can provide a list of the complaint codes.
- Verified – After investigation, mark Yes if you verified the complaint (found it to be generally accurate). If not, mark No. A certified ombudsman may work to resolve a complaint regardless of verification.
- Disposition - For each complaint, choose a disposition that best describes the outcome after you have done all you can to seek resolution. If you refer a complaint to an agency that reports the outcome to you, code with the appropriate disposition. If the agency did not notify you of the disposition, choose d1, d2 or d3. Dispositions include:
    a government/legislative (policy, regulatory change or legislative action is required)
    b not resolved
    c withdrawn
    d1 referred: disposition not obtained
    d2 referred: failed to act on complaint
    d3 referred: complaint not substantiated
    e no action needed
    f partially resolved (some problem remained)
    g resolved
- Date Closed – Enter the date you closed the case because complaints required no further action.

Supplement 11-A – Researching Statutory Support

This exercise may be completed either in class or as self-study as directed by your instructor. Use the provided links (or handbook) to find the rule. The first one has been completed for you. To shorten your search using the links below, you can use "Ctrl F" to complete a word search.

Nursing Facility Requirements for Licensure and Medicaid Certification Handbook: http://www.dads.state.tx.us/handbooks/nfr-lmc/

Nursing Home

1. Can medications be released to residents?

   Reference §19. 507(a)(b)___

   [**Hint:** Find - Subchapter P, Pharmacy Services, §19.507 Drug Release]

2. Who prepares the comprehensive care plan?

   Reference §19. _____

3. What is the facility's responsibility for enforcement of smoking policies?

   Reference §19. _____

4. What is the maximum time period between meals?

   Reference §19. _____

5. Must the facility provide physician-ordered medical transportation to medical services outside the facility? Reference §19._____

6. Can a resident administer his or her own medications?

   Reference §19. _____

7. What types of information must be conspicuously and prominently posted in a licensed facility? Reference §19._____

8. Does the resident have to be provided access to representatives of the ombudsman program? Reference §19. _____

9. In 19.307, where does it discuss accessibility of resident call cords?

   Reference §19.307_____

10. Where can you find information about appropriate reasons for a discharge?

    Reference §19. _____

Supplement 11-A – Researching Statutory Support

Licensing Standards for Assisted Living Facility Handbook:
http://www.dads.state.tx.us/handbooks/ls-alf/

Assisted Living Facilities (ALFs)

1. What criteria are used to determine if a resident is placed appropriately in a Type A assisted living facility? [**Hint:** Types of ALFs] Reference §92.3(b)_____

2. Does the resident service plan have to be approved and signed by the resident or resident's responsible party for making health care decisions?
Reference §92._____

3. May a resident self-administer medications? Reference §92._____

4. Which staff can administer medications to a resident and what training does he or she need? Reference §92._____

5. The assisted living facility must keep supplies of staple foods for a minimum of _____ day period and perishable foods for a minimum of a ____ day period.
Reference §92._____

6. Does the resident have to be provided access to representatives of the ombudsman program?
Reference §92._____

7. What required postings must an assisted living facility prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees, and visitors?
Reference §92._____

8. Can a facility discharge a resident because covert electronic monitoring is being conducted by or on behalf of a resident?
Reference §92._____

9. Is a 30-day discharge notice required?
Reference §92._____

10. Can an assisted living facility provide skilled nursing services?
Reference §92. _____

Supplement 11-B – Consistency in Reporting Case Work

1. A resident tells the ombudsman she used her call light twice today. Each time, she had to wait 20 minutes before someone came to help. She asks the ombudsman for help. The ombudsman asks the resident to push the call button and checks the nurses' station. The call light works. The ombudsman asks who worked the morning shift. A new CNA started yesterday. Staff said they would focus training on call lights. During a follow up visit, the resident says she doesn't have to wait long for someone to respond to the call light. The ombudsman closes the case.

Number of complaints:
Complainant:
Complaint(s) verified: Yes __ No __
Complaint code(s):
Disposition:

2. A resident complains his home only offers one alternative meal at dinner and he would like two. He would also like to have a larger screened TV in the lounge closest to his room. He requests to remain anonymous and asks the ombudsman to investigate. The facility says the small lounge rooms are too small for a big screen TV, but there is a big screen TV in the main lounge. Staff arranges two alternative meals during the week but cannot offer two on weekends. The resident is satisfied with alternative meals during the week, because his family often brings special treats on the weekends. But, he is not happy about the TV. The ombudsman closes the case.

Number of complaints:
Complainant:
Complaint(s) verified: Yes __ No __
Complaint code(s):
Disposition:

3. A daughter complains that her mother needs to move closer to the nurse's station. The daughter has MPoA (An MPoA (medical power of attorney) allows the agent to make health decisions for the principal if the principal (mother) is incapacitated.) for her mother. The resident agrees she would feel safer in one of two rooms near a nurse station. The ombudsman investigates and finds no empty beds in either room. The daughter insists that her mother needs to move. The ombudsman visits the resident twice and both times, she says she wants to forget the whole thing. Her current room is OK, and all the commotion about moving is upsetting her. The ombudsman closes the case.

Number of complaints:
Complainant:
Complaint(s) verified: Yes __ No __
Complaint code(s):
Disposition:

4. The ombudsman observes roaches in three resident rooms. This is the fourth complaint opened concerning roaches in the past year. Each time, the ombudsman contacts the local health department and corporate office. The facility addressed the problem temporarily, but the roaches return. This time, after contacting the health department and corporate office, the ombudsman refers the case to Regulatory Services. (For this exercise, assume there is nothing more the ombudsman can do.) Regulatory staff doesn't find any roaches the day they inspect the facility so they do not substantiate the complaint. The ombudsman closes the case.

   Number of complaints:
   Complainant:
   Complaint(s) verified: Yes __ No __
   Complaint code(s):
   Disposition:

5. A resident's son calls the ombudsman with a complaint about food. Meat is often tough to cut and chew, and his mother rarely eats most of her dinner. He visits his mother most dinner meals. The ombudsman offers to investigate by speaking with the complainant's mother on a future visit. The ombudsman visits the nursing home and discreetly visits the resident to ask about food quality, temperature and taste. The resident doesn't report any concerns. The ombudsman tells the resident about her son's call and his concern that sometimes the meat is tough. The resident says her son "worries too much" and she doesn't mind the food. The ombudsman watches the evening meal and asks eight residents about the meal. No concerns are noted. By phone, the ombudsman informs the son that as a resident advocate, she takes action based on resident interests. The son is dissatisfied to learn the ombudsman will not work the complaint further. The ombudsman closes the case.

   Number of complaints:
   Complainant:
   Complaint(s) verified: Yes __ No __
   Complaint code(s):
   Disposition:

6. A Resident Council president makes a complaint about the amount of the Personal Needs Allowance (PNA) for Medicaid residents. Invited to the next council meeting, the ombudsman explains the Texas Legislature determines the PNA. The residents ask the ombudsman's help to present this issue to an advocacy organization to lobby on behalf of residents. The ombudsman meets with an advocacy organization representative, and the organization agrees to lobby for a PNA increase during the next legislative session. The ombudsman closes the case.

   Number of complaints:
   Complainant:
   Complaint(s) verified: Yes __ No __
   Complaint code(s):
   Disposition:

7. On June 1, the ombudsman observes seven call buttons out of reach of residents:

- 3 residents told the ombudsman they didn't realize the call buttons were out of reach.
- 1 resident said he would call out if he needed anything.
- 3 residents were unable to express their needs and didn't seem to be able to use the call button.

The ombudsman visited 25 rooms and contacted 40 residents. Some beds with call buttons out of reach were made while others were not, indicating housekeeping may have misplaced the call buttons. For the remaining rooms, the ombudsman talks with a nurse and two CNAs. The nurse reports it is a mistake and places the buttons within residents' reach. Both CNAs report they check more frequently on the residents who cannot use the call buttons. The ombudsman reports the concern to the administrator who states she will talk with the housekeeping supervisor and in-service direct-care staff on proper placement of call buttons. The ombudsman suggests more frequent checks on residents by a CNA seems a good strategy to help meet all residents' needs. The ombudsman keeps the case open.

On July 14, the ombudsman monitors the original seven residents and others who did not have access to their call buttons. Housekeeping has cleaned each room, and all buttons are within the residents' reach. The male resident says it works to call out for help. CNAs report making frequent checks on residents who cannot use a call button. The ombudsman interviews another nurse who goes into a resident's room and asks, "Do you know how to use the call light?" The resident replies, "yes," but the ombudsman suspects the resident may not be capable. The ombudsman reports to the administrator: CNAs appear to have a good protocol; housekeeping appears to have made adjustments; but nurses appear to not recognize how to best meet the residents' needs. The administrator says she can't do more than provide another in-service. The ombudsman offers to assist, but the administrator declines. The ombudsman closes the case.

Number of complaints:
Complainant:
Complaint(s) verified: Yes __ No __
Complaint code(s):
Disposition:

Supplement 11-C – Complaint Codes Descriptions - LTCOP

A complaint is about a problem of commission or omission.

Each case may have more than one complaint. However, each problem will have only one code. Use only one category for each type of problem. (Do not check both A.3 and D.26 for the same staff behavior. Determine which category is most appropriate to the particular problem.)

Residents' Rights

A. ABUSE, GROSS NEGLECT, EXPLOITATION

Use categories in this section only for serious complaints of willful mistreatment of residents by facility staff, management, other residents (use category 6), or unknown or outside individuals who have gained access to the resident through negligence or lax security on the part of the facility or for neglect which is so severe that it constitutes abuse. Use P.117 and P.121 for complaints of abuse, neglect, exploitation by family members, friends, and others whose actions the facility could not reasonably be expected to oversee or regulate.

For all categories in this part, use the broad definitions of abuse, neglect, and exploitation in the Older Americans Act (OAA), which is almost identical to that in regulations for nursing homes participating in the Medicare and Medicaid programs (42 CFR 488.301): The term

Abuse means the willful

(A) infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain or mental anguish; or
(B) deprivation by a person, including a caregiver, of goods or services necessary to avoid physical harm, mental anguish, or mental illness. (OAA, Section 102 [13])
(Financial) exploitation means the illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit or gain. (OAA, Section 102[24])

In addition to the above broad definitions, use the definitions for specific categories below from the Centers for Medicare and Medicaid Services (CMS) Interpretive Guidelines, section 483.13(b) and (c). The guidelines are available at https://www.cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf See page 61 and surveyor guidance at deficiency tags F223 to F226.

Use resident-to-resident physical or sexual abuse (A.6) only for willful abuse of one resident by another resident, not for unintentional harm or altercations between residents who require staff supervision, which should be coded in category I-66, "Resident conflict, including roommates." (For example, a confused resident who strikes out is categorized at I.66 and an alert resident who strikes out is A.6.)

1) Abuse, physical (including corporal punishment)
Includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.

2. Abuse, sexual
Includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

3. Abuse, verbal/psychological (including punishment, seclusion)
Use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or to their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability. (Use D.26 for less severe forms of staff rudeness or insensitivity; use M.100 if staff is unavailable, unresponsive to residents.) Psychological or mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Involuntary seclusion means the separation of a resident from other residents or from his/her room against the resident's will or the will of the resident's legal representative. Emergency or short term monitored separation is not considered involuntary seclusion if used for a limited period of time as a therapeutic intervention to reduce agitation.

4. Financial exploitation (use categories in Section E for less severe financial complaints)
The illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit or gain.

5. Gross neglect (for non-willful forms of neglect, use Care, Sections F & G)
The willful deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness. (Use only for the most extreme forms of willful neglect. Use the appropriate categories under Resident Care, Quality of Life or, in some cases, Administration for less severe forms or manifestations of resident neglect.)

6. Resident-to-resident physical or sexual abuse
Use only for complaints of abuse by a resident against one or more other residents which meet the definitions of abuse provided above. (For unintentional harm or altercations between residents who require staff supervision, use category I-66, "Resident conflict, including roommates.")

7. Not Used

B. ACCESS TO INFORMATION BY RESIDENT OR RESIDENT'S REPRESENTATIVE
Use categories in this section for complaints involving access to information or assistance made by or on behalf of the resident or the resident's representative. Use B.9 if the ombudsman is denied access in response to a complaint. If there is a general problem with ombudsman access to one or more particular facilities

or types of facilities, but no complaint has been filed, do not use complaint categories. Describe the access problem under Part III, B - Statewide Coverage. Categories B.14, D.29, and M.96 all involve communication /language barriers and yet are different. Use B.14 if information regarding rights, medical condition, benefits, services, etc. is not communicated in an understandable language.

8. Access to own records
Use if complainant is denied or delayed access to resident's record.

9. Access by or to ombudsman/visitors
Use if access to the facility or certain parts of the facility is denied to the ombudsman. Use also if ombudsman or visitors are denied access to a resident.

10. Access to facility survey/staffing reports/license
Use if the licensing and certification agency's survey is not posted in a prominent place or not provided when requested. Use also when the facility's license is not posted or available. Use if the facility daily staffing report is not posted.

11. Information regarding advance directive
Use related to advance health care directive, living will, do not resuscitate (DNR) order, and similar problems.

12. Information regarding medical condition, treatment and any changes
Use if information is denied, delayed.

13. Information regarding rights, benefits, services, the resident's right to complain
Use related to resident rights (including the right to complain), Medicaid information/process, social services, staff not wearing name badges, and similar problems.

14. Information communicated in understandable language
Use if information is not provided in a language which the resident or her representative can understand or the staff speaks in a confusing manner.

15. Not Used

C. ADMISSION, TRANSFER, DISCHARGE, EVICTION
Use the appropriate category for complaints involving placement, whether into, within or outside of the facility. If resident requests assistance in transferring to another facility and there is no stated problem (complaint), record as information and assistance to individuals in Part III, Other Ombudsman Activities. If a resident requests assistance in moving out of the facility but there are no feasible alternative options, record as P.128 "Request for less restrictive placement," since the problem is a lack of care alternatives within the long-term care system.

16. Admission contract and/or procedure
Use if no contract; contract contains illegal wording requiring waiver of rights or guarantee of payment; admission procedure not followed; admission procedure does not contain required elements, and similar problems.

17. Appeal process - absent, not followed
Use if resident/representative not given required number of days to appeal a discharge; facility failed to follow appeal ruling; no appeal process in place; and similar problems.

18. Bed hold - written notice, refusal to readmit
Use if bed not held required number of days; resident/representative not advised of bed hold policy; incorrect bed hold procedure; bed held but resident not readmitted and similar problems.

19. Discharge/eviction- planning, notice, procedure, implementation, including abandonment
Use if no discharge notice; required notice not given to resident/representative; required notice not given to the ombudsman program in required time frame; required notice lacks documentation, is incomplete, incorrect; discharge is for inappropriate reasons; discharge planned or implemented to inappropriate environment; level of care is changed against resident's will, and similar problems.

20. Discrimination in admission due to condition, disability
Use for refusal to admit resident due to medical condition, disability.

21. Discrimination in admission due to Medicaid status
Use if resident not admitted due to Medicaid status or pending Medicaid status.

22. Room assignment/room change/intra-facility transfer
Use if resident wants room change or resident objects to planned room change; no notice or inadequate notice of change; excessive room changes; or similar problems.

23. Not Used

D. AUTONOMY, CHOICE, PREFERENCE, EXERCISE OF RIGHTS, PRIVACY
Use for any complaint involving the resident's right, as stated in the category. If it is a related problem, but not one specific to this heading, use a category under another heading. For example, if the resident is permitted to choose her personal physician but that physician is unavailable, use P.125.

Note that D.29, B.14 and M.96 all involve communication/language barriers and yet are different. Use D.29 if the resident has a communication or language barrier. Use M.96 if staff has the communication or language barrier.

Use D.27 for right to smoke. Use K.77 for smoke-polluted air.

24. Choose personal physician/pharmacy/hospice/other health care provider
Use when the resident is denied the right to choose his own physician/pharmacy/hospice or other outside health care provider.

25. Confinement of facility against will (illegally)
Use when the resident is denied the right to leave the facility or go outside of the facility. (Use P.128 “other” for resident requests for assistance in moving out of the facility when feasible alternative options are not available.)

26. Dignity, respect - staff attitudes
Use when resident is treated with rudeness, indifference or insensitivity, including failure to knock before entering room, facility posts signs relating to individual’s care and similar problems.

27. Exercise preference/choice and/or civil/religious rights, individual’s right to smoke
Use when the resident is denied choice and exercise of rights; for example: voting; speaking freely; access to a smoking area, preference in sleeping and rising times, community activities, the outdoors, television program of choice and similar problems. (Use D. 31 for rights involving privacy.)

28. Exercise right to refuse care/treatment
Use if the resident is denied the right to refuse care/treatment; including resident’s right to refuse eating, bathing, or taking medication.

29. Language barrier in daily routine
Use if caregiver does not speak the resident’s language, resident cannot communicate.

30. Participate in care planning by resident and/or designated surrogate
Use if the resident or the resident’s legal representative is denied access to or not informed of a care plan/care plan meeting.

31. Privacy - telephone, visitors, couples, mail
Use if the resident is denied access to a telephone, visitors or mail; phone calls are monitored; mail is opened by someone other than the resident or the resident’s legal representative; couples denied privacy.

32. Privacy in treatment, confidentiality
Use if the resident is denied privacy in treatment; confidential information has been disclosed.

33. Response to complaints

Use if complaints are ignored or trivialized by facility staff: administrator, social worker, nurses, and other staff.

34. Reprisal, retaliation
Use if the resident has experienced reprisal/retaliation (threat of discharge, lack of care, requests ignored, call lights unanswered, rough handling, etc.) as a result of a complaint.

35. Not Used

E. FINANCIAL, PROPERTY (EXCEPT FOR FINANCIAL EXPLOITATION)
Use the appropriate category for complaints involving non-criminal mismanagement or careless with residents' funds and property or billing problems. Use A.4 for complaints involving willful financial exploitation, including, but not limited to, criminal activity.

36. Billing/charges - notice, approval, questionable, accounting wrong or denied (includes overcharge of private pay residents)
Use if complainant alleges resident does not owe the amount billed; the resident never received the bill for amount owed; bill in error, supplies not provided as part of the daily rate and similar problems.

37. Personal funds - mismanaged, access/information denied, deposits and other money not returned (report criminal-level misuse of personal funds under A.4)
Use for problem with personal funds, for example, staff denies a resident use of her personal needs allowance; staff uses a nursing home resident's trust fund without consent, and similar problems.

38. Personal property lost, stolen, used by others, destroyed, with-held from resident
Use for property (including prostheses, dentures, hearing aid, glasses, radio, watch) missing/stolen at the facility or if the facility withholds or mismanages personal property (non-monetary). Use K.82 for loss of laundry.

39. Not Used

Resident Care

F. CARE
Use appropriate category for complaints involving negligence, lack of attention and poor quality in care of residents. If the care situation is so poor the resident is in a condition of overall neglect which is threatening to health and/or life, use A.5, "gross neglect."

40. Accidental or injury of unknown origin, falls, improper handling

Use for unexplained bruises, scratches, cuts, skin tears; falls from bed, wheelchair, or when standing; when resident is handled improperly or dropped during transfer or other assistance; and similar problems.

41. Failure to respond to requests for assistance
Use for call lights or requests for assistance not answered, or not answered in a timely manner. Includes requests for going/returning to resident's room, transfers to chairs/bed, etc.

42. Care plan/resident assessment - inadequate, failure to follow plan or physician orders (put lack of resident/surrogate involvement under D. 30)
Use for problem related to care plan: plan is incomplete or not reflective of resident's condition; staff has disregarded or is not informed of the plan; staff fails to respond, or responds slowly, to physician orders and similar problems.

43. Contracture
Use for problem related to resident's hands, arms, feet, or legs being drawn up and contorted.

44. Medications - administration, organization
Use for medications not given on time or not at all, medication administration not documented or incorrectly documented, medications not secured, incorrect medication or dosage; negligence, lack of attention or poor quality in care related to medication that is: run out; expired; not filled in a timely manner; incorrectly labeled, and similar problems.

45. Personal hygiene (includes nail care & oral hygiene) and adequacy of dressing & grooming
Use for resident: not bathed in a timely manner, not clean, not bathed at all, allowed to remain in soiled clothing, diaper, bed, chair; hands and face not washed after meals; teeth/dentures not cleaned; and similar problems.

46. Physician services, including podiatrist
Use for failure of facility to obtain physician services upon a change in resident's condition, or if medical attention, including podiatrist service, is not obtained in a timely manner or not obtained at all.

47. Pressure sores, not turned
Use for pressure sore(s) that may have occurred at the facility or elsewhere. Use when facility fails to treat, document, monitor pressure sores. Use if resident is not turned per medical order or treatment standard, or when turning is undocumented.

48. Symptoms unattended, including pain, pain not managed, no notice to others of changes in condition

Use if facility fails to accommodate, notice, or provide services related to a change in resident's condition.

49. Toileting, incontinent care
Use when resident is not toileted in a timely manner, as needed or requested, or as directed by the care plan; facility is using diapers or catheters rather than toileting. Use G.54 for inadequate or non-existent bowel and bladder plan/training.

50. Tubes - neglect of catheter, gastric, NG tube (use D.28 for inappropriate, forced use)
Use if tube is not cleaned, changed, or monitored appropriately.

51. Wandering, failure to accommodate/monitor exit-seeking behavior
Use for resident wandering, failure to redirect wanderers.

52. Not Used

G. REHABILITATION OR MAINTENANCE OF FUNCTION
Use appropriate category for complaints involving failure to provide needed rehabilitation or services necessary to maintain the expected level of function.

53. Assistive devices or equipment
Use if facility lacks, fails to maintain or has problems with Hoyer lift, handrails/grab bars, toilet seat, elevators, ambulation aids, wheelchair (no brakes or footrests, etc.), hearing or visual aids, and other assistive devices or equipment.

54 Bowel and bladder training
Use if facility fails to provide training, has no schedule, or schedule not maintained. See F.49.

55. Dental services
Use if dental services not provided or arranged for resident.

56. Mental health, psychosocial services
Use if these services not provided, arranged for resident.

57. Range of motion/ambulation
Use if services not provided; resident not assisted or encouraged in ambulation as appropriate; no appropriate exercise available; exercise resident wants is unavailable.

58. Therapies, physical, occupational, speech
Use for failure to provide or arrange for therapies with outside agency or provider.

59. Vision and hearing
Use for failure to provide or arrange for vision and hearing services or for problems with services.

60) Not Used

H. RESTRAINTS - CHEMICAL AND PHYSICAL
Use the appropriate category for any complaint involving the use of physical or chemical restraint.

61. Physical restraint - assessment, use, monitoring
Use for any physical restraint: lap buddy, bed rail(s), bindings, placement of furniture, resident not released from restraints for a specified time; no order in file; and similar problems including locked units.

62. Psychoactive drugs - assessment, use, evaluation
Use for any chemical restraint including excessive or unnecessary medication.

63. Not Used

Quality of Life

I. ACTIVITIES AND SOCIAL SERVICES
Use categories under this heading for complaints involving social services for residents and social interaction of residents. Note transportation is included in category I.65 because community interaction sometimes (not always) depends upon transportation.

64. Activities - choice and appropriateness
Use for lack of activities appropriate for each resident; facility fails to consider residents ability to perform certain activities/and preferences; variety limited; no activities; posted activities not conducted.

65. Community interaction, transportation
Use for any complaint involving the resident's need for transportation, for whatever reason and/or when facility does not assist residents in participating in community services or activities or curtails community interaction.

66. Resident conflict, including roommates
Use for any complaint involving conflict between residents, including roommate conflict and inappropriate behaviors that impact another resident's quality of life.

67. Social services – availability/appropriateness (use G.56 for mental health, psychosocial counseling/service)

Use if social services department fails to provide social services or encourage social interaction; fails to provide services if resident isolates himself or refuses to participate in activities, and similar problems.

68. Not Used

J. DIETARY

Use the appropriate category for complaints involving food and fluid intake. Use the appropriate category under A (A.1 or A.5) for willful cases of food deprivation.

69. Assistance in eating or assistive devices

Use for failure to provide assistance in eating; facility has not provided tools to assist resident in self-feeding, meal set-up, i.e., opening milk cartons, tray not within reach.

70. Fluid availability/hydration

Use for complaint that resident is not reminded to drink; bedside water is not provided, not fresh or not in reach; fluids are not readily available; resident is dehydrated.

71. Food service - quantity, quality, variation, choice, condiments, utensils, menu

Use for posted menu not served; alternate selections not offered; servings too small; no variety; quality is poor; food has little nutritional value, nutrients out of date, condiments or utensils not provided, presentation, timely delivery and/or removal of trays.

72. Snacks, time span between meals, late/missed meals

Use for snacks not readily available or offered between meals; excessive time span between dinner and breakfast.

73. Temperature

Use for food or beverage not served at appropriate temperature.

74. Therapeutic diet

Use for complaint resident's therapeutic diet is not served as ordered; resident's dietary needs not accommodated.

75. Weight loss due to inadequate nutrition

Use A.1 or A.5 for willful food deprivation.

76. Not Used

K. ENVIRONMENT/SAFETY

Use the appropriate category for complaints involving the physical environment of the facility and resident's space.

77. Air/environment: temperature and quality (heating, cooling, ventilation, water), noise

Use for complaints about building, room or water temperature too hot or cold; ventilation inadequate; indoor cigarette smoke; noise in the facility; and similar problems.

78. Cleanliness, pests, general housekeeping

Use for uncleanliness or pests (insects, vermin - live or dead) in resident's room or other facility area. Also use for ant, snake, rat or mosquito bite.

79. Equipment/Buildings - disrepair, hazard, poor lighting, fire safety, not secure

Use for elevator malfunctioning/not maintained; paint/wallpaper peeling; lights burned out or insufficient lights; exterior not maintained, littered; inaccessible entrances/exits or hallways; inadequate/non-functioning/expired fire extinguishers; malfunctioning automatic doors; fire alarms, smoke detectors, and other emergency equipment not present, malfunctioning or inadequate; and any other building maintenance problem. Also use for premises not secured; lacking or broken window bars; unauthorized person gained entrance to facility; unauthorized weapon in facility, and similar problems.

80. Furnishings, storage for residents

Use for furnishing in disrepair; lack of furnishings; inadequate storage space for belongings, including valuables.

81. Infection control

Use for insufficient measures to prevent infection; spread of infection; resident at risk; infection unreported or not treated appropriately, and similar problems**.**

82. Laundry - lost, condition

Use for no clean clothes available; clothing lost, damaged**.**

83. Odors

Use for urine, feces, any other offending odor or any odor which is a detriment to the health of the resident.

84. Space for activities, dining

Use for: inadequate space for scheduled activity or residents' attendance/participation in activity; dining area does not promote resident interaction; inadequate space for wheelchair or other assistive devices while dining; activity, dining areas converted to other uses.

85. Supplies and linens

Use for no clean linens available or in poor condition; shortage of supplies, for example, soap, gloves, toilet paper, incontinence pads, and nursing supplies.

86. Americans with Disabilities Act (ADA) accessibility
Use for complaints regarding the facility's compliance with the ADA; for example, no handicapped access.

Administration

L. POLICIES, PROCEDURES, ATTITUDES, RESOURCES
Categories under this heading are for acts of commission or omission by facility managers, operators, or owners in areas other than staffing or specific problems included in previous sections.

87. Abuse investigation/reporting, including failure to report
Use for failure of facility to report or investigate suspected resident abuse/neglect or exploitation to the specified authority, no matter where alleged abuse occurred.

88. Administrator(s) unresponsive, unavailable
Use for failure of administrator or administrative staff to respond to or communicate with others.

89. Grievance procedure (use C for transfer, discharge appeals)
Use if there is no grievance procedure for handling complaints or if the procedure is not made known to residents or not complied with by the facility.

90. Inappropriate or illegal policies, practices, record keeping
Use if records are incomplete, missing, or falsified, including staff references not checked, or when required background screening has not been performed. Use also for complaints about health care fraud, waste, and abuse.

91. Insufficient funds to operate
Use if there is a substantiated complaint of shortage of staff, lack of food, utilities cut off, etc. that could indicate bankruptcy or insufficient funds. Also use if a complainant alleges the facility has insufficient funds to operate.

92. Operator inadequately trained
Use for complaint that owner/administrator has no documentation of administrator's license, training or updates, and other certifications required by the state.

93. Offering inappropriate level of care (for B&C/similar)
Use if facility admits or retains resident whose medical and/or care needs are greater than the facility can meet or arrange to have met and similar problems.

94. Resident or family council/committee interfered with, not supported

Use if facility interferes with or fails to support resident or family councils, attempts to organize councils and related problems.

95) Not Used

M. STAFFING

Use appropriate categories under this heading for complaints involving staff unavailability, training, turnover, and supervision.

96. Communication, language barrier

Use for staff language or other communication barrier. Use D.29 if problem involves resident inability to communicate.

97. Shortage of staff

Use for insufficient staff to meet the needs of the resident(s); staffing is below the minimum standard.

98. Staff training

Use when staff has not received training sufficient to meet the needs of the resident(s); including basic care and technical training, including the use of a Hoyer lift, CPR, first aid, mental health, and dementia training.

99. Staff turnover, over-use of nursing pools

Use when there is no continuity of care for the residents; new staff on board and pool/agency staff are regularly used.

100. Staff unresponsive, unavailable

Use if staff is unresponsive or unavailable. Use D.26 if staff is available but rude or otherwise disrespectful to resident. Use A.3 or other category under A if rudeness or disrespect is so severe that it qualifies as abuse.

101. Supervision

Use when the staff duties are not overseen or not reviewed by a supervisor. Use when there is no ALF staff monitoring residents.

102. Eating Assistants

Use for complaints about inappropriate use of and training of eating assistants. Use J. 69 for failure to provide assistance in eating or facility has not provided tools to assist resident in self-feeding, meal set-up, i.e., opening milk cartons, tray not within reach.

Problems with Outside Agency, System, or People (Not Against the Facility)

Use these categories for all complaints involving decisions, policies, actions or inactions by the state agencies which license facilities and certify them for participation in Medicaid and Medicare.

N. CERTIFICATION/LICENSING AGENCY

103. Access to information (including survey)
Use if licensing agency does not provide facility information to ombudsmen, public.

104. Complaint, response to
Use when agency fails to respond adequately to any complaint or referral, from the resident, ombudsman or public.

105. Decertification/closure
Use for individual complaints about decertification/closure and if agency fails to decertify/close a facility when within residents' best interests or with disregard to residents' rights.

106. Sanction, including Intermediate
Use if licensing agency fails to sanction facility appropriately.

107. Survey process
Use if agency fails to survey facility as required by law.

108. Survey process - Ombudsman participation
Use if ombudsmen not notified and/or included in survey process.

109. Transfer or eviction hearing
Use for complaints of decisions, policies, actions or inactions by the licensing agency regarding resident discharge hearings.

110. Not Used

O. STATE MEDICAID AGENCY and MANAGED CARE

Categories in this section are for complaints about Medicaid coverage, benefits and services.

* For each managed care complaint (MC), OmbudsManager records must indicate which MCO is associated with the case. Specify the MCO in the "user field" of a case record. Journal entries and details in the complaint intake fields are also needed to explain the problem and who is at fault, such as the nursing facility, MCO, or both.
MCO – Managed Care Organization

100134 MC Enrollment*

Use if the nursing facility is steering residents to a certain MCO or if an MCO is coercing residents to choose them. Also report technical issues with enrollment.

100135 MC Service coordination*

Use if MCO service coordinator is unavailable, not helpful, or disrespectful to the resident.

100138 MC Value added*

Use if resident needs a value added service and the MCO does not deliver that service; or if the resident continues to need a value added service and it is denied.

100140 MC Appeals, denials*

Use if resident has received a denial, reduction, or termination of any service provided through the MCO. This code includes helping the resident or representing the resident in an MCO appeal or a state fair hearing if it relates to a managed care decision.

NOTE: Facility discharge notices are the responsibility of a nursing facility or ALF, not an MCO. Code discharge issues as 17, 19, or 109 as appropriate.

100142 MC Dignity, respect, MC staff attitudes*

Use if any MCO staff are not treating the resident with dignity or respect, regardless of the issue.

100143 MC Choice of provider or doctor*

Use if the MCO is not allowing choice of providers or doctors, either by purposely blocking a resident from seeing a certain physician or because the physician the resident wants is not with the plan or is not accepting new patients.

100144 MC Add-on service (ACD, CPWC, CWC, DME, additional therapies)*

Use if MCO is not helping a resident get services they need that require authorization from the MCO to get the service.

111. Access to information, application

Use if information is denied or delayed to resident or legal representative; case worker is unavailable, or unresponsive to requests for information or application status.

112. Denial of eligibility

Use for complaint that resident is denied Medicaid.

113. Non-covered services

Use for complaints about services not covered by Medicaid.

114. Personal Needs Allowance
Use for complaints about the insufficiency of the personal needs allowance.

115. Services
Use for complaints about the quality or quantity of services covered by Medicaid or difficulty in obtaining services. (Use 113 for non-covered services.)

116. Not Used

P. SYSTEM/OTHERS
*Use appropriate categories in this section to document the range of complaints against or involving individuals who are not managers/staff of facilities * or of the State=s licensing and certification or Medicaid agency. (*except for 119, as specified)*

117. Abuse/neglect/abandonment by family member/friend/guardian or, while on visit out of facility, any other person
Use for abuse/abandonment by individuals other than facility staff, when the facility could not reasonably have been expected to observe the acts. Use A.1 or other A categories when the facility should have overseen and acted.

118. Bed shortage - placement
Use when resident is unable to find a facility placement, or for a bed shortage.

119. Facilities operating without a license
Use for complaints about facilities providing services to residents which should only be offered in a regulated environment.

120. Family conflict; interference
Use when a family conflict interferes with resident's care. Use only if the conflict or problem affects the resident's care or wellbeing.

121. Financial exploitation or neglect by family or other not affiliated with facility
Use for cases of financial exploitation or financial neglect of a resident by individuals whose actions the facility could not reasonably be expected to oversee or be responsible.

122. Legal - guardianship, conservatorship, power of attorney, wills
Use if the complaint involves any of the above legal issues.

123. Medicare
Use if resident has complaint related to Medicare coverage.

124. Mental health, developmental disabilities, including PASRR
Use for problems with access to services for persons with mental illness or developmental disabilities or for problems involving implementation of the Pre-Admission Screening and Resident Review (PASRR) requirements of the Nursing Home Reform Act related to individuals with mental illness, mental retardation, or a developmental disability living/making application to live in a Medicaid-certified nursing home.

125. Problems with resident's physician/assistant
Use if the resident's physician or assistant fails to provide information, services, is not available**,** or makes inappropriate or fraudulent charges**.** (Use F.46 if facility fails to arrange for physician service and P.48 if facility fails to attend to medical symptoms or notify family of change in resident's condition.)

126. Protective Service agency
Use for complaints involving the agency in the State charged with investigating reports of adult abuse or exploitation and providing protective services for victims of abuse and exploitation.

127. SSA, SSI, VA, other benefits/agencies
Use for complaints for these non-Medicaid and non-Medicare benefits and the agencies which administer them.

128. Request for less restrictive placement
Use for a complaint against any other agency or individual, but not facility staff or licensing agency staff. Use for resident requests for assistance in moving out of the facility and/or ombudsman initiative to help resident find less restrictive placement. Includes work to implement the Supreme Court's Olmstead decision.

Q. COMPLAINTS ABOUT SERVICES IN SETTINGS OTHER THAN LONG-TERM CARE FACILITIES OR BY OUTSIDE PROVIDER
Use categories in this section to document any complaints accepted and acted upon by the ombudsman involving individuals living in private residences, hospitals or in hospice care, and congregate and/or shared housing not providing personal care. Also use for services in a facility provided by an outside provider.

129. Home care
Use if complaint is made by or on behalf of an individual living in a private residence.

130. Hospital or hospice
Use for complaint involving hospital or hospice care, service, or administration.

131. Public or other congregate housing not providing personal care
Use for complaint made by or on behalf of individual living in public or private congregate housing unit where personal care is not included in the rental contract.

132. Services from outside provider
Use for services from an outside provider which are not included in other categories for which the facility makes arrangements; for example, personal and homemaking services in an assisted living facility, therapies, non-Medicaid transportation, psychosocial service. (Use P.125 for outside physician services.)

133. Not Used

Notes:

Notes:

Ombudsman Certification Training

CHAPTER 12: Resident Records

Resident Records

Chapter 12 is about ombudsman program authority to access resident records and other confidential information. Ombudsmen must get resident consent before accessing their records and then must keep all information confidential.

Learning Objectives

- Know which facility records ombudsmen can access
- Understand the requirement to get resident consent
- Distinguish when reviewing resident records is necessary
- Identify elements of medical records

Contents

- Ombudsman Access
- Consent to Access Confidential Records
- Request, Review, and Use of a Record
- Types of Resident Records

DVD(s), Supplements, Forms

- DVD: YouTube Video - Medical Records and Terminology
- Supplement 12-A: Common Medical Chart Abbreviations
- Supplement 12-B: Consent to Release Records to the Certified Ombudsman Form 8624-O (oral)
- Supplement 12-C: Consent to Release Records to the Certified Ombudsman Form 8624-W (written)

Ombudsman Access

The Older Americans Act requires each state to ensure ombudsmen have access to facilities, residents, and medical and social records of residents. In Texas, only certified ombudsmen may access a resident's records with consent. Ombudsman *interns do not have access* to a resident's record or its contents.

In Texas, laws and rules require nursing homes and assisted living facilities to allow ombudsman entry and private visits with residents. All Information documented in a resident's records or shared orally by a caregiver, resident, or physician is confidential. Laws and rules require ombudsmen to protect resident confidentiality. Never share information about a resident without the resident's consent.

Residents or legal representatives have the right to access the residents' records, and facilities must comply with:

- Nursing facility requirement §19.403(f)
- Assisted living facility standard §92.125(a)(3)(m)

Residents have the right to review all medical and financial records pertaining to them. _____ True (T) or False (F)

Consent to Access Confidential Records

In all cases, obtain resident consent to access a confidential record and document it. If the resident declines, stop the process. Other situations may include:

- If the complainant is not the resident, get resident consent before proceeding.
- If the resident is unable to communicate consent and has a Legally Authorized Representative (LAR), get the LAR's consent.
- When a resident is unable to communicate consent and has no LAR, consult with your supervising staff ombudsman who then consults with the state ombudsman. Certified staff ombudsmen (including managing local ombudsmen) who want to review a record of a resident who cannot consent and has no LAR must have approval from the state ombudsman before accessing the record.

Obtain resident consent to access a _____ record.

Request, Review, and Use of a Record

After a resident grants consent, request only the records necessary to investigate. Request a record at the nurse's station or administrative office. If facility staff asks for proof of consent, present documentation such as Form 8624, or if the resident consented orally, staff may confirm the request with the resident.

Records that facilities are not required to provide to ombudsmen include:

- Personnel
- Facility budget and accounting
- Quality assurance committee documentation

To review a record, find a private location. Review only records pertinent to the concern or inquiry and use the findings appropriately. If possible, involve the resident in the review.

Inform the resident, or LAR if appropriate, of findings on an ongoing basis. Present information to facility staff only according to resident wishes.

Documentation

Ombudsmen document consent in case notes, the Long-term Care Ombudsman Activity Report, Consent to Release Records to the Certified Ombudsman Form 8624-O (oral), or Consent to Release Records to the Certified Ombudsman Form 8624-W (written). See Supplement 12-B and Supplement 12-C at the end of this chapter.

In preparation for some meetings, such as care or service plan meetings or fair hearings, an ombudsman may make copies from the resident's clinical record. These then become a confidential record and should be protected as such.

Before closing a case, transfer temporary notes to a reporting form and submit all records and documentation to the local ombudsman program, who must keep it secure.

Types of Resident Records

To access a resident's medical, incident, financial, and other records, an ombudsman must get consent from the resident or his or her legal representative.

Medical: Refer to the medical records section of this chapter for more information.

Incident: Regulatory Services requires staff to report incidents that are abnormal events, including accidents or injury to staff or residents. A facility may keep incident reports in one location rather than in an individual resident record.

Financial: Residents have the right to manage their financial affairs. If a facility manages funds for the resident, it must protect resident funds with some distinction between licensed-only and Medicaid-certified facilities.

Other records: Facilities keep records such as:

- Care or service plans
- Bathing schedules
- Care notes
- Dietary orders
- Grievance reports
- Medication administration records

Residents, guardians, family members, powers of attorney, the state ombudsman, or your supervising staff ombudsman may ask you to review a record. In every case, follow ombudsman procedures.

- When residents ask you to look at their records, you may assist immediately and involve them in the request to facility staff.
- If you decide that review of a record is necessary to investigate a complaint, volunteers should consult with your supervising staff ombudsman before proceeding.
- Always get written or oral consent from the resident or legal representative.
- Always document that the resident or legal representative gave consent and provide documentation to your ombudsman office.

Consider the following questions before consulting your supervising staff ombudsman:

- What is the issue or concern?
- With consent, could you get reliable information by asking questions to a facility staff person?
- Does the resident understand a request for records will identify him or her?
- Does the resident know he or she has the right to review personal records?
- What factors make review of a record necessary?
- What specific facts are you looking for?
- Does the resident have a legally authorized representative?

Based on the answers, you may need to access a resident record. The next step is to consult with your supervising staff ombudsman to seek agreement that review of a

medical record is necessary. Under some circumstances, a staff ombudsman must also consult with the state ombudsman. If all parties agree, proceed with seeking consent from the resident; if parties do not agree, stop.

Medical Records

Ombudsmen do not need to be experts on clinical records. However, records can be an important source for information during investigation of a complaint. Do not make medical assumptions, interpretations, or provide medical advice. As an advocate, ask questions and stay grounded in resident rights.

To provide quality care, members of the health care team must communicate. Medical records should facilitate communication among all team members who are involved. Medical offices, hospitals, and care facilities keep medical records. Records may be paper, electronic, or a combination. All entities must comply with privacy laws:

- State: Health and Safety Code Chapter 181 Medical Records Privacy
- Federal: Public Law 104-191 Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Medical records in nursing homes and assisted living facilities vary on how much and what resident information is included. Because nursing homes provide more services, a nursing home resident's medical record will be extensive. In an assisted living facility, the medical record might be more limited, especially in smaller, residential assisted living facilities.

Medical records in nursing homes and assisted living facilities vary on how much and what resident information is included.

On Your Own: *Medical Records and Terminology*

Watch the video *Medical Records and Terminology* found on the Texas Long-term Care Ombudsman YouTube channel. Refer to Supplement 12-A: Common Medical Chart Abbreviations found at the end of this chapter.

Follow this link: https://www.youtube.com/watch?v=2B216kPZpTY
Run Time: 23 min

Staff organize content in resident medical records by sections that often include the following information.

Administration

- Admission paperwork (contracts, face sheet, required information notification acknowledgements)
- Advance care planning such as Directive to Physician, Medical Power of Attorney, Durable Power of Attorney, Out-of-Hospital Do Not Resuscitate, and Guardianship

History and Physical

- Latest comprehensive medical history and physical exam done by the physician
- Sometimes includes a discharge summary from a recent hospitalization
- Medical overview of the patient

Vital Signs

- Temperature
- Blood pressure
- Heart rate
- Respiratory rate
- Pain assessment
- Other measurements
- I/Os (input and outputs), such as fluid intake or a bowel movement log

Progress Notes

- Dated "SOAP" notes
  - S = Subjective: what the patient states or is reported
  - O = Objective: what the physician can measure or evaluate by a physical examination
  - A = Assessment: summary of the current situation and working diagnoses
  - P = Plan: what the physician plans to do next
- Physicians must sign their notes.

Physician Orders

Instructions to support personnel for any service to be done for the resident

- Medication
- Lab test or x-ray
- Therapy: speech, physical, occupational
- Activity level

Individual Assessment, Care and Service Plans

- See Chapter 8: Care Planning

Nurses Notes

Reports on what happened during each shift

Labs

Reports of laboratory results

- Blood chemistry
- Urine cultures
- Sputum cultures
- Feces test

Imaging

Reports of any imaging study

- X-rays
- CT scans (computed tomography)
- MRIs (magnetic resonance imaging)
- Others

Do not make medical assumptions, interpretations, or provide medical advice.

Therapy

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy (ST)

Case Management

- Transfer or discharge plan: which location and when
- Social service notes

Negotiated Risk Agreements

- Documentation of a negotiated risk such as a resident refusing thickened liquids to prevent choking, or documentation that a resident understands the risk involved in using a bed mobility and transfer assist device like a bed assist rail.

Information that may be stored outside of an individual medical record:

- Medication Administration Record (MAR). This is the list of all medication given; usually found in or near the medication room or nurses' desk
- Social services and activity notes may be stored in individual charts or in a separate folder
- Incident reports

If you cannot find information, ask a charge nurse for help. Many care providers use electronic records and an ombudsman has access to the same information in them as a written medical record.

Exercise: Name the Medical Record Section

In which section of the medical record would you find the following?

1. What care does the morning shift need to give following the night shift?

   _____

2. Who did the resident name as her Medical Power of Attorney?

   _____

3. What kind of rehab does the resident need and how often?

   _____

4. When was the last x-ray to check whether the hip healed?

   _____

5. When did the resident return from the hospital?

   _____

6. What is the resident's working diagnosis?

   _____

7. Did the physician prescribe Ativan?

   _____

8. When does the facility plan to discharge the resident?

   _____

Supplement 12-A: Common Medical Chart Abbreviations

AB	Antibody
ABD, ABDOM	Abdomen
ABN	Abnormal
ADENOCA	Adenocarcinoma
ADM	Admission
ADR	Adverse drug reaction
AK(A)	Above knee (amputation)
AKA	Also known as
BCC	Basal cell carcinoma
BE	Barium enema
B/F	Black female
BIL	Bilateral
BK(A)	Below knee (amputation)
BM	Bone marrow
BM	Bowel movement
B/M	Black male
BP	Blood pressure
BX	Biopsy
CC	Chief complaint
CHF	Congestive heart failure
CIS	Carcinoma-in situ
CRF	Chronic renal failure
CT SC	Computerized tomography scan
CVA	Cerebrovascular accident
CVA	Costovertebral angle
CXR	Chest x-ray
DC	Discharge
DC	Discontinued
DNR	Do not resuscitate
DO	Doctor of Osteopathic Medicine
DTR	Deep tendon reflex
DX	Diagnosis
ECF	Extended care facility
ECG, EKG	Electrocardiogram
EEG	Electroencephalogram
EENT	Eyes, ears, nose, & throat
EGD	Esophagogastroduodenoscopy
EMG	Electromyogram
ENL	Enlarged
ENT	Ear, nose & throat
FBS	Fasting blood sugar
FU	Follow up
FUO	Fever unknown origin
FX	Fracture
GB	Gallbladder
GI	Gastrointestinal
HB	Hemoglobin
HEENT	Head, eyes, ears, nose, throat
HGB	Hemoglobin
H&P	History and physical
IM	Intramuscular
IV	Intravenous
K	Potassium
L1-L5	Lumbar vertebrae
LE	Lower extremity
LFT	Liver function test
LLE	Left lower extremity
LLL	Left lower lobe (lung)
LLQ	Left lower quadrant (abdomen)
L-SPINE	Lumbar spine
LUE	Left upper extremity
LUL	Left upper lobe (lung)
LUQ	Left upper quadrant (abdomen)
MD	Doctor of Allopathic Medicine
MI	Myocardial infarction
MRI	Magnetic resonance imaging
NEURO	Neurology
N&V	Nausea and vomiting

OP	Operation
OP	Outpatient
OPHTH	Ophthalmology
OR	Operating room
OSTEO	Osteomyelitis
OT	Occupational therapy
OV	Office visit
PA	Posteroanterior
PA	Pulmonary artery
PA	Physician assistant
PALP	Palpable, palpated, palpation
PATH	Pathology
PDR	Physician's Desk Reference
PE	Physical examination
PEG	Percutaneous gastrostomy tube
PMD	Personal (primary) medical doctor
PMH	Past medical history
PND	Postnasal drip
POD	Postoperative day
PRN	As needed (pro re nata)
PT	Patient
PT	Physiotherapy
Q	Quadrant
q	every
QID	Four times a day
qd	Every day
RLE	Right lower extremity
RLL	Right lower lobe (lung)
RLQ	Right lower quadrant
RML	Right middle lobe (lung)
RO, R/O	Rule out
ROM	Range of motions
RT	Right
RUE	Right upper extremity

RUL	Right upper lobe
RUQ	Right upper quadrant
RX	Treatment
SCC	Squamous cell carcinoma
SNF	Skilled nursing facility
SOB	Shortness of breath
STAPH	Staphylococcus
STAT	Immediately (statim)
STREP	Streptococcus
SUB-Q, SUBQ	Subcutaneous
SX	Symptoms
T1-T12	Thoracic vertebra
TID	Three times a day
T-SPINE	Thoracic spine
UE	Upper extremity
UGI	Upper gastrointestinal
URI	Upper respiratory infection
UROL	Urology
UTI	Urinary tract infection
VS	Vital signs
W/	With
W/F	White female
WNL	Within normal limits
W/O	Without
WT	Weight
W/U	Work-up
XR	X-ray

Differential Diagnosis: The process of weighing the probability of one disease versus that of other diseases possibly accounting for a patient's illness. For example, the differential diagnosis of rhinitis (a runny nose) includes allergic rhinitis (hay fever), the abuse of nasal decongestants, and the common cold.

Supplement 12-B: Form 8624-O (oral)
Consent to Release Records to the Certified Ombudsman
http://www.dads.state.tx.us/news_info/ombudsman/certifiedombudsman/

Texas Department of Aging
and Disability Services

Form 8624-O
May 2009

Long-Term Care Ombudsman Program (LTCOP)
Consent to Release Records to the Certified Ombudsman

As a representative of the Office of the State Long-Term Care Ombudsman, I received permission from

_____ of _____
(Name of Resident) (Name of Facility)

to access the following records:

- ☐ Medical
- ☐ Financial
- ☐ Incident
- ☐ Other

Disclosed records are protected under confidentiality laws that apply to the LTCOP and may be released only by a resident or by court order. A copy of this form may be provided to the facility for its records. If health information is released to other parties, it may no longer be protected by privacy regulations.

_____
Printed Name – Certified Ombudsman

_____ _____
Signature – Certified Ombudsman Date

Relevant Law and State Regulations

Federal Law – 42 USC 1396(c)(3)(E)

Nursing homes and assisted living facilities must allow certified ombudsmen access to residents, resident information and records according to state regulations.

- *Nursing Facility Requirements for Licensure and Medicaid Certification*
  40 TAC §19.413 Access and Visitation Rights
- *Licensing Standards for Assisted Living Facilities*
  40 TAC §92.801 Access to Residents and Records by the Long-Term Care Ombudsman Program

Supplement 12-C: Form 8624-W (written)
Consent to Release Records to the Certified Ombudsman
http://www.dads.state.tx.us/news_info/ombudsman/certifiedombudsman/

Texas Department of Aging
and Disability Services

Form 8624-W
May 2009

Long-Term Care Ombudsman Program
Consent to Release Records to the Certified Ombudsman

I give permission to the Long-Term Care Ombudsman Program (LTCOP) to access my records from the following facility: _____

Records:

- ☐ Medical
- ☐ Incident
- ☐ Financial
- ☐ Other

I give this consent to the LTCOP to respond to my request(s) and my consent continues until _____. I may revoke this consent at any time, but revocation will not affect any information already disclosed.
(Date or Description of Situation)

I understand that disclosed records are protected under confidentiality laws that apply to the LTCOP and may be released only by my request or by court order. A copy of this form may be provided to the facility for its records. If I authorize release of my health information to other parties, it may no longer be protected by privacy regulations.

_____
Printed Name – Resident or Legally Authorized Representative

_____ _____
Signature – Resident or Legally Authorized Representative Date

If I am not the subject of the records, I have authority to sign because I am the:

- ☐ Legal guardian
- ☐ Power of attorney
- ☐ Other: _____

Ombudsman Section

I have verified the legally authorized representative's authority.

_____ _____
Printed Name – Certified Ombudsman Local LTCOP

Relevant Law and State Regulations

Federal Law – 42 USC 1396(c)(3)(E)

Nursing homes and assisted living facilities must allow certified ombudsmen access to residents, resident information and records according to state regulations.

- *Nursing Facility Requirements for Licensure and Medicaid Certification*
  40 TAC §19.413 Access and Visitation Rights
- *Licensing Standards for Assisted Living Facilities*
  40 TAC §92.801 Access to Residents and Records by the Long-Term Care Ombudsman Program

Ombudsman Certification Training

CHAPTER 13: Regulators and Other Resources

Regulators and Other Resources

Chapter 13 is about federal and state agencies that license and certify nursing homes. It also discusses agencies that license assisted living facilities and programs within state agencies that can impact residents.

Learning Objectives

- Become familiar with federal and state agencies that regulate nursing homes and assisted living facilities
- Know the basic roles of each agency
- Learn the enforcement options available to regulatory to bring operators into regulatory compliance
- Learn about programs related to residents and staff

Contents

- Regulatory Agencies
- Surveys and Licensures
- Enforcement
- Credentialing
- Resources
- Ombudsman Role

DVD(s), Supplements, Forms

- Supplement 13-A: Program Agreement between Long-term Care Ombudsman Program and Regulatory Services
- Supplement 13-B: Memorandum of Understanding between DFPS Adult Protective Services and Long-term Care Ombudsman Program
- Supplement 13-C: PASRR Excerpt from Nursing Facility Requirements for Licensure and Medicaid Certification

Regulatory Agencies

Agencies in our federal and state governments have responsibilities to oversee health care facilities on behalf of residents as consumers, beneficiaries, and citizens. Responsibilities belong to:

- Federal - Centers for Medicare and Medicaid Services (CMS)
- State - Regulatory Services

Nursing homes are regulated by CMS and Regulatory Services. Assisted living facilities are regulated by Regulatory Services only.

Centers for Medicare and Medicaid Services (CMS)

The CMS mission is to assure health care security for beneficiaries with the goal to protect and improve beneficiary health and satisfaction. The agency has program and operational objectives. Program objectives are:

- give access to quality care by protecting beneficiaries from substandard or unnecessary care; and
- provide services to beneficiaries by improving beneficiary satisfaction with programs, services, and care.

Ombudsmen do not often interact with CMS surveyors and other staff. The CMS surveyor role is to monitor state surveyors for compliance with federal policy and procedures in the survey process; thus, ensuring federal requirements are consistently applied across state survey agencies.

Because assisted living has no federal definition or requirements, CMS has no role in regulating assisted living facilities.

Regulatory Services

Regulatory Services' main responsibilities are licensure and certification of facilities. This is accomplished through inspections of a number of facility types and services related to long-term services and supports. It monitors facilities for compliance with rules in the Nursing Facility Requirements and Licensing Standards for Assisted Living Facilities. Another major responsibility is to conduct investigations of complaints and incidents.

Regulatory Services staff who conduct inspections are commonly referred to as "surveyors."

Regulatory Services staff:

- determines that regulated facilities comply with federal and state rules;

- determines if providers are meeting the minimum standards and requirements for service, determines conditions that may jeopardize client health and safety, and identifies deficient practice areas;
- monitors providers' plans of correction to ensure that areas of inadequate care are corrected and comply with state and federal requirements; and
- takes enforcement actions if facilities are not in compliance with requirements.

By federal and state laws, both Regulatory Services and the Long-term Care Ombudsman Program have mandates to receive and investigate complaints. To expedite investigations, a Program Agreement explains their joint and individual responsibilities. See Supplement 13-A: Program Agreement at the end of this chapter.

Regulatory Services and the Long-term Care Ombudsman Program are mandated to investigate complaints. To expedite investigations, a Program Agreement explains our joint and individual responsibilities.

Important: The Long-term Care Ombudsman Program does not investigate whether alleged ANE happened. Regulatory Services determines if alleged ANE occurred in a facility.

Surveys and Licensures

Initial Licensure

Background checks are conducted on the individuals and corporations responsible for resident health and safety in nursing homes and assisted living facilities. Checks are made to ensure the responsible parties have a good history of operating long-term care facilities. If new owners and operators are added to a license, their backgrounds are also checked and must be approved for a license to remain valid.

For a facility to keep its license, the results of any inspection, follow-up visit, complaint investigation, and incident investigation must show the facility complies with current state licensure laws and rules.

- Nursing Homes
  To become a provider, a nursing home operator submits a license application, pays an annual fee, and the facility passes a health and life safety code inspection. Facilities choose to be private pay (licensed only), Medicaid- or Medicare-certified, or dually certified to be reimbursed for Medicaid and Medicare services.

- Assisted Living Facilities
  To become licensed, an applicant submits an application, completes Assisted Living Facility Pre-licensure computer-based training, pays an annual fee, and the facility passes a health and life safety code inspection. Under some circumstances, a facility can get licensed after a life safety inspection only.

Regulatory Services conducts surveys and licensing inspections of nursing facilities. The licensing inspection is usually conducted in conjunction with the annual recertification survey. These visits:

- are unannounced;
- may take place on any day of the week at any time of day;
- have results that are available to the public; and
- are resident-directed and outcome-oriented.

For assisted living facilities, Regulatory Services conducts similar licensure inspections, on average once every two years, to determine if the facility is in compliance with licensing standards. These standards are less rigorous than requirements of nursing homes.

Just like ombudsman visits, surveyor visits to facilities are unannounced. If you become aware of a scheduled Regulatory Services survey, it is a felony to disclose the information outside of the ombudsman program.

Purposes of a Survey

Surveys monitor whether nursing homes provide care and services to residents that meet licensing standards. In certified facilities, surveys also determine if the facility meets standards for participation in Medicare or Medicaid. Inspections include a sample of residents to gather information about facility compliance with requirements. Outcomes include both actual and potential negative outcomes, as well as failure of a facility to help residents achieve their highest practicable level of well-being.

They also monitor whether assisted living facilities provide services and care to residents that meet licensing standards.

Ombudsman Tip: Survey inspection reports and copies of other inspection reports must be made available to the ombudsman upon request to Regulatory Services.

Surveyors complete seven tasks during a standard survey.

1. Offsite preparation. Surveyors review the facility's history and identify any existing concerns. They may pre-select potential residents for the sample. They determine if any features of the facility require specialty surveyors, such as pharmacists and dieticians, to join the survey team. These surveyors may be onsite only for the portion of the survey relevant to their expertise.
2. Entrance conference and onsite preparatory activities. At the entrance conference, the team leader informs the administrator of the survey and introduces the team members. While the team leader requests additional information from the administrator, other team members may begin task 3, the initial tour.
3. Initial tour. Surveyors review the facility, staff, and residents, obtain an initial evaluation of the environment including the kitchen, confirm or invalidate any pre-selected concerns, and add concerns discovered during the tour.
4. Sample selection. Surveyors select a case-mix stratified sample of residents based on quality indicators (known as QIs) and other offsite and onsite sources of information in order to assess compliance with resident-centered requirements.
5. Information gathering. Surveyors make observations of the facility, kitchen, residents, quality of life assessments, medication passes, quality assessment and assurance review, and abuse prohibition review. They hold a resident group interview and ask standard questions about rights and care.
6. Information analysis for deficiency determination. Surveyors review the collected information and determine whether or not the facility failed to meet one or more of the regulatory requirements.
7. Exit conference. Surveyors inform the facility of their observations and the preliminary findings.

The purpose of a survey is to determine whether facilities meet licensing standards and whether the facility meets standards for _____ in Medicare or Medicaid.

Throughout the survey, the team discusses observations and information collected. Surveyors can extend a survey beyond the typical four days in a nursing home and one day in an assisted living facility.

If the facility is out of compliance with any regulations, they send an official statement of deficiencies to the facility within 10 working days after the end of a survey. The facility

must respond within 10 calendar days with a plan of correction for each item of noncompliance and establish a timeframe for correcting the problem. Regulatory Services will then conduct a follow-up visit, or conduct a desk review, to determine if the proposed corrections were made.

Complaint Investigations

A survey team may also conduct an abbreviated survey to investigate a complaint and determine if the facility violated any requirements. If a complaint specifies conditions on a certain day, such as on weekends, or during a particular shift, then the survey team should investigate on that day or during that time frame.

Substandard Quality of Care (SQC)

SQC indicates a systemic deficiency in quality of care and quality of life within a nursing home. For this designation, citations relate to the quality of resident care such as wound care. In addition, for this designation, the deficiency must be severe or impact several residents. An SQC finding indicates Regulatory Services found the nursing home to have had a significant deficiency (or deficiencies), which the home must address and correct quickly to protect the health and safety of residents.

Immediate Jeopardy (IJ) or Immediate Threat (IT)

An IJ or IT is a situation in which the provider's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or several residents. If surveyors identify an IJ to residents' health and safety, they notify the administration with specific details, including the individuals at risk, before the survey team leaves the facility. The facility must immediately implement corrective measures and faces daily fines until the problem is corrected. Only onsite confirmation by surveyors of the facility's corrective actions can remove IJ status.

SOURCE: Nursing Facility Requirements §19.409, Examination of Survey Results

Residents have the right to examine the results of the survey of a facility conducted by federal or state surveyors and any plan of correction.

The facility must make the results available for examination in a place readily accessible to residents, and must post notice of their availability.

Enforcement

The Enforcement Section of Regulatory Services may impose remedies on all licensed facilities and Medicaid-certified facilities. When surveyors determine a facility is out of compliance with licensure rules, they may send a warning letter to the facility. The letter notifies the facility that the violations of licensing rules must be corrected. The Enforcement Section may take one of several possible actions against an operator's license, and may take several actions simultaneously, including:

- suspension of a license;
- revocations of a license;
- emergency suspension and closing order;
- referral to the Attorney General;
- suspension of admissions; and
- administrative penalties, which range from $100 to $10,000 based on severity.

If a nursing facility is Medicaid-certified, additional compliance remedy options exist. Enforcement actions in a Medicaid-certified facility are recommended by Regulatory Services to CMS and have slightly different means of correction and appeal for the provider. Appeal options include informal dispute resolution arbitration, and appeal through CMS. Nursing facility Medicaid enforcement actions include:

- imposition of civil money penalties; and
- termination of the provider agreement (loss of Medicaid contract).

Administrative Penalties

Administrative penalties are created by state law and rule. Most administrative penalties allow a facility to correct the problem and remove the penalty. Some violations are <u>not</u> eligible for the right to correct, including:

1. a violation that:
    - results in serious harm or death to a resident,
    - is a serious threat to the health or safety of a resident, or
    - substantially limits the facility's capacity to provide care;
2. specific portions of the criteria for denying a license; or
3. a violation of a resident right.

Ask the Trainer: Enforcement

Which enforcement action have you seen most commonly taken?

_____

Amelioration

Amelioration is a term used in enforcement to describe the option to make facility improvements with money imposed as a penalty. Amelioration allows a facility to submit a plan for approval by the State of Texas. The plan must propose how part of the administrative penalty will be used to improve services in a nursing home or assisted living facility. Rules apply.

Trustee Appointment

With assistance from the Office of the Attorney General, Regulatory Services may petition a Travis County court for the involuntary appointment of a trustee. This enforcement action is rare as it is costly and likely results in the forced closure of the facility and relocation of all residents. Regulatory Services argues its case to the court and the facility has an opportunity to make counter arguments. If a trustee is appointed, the trustee controls all facility operations and serves as an officer of the court until dismissed by the court.

Another option of a trustee placement is by agreement between Regulatory Services and the facility operator. In the case of a trustee by agreement, the operator pays all costs for the trustee. In practice, operators are more likely to hire a consultant to serve this function and not formally agree to a trustee.

Credentialing

Many types of personnel work in nursing homes and assisted living facilities. Professional boards license physicians, nurses, pharmacists, social workers, and others are regulated by state agencies and boards. The programs are regulated in the same agency as Regulatory Services.

Nursing Facility Administrator (NFA) Licensing and Investigations Program

- Issuance, renewal, revocation of a license, as well as continuing education
- Investigate complaints or referrals resulting from findings of substandard quality of care and violations of the NFA standards of conduct
- Impose and monitor sanctions
- Provide quarterly training for administrators in training

Nurse Aide Registry

- Maintain a registry of all nurse aides who are certified. Certified Nurse Aides are required to have:
  - participated in a state-approved nurse aide training and competency evaluation program: 60 classroom hours; 40 hours clinical training
  - passed skills and written portions of the competency evaluation program test

- review and investigate allegations of abuse, neglect, or misappropriation of resident property by nurse aides

Medication Aide Program

- Issue and renew Medication Aide permits and review continuing education
- Impose sanctions
- Approve and monitor medication aide training programs
- Develop educational, training, and testing curricula
- Coordinate and administer tests

All long-term care facilities must check the Nurse Aide Registry and Employee Misconduct Registry on the state website (*https://emr.dads.state.tx.us/DadsEMRWeb/*) before hiring a person. This will determine if the person is listed as having committed an act of abuse, neglect, exploitation, misappropriation, or misconduct against a resident or consumer, and is therefore, unemployable.

All nursing home and assisted living facility employees must be determined employable. Operators must check what two registries?

1. _____
2. _____

Resources

Within state government, agencies hold authorities and responsibilities that may impact people who live and work in nursing homes and assisted living facilities. Long-term care ombudsmen interact with agency staff on various levels. Ombudsmen most often work with staff in divisions of the following agencies:

- Health and Human Services Commission
- Department of Family and Protective Services

Center for Policy and Innovation

Quality Monitoring Program (QMP)

The Quality Monitoring Program (QMP) provides an educational - rather than regulatory - approach to quality improvement in facilities.

QMP helps providers improve services and supports, so the right thing is done for the right person at the right time. To promote the highest quality services and supports, the program shares best practices for specific focus areas such as pain management, managing fall risk, and use of antipsychotics.

QMP is not a regulatory program. Quality monitors do not cite nursing homes or assisted living facilities for deficient practices. Staff includes nurses, dietitians, pharmacists, psychologists, and social workers. Located across Texas, they work together with providers to implement best practices. Through partnerships, providers and monitors assess and strengthen facility clinical systems to improve resident outcomes.

The Quality Monitoring website was developed by the Center for Policy and Innovation (CPI). This website will direct you to a variety of resources and initiatives that are resources for ombudsmen to share with facility staff or to learn more about evidence-based best practices for providers:
http://www.dads.state.tx.us/providers/qmp/about.html.

Preadmission Screening and Resident Review (PASRR)

The Preadmission Screening and Resident Review (PASRR) process is a federal requirement to ensure that people are not inappropriately placed in nursing homes. It requires all applicants, prior to admission to a Medicaid-certified nursing home, are assessed to determine whether they might have mental illness, an intellectual disability, or a developmental disability. The preadmission screening is called a "PASRR Level I Screen."

- If an individual's PASRR Level I (PL1) screen is negative, the person is not suspected of having a mental illness, an intellectual disability, or a developmental disability. The PASRR process ends for that person.
- If the person's PASRR Level I screening is positive, additional screening is provided. For a person with an intellectual disability, a professional from a local intellectual and developmental disability authority (LIDDA) completes and submits an in-depth PASRR II evaluation. For a person with a mental illness, a local mental health authority (LMHA) responds.

PASRR evaluations help determine the most appropriate setting, and help to develop recommendations for specialized services for the person's plan of care.

See Supplement 11-C: *PASRR Excerpt from Nursing Facility Requirements for Licensure and Medicaid Certification* for a detailed discussion of the process.

Client Trust Fund – Nursing Homes

Residents have the right to manage their financial affairs or designate other people to do so. Some residents deposit personal funds with the nursing home. Families and guardians often want facilities to assume this responsibility. If residents deposit their funds, staff manages resident funds but must keep them separate from facility funds.

To safeguard Medicaid-eligible residents' money, nursing homes use an accounting system for their incomes and expenses. Trust Fund Monitors audit facility systems that include:

- A collective bank account for all participating residents;
- Individual resident files showing all deposits and withdrawals;
- A petty cash fund to provide small amounts of money; and
- Receipt files for each resident of all purchases and payments made by and for that resident.

When a resident dies or moves, the nursing home closes the resident's trust fund account. Within 30 days of death, the facility must release the resident's funds to the individual or probate jurisdiction managing the estate. If the resident moves, the facility releases the funds within five days. Details about nursing home trust funds are in Protection of Personal Funds NFR §19.404, which is part of the resident's rights section of nursing home rules. Assisted living facility licensing standards do not address resident trust funds.

Promoting Independence

Money Follows the Person (MFP)

The Promoting Independence initiative came about as a result of the 1999 Supreme Court decision known as Olmstead, which upheld the rights of individuals with disabilities to receive services and supports in the setting of their choice and in the least restrictive setting possible. MFP allows residents to move out of nursing homes to receive services in the community. They bypass any waiting list for long-term services and supports (Medicaid waiver services). In 2008 the state was awarded a federal grant from CMS called the MFP Demonstration. The state receives extra federal funding for people who choose to participate in the MFP Demonstration. The grant provides federal funding for a variety of efforts that supports a person's choice to live in the community (home, apartment, assisted living) instead of an institutional setting (nursing home). The Long-term Care Ombudsman Program is part of the grant, and received funds to support our work from 2012-2016.

To support people who choose to relocate to the community, relocation contractors across the state hire relocation specialists. Specialists work with residents and managed care service coordinators to explore their interest in returning to the

community. Residents have a right to interact with relocation specialists to get information about moving back to the community. Specialists educate residents and identify those who want to access community services through MFP.

Nursing home administrators and staff must support and assist in all MFP activities. Facilities should give relocation specialists private access to residents, along with family and others with the resident's approval, and provide access to clinical records and other documentation as needed.

Department of Family and Protective Services (DFPS)

Adult Protective Services (APS)

APS investigates abuse, neglect, and exploitation of adults who are age 65 or older, and age 18-64 with a disability.

APS caseworkers investigate reported abuse, neglect, or exploitation to determine if the reported situation exists and to what extent it adversely affects the elder or adult with disabilities. They must initiate an investigation within 24 hours of receipt of the report by DFPS. Through assessments, they determine the alleged victims' situations and needs as well as identify and address root causes.

To lessen or prevent further mistreatment, caseworkers provide or arrange for services such as financial help for rent and utilities, social and health services, and referrals to a Guardianship Program. Caseworkers may provide direct services, arrange services by others, or purchase services on a short-term, emergency basis.

For people who live in nursing homes, assisted living facilities, and other institutions, APS investigates financial exploitation if the alleged perpetrator lives in the community. If abuse, neglect, or exploitation happen within a facility by staff or others, Regulatory Services staff investigates.

Refer to Supplement 13-B: *Memorandum of Understanding* (Between APS and Long-term Care Ombudsman Program) for more information about how these two programs work together.

Health and Human Services Commission (HHSC)

Fair and Fraud Hearings

The Fair and Fraud Hearings section of the HHSC Appeals Division receives appeal requests from applicants and clients to contest actions taken regarding benefits and services. The programs include all Medicaid-funded services, the Supplemental Nutrition Assistance Program (formerly known as the Food Stamp Program), and other agency programs required by law or rule to provide the right to a fair hearing.

Fair and Fraud Hearings provide accessible, neutral forums to conduct administrative hearings while issuing just and impartial decisions with respect for the dignity of individuals and their due process rights. Hearings officers' conduct the hearings, consider evidence, and issue decisions in accordance with rules, regulations, and laws.

State and federal laws require hearings officers to be impartial and to not have prior knowledge of any case. They may only consider evidence and testimony provided at the hearing to make a decision on a case.

Most hearings are held by phone but may be face-to-face if requested. The date, time, and call-in number are in the hearing notice. Once everyone is in attendance, the hearings officer explains what will happen and swears in everyone. The agency representative explains the action they took. Then appellants ask questions and explain why they disagree with the agency's action or inaction.

Hearings officers must issue a decision no later than 90 days from the date of the appeal request. Some circumstances could extend the time. Appellants have 30 days from the date on the decision to ask the hearings officer to reopen an appeal.

Office of Eligibility Services

Staff who determine Medicaid eligibility are called eligibility workers and are often responsible for handling other benefit applications. Duties of these workers include interviewing applicants and verifying application information, as well as helping clients to obtain necessary documentation. Authorizing approval for benefits, maintaining records, and investigating possible fraud are other required activities.

Residents interact with Medicaid eligibility (ME) workers if and when they apply for the Medicaid program or if they want to appeal a discharge from the nursing home. ME workers almost always provide assistance over the telephone because they assist clients all over the state. Ombudsmen may contact ME workers to assist in overcoming any barriers to services for a resident, to get information about eligibility or the application process, and to initiate an appeal request on behalf of a resident.

Nursing Home Discharge Appeal

If a nursing home resident wants to stay in a facility while a discharge appeal decision is made, the nursing home resident has 10 days from the date of the notice to request an appeal with the Office of Eligibility Services. Otherwise, the resident has 90 calendar days from the date of the notice to request an appeal. (Assisted living facility residents do not use this appeal process.)

To file a discharge appeal, fax the request to the statewide fax intake for appeals at (866) 559-9628*. An ombudsman can help with this step. The request should include:

- Resident's name

- Date of birth
- Social security or Medicaid number
- Facility name and address
- Name(s) of anyone who will serve as a witness or representative for the resident, including address and phone number
- Need for interpreter, if applicable
- A copy of discharge notice, if possible
- Signature of the resident or authorized representative
- Date

The resident or resident's representative is not required to notify the nursing home.

SOURCE: Fraud and Fair Hearings Handbook, TAC §357.3 **and** Title 40, TAC§19.502, Part 1, Chapter 19, Subchapter F

*If you have trouble faxing to this number, fax the request to TIERS in Midland. (877) 447-2839

KEPRO – Medicare Quality Improvement Organization (QIO)

KEPRO is a QIO that works under contract with the CMS. KEPRO is a resource for residents who are Medicare recipients. Residents who are not satisfied with the quality of care received, the discontinuation of skilled nursing services, or Medicare discharge plans, can call the KEPRO Medicare Beneficiary Helpline at 1-844-430-9504. A complaint form can be downloaded from the company's website at www.keproqio.com/bene/helpline.aspx.

More information about QIOs may be found on the CMS website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html

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Exercise: Help! – Identify the Right Resource

Write the program or the best person to help solve each problem. To take action on a resident's behalf, you always need resident consent. For this exercise, assume you obtained consent from the resident.

1. Mrs. Cash moved to a new nursing home. She asks for her personal funds deposited with the home and is told no money is available.

   _____

2. When Mr. Rich moved in, he was private pay. Now he has spent down to a total of $2,000 in his accounts. Where does he apply for Medicaid?

   _____

3. You notice numerous residents are restrained. Facility staff says they use physical restraints to prevent falls, but they want to learn best clinical practices to keep residents safe.

   _____

4. Mr. Brown's bill hasn't been paid for the past three months. His dementia got worse and his son started paying. The business office manager believes the son is paying his own house payments out of his dad's money.

   _____

5. Each time you visit Ms. Morrow, she talks about moving out of the nursing home because everyone is old and she believes she could live in an apartment.

   _____

6. The nursing home sent Mr. Chang a 30-day discharge notice that they cannot meet his needs. He doesn't understand because other residents are in the same condition. He wants to stay.

   _____

Ombudsman Role

With regulators and other agency resources, ombudsmen communicate professionally as advocates and work on behalf of residents with their consent. They maintain resident and complainant confidentiality.

A member of the Regulatory Services survey team should contact the local ombudsman program within two hours of entering a facility to ask about concerns and to say when the resident group interview is scheduled. With resident and complainant permission, ombudsmen provide resident names to include in the survey sample or for record review, and family members for interviews. Ombudsmen may attend the resident group meeting if invited by residents, attend the exit interview, and participate in other activities as agreed upon.

Ombudsmen also describe systemic or serious concerns they have not been able to resolve. Generally, ombudsmen do not report complaints they are currently working to resolve as it may trigger the surveyors to investigate the same issue.

If you arrive at a nursing home or assisted living facility while Regulatory Services is conducting a survey, introduce yourself to the lead surveyor, provide relevant

information about the facility, and exit the building unless you plan to attend the resident group interview. This signals to residents and facility staff that surveyors are regulators and ombudsmen are advocates.

While educating, advocating, or solving problems, ombudsmen may consider supports and services at agencies and programs. Before using outside resources, discuss the situation with your supervising staff ombudsman. By contacting these resources or referring others to them, staff with in-depth knowledge of their agency programs provide answers in the most effective and efficient manner. With consent from residents and complainants, provide detailed information to help reach resolution appropriately and quickly.

If you make referrals, follow up with the residents to see if they received answers to their questions, information about their issues, or resolution to their problems. If not, ask whether they want you to take further action or pursue a different approach. Even when you refer a problem to another resource, it's your responsibility to follow-up and follow-through with the case. Assign a disposition to each complaint based on the resident's or complainant's feedback on resolution.

Supplement 13-A: Program Agreement
(Between Long-term Care Ombudsman Program and Regulatory Services)

http://www.dads.state.tx.us/handbooks/oppm/res/Program%20Agreement%20Between%20LTC%20OP%20and%20RS.pdf

Supplement 13-B: Memorandum of Understanding
(Between DFPS Adult Protective Services and Long-term Care Ombudsman Program)

http://www.dads.state.tx.us/handbooks/oppm/res/signed-MOU-feb2010.pdf

Supplement 13-C: PASRR Excerpt from Nursing Facility Requirements for Licensure and Medicaid Certification

Subchapter BB, Preadmission Screening and Resident Review

§19.2701 Purpose

The purpose of this subchapter is to:

(1) describe the requirements of a nursing facility related to preadmission screening and resident review (PASRR), which is a federal requirement in Code of Federal Regulations, Title 42, Part 483, Subpart C to ensure that:

(A) an individual seeking admission to a Medicaid-certified nursing facility and a resident of a nursing facility receives a PASRR Level I screening (PL1) to identify whether the individual or resident is suspected of having mental illness (MI), an intellectual disability (ID), or a developmental disability (DD); and

(B) an individual or resident suspected of having MI, ID, or DD receives a PASRR Level II evaluation (PE) to confirm MI, ID, or DD and, if confirmed, to evaluate whether the individual or resident needs nursing facility care and specialized services; and

(2) describe the requirements of a nursing facility related to a designated resident who receives service planning and transition planning.

§19.2704 Nursing Facility Responsibilities Related to PASRR

(a)If an individual seeks admission to a nursing facility, the nursing facility:

(1) must coordinate with the referring entity to ensure the referring entity conducts a PL1; and

(2) may provide assistance in completing the PL1, if the referring entity is a family member, LAR, other personal representative selected by the individual, or a representative from an emergency placement source and requests assistance in completing the PL1.

(b) A nursing facility must not admit an individual who has not had a PL1 conducted before the individual is admitted to the facility.

(c) If an individual's PL1 indicates the individual is not suspected of having MI, ID, or DD, a nursing facility must enter the PL1 from the referring entity into the LTC Online Portal. The nursing facility may admit the individual into the facility through the routine admission process.

(d) For an individual whose PL1 indicates the individual is suspected of having MI, ID, or DD, a nursing facility:

(1) must enter the PL1 into the LTC Online Portal if the individual's admission category is:

(A) expedited admission; or

(B) exempted hospital discharge; and

(2) must not enter the PL1 into the LTC Online Portal if the individual's admission category is pre-admission.

(e) Except as provided by subsection (f) of this section, a nursing facility must not admit an individual whose PL1 indicates a suspicion of MI, ID, or DD without a complete PE and PASRR determination.

(f) A nursing facility may admit an individual whose PL1 indicates a suspicion of MI, ID, or DD without a complete PE and PASRR determination only if the individual:

(1) is admitted as an expedited admission;

(2) is admitted as an exempted hospital discharge; or

(3) has not had an interruption in continuous nursing facility residence other than for acute care lasting fewer than 30 days and is returning to the same nursing facility.

(g) A nursing facility must check the LTC Online Portal daily for messages related to admissions and directives related to the PASRR process.

(h) Within seven calendar days after the LIDDA or LMHA has entered a PE or resident review into the LTC Online Portal for an individual or resident who has MI, ID, or DD, a nursing facility must:

(1) review the recommended list of nursing facility specialized services, LIDDA specialized services, and LMHA specialized services; and

(2) certify in the LTC Online Portal whether the individual's or resident's needs can be met in the nursing facility.

(i) After an individual or resident who is determined to have MI, ID, or DD from a PE or resident review has been admitted to a nursing facility, the facility must:

(1) contact the LIDDA or LMHA within two calendar days after the individual's admission or, for a resident, within two calendar days after the LTC Online Portal generated an automated notification to the LIDDA or LMHA, to schedule an IDT meeting to discuss nursing facility specialized services, LIDDA specialized services, and LMHA specialized services;

(2) convene the IDT meeting within 14 calendar days after admission or, for a resident review, within 14 calendar days after the LTC Online Portal generated an automated notification to the LIDDA or LMHA;

(3) participate in the IDT meeting to:

(A) identify which of the nursing facility specialized services, LIDDA specialized services, and LMHA specialized services recommended for the resident that the resident, or LAR on the resident's behalf, wants to receive; and

(B) determine whether the resident is best served in a facility or community setting.

(4) provide staff from the LIDDA and LMHA access to the resident and the resident's clinical facility records upon request from the LIDDA or LMHA;

(5) enter into the LTC Online Portal within 3 business days after the IDT meeting for a resident:

(A) the date of the IDT meeting;

(B) the name of the persons who participated in the IDT meeting;

(C) the nursing facility specialized services, LIDDA specialized services, and LMHA specialized services that were agreed to in the IDT meeting; and

(D) the determination of whether the resident is best served in a facility or community setting;

(6) include in the comprehensive care plan:

(A) the nursing facility specialized services agreed to by the resident or LAR; and

(B) the nursing facility PASRR support activities;

(7) if Medicaid or other funding is available:

(A) initiate nursing facility specialized services within 30 days after the date that the services are agreed to in the IDT meeting; and

(B) provide nursing facility specialized services agreed to in the IDT meeting to the resident; and

(8) for a resident who is a Medicaid recipient, annually document in the LTC Online Portal all nursing facility specialized services, LIDDA specialized services, and LMHA specialized services currently being provided to a resident.

§19.2708 Educational and Informational Activities for Residents

A nursing facility must:

(1) allow access to residents by representatives of the Office of the State Long Term Care Ombudsman and Disability Rights Texas to educate and inform them of their rights and options related to PASRR;

Notes:

Ombudsman Certification Training

CHAPTER 14: Resident-directed Care

Resident-directed Care

Chapter 14 is about nursing homes and assisted living facilities providing care based on what each individual resident wants and needs and involving residents, family members, staff, and management. “Resident-directed care” is the goal.

Learning Objectives

- Increase knowledge of individualized care as directed by the resident
- Be aware of reasons why facilities are changing
- Know major components of resident-directed care
- Distinguish between resident-directed and traditional practices

Contents

- Resident-directed Care and Culture Change
- Traditional Care Practices
- Person-directed Practices
- Connecting Regulatory Compliance with Resident-directed Care
- Language of Long-term Care

DVD(s), Supplements, Forms

- Mystery Game
- DVD: CMS Hand in Hand Training Module 4: Being with a Person with Dementia: Actions and Reactions
- Internet Video: Dining With Friends

Resident-directed Care and Culture Change

A nursing home must “care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.” Based on the Nursing Home Reform Law of 1987, this requirement emphasizes dignity, choice, and self-determination for the people who live in nursing homes.

Even with laws emphasizing the need to focus on each resident, many nursing homes continue to provide institutionalized care based on a medical model. Since the 1990s, advocates, regulators, and providers have been working to more effectively blend a medical model with a social model. This transformation movement is known as culture change.

Like a nursing home, an assisted living facility is responsible for all care provided to residents. Residents should receive the kind and amount of supervision and care they require to meet their basic needs. No federal regulations exist for assisted living facilities, but in Texas, facilities must comply with Licensing Standards for Assisted Living Facilities.

While residents who live in assisted living tend to be more independent, the facilities also risk becoming institutionalized. Culture change principles can transform assisted living facilities the same as nursing homes.

Culture Change

- Culture change - a movement working to radically transform facility care and help facilities transition from institutions to homes
- Person-directed care - residents make decisions about individual routines of daily life, as well as directly influence how their home operates

Culture change is a philosophy that focuses on fostering a person-centered, and ideally a person-directed, care system. Person-directed care means the resident actively determines the course of his or her life in daily activities, care, and choices. When a resident cannot fully direct personal care, because of physical or cognitive disabilities, caregivers and advocates look to the person’s expressed wishes for clues to provide resident-centered care.

Culture change is a philosophy that focuses on fostering a person-centered, and ideally a person-directed, care system. Person-directed care means the resident actively determines the course of his or her life in daily activities, care, and choices.

Clues can come from advance care planning documents, known or previously expressed wishes, lifelong preferences, and input from family and friends. Person-centered and person-directed care requires regular communication with the resident to learn the resident's wishes and to create opportunity for the person to exercise choice and control over his or her life. Ombudsmen are trained to follow this same principle as we work to protect resident rights and resolve complaints.

Care providers report that a commitment to culture change improves the quality of care and life for residents and the quality of work experience for staff.

Continuum of Resident-directed Culture

Sue Misiorski and Joanne Rader developed this continuum of direction to the differences between staff-directed and person-directed culture. Staff directed cultures are low on the continuum of resident-directed care. The progression of resident-directed culture is outlined below.

Low — Continuum of Person-directedness — High

Provider-directed

Management makes most decisions with little conscious consideration of the impact on residents or staff.
Residents accommodate staff preferences and are expected to follow existing routines.

Staff-centered

Staff consults residents or puts themselves in the residents' place while making the decisions.
Residents accommodate staff much of the time but have some choices within existing routines and options.

Resident-centered

Resident preferences or past patterns form the basis of decision-making about some routines.
Staff begins to organize routines to accommodate expressed or observed resident preferences.

Resident-directed

Residents make daily decisions about individual routine. When not capable of stating needs, staff honor habits and observed preferences.
Staff organizes their hours, patterns, and assignments to meet resident preferences.

The State of Texas supports moving nursing homes and assisted living facilities away from institutional models to person-directed models. The initiative expands the focus of care to include not only clinical and safety concerns but also residents' quality of life, relationships, and respect for individual needs and wishes.

Words can affect our ability and willingness to change by influencing how we see the people and places around us. Words can make a difference, such as calling a child difficult rather than high-spirited, or the grocery store clerk slow instead of careful.

Changing our language can lead to changing our perspective on the places residents call home. For help with the exercise below, refer to the *Language of Long-term Care* table at the end of this chapter.

Exercise: Suggest how traditional words could be replaced with words that emphasize the person.

1. Nursing facility _____
2. Staff _____
3. Resident _____
4. Hallway/unit_____
5. Nourishment _____
6. Pet therapy _____
7. Activities room _____
8. Resident council _____
9. Therapy room _____
10. Meal tray _____

Traditional Care Practices

Traditional practices focus on the efficiency of business. Many nursing homes are large physical buildings based on efficiency principles to maximize economies of scale and get things done quickly, smoothly, and routinely. Power is held by managers and corporate staff.

For efficiency, management tightly controls staff life. Direct care staff voice concerns including:

- Lack of respect
- Not being valued by the organization
- Lack of good leadership role models
- Stress of working short staffed
- Lack of empowerment or adequate training
- Limited opportunities for growth

Facility practices encourage absenteeism:

- Incentives to waive benefits
- Denial of pay for absences less than two days
- Use-it-or-lose-it sick pay
- Rotating staff assignments; not having consistent caregivers inhibits relationships between residents and caregivers

Person-directed Practices

The person-directed care model involves three interconnected areas: environment, care, and work. Changes can range from simple and inexpensive to complex and costly.

Environmental

- Create a home with a sense of community and safety for residents and staff.
- Demonstrate affection, validation, and support.
- Shift toward neighborhoods and communities within a building.
- Reduce noise from overhead paging with pagers or wireless phones.
- Change centralized nursing stations to several nursing areas.
- Exchange medication carts for locked medication storage in resident rooms.
- Remove institutional signage.
- Serve meals from a buffet or use table service rather than using trays.
- Construct private rooms and private baths.
- Build smaller houses where 10-12 residents live together with a caregiver.

Care

- Use creative care solutions based on resident preferences.
- Be flexible about waking and sleeping times.
- Make dining more personal and pleasant.
- Accommodate resident bathing preferences.
- Create and honor rituals and celebrations.
- Design social activities based on individual and group preferences.
- Staff promotes individuality and normalcy and gives residents as much choice and control as possible.

Workplace

- Establish relationships as the number one organizational priority.
- Promote high quality leadership.
- Value and respect caregivers and their needs.
- Develop leadership opportunities for direct care staff.
- Assign direct care staff consistently to the same residents.

How can person-directed care improve quality of life in nursing homes and assisted living facilities?

_____

_____

_____

Comparing Models of Care

Traditional	Staff provides standardized treatments based on medical diagnosis
Person-directed	Staff establishes care based on individualized care needs and personal wishes
Traditional	Facility designs schedules and routines; staff and residents comply
Person-directed	Flexible schedules and routines match resident needs and wishes
Traditional	Task-oriented work; staff rotates assignments and knows how to perform tasks on any resident
Person-directed	Relationship-centered work; consistent staff assignments brings personal knowledge of residents into caregiving

Traditional Person-directed	Management makes all decisions Residents and those close to them make decisions
Traditional Person-directed	Facility is staff's workplace Facility is resident's home
Traditional Person-directed	Isolation, loneliness, and feeling of homelessness are common Residents and staff share a feeling of community and belonging
Traditional Person-directed	Resident adapts to facility Facility adapts to the resident. Residents make decisions about their daily routines such as waking, sleeping, dining, bathing, and participating in activities
Traditional Person-directed	Medical model focus Staff supports quality of life with quality of care by considering the resident's spiritual, mental, and physical well-being in all decisions
Traditional Person-directed	Impersonal work practice Facility involves employees, residents, and family to support relationships; invests in staff through time, education, and commitment
Traditional Person-directed	Authoritarian process Facility creates opportunities where individuals make decisions and take greater responsibility to better the home and their lives and implements a team-driven change process
Traditional Person-directed	Resident sees the nursing home as a place to die Rituals and celebrations acknowledge life and establish an environment where everyone thrives and grows • noting large and small accomplishments • celebrating the lives of residents and employees • supporting life and growth through daily activities providing purpose, diversity, and spontaneity

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List two differences between traditional care practices and person-directed care practices.

Traditional _____

Person-directed _____

Traditional _____

Person-directed _____

Activity: Mystery Game

Objectives:
This game introduces person-directed thinking through three objectives:

1. Recognize how current circumstances and culture inadvertently create problems.
2. Apply person-directed thinking to develop solutions for the resident.
3. Understand that changing to more person-directed practices requires changes in the entire facility system and all departments.

Directions:
Starting with a set of 42 clues, hand out the clues, face up, as if dealing a deck of cards. Everyone at the table will have several clues. Game time is about 20 minutes.

Each card contains pieces of information about Thomas McNally who lives in a nursing home. Information is clinical and personal. All the information is necessary to solve the mystery.

After all clues are handed out, everyone shares their clues with each other to solve the mystery. The facilitator can document answers on a board or chart.

Discussion:
The group answers the following:

- How are facility routines contributing to Mr. McNally's decline?
- What clues do you have about his strengths and interests?
- How can staff use his strengths and interests to start a person-directed approach that may reverse his decline?
- What changes in his routine need to be put in place? What changes in facility routine need to happen so his personal routines can be restored?
- What additional information is needed?
- Who else needs to be involved in the discussion?

Additional Discussion
Learn the word "i-atro-gen-e-sis," which is Greek for "we caused it." A formal definition is "inadvertent and preventable induction of disease or complications by the medical treatment or procedures of a physician." This term describes a clinical problem caused by clinical treatment. Draw a parallel to using restraints: while used for safety, they unintentionally cause harm.

Other facility routines meant to provide care for residents inadvertently harm them. Centering care around a person's routines, instead of facility routines, can reverse this harm and help people thrive.

What can an ombudsman do to help a facility implement person-centered care planning?

_____

_____

_____

CMS Hand in Hand Training – Module 4: Being with a Person with Dementia: Actions and Reactions

Run Time: Approximately 1 hour to view video clips and discuss

When we think about behaviors of persons with dementia, we may often think of them as negative, bad, or challenging. When we reframe behaviors as actions and reactions, it helps us understand that behaviors are a form of communication.

There are many reasons why a resident with dementia might act the way they do. These reasons might be related to health conditions, medications, communication, the environment, the task itself, unmet needs, a resident's life story, and your interaction with that resident. When we understand the meaning of the actions and reactions of the resident, we are better able to respond to them and fulfill their needs.

Answer the following questions about CMS *Hand in Hand Module 4*.

1. All behaviors or actions are a form of _____. We must try to understand their world.
2. List three possible reasons behind the actions or reactions of an individual with dementia:
   a) _____
   b) _____
   c) _____
3. Medications can contribute to changes in a resident's actions. Any change in a resident's behavior or condition should be _____ immediately.
4. In the *I Want to Go Home* video clip, why might Mrs. Caputo say she wants to go home?
   a) _____
   b) _____

c) _____

5. In coming up with ways to respond to actions and reactions, what are the three 'P's' you should think about? Define the three P's.
   a) _____
   b) _____
   c) _____

Connecting Regulatory Compliance with Resident-directed Care

Facility staff may find it challenging to connect culture change principles and regulatory compliance. The Centers for Medicare and Medicaid (CMS) State Operations Manual provides interpretive guidelines on how to conduct nursing home surveys and determine compliance. The manual is routinely updated and many culture change principles are incorporated.

This section reviews several State Assisted Living Standards, and Nursing Facility Requirements. It is adapted from training designed for providers and surveyors to understand and support culture change in Texas nursing homes.

In light of person-directed principles of respect, choice, empowerment, relationships, and community, ombudsmen help influence how facilities can change. When reviewing the following pages, think about how assisted living facilities and nursing homes can comply with regulations and be resident-directed.

Exercise: Practice Connecting Regulatory Compliance with Resident-directed Care

Directions:
Review the following regulations for nursing homes (TAC §19) and assisted living facilities (TAC §92). Answer the correlating questions to practice promoting resident-directed care.

Introduction

Nursing Homes
§19.401 **F-150**

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident.

Assisted Living Facilities
§92.1 (b)

Assisted living services are driven by a philosophy that emphasizes personal dignity and autonomy to age in place in a residential setting while receiving increasing and decreasing levels of services as the person's needs change.

List some practices a facility can do to promote dignity and choice?

- Build relationships with residents, families, and physicians to understand residents as individuals and provide care according to resident preferences.
- Enable residents to self-administer medications if they want to and it is safe.
- _____
- _____

Notice of Rights and Services

Nursing Homes
§19.403 **F-154**

(h) The resident has the right to refuse treatment, to formulate an advance directive, and to refuse to participate in experimental research.

Assisted Living Facilities
§92.125 (a) (P)

The resident has a right to be given the opportunity to refuse medical treatment or services after the resident is advised of the possible consequences and acknowledges understanding.

How can a care provider support resident-directed care, including the right to refuse care?

- Learn the person's cultural and spiritual practices and how they may affect treatment decisions.
- Determine exactly what service a resident is refusing and why.
- _____
- _____

Grievances

Nursing Homes
§19.408 **F-165**

A resident has the right to voice grievances without discrimination or reprisal.

Assisted Living Facilities
§92.125

(a)(3)(H) A resident has a right to complain about the resident's care or treatment. The complaint may be made anonymously or communicated by a person designated by the resident. The provider must promptly respond to resolve the complaint. The provider must not discriminate or take punitive action against the resident who makes a complaint

How can the right to complain be assured?

- Empower residents to feel comfortable voicing complaints to the ombudsman, facility staff, and family members to find a solution to their complaints.
- Empower resident and family groups to help resolve conflicts, grievances, and complaints, thus keeping problems close to their source.
- _____
- _____

Privacy and Confidentiality

Nursing Homes
§19.407 **F-164**

The resident has the right to personal privacy and confidentiality of his personal and clinical records.

1. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.
2. The resident may approve or refuse the release of personal and clinical records to any individual outside of the facility.
3. The resident's right does not apply when transferred to another health care institution; record release is required by law; or during surveys.

Assisted Living Facilities
§92.125 (a) (Q) & (R)

A resident has a right to unaccompanied access to a telephone at a reasonable hour or in case of an emergency or personal crisis. A resident also has a right to privacy, while attending to personal needs and a private place for receiving visitors or associating with other residents, unless providing privacy would infringe on the rights of other residents. This right applies to medical treatment, written communications, telephone conversations, meeting with family, and access to resident councils. If a resident is married and the spouse is receiving similar services, the couple may share a room.

Assisted Living Facilities
§92.41 (h) (1)

Records that pertain to residents must be treated as confidential and properly safeguarded from unauthorized use, loss, or destruction.

How can privacy be respected and allow residents to thrive?

- Teach staff that only persons directly involved in providing treatments, delivering care, or to whom the resident has given consent can be present during care.
- Ensure privacy when residents go to the bathroom and receive other hygiene care.
- _____
- _____

Ombudsman Access

Nursing Homes
§19.413 Access and Visitation Rights (a) **F-172**

A resident has the right to have access to, and the facility must provide immediate access to a resident to a representative of the Office of the State Long Term Care Ombudsman.

Assisted Living Facilities
§92.801 Access to Residents and Records by the Long-term Care Ombudsman Program (a)

A resident has the right to be visited by, and a facility must provide immediate access to any resident to:

(1) a staff person of the Office of the State Long-term Care Ombudsman (the Office) employed by DADS;
(2) a certified ombudsman; and
(3) an ombudsman intern.

How can ombudsmen respect residents' privacy?

In rooms:

_____

Visiting a resident with a complaint:

_____

Investigating a complaint:

_____

Accessing resident's medical records:

_____

Quality of Life

Nursing Homes
§19.701 **F-240**

A facility must care for its residents in a manner and environment that promotes maintenance or enhancement of each resident's quality of life.

Suggest some changes in facility environments to enhance quality of life.

- Furnish the home with personal items, such as pictures and furnishings that belong to the residents.
- Offer parties, dinners, and celebrations.
- Provide a variety of spiritual opportunities, such as speakers, services, and music.
- _____
- _____

Dignity

Nursing Homes
§19.701(1) **F-241**

The facility must promote care in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of individuality.

Assisted Living Facilities
§92.125

(a) (E) A resident has a right to be treated with respect, consideration, and recognition of his or her dignity and individuality, without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. This means that the resident has a right to make his/her own choices regarding personal affairs, care, benefits, and services; has the right to be free from abuse, neglect, and exploitation; and if protective measures are required, has the right to designate a guardian or representative to ensure the right to quality stewardship of his/her affairs.

How can resident dignity, respect, and individuality be enhanced?

- Get resident input before choosing a radio or television station.
- Offer choice of paint colors to decorate rooms.
- _____
- _____

Activities

Nursing Homes
§19.702 **F-248**

The facility must provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, interest, and the physical, mental, and psychosocial well-being of each resident.

Assisted Living Facilities
§92.41 (b)

A facility must provide an acitivity and/or social program at least weekly for the residents.

Assisted Living Facilities
§92.51 Alzheimer's Certified Facilities (g)

A facility must encourage socialization, cognitive awareness, self-expression, and physical activity in a planned and structured activities program. Acitivities must be individualized, based upon the resident assessment, and appropriate for each resident's abilities.

How can a home provide meaningful activities that offer interesting activity for all?

- Incorporate lifelong interests into activity options.
- Consider male and female, all ages, and various cultures and religions.
- _____
- _____

Quality of Care

Nursing Homes
§19.901 **F-309**

Each resident must receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

How can care practices help a person attain physical and mental well-being?

- Ensure direct care staff recognize and know how to report changes in a resident's condition.
- Develop a staff training program with opportunities for interactive learning and resident participation.
- _____

Food

Nursing Homes
§19.1108 **F-364**

Each resident must receive and the facility must provide food prepared by methods that conserve nutritive value, flavor, and appearance and food that is palatable, attractive, and proper temperature.

Assisted Living Facilities
§92.41Food and nutrition services (m) (3)

Menus must be planned one week in advance and must be followed. Variations from the posted menus must be documented. Menus must be prepared to provide a balanced and nutritious diet, such as that recommended by the National Food and Nutrition Board. Food must be palatable and varied. Records of menus as served must be filed and maintained for 30 days after the date of serving.

How can food taste and appear better to residents?

- Kitchen staff can be trained on cooking methods that enhance tastiness.
- During meals, observe whether food is attractive and eaten.
- Routinely survey all residents about their opinions of food served.
- Make fresh fruits and vegetables readily available.
- _____

Nursing Homes
§19.1110 Frequency of Meals **F-368**

(a) Each resident receives and the facility provides three meals daily, at regular times.
(b) There must not be more than 14 hours between a substantial evening meal and breakfast the following day.
(c) The facility must offer snacks at bedtime daily.
(d) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast.

Assisted Living Facilities
§92.41 Food and nutrition services (m) (2)

At least three meals or their equivalent must be served daily, at regular times, with no more than a 16-hour span between a substantial evening meal and breakfast the following morning. All exceptions must be specifically approved by DADS.

What are some ways for residents to direct meal times?

- Use neighborhood meetings (resident councils) to identify the best meal times.
- Accommodate individual preferences regarding waking and sleeping.
- _____
- _____

On Your Own:

Watch the Alzheimer's Resource Center of Connecticut, Inc. twenty minute video about an innovative approach to dining for people with dementia, "Dining with Friends."

https://www.arc-ct.org/dwf_view.php
Run Time: 21 min 45 sec

This video shows innovative solutions to the adverse effects dementia has on nutrition, hydration, and socialization. It addresses these obstacles and intends to improve the lives of people with dementia.

Language of Long-term Care

The language of long-term care belongs to all of us. The most urgent task may be agreeing which old words to throw away. Finding new ones should be easier. It's a matter of choosing accurate and respectful words.

PEOPLE	
OLD WORDS	**NEW WORDS**
grandma, mommy, sweetie, kid, honey, girls, old timer	resident's name, Mr./ Mrs./ Ms.
wheelchairs/walkers	people who use a wheelchair/walker
the elderly	elders, older adults
patient	resident, client, neighbor, friend
residents known by diagnosis	their name -- learn it!
wanderers	people who like to walk
disabled, diabetic, , quad, , CVA	a person who has (whatever condition)
toilet resident	needs help in the bathroom
activity director	community life coordinator
non-nursing/ancillary staff	(name) from (department)
new admit	someone at a home here, new neighbor
feeder, feeder table	person needing help to eat, dining table
dementia/demented	person with cognitive losses
girl, guy (CNA)	their name, my friend
I	We, the team
nurse aide, CNA, nursing assistant, front line staff	resident assistant, certified resident assistant
food service worker, hey you	their name
problem resident, behavior problem	person with behavioral symptoms

PLACES	
OLD WORDS	**NEW WORDS**
facility, institution, nursing home	home, life center, living center
agency	supplemental staffing
lobby, common area	living room, parlor, foyer
ward, unit	Village, neighborhood
nurses' station	work area, den, support room, desk
tray line	fine dining
100-bed facility	100 people live in this home

THINGS	
OLD WORDS	**NEW WORDS**
activities	meaningful things to do
mechanical soft food	chopped food
nourishment	snack
bibs	napkin, clothing protector
diapers, pampers, pull-ups	briefs, panties, attends, brand names
dietary services, food service	dining services

ACTIONS	
OLD WORDS	**NEW WORDS**
admit, place	move in
discharge	move out
transport	assist to…
ambulation, wandering	walking
eloped, escaped, elopement	left the building, unescorted exiting
toileting	using the bathroom
baby-sit	resident interaction
allow	help, facilitate, encourage, welcome
claims	states, says

ATTITUDES	
OLD WORDS	**NEW WORDS**
care plan problem	resident strength
"I didn't know she could do that."	"I love it when she does that!"
problem	challenge, opportunity
"You need to…"	"Would you like to...?"
"Sit down, you'll fall."	"Let’s walk!"
"Trays are here."	"Dinner is served."; "It is dinnertime!"
"He’s on the pot."	"He’s not available right now."

long-term care industry	long-term care community
a two-assist	requires two helpers
"We're already doing that."	"We need to really do that."
"We tried that."	"Let's try again."
"That's not my job."	"I'll take care of that."
14-hour rule	freedom of choice
old ways	change in order
can't escape	would like to go outside
CONDITIONS	
OLD WORDS	**NEW WORDS**
confined to wheelchair	uses a wheelchair
"victim of..." or "suffering from..."	person "has..." or "with..."
agitated	active, communicating distress

SOURCE: Culture Change Language, Pioneer Network
SOURCE: Karen Schoeneman, Senior Policy Analyst, Centers for Medicare and Medicaid Services, Opinions expressed above are those of the author, not necessarily shared by CMS.

Ombudsman Certification Training

CHAPTER 15: Systems Advocacy

Systems Advocacy

Chapter 15 describes how influencing and changing a system benefits people who live in nursing homes and assisted living facilities. Long-term care ombudsmen can impact changes to laws, regulations, policies, facility practices, and community attitudes.

Learning Objectives

- Distinguish between individual and systems advocacy
- Be aware of relevant statutory language in the Older Americans Act
- Understand the ombudsman role in systems change

Contents

- What is Systems Advocacy?
- The Older Americans Act and Systems Advocacy
- Distinguishing Systems and Individual Change
- Systems Advocacy in Texas

DVD(s), Supplements, Forms

- Internet video: Reducing Antipsychotic Drug Use – A Story of Hope

What is Systems Advocacy?

Ombudsmen can advocate to change systems as well as to solve individual problems. Changing a system can impact a single facility, all facilities operated by a provider, or all facilities in the U.S. This level of advocacy requires ombudsmen to identify broad trends across the long-term care system and to work in unison with the state ombudsman.

Chapter 14 described person-directed care and culture change, which are systems change efforts. In assisted living facilities and nursing homes, systems may need to change in order to improve the quality of life and care of the people who live there. Systems may also improve the work setting of facility staff.

The Older Americans Act and Systems Advocacy

The federal Older Americans Act established the long-term care ombudsman program and ombudsman mandates. Ombudsman representatives at the state and local programs fulfill several duties. The following references from the Older Americans Act are closely related to systems advocacy:

- Represent the interests of residents before government agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents.

  Example: Participate in coalitions to improve long-term care services and represent the interest of residents.

- Review and comment on existing and proposed laws, regulations, and other government policies and actions, pertaining to resident well-being and rights.

  Example: Testify at a public hearing to illustrate the impact of a law on long-term care residents.

- Facilitate the public's ability to comment on laws, regulations, policies, and actions.

  Example: Share state ombudsman notices of opportunities to comment or testify with the ombudsman network and other advocates.

- Promote and provide support for the development of resident and family councils.

  Example: Provide councils samples of agendas and bylaws.

- Carry out other activities the ombudsman determines to be appropriate.

  Example: Respond to state ombudsman requests to comment on proposed state rules about assisted living facility operations.

To assure resident interests are represented to the public and lawmakers, ombudsmen:

- Report complaints and other work as part of state and federal reporting;
- Educate advocacy groups, governmental agencies, and policy-makers regarding the impact of laws, policies, or practices on residents;
- Provide community education or information; and
- Educate other aging service providers, advocacy groups, and the public on long-term care issues.

Additionally the State Long-term Care Ombudsman will:

- Provide leadership to ombudsmen on the statewide systems advocacy efforts on behalf of long-term care residents.
- Provide information to public and private agencies, legislators, the media, and other people, regarding the problems and concerns of residents and recommendations related to the problems and concerns.
- Represent the determinations and positions of the State Long-term Care Ombudsman Program and not necessarily represent the determinations or positions of the State agency where the program is located.

According to Federal Rule [Part 1327.13(a)(7)(vii)], systems advocacy efforts by ombudsmen on behalf of long-term care residents does not constitute lobbying activities. “In carrying out systems advocacy efforts of the Office on behalf of long-term care facility residents and pursuant to the receipt of grant funds under the Act, the provision of information, recommendations of changes of laws to legislators, and recommendations of changes of regulations and policies to government agencies by the [State] Ombudsman or representatives of the [State] Office do not constitute lobbying activities as defined in 46 CFR part 92.”

For effective coordination, state and local ombudsmen need to exchange information on systems advocacy issues and activities. Good communication and coordination synchronizes messages and creates a broader impact to align systems with residents’ interests. Based on ombudsman complaint data, the state ombudsman sets a systems advocacy agenda that serves as the basis for local and state systems advocacy.

Distinguishing Individual and Systems Change

Making changes can help one person, several individuals, or thousands.

Common complaints ombudsmen investigate have different root causes, such as unanswered call lights (out of resident reach, electrical malfunctioning, short staffing), dental care (neglect, access to dentists, lack of social and health services, lack of information about benefits), or physical restraints (family fears a fall and injury, resident wants to assume certain risks, facility policies). Solving any one of these problems for one person is an example of individual change. If an ombudsman works to change the problem’s root cause and takes into account how the same problem can be avoided in

the future, an ombudsman can help develop a systemic solution to impact many residents.

Outcome for both individual and systems change may appear the same, but difference is apparent over time. Systems change will show a more lasting impact on the problem.

U.S. citizens have the right to vote in local, state, and national elections. Individual and systemic approaches can help ensure this right.

- Individual - arranging transportation for one resident to travel to the voting precinct on Election Day.
- System - arranging for residents in a nursing home to vote via absentee ballots, establishing the nursing home as a precinct voting site, supporting the resident council's efforts to invite candidates to the home for a debate, and arranging transportation to a voting location on Election Day.

These activities are not directly arranged by an ombudsman, but ensuring the facility fulfills its obligation is action the ombudsman can take to provide individual and systems advocacy regarding voting rights.

A resident council discusses their home's cutting back van travel on weekends. Identify one individual and one systems advocacy approach to resolve this problem.

Individual - _____

_____

Systems - _____

_____

Moving out of a Nursing Home

Another activity that demonstrates the difference between individual and systems change is the process of a person moving out of a nursing home. This example also shows how individual advocacy may depend first on systems change.

Systems Change

1. A guardian ad litem for two individuals with mental and cognitive disabilities who live in a state institution files a lawsuit for their right for care in an integrated setting. The lawsuit is based on the Americans with Disabilities Act.
2. The U.S. Supreme Court rules in Olmstead v. Zimring that states must provide community-based services for persons with disabilities who would be entitled to institutional services.
3. Governor George W. Bush issues an Executive Order in 1999, requiring the state of Texas to offer community-based alternatives for persons with disabilities.
4. The Texas Health and Human Services Commission develops the Texas Promoting Independence Plan with an initiative allowing an individual with a disability to live in the most integrated care setting available.
5. Governor Rick Perry signs Executive Order RP 13, also relating to community-based alternatives for people with disabilities.
6. The Money Follows the Person (MFP) initiative helps people who receive long-term services and supports in a nursing home or state supported living center return to the community to receive their services without waiting. Texas receives federal funds to help older adults and people with disabilities move out of institutional settings. Ombudsmen help statewide by identifying residents who wish to move and supporting residents with resolving complaints associated with relocation.
7. By 2012, more than 30,000 Texans moved to community-based settings with long-term services and supports.
8. The Minimum Data Set (MDS) version 3.0, Section Q began implementation in September 2010. The assessment tool now asks every nursing home resident in the U.S. about their wishes to live in a community-based setting and requires the nursing home to act upon those wishes. Ombudsmen helped shape the MDS 3.0 assessment tool, trained facility staff, and will monitor for interference with residents' rights.

Individual Change

1. A resident sits in a wheelchair in the front lobby. She tells everyone who walks by that she would like to go home.
2. During a visit, the ombudsman speaks with the woman about what she would like to do and where she would like to live.
3. She has lived in the nursing home for 14 months, is Medicaid-eligible, and owns her home.
4. Explaining MFP policy, the ombudsman asks if the resident would like to speak with the local relocation contractor.
5. The resident asks the ombudsman to start the process on her behalf. The ombudsman contacts the local relocation specialist.
6. A relocation specialist visits the resident and explains the process of moving out of the home using MFP. The resident works with agencies to prepare for her

move. The ombudsman follows up to monitor progress and respond to the resident's concerns about the process.

7. The relocation specialist works with nursing home and managed care staff regarding the resident's needs and arranges for the necessary long-term services and supports. The specialist arranges housing, furnishings, Medicaid-waiver services, and home delivered meals.
8. The resident moves back to her home to receive care. She knows who to call if problems arise and has a network in place to support her. The relocation specialist follows up with her for six months after her return home.

How does the successful relocation of the person described above depend on a systems change? _____

_____

Find two system advocacy activities in the example above in which ombudsmen can participate: _____

_____

_____

Membership Organizations

There are two national membership organizations that support quality of care. Many ombudsmen choose to join.

1. The National Consumer Voice:
   The National Consumer Voice for Quality Long-Term Care advocates for public policies that support quality care and quality of life in all long-term care settings. Signup to receive, via email, the weekly Voice, Action Network alerts and more at this link: http://wfc2.wiredforchange.com/o/8641/signup_page/join-us

2. National Association of Local Long-Term Care Ombudsmen (NALLTCO):
   NALLTCO works to organize and provide a common voice for long-term care ombudsmen. More information about NALLTCO can be found at this link: http://www.nalltco.org/

Systems Advocacy in Texas

The long-term care ombudsman program in Texas has been active in systems change since the mid-1980s. Some activities have succeeded such as an increase above the $30 federal personal needs allowance and others with limited success such as improving consumer protections for assisted living residents.

Systems within the industry, regulatory services, funding sources, advocacy groups, legal resources, and others may be involved. The needed change will determine which stakeholders must work together to achieve the best outcome.

The following examples demonstrate the:

- stakeholders involved;
- change accomplished; and
- future advocacy needed to resolve the systemic problem.

Example 1: Personal Needs Allowance Increase

Medicaid-eligible individuals who live in nursing homes and assisted living facilities keep some of their income. This is called Personal Needs Allowance (PNA) and they use the money as they choose. The remainder of their income, known as applied income, is paid to the facility for their care.

Federal law established PNA to provide funds for Medicaid residents in nursing homes to purchase goods and services. The federal minimum PNA is $30 a month. State legislatures can appropriate additional funds. On September 1, 1999, Texas increased PNA to $45. Since then, it has been $60, back to $45, and as of 2011, is $60.

- Stakeholders
  - Residents and family members
  - Citizen advocacy groups
  - Health and Human Services Commission Office of Medicaid Eligibility
  - Regulatory Services, LTC Ombudsman Program
  - Nursing home and ICF-MR providers
- Changes
  - The Texas Legislature enacts laws within the Texas Human Resources Code (HRC) Chapter 32 – Medical Assistance Program; this chapter enables Texas to provide medical assistance on behalf of needy individuals (Medicaid) and to obtain all benefits for persons authorized under the Social Security Act or any other federal act.
  - Policy interpretation is released to clarify PNA for veterans and others.
    - For Supplemental Security Income (SSI) recipients who receive the $30 reduced federal benefit, the state pays the person the remaining $30 to reach the minimum PNA level set by HHSC.

        - If a veteran without a spouse or child, or a surviving spouse without a child, is covered by Medicaid for nursing home services, the Veterans Administration pays $90 to the veteran or surviving spouse in addition to the PNA amount.

- Future advocacy
    - Change laws impacting PNA to include a cost of living adjustment to avoid needing to routinely seek statutory change.
    - Monitor for residents who are restricted from using their PNA as they wish and identify policy changes that may be necessary.
    - Monitor for issues of possible financial exploitation related to PNA and continuously educate facility staff of their requirement to report suspected financial exploitation. Continue to educate Adult Protective Services about their role in financial exploitation alleged to have occurred by family or others not associated with the nursing home.

Example 2: Physical Restraint Reduction

A physical restraint is anything that keeps residents from moving around or getting to a part of the body. Residents have the right to be free from physical restraints imposed for discipline, convenience, or when not required to treat the resident's medical symptoms. Family members and facility staff may believe restraints keep people safer.

If used inappropriately, restraints can be harmful. Residents who have been restrained for long periods can have poor circulation, constipation, incontinence, weak muscles and bones, pressure sores, poor appetite, and infections. Restraints can cause agitation, less ability to do daily activities, less social contact, withdrawal, depression, and poor sleep. Some residents have died from restraints.

- Stakeholders
    - Residents and family members
    - Citizen advocacy groups
    - Quality Monitoring Program, Regulatory Services, and LTC Ombudsman Program
    - Nursing homes and assisted living facility providers

- Changes
    - In 2000, Texas ranked among the four states with the highest prevalence of restraint use. A statewide assessment indicated 19.5% of nursing home residents were physically restrained.
    - Nursing home providers, Regulatory Services, Quality Monitoring, and LTC ombudsman programs concentrated education, policy, and practice on restraint reduction.
    - Quality monitors organized training for facility staff, long-term care ombudsmen conducted education programs for families, facility staff revised policies and procedures, and residents and families discussed restraint use in care plan meetings.

- In fall 2005, the Centers for Medicare and Medicaid Services reported restraint use in Texas at 6%.
- In 2012, the Advancing Excellence in America's Nursing Homes campaign issued new goals. *Increase Resident Mobility* recognized the importance of mobility to physical and psychological well-being. Staff addressed range of motion, restraint use, fall prevention, and transfer. Consumers, staff, and advocates helped to influence reducing and eliminating restraints.
- Based on resident data, medically unavoidable restraints are estimated at 1-2%. Restraint reduction trials show restraint use can be decreased to 5% or less. Therefore, Texas' goal is to reduce the occurrence of restraint use to below 5%.
- As of April 2015, the percent of daily usage of physical restraints in Texas is less than 1%.

- Future advocacy
  - In some facilities, restraint use is on the rise, including the use of bed rails.
  - See Consumer Voice material on the dangers of bedrails and provide to resident and family councils as needed. See Consumer Voice information at this link: http://theconsumervoice.org/uploads/files/long-term-care-recipient/PhysicalRestraintFreeCare-FINAL.pdf

Example 3: Consumer Protection for Residents in Assisted Living Facilities

The people who live in assisted living facilities (ALFs) today would have lived in nursing homes 10-15 years ago. ALF residents may be on hospice, have complex medical needs, and many have cognitive impairments associated with dementia of the Alzheimer's type. While needs have increased, licensure standards do not require ample training of staff, nor provide sufficient consumer protection from discharge or other adverse actions.

- Stakeholders
  - ALF residents and family members
  - Texas Association of Area Agencies on Aging (T4A), Texas Senior Advocacy Coalition (TSAC), AARP, Inc. (formerly the American Association of Retired Persons), and Texas Silver Haired Legislature (TSHL)
  - Quality Monitoring Program, Regulatory Services, and LTC Ombudsman Program
  - Assisted living facility providers, including the Texas Assisted Living Association (TALA) and the Texas Organization of Residential Care Homes (TORCH)
  - Physicians, physician assistants, nurse practitioners, nurses, and unlicensed caregivers

- Changes
  - After stakeholders identified issues related to medications in assisted living facilities, the state began to revise rules with input from the State Long-term Care Ombudsman, and invited stakeholders including local long-term care ombudsmen to form a medication administration work group. All parties agreed on rule revisions for greater clarity. After this accomplishment, the rule process stalled and new rules have not been released.
  - After unanimous support from T4A, TSAC, and TSHL, funding for assisted living long-term care ombudsmen was incorporated in the 2012-2013 and 2014-2015 agency legislative appropriations request. This effort failed due to state budget constraints, but served as the foundation for future requests.
  - In the 83rd Texas Legislature, a request for assisted living facility ombudsman funds was approved for an increase of 1.8 million dollars over the 2014-2015 biennium.
  - In the 84th Texas Legislature, a second request for assisted living facility ombudsman funding was approved. Another 1.9 million was approved for the 2016-2017 biennium, and the previous 1.8 million continues to support assisted living facility ombudsmen.

Future advocacy – ombudsmen can:

- Use the Long-term Care Ombudsman annual report recommendations to keep the needs of assisted living residents on the minds of stakeholders and lawmakers.
- Tell the public and lawmakers about the benefits of applying the assisted living facility Alzheimer's licensure standards for manager and staff training, staffing, and activities to all Type B assisted living facilities. Review the standards in Chapter 92 of the Texas Administrative Code.
- Support the need to require assisted living facility employees who provide direct care to be Certified Nurse Aides (CNAs). Inform the public and stakeholders about the benefits of trained and certified caregivers on the quality of life and care for assisted living facility residents.
- Advocate for the need to provide a fair hearing appeal for assisted living residents facing discharge to give assisted living facility consumers protection from illegal eviction.

List two ways you can help the public and lawmakers understand the needs of people who live in assisted living facilities.

1. _____
2. _____

Example 4: Resident-directed Care

Chapter 14 described person-directed care and culture change. Resident-directed care requires many people to change their attitudes about nursing homes from institutions of efficiency to places where individuals live, thrive, and exercise choice and control. This transformation requires changes in organization practices, physical environments, relationships at all levels, and workforce models. The change from institutional to individual practices does not require radical physical changes or expensive remodeling. In fact, it does not have to cost anything, but must be supported by direct care providers and management.

Ombudsmen can play an important role in a home's decision to implement resident-directed care and to change their culture from an institution to a place to thrive.

- Stakeholders
  - Residents and family members
  - Citizen advocacy groups
  - Quality Monitoring Program, Regulatory Services, and LTC Ombudsman Program
  - Nursing home and assisted living facility providers, including the Texas Health Care Association (THCA) and LeadingAge Texas

- Changes
  - Several early models of this change were presented at the 1995 National Consumer Voice conference. One outcome was the Pioneer Network.
  - At the invitation of the Texas State Long-term Care Ombudsman, the Pioneer Network Board of Directors conducted training for providers and ombudsmen in San Antonio in 2002.
  - In 2006, CMS provided national guidance to support facility implementation of culture change. The federal State Operations Manual includes guidance that encourages person-directed care and other elements of culture change.
  - The state hosted regional joint training on individualized care for providers, regulatory services staff, and long-term care ombudsmen; provided at no charge.
  - In 2010, state agency staff interested in moving nursing homes from an institutional to a person-directed model created a Culture Change Initiative. The group's mission is to promote and support nursing home providers as they transform from a traditional system-directed culture to one that is person-directed or centered. For resources, go to www.dads.state.tx.us/culturechange.
  - In July 2010, the Texas Culture Change Coalition (TxCCC) was formed. The statewide membership of consumers, providers, advocates, agencies, and organizations is dedicated to culture change in a variety of aging and disability service provider types, including nursing homes and assisted living facilities.

- In 2014, Texas Administrative Code was changed to reflect a new state law to encourage building small home nursing homes. (Small house waiver: TAC §19.2232(h)(9) and Small house requirements: TAC §19.345)

Exercise: Future Advocacy

Promote resident-directed care. Brainstorm ideas for systemic change in your assigned facility. Consider the following areas:

- Meal service: _____
- Bathing and hygienic experiences: _____
- Social activities: _____
- Sexual intimacy: _____

In general, what is one change that could provide all residents with an opportunity to exercise more choice and control?

_____

Example 5: Reducing Unnecessary Antipsychotics in Nursing Homes

Texas holds the dubious status of being one of the worst nursing home state for its use of antipsychotic drugs. About 26% of all long-term care residents are on an antipsychotic drug. Nationally, there has been a 15% reduction in the prevalence of antipsychotic use for long-stay residents between 2011 and 2012. Texas has only reduced use by 8.1%.*

The Texas Legislature recognized the need to improve person-centered care in Texas nursing homes and directed the state regulatory agency to conduct a pilot project to help nursing homes understand, consider, and implement resident-centered care.** This pilot project will be completed concurrently with a statewide training and support effort lead by the Quality Monitoring Program.

*Interim report on the CMS National Partnership to Improve Dementia Care in Nursing Homes: Q4 2011 – Q1 2014 http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-14-19.pdf

** Rider 30, General Appropriations Act for the 2014-2015 Biennium, Eighty-third Texas Legislature, Regular Session, 2013.

- Stakeholders
  - Residents and family members
  - Citizen advocacy groups
  - Quality Monitoring Program (QMP), TMF Health Quality Institute, and LTC Ombudsman Program
  - Nursing home providers

- Changes
  - CMS launched a 2012 initiative: *Improve Behavioral Health and Reduce the Use of Antipsychotic medication in Nursing Home Residents.*
  - The *National Partnership to Improve Dementia Care* training for surveyors was released and changes to the CMS State Operations Manual were made. Changes set expectations of dementia care that does not rely on chemical restraints or misuse of drugs to sedate dementia residents.
  - In 2013, local program staff ombudsmen were trained in CMS *Hand in Hand: A Training Series for Nursing Homes*. *Hand in Hand* addresses how to better understand and how to provide improved care for residents with dementia. Ombudsmen can train any facility using these materials.
  - In 2014, QMP, TMF*, and the Long-term Care Ombudsman program launched an initiative to reduce the unnecessary use of antipsychotic medications and improve dementia care in Texas nursing home residents: *Get on Board the TRAIN* (Texas Reducing Antipsychotics in Texas).
  - Phase I provided one-day training sessions to nursing home staff in 10 regions throughout the state.
  - QMP visit strategies were changed to include antipsychotic medication usage and pain assessment for people with dementia.
  - In 2015, QMP, Regulatory Facility Liaisons, TMF Quality Improvement Organization, Quality Innovation Network consultant staff, and members of the Texas Advancing Excellence Campaign Local Area Network of Excellence recruit nursing homes into Phase II of the project, where individualized assistance and support will occur.
  - Phase II includes: special focus visits with individualized assistance and support, regional nursing home staff peer to peer meetings, dementia care certification, and person-centered care classes.
  - In 2015, ombudsman basic certification training incorporated the Hand in Hand training to ensure all certified ombudsmen understand and promote the principles of individualized dementia care.

*TMF Health Quality Institute (TMF) is a federally funded Austin, Texas-based consulting company focused on promoting quality health and quality care through contracts with federal, state, and local governments, as well as private organizations.

Name the training material that ombudsmen can deliver to long-term care staff.
CMS _____ _____ _____.

Long-term care ombudsmen have been and continue to be active in systems advocacy issues. When systems change, ombudsmen watch to assure the change is implemented as intended and resident quality of care and life are improved.

On Your Own: *Reducing Antipsychotic Drug Use – A Story of Hope*

Reducing antipsychotics in Texas nursing homes is possible. Watch the YouTube video *Reducing Antipsychotic Drug Use – A Story of Hope.* Use the link below.

Follow this link:
https://www.youtube.com/watch?v=wjSVY3kf9S8&app=desktop
Run Time: 7 min 48 sec

Name one thing Town and Country changed or implemented in their nursing home to reduce the use of antipsychotics.

_____

_____

Notes:

Notes:

Ombudsman Certification Training

CHAPTER 16: Exercise: Getting Acquainted with Policies and Procedures & Ombudsman Policies and Procedures

Exercise: Getting Acquainted with Ombudsman Policies and Procedures

Section 100 Introduction

1. According to Section 100, what gives the Long-term Care Ombudsman Program legal authority?

2. Section 103 describes the line of communication for the ombudsman program. To whom should a volunteer ombudsman take consultations, grievances, and escalation of complaints?

Section 200 Roles and Responsibilities

1. Section 201.2 describes staff responsibilities, some required by a Managing Local Ombudsman and others that may be executed by any certified staff ombudsman. To access confidential program information, what happens first?

2. In Section 202, what is one capacity in which an ombudsman may not serve a resident because it is a conflict of interest?

3. According to Section 204, what must an ombudsman do if participating on behalf of the ombudsman program in local activities pertaining to policy or legislation?

4. Section 205.3 describes interaction between Regulatory Services and Ombudsman Program. Name 2 reasons an ombudsman contacts Regulatory Services (RS).

5. In Sections 207.1 and 207.2, what are suggested topics for an ombudsman to present to residents and families and facilities?

Section 300 Conflict of Interest

1. Section 301 states it is best to _____ rather than _____ conflicts.

2. In Section 301.1, any person seeking employment or certification as staff or volunteer must disclose all information relevant to:

3. According to Section 302, an ombudsman may not accept _____, _____, or _____ _____ from a LTC facility, resident, or anyone other than the local LTCOP for performing ombudsman services.

4. According to Section 303.1, what steps must be followed to remedy an individual conflict of interest?

Section 400 Consent

1. In Section 400, an ombudsman is required to obtain a resident's consent to do what?

2. According to Section 400, consent applies only to the _____ case and does not extend to _____ work.

3. Section 401 states that if a complainant is not a resident, the ombudsman seeks agreement from the resident to work on an issue. What happens if the resident declines to give consent?

4. In Section 402, an ombudsman is required to protect the identity of _____ complainants the same as residents.

5. According to Section 403, an ombudsman should be prepared with applicable _____ and _____ and if facility staff denies access, consult with _____ or _____.

Section 500 Access

1. Section 501 says ombudsman visits to a facility should be _____.

2. In Section 501.1, ombudsmen visit during the regular visiting hours when residents are awake. For what reason would an ombudsman visit at other times and who would the ombudsman consult first?

3. Section 502.1 states review of facility policies may be relevant if staff refer to policy as a reason for a decision or action. When should an ombudsman consult with facility staff and the MLO regarding a policy?

4. Section 503.1 introduces the term “responsible party.” Why should an ombudsman be careful when the facility uses this term?

5. Section 503.4 discusses resident and family groups. An ombudsman attends a resident or family council meeting by _____ only.

Section 600 Consultations and Cases

1. Section 602.1 states some complaints are inappropriate for ombudsman activity. What are some examples of complaints an ombudsman should not investigate?

2. In Section 602.2, what does it say an ombudsman should explain to a complainant who wishes to remain anonymous?

3. Section 602.3 explains an ombudsman should respond to a complaint within two business days or sooner if circumstances appear urgent. What complaints take priority over others?

4. In Section 602.4, what should the ombudsman discuss with the resident?

5. Section 603 describes the investigative process. What questions should an ombudsman ask to determine facts about the issue?

6. Section 604 describes actions an ombudsman can take toward the resolution of a complaint. What is the first action?

Section 700 Reporting

1. In Section 700, what are some purposes of reporting?

2. In Section 700, what form is used to collect information from volunteers?

3. According to Section 701.2, to be considered active in a quarter, what criteria must an ombudsman meet?

Section 800 Records

1. According to Section 802.1, three signed forms must be included in all certified ombudsman records. What are they?

2. Section 802.1 describes what must be included in a certified ombudsman file to document continuing education. What should the documentation of continuing education include?

3. According to Section 802.3, what notes are included in ombudsman case records?

Section 900 Disclosure of Confidential Information

1. According to Section 902, what does confidential information include and not include?

2. In Section 903, it states confidential information may only be disclosed according to the Older Americans Act. Why is it important for an ombudsman to keep information confidential?

3. According to Section 904, what are some situations in which an ombudsman might need to orally disclose confidential information?

4. Section 905.2 describes the process for disclosure when a complaint is filed on behalf of a resident who does not have a Power of Attorney. What should the ombudsman do once he or she determines it is necessary to disclose confidential information?

5. According to Section 905.3, when responding to a request for information about a resident's health condition, what procedure should an ombudsman follow?

Section 1000 Legal Counsel

1. According to Section 1000, certified ombudsmen and ombudsman interns are provided legal counsel, free of _____ of interest, for legal representation and consultation in the performance of their official _____.

2. Section 1001.2 describes under what circumstances an ombudsman consults with the SLTCO regarding legal matters. What are these circumstances?

3. Give two examples of appropriate legal resources to provide a resident or their legal representative.

4. Give one example of a legal resource an ombudsman should never provide to a resident.

Section 1100 Volunteer Management

1. According to Section 1101.1, what is the definition of an ombudsman volunteer?

2. Section 1102.2 describes actions for which a CVO must get approval from the MLO. What are some examples of these actions?

3. In Section 1103.1, a volunteer who doesn't wish to investigate complaints may do what?

4. In Section 1103.4, what does a CO agree to by signing the CO application?

5. According to Section 1104.3, a CO can request alternate CE. What must happen prior to using these resources for CE credit?

6. Section 1105.1 describes the certification process upon completion of certification training. What are the steps after the MLO recommends the volunteer to the SLTCO for certification?

7. According to 1105.2, the LTCOP may recommend decertification on what grounds?

8. Section 1106.3 describes the evaluation process for each CVO. What is one purpose of the annual evaluation of a CVO?

Section 1200 Program Awareness

1. Section 1201.2 provides examples of settings in which a LTCOP can provide community education to specific audiences. List two examples:

2. According to Section 1202.3, who should be contacted prior to participating in press conferences or other media activities?

3. Section 1203.3 identified "best practices" while working on social media. List these "best practices."

Section 1300 Other Required Documents

- Program Agreement between the LTC Ombudsman Program and Regulatory Services – Signed

- Memorandum of Understanding with DFPS Adult Protective Services – Signed

Intern _____ Facility _____

Certified Ombudsman _____ Date: _____

Things to observe about the ombudsman:

1. Physical appearance

2. Items carried into each facility

3. The first actions the ombudsman takes upon entering a facility

4. Facial and verbal expressions to residents

5. Facial and verbal expressions to facility staff

6. Communication with which staff

7. Note taking

8. How the ombudsman takes direction from residents

9. Obtaining consent from residents and other complainants

10. Not taking action on any request

Things to ask the ombudsman (in a private setting):

1. Do you need to vary your attire when visiting certain types of facilities? If so, why?

2. What support documents and materials do you keep with you or in your car?

3. Do you have a protocol at the start of each facility visit?

4. How many residents do you usually visit? How do you make sure all residents are visited over time?

5. How do you keep professional limits with facility staff?

6. How do you decide which staff to talk to about a complaint? How do you decide whether to “go up the chain of command” on a complaint?

7. What are the most important things to document in your notes?

8. What are some tips for staying resident-directed when you work on a case?

9. How do you get consent from a resident? What do you specifically ask?

10. I noticed you told _____ that you could not assist with a request about _____. Why is that something you did not take action on?

11. How do you keep ombudsman records secure, including print copies, email, and phone calls?

12. What strategies have you used with success in responding to clients who are:
    - ➔ Angry or attacking

➔ Tearful

➔ Unfocused (struggling to make or stay on point)

➔ Suspicious

➔ Reluctant to talk

➔ Cognitively impaired

➔ Speech impaired

13. Other questions asked:

Shadow visit—reflective questions

Answer these questions within one week of completing your facility visit. Discuss them with your supervising staff ombudsman. Answers don't have to be lengthy, but they should be substantive and reflect your insights into the experience.

1. What made the biggest impression on you?

2. What were some words or phrases you heard the ombudsman use that you will strive to use in your work?

3. Describe something you observed and how you might have handled it differently—explain why.

4. What are some questions the experience left you wondering? Who do you need to direct those questions to?

Follow-up with managing local ombudsman

When you have reflected on the experience and discussed with your supervising staff ombudsman, contact your managing local ombudsman with any remaining questions and to share your insights.

Ombudsman Certification Training

APPENDIX 1: Chapter Questions and Exercises

Chapter 1: Long-term Care Ombudsman Programs

Trainee Name: _____

Date Completed: _____

My Managing Local Ombudsman is _____.

My supervising staff ombudsman is
_____.

The Texas Long-term Care Ombudsman Program advocates for quality of _____ and quality of _____ for people who live in nursing homes and _____ _____ facilities.

The next page provides a table with long-term care ombudsman responsibilities. Using the table, determine whether each statement is True (T) or False (F).

_____ Certified volunteer and staff ombudsmen, and the state office, have a role in ensuring residents have regular and timely access to an ombudsman.

_____ When acting as an ombudsman, volunteers and staff may comment on proposed laws in coordination with the Texas State Long-term Care Ombudsman.

_____ All staff and volunteers in the ombudsman program help to protect resident rights.

_____ Ombudsmen protect the confidentiality of all residents.

_____ Ombudsmen interns do <u>not</u> identify, investigate, and resolve complaints made by, or on behalf, residents.

Video: Advocates for Resident Rights: The Older Americans Act Long-term Care Ombudsman Program

Describe what you learn below.

1. How does Older Americans Act describe the long-term care ombudsman role?

_____

_____

2. What is the purpose of long-term care ombudsman program?

_____

_____

3. What are some functions of a long-term care ombudsman?

_____

_____

4. What are some complaints ombudsmen work to resolve?

_____

_____

What questions do you have about being an ombudsman?

_____

_____

How many people live in a nursing home or assisted living facility in Texas? _____

How many nursing homes are in Texas? _____

How many assisted living facilities are there in Texas? _____

What is advocacy?

_____

_____

Why do you think residents in nursing homes and assisted living facilities need advocates?

_____

_____

List two physical and cognitive barriers to self-advocacy

1. _____

2. _____

Two personal feelings that are barriers to self-advocacy are:

1. _____
2. _____

Long-term care ombudsmen are impartial and objective while investigating a complaint, but become an _____ and represent the interests of the _____ when working to resolve a problem.

Chapter 2: Aging and Residents

Trainee Name: _____

Date Completed: _____

Describe one physical change associated with aging. _____

_____

Activity: Attitudes about Aging
True (T) or False (F)

__ 1. The majority of adults over 65 have memory loss, disorientation, or dementia.

__ 2. All five senses tend to decline in old age.

__ 3. Lung capacity tends to decline in old age.

__ 4. Physical strength tends to decline in old age.

__ 5. Older adults have no interest in sexual relations.

__ 6. Older drivers have fewer accidents per person than drivers under age 65.

__ 7. Older workers are less effective than younger workers.

__ 8. About 80% of older adults are healthy enough to carry out normal activities.

__ 9. Older adults are set in their ways and unable to change.

__ 10. Older adults usually take longer to learn something new.

__ 11. Most older adults' reaction time tends to be slower than younger adults.

__ 12. It is almost impossible for most older adults to learn new things.

__ 13. In general, most older adults are much alike.

__ 14. Older workers have fewer accidents than younger workers do.

__ 15. The majority of older adults are socially isolated and lonely.

__ 16. Over 20% of the U.S. population is now aged 65 or over.

__ 17. Most medical professionals tend to give low priority to older adults.

__ 18. The majority of older adults have incomes below the poverty level.

__ 19. The majority of older adults work or would like to do some kind of work, including volunteering.

__ 20. In the U.S., families provide about 80% of the care for older family members.

__ 21. People tend to become more religious as they age.

__ 22. Most American workers receive private pensions and Social Security when they retire.

Exercise: Choice or Restriction

List three morning activities you routinely do.

1. _____
2. _____
3. _____

How might you feel if others changed your routine? _____

_____

True (T) or False (F)**:**

___ 1. Nursing home staff must provide services and care in ways that help each resident live to his or her fullest potential physically, mentally, and emotionally.

___ 2. Supporting each resident's individuality is an important standard of care.

___ 3. Residents may experience disconnection and loss of identity.

___ 4. Staff should support each resident's life patterns.

___ 5. Facilities need rules that determine everyone's routines, such as when to go to bed, when to turn the TV off, when to take baths, and when visitors can come and go.

___ 6. A major loss to residents might be losing their daily routines.

___ 7. All residents are entitled to participate in planning their own care.

Give an example of what you believe privacy means in a facility setting.

_____

_____

Why should residents be able to control their lives after moving to an assisted living facility or nursing home? _____

_____

_____

What percentage of adults age 65+ live in nursing homes? _____

Why might older adults disengage from their community?

_____

_____

What is at risk if an older adult has someone do everyday tasks for them?

_____

One reason decline in a person's health might be unavoidable is if _____

_____.

Another term for "bed sore" is pressure _____.

Using a restraint on a person puts them at risk of serious _____ and death.

Exercise: Your Perfect Long-term Care Home

If you became unable to care for yourself in your private home, describe the home in which you would want to live and how staff will care for you.

_____

_____

_____

_____

_____

_____

_____

_____

Video: Answer the following questions about *Hand in Hand Module 1, Understanding the World of Dementia: The Person and the Disease*

1. Define dementia: _____

   _____

2. Who gets dementia?

   _____

   _____

3. Identify the three of the seven symptoms of dementia:

   _____

   _____

   _____

4. Identify two irreversible types of dementia:

   _____

   _____

5. Identify two other conditions that might present with symptoms that can look like dementia:

   _____

   _____

6. List three conditions that may worsen symptoms of dementia:

   _____

   _____

   _____

Chapter 3: Communication and Consent

Trainee Name: _____

Date Completed: _____

Active listening requires concentration and sincerity. One goal is to hear what the person says by listening for the intent and _____ of what is being said as well as the words.

Empathy Video: Watch the RSA Short – *The Power of Empathy* and answer the following questions.

1. What is the difference between empathy and sympathy? _____

   _____

2. What are three qualities of empathy?
   a) Ability to recognize the individual's perspective as his or her truth. _____
   b) _____

   _____

Exercise: Rate Your Listening Skills

Take the listening skills assessment. It will give you an idea of which listening habits you might want to reshape. Think about how you listen and rank your behavior frequency in the list below with a 1, 2, 3, 4, or 5. Total the numbers for your score.

1 – Rarely 2 – Occasionally 3 - Neutral 4 - Fairly often 5 - Frequently

___ Talking too much, not giving the other person a chance to talk
___ Interrupting others when they are talking
___ Not looking at the person talking
___ Fidgeting with pencil and paper, tapping your legs, etc. when someone is talking
___ Having a "poker face," blank look, or manner which makes it difficult for another to know if you are listening
___ Trying to do other things while another is talking
___ Letting emotional-laden words arouse personal ill feelings
___ Daydreaming or thinking about other things while another is talking
___ Blaming the speaking habits or mannerisms of another
___ Finishing the other person's statements
___ Drawing conclusions about the subject before actually listening to it

___ Cleaning fingernails, glasses, etc. while the other person is talking
___ Listening only to the facts being said, not to emotional aspects
___ Sitting too close, being in another's personal space
___ Looking frequently at your watch or clock while another is talking
___ Letting your feelings get in the way while listening
___ Asking many questions while another is talking
___ ***Total score***

It is always a good idea to approach any resident from the _____.

In general, let a resident tell you if they need any help with their physical impairment.

And, respect assistive devices as _____ _____.

Video: Answer the following questions about CMS Hand in Hand Module 3.

1. Because communication can be difficult for an individual with dementia, we have to learn to look for the meaning in their _____ and nonverbal communication.

2. Identify three ways memory loss affects how an individual with dementia communicates:
   (1) _____
   (2) _____
   (3) _____

3. In *Good Morning Video Clip 1*, what did you notice about Mrs. Caputo's communication?

_____

_____

4. In *Good Morning Video Clip 1*, what did you notice about how Jane communicated with Mrs. Caputo?

_____

_____

5. In *Good Morning Video Clip 2*, what did you notice about Mrs. Caputo's communication? How was she communicating?

_____

_____

6. In *Good Morning Video Clip 2*, what did you notice about how Heather communicated with Mrs. Caputo? How did Mrs. Caputo respond?

_____

_____

Exercise: Demonstrating an Ombudsman Introduction to a Resident

Think about how you will introduce yourself when you meet a resident for the first time. Your instructor will demonstrate. Answer the following questions.

1. How did the ombudsman describe the role of the ombudsman?

   _____

   _____

2. What listening techniques were used?

   _____

   _____

3. What will you say when you introduce yourself to residents and staff? Create your own introduction. Practice introductions with your instructor and other trainees.

   _____

Consent is required for an ombudsman to work on a resident's _____, reveal a resident's or complainant's name, or access a resident's record or other _____ information.

Unless a court rules a resident is _____, a resident speaks for himself or herself.

If an ombudsman determines a problem affects other residents but the resident does not give consent, the ombudsman could take action with the ombudsman as the complainant, but must _____

Ask the trainer. Discuss the following situations with your instructor.

1. Several younger residents engage in activities that intimidate older residents. Younger residents say they are exercising their choices and preferences. The older residents ask the ombudsman to represent them in making the younger residents change their behavior.

   - How does the ombudsman decide whom to represent? _____

     _____

   - What are some strategies to consider when residents have problems with other residents? _____

     _____

2. A resident with dementia has no legal representative. Some of her behaviors and statements lead the ombudsman to wonder if her care plan needs updating.

   - What is the role of the ombudsman? _____
   - What authority, if any, does an ombudsman have to seek changes for a resident?

     _____

     _____

   - What if there are negative outcomes to a resident based on the ombudsman's actions? _____

3. A facility asks the ombudsman what to do with a resident they are discharging.

   - What is appropriate for the ombudsman to say and do? _____

     _____

   - What should the ombudsman avoid doing? _____

     _____

   - How does the facility's request for help affect the ombudsman's actions? _____

     _____

   - Will the ombudsman instill trust in other residents if he or she helps facility staff in discharging the resident? _____

4. A resident tells you that her breakfast is always served with coffee and not hot tea which she has requested multiple times. The ombudsman visits with the administrator about the resident's breakfast drink preference and will watch meal service several times during the next month. Does you have consent to work the

complaint?

_____ Yes (Y) or No (N)

Information acquired within a record or disclosed orally is essentially the same. It is _____.

HIPAA applies to _____.

Older Americans Act applies to _____.

Chapter 4: Abuse, Neglect, and Exploitation

Trainee Name: _____

Date Completed: _____

Ombudsmen do not determine whether abuse, _____, or exploitation happened. We act as an _____ for the resident by helping report, and ensuring the resident and other residents are protected from further harm.

Neglect is the failure to care for a person in a manner which would avoid _____ or emotional harm or pain, or the failure to react to a situation which may be harmful. Neglect may or may not be intentional.

Exploitation is defined as the _____ or improper act or process of a caretaker using the resources, such as money, assets, or property, of an elderly or disabled person for _____ or personal benefit.

Video: Watch CMS *Hand in Hand Module 2.* Answer the following questions.

1. List three types of abuse:
   a) _____
   b) _____
   c) _____

2. An example of verbal abuse is:
   _____

3. An example of physical abuse is:
   _____

4. An example of involuntary seclusion is:
   _____

5. Misappropriation of property is probably most-commonly thought of as _____, but also includes deliberately misplacing a resident's belongings or money; using a resident's belongings without his or her permission.

6. List several signs of abuse:
   - _____
   - _____
   - _____

Case Examples

Case 1: A resident tells you he was injured by someone who works at the assisted living facility where he lives. He tells you he didn't want to shower and the shower aide tried to force him. He does not give you consent to report the ANE nor to disclose any identifying information.

Ask the trainer. What other advocacy options might be used?

_____

_____

_____

Case 2: A facility staff person shares an allegation of abuse with you.

Ask the trainer. You personally witness abuse. What should you do?

During a facility visit, you see and hear an altercation between a nurse and a resident during a birthday party. The resident is crying and holding her arms up in front of her face as if to protect herself. Four residents and two aides are also in the room where the verbal confrontation is occurring. What should you do?

_____

_____

_____

_____

Video: Watch CMS *Hand-in-Hand Training - Module 5:* Fill in the blanks below.

1. Abuse is sometimes the results of a series of actions and_____ that could have been prevented.

2. Identify several ways to respond to a resident's actions that might prevent abuse.

- _____
- _____
- _____

3. _____ True (T) or False (F)?

   A nursing home is required by federal regulation to report alleged violations of mistreatment, neglect or abuse to the survey agency immediately.

4. Facility staff must report suspicion of a crime within _____ hours, if the events result in serious bodily injury to a resident.

Chapter 5: Residents' Rights

Trainee Name: _____

Date Completed: _____

How might individual routines impact resident rights?

_____

_____

Describe Empowerment. _____

_____

_____

Once disempowered, a person may feel powerless,

_____ or _____.

What are some reasons residents might not complain when their rights are violated?

_____

_____

_____

_____

Video: Voices Speak Out Against Retaliation: Answer the following questions:

When speaking about fear of retaliation, what did the residents tell you?

_____

_____

_____

What can you do as an ombudsman to reduce fear of retaliation?

_____

_____

_____

Resident direction is the key to an ombudsman helping to empower residents because…

_____

_____

_____

How can short staffing negatively affect resident rights? Short staffing prevents staff from taking the time to:

_____

_____

_____

Ask the Trainer: Meal times

A nursing home changed breakfast time from 8:00 to 7:00 a.m., but a group of residents don't want to get up that early.

1. Do residents have a say in this policy? _____

2. How would you approach this problem as the ombudsman?

_____

_____

Ask the Trainer: Late Night Television

A resident wants to watch television in the living room of his assisted living facility in the late hours of the evening. The manager said the TV must be off at 8:00 p.m. because it keeps other residents awake.

- Whose rights need to be protected, the complainant or those who go to bed at 8:00? _____
- Are there differences in resident rights in an assisted living facility as opposed to a similar situation in a nursing home?

_____

_____

Residents can leave their nursing home for visits and can stay overnight.
_____ True (T) or False (F)

Residents have the right to determine their personal care schedule, such as activities, bathing, and bedtime. _____ True (T) or False (F)

Residents have the right to keep money in their room. _____ True (T) or False (F)

Ask the Trainer: Love and Marriage

A nursing home administrator told marriage-bound residents, "You can get married, as long as your children give permission. I'm not sure you'll be able to share a room."
Do residents need permission to marry? _____

Will the newlyweds be entitled to their own room? What if a couple is not married, can they room together? _____

Residents have the right to receive their mail unopened, including government benefit checks that will pay for their care at the facility. _____ True (T) or False (F)

Facility staff may monitor resident visits with a long-term care ombudsman.
_____ True (T) or False (F)

Residents do not have the right to communicate in their native language to get or receive treatment, care, or services. _____ True (T) or False (F)

Residents have the right to refuse food, medicine, therapy, and other services.
_____ True (T) or False (F)

Residents should receive a ____ - day notice of a home's intent to discharge them. It must be in _____. The resident has ____ days to appeal.

Exercise: Residents Have Rights

Residents have a right to complain only about situations that directly affect them.

_____ True (T) or False (F)

Only approved residents have the right to attend and participate in resident council meetings. _____ True (T) or False (F)

Use Supplement 6-A or 6-B to choose the resident right to help resolve the complaint.

1. My doctor won't listen to me. He is always in a rush. I want to see another doctor.

_____

_____

2. No one will tell me why I have to take so many pills every day.

_____

_____

3. Tomorrow they are moving me to another hallway. I don't want to move.

_____

_____

4. My mother is very frail and I don't want her to fall. Yet they won't put side rails up on her bed at night.

_____

_____

5. My friend is very critical of staff when she comes. The administrator says if she doesn't stop, she cannot visit any more.

_____

_____

6. The staff who feed my Dad shoves food into his mouth without care or attention.

_____

_____

7. My sister stopped eating and is losing weight. The doctor wants to insert a feeding tube, but my sister always said she didn't want one.

_____

_____

8. The activities are boring here … TV, bingo, or playing with paint like children!

_____

_____

9. My hearing aid is lost. They won't get me another.

_____

_____

10. Someone is spying on me. My mail is opened before I get it.

_____

_____

11. I told the nurse last week there's a sore on my leg. No one has checked it yet.

_____

_____

12. This place is like a prison. I want to go home and they won't let me.

_____

_____

13. The housekeeping staff always barges in when I'm undressed. No one ever knocks before they come into my room.

_____

_____

When I visit Dad, he's usually sitting in a soiled brief. When I tell the nurse, she says, "I'm busy now. I'll come as soon as I can," and then comes an hour later.

_____

Family has a right to be notified within 24 hours of an _____ or a significant change in the resident's physical, mental, or _____ status. Family also has a right to participate in the _____ planning process.

Chapter 6: Facilities

Trainee Name: _____

Date Completed: _____

1. Most assisted living staff is not _____ or _____.
2. In Texas, assisted living services emerged in what decade? _____
3. Assisted living can only be paid for with private funds (not Medicaid).

   _____ True (T) or False (F)
4. Since residents can require help to evacuate, the highest level of care available is in a Type _____.

Exercise: Introduction to a Nursing Home Administrator

A staff ombudsman goes with an ombudsman intern to a nursing home. After the staff ombudsman introduces the intern, the administrator says, "You know we haven't needed an ombudsman for a long time. Regulatory Services surveys us and thinks we're doing a great job. You probably won't have much to do here."

Questions about scenario:

1. Why do you think the administrator made the statement above?

   _____
2. What are some positive aspects of the program you would stress to the administrator?

   _____

   _____

Exercise: Help! – Identify the Right Person

Identify the best person to help solve each problem. Assume you obtained consent from the resident in order to take action.

Activities director	Charge nurse	Dietary staff	Medical director
Administrator	Certified nurse aide	Family member	Social worker
Business office staff	Director of nursing	Housekeeping staff	Staff ombudsman

1. Mrs. Ortiz speaks Spanish, and you need an interpreter to communicate with her. _____
2. You notice Mr. Smith's drinking water container is empty. _____
3. Mrs. McMillan reports that she lost a sweater. _____
4. Mr. Jones appears to be uncharacteristically depressed. _____
5. There is something extremely sticky on the floor of the main entrance. _____
6. Several call bells are answered slowly and some not at all. _____
7. Mr. Jenkins is worried about his bills. _____
8. A resident tells you the aide named "Mary" hit her. _____
9. Mrs. Nelson tells you she does not get her personal needs allowance. _____
10. A number of residents tell you they have not seen the doctor this month. _____
11. The social worker asks if you can help with a resident's Power of Attorney who is not paying the nursing home bill. _____
12. After speaking several times with the Director of Food Services, you find that complaints are not getting resolved. _____
13. You notice a resident is sliding out of a chair. _____
14. Mr. Sims appears lonely and bored. _____
15. Two roommates are arguing with each other. _____

On average, how many nursing home residents pay with Medicaid? _____%

A person using Medicaid to pay for nursing home care keeps $_____
each month. This is called a personal needs _____.

What is "applied income?" _____ _____

The State of Texas contracts with TMHP to determine a resident's

_____ _____.

Exercise: Walk the Fine Line - During the presentation, consider the following questions:

- How can an ombudsman 'walk the fine line' between residents and staff in a way that increases residents' trust?

  _____

- How can an ombudsman help residents see an ombudsman as a resident advocate, but not cross the line and create a dependent relationship?

  _____

- How can an ombudsman develop relationships with staff that improves quality of life and care for residents, without crossing a boundary with staff?

  _____

- Give an example of an ombudsman being pro-facility:

  _____

Chapter 7: Resident and Family Councils

Trainee Name: _____

Date Completed: _____

Ask the Trainer: Resident Council

What is the key to success of a resident council?

_____

_____

How do I learn when the council meets in the home where I am assigned?

_____

_____

Ombudsmen attend council meetings if _____.

A facility must assign a _____ _____ to support council needs

Appropriate ways ombudsmen support councils (Mark the ones that apply):

__ Encourage residents to attend

__ Explain the ombudsman program at a meeting

__ Create and distribute minutes

__ Attend every month

A new ombudsman should make contact with the _____.

Video: Strength in Numbers: The Importance of Nursing Home Family Councils

Watch the video and answer the questions that follow.

1. On a scale from 1-10, how well do you think the administrator ___ and staff ___ would receive a family council in your assigned home?

2. How could the council recruit more family members? _____

_____

_____

3. What guidelines might help a first meeting be successful?

_____

_____

_____

4. Do you have any concerns about the family council at your assigned home?

_____

_____

5. Identify a barrier to starting a family council _____

_____

_____

6. Identify a facility staff that supports a family council _____

_____

Chapter 8: Care Planning

Trainee Name: _____

Date Completed: _____

Exercise: Create Wilma's Care Plan

Wilma is an 88-year old woman with dementia. She has a short attention span and usually has a cheerful demeanor. Wilma likes to walk around the facility for most waking hours. She is unable to distinguish between areas she is allowed to enter and those that she should not. Her ambulation skills are excellent; she requires no assistance. Wilma disturbs some residents because she may enter their rooms against their wishes. She prefers to be with staff at all times; she does not tolerate being alone very well. She and her husband raised eleven children. They owned a hardware store and were respected business owners in town.

Wilma's Individualized Care Plan

Needs	Goal	Approaches

Video: Answer the following questions about CMS *Hand in Hand Module 6*.

1. In the *Mrs. Johnson, Part I* video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?

- _____
- _____
- _____

2. In the *Mrs. Johnson, Part 2* video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?

- _____
- _____
- _____

3. In the *Mrs. Johnson, Part 3* video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?

- _____
- _____
- _____

4. In the *Mrs. Johnson, Part 4* video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?

- _____
- _____
- _____

5. In the *Mrs. Johnson, Part 5* video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?

- _____
- _____
- _____

6. Good dementia care involves fulfilling these basic human needs:

- _____
- _____
- _____

The person named in a Medical Power of Attorney to make decisions is called the _____.

Ask the Trainer: Family Members Disagree

The doctor told a resident there are no more treatments to improve her health and he recommends hospice care. One daughter agrees but the other wants aggressive treatments to continue.

- Whose wishes do you advocate for? _____
- What should an ombudsman do when family members disagree?

  _____

  _____

Name one person who can be a surrogate decision maker? _____

Unless specifically authorized by court, or named by a resident as an agent in advance directives, family members and professional caregivers do not have legal authority to make decisions for residents. _____ True (T) or False (F)

Chapter 9: Recognizing, Receiving and Investigating Complaints

Trainee Name: _____

Date Completed: _____

When receiving a complaint from anyone other than a resident, let that person know you take _____according to the resident's wishes.

Video: Watch the YouTube video *The Monkey Business Illusion*

Follow this link: http://www.youtube.com/watch?v=IGQmdoK_ZfY

In the video people are passing basketballs. One group is wearing white shirts; the other group is wearing black shirts. Count the number of times the team in white shirts passes the basketball. After watching the video, answer the following questions.

How many times did the team in the white shirts pass the basketball? ____

Did you see anything strange? _____ Yes (Y) or No (N)

What did you see? _____

Did the curtain change color? _____ Yes (Y) or No (N)

Did any players leave the game? _____ Yes (Y) or No (N)

Video: Long-term Care Ombudsman Casework: Advocacy and Communication Skills, Scenario #1: Anne Walker

INSTRUCTIONS: Watch the video and answer the following questions. Be prepared to discuss your responses with your trainer.

Note: Some questions seek specific examples from the scenarios so it may be helpful to review the questions before watching the video to understand what you will be asked to identify.

An ombudsman investigation should be _____, _____, and _____.

How did Gloria use her senses to gather evidence during her visit and complaint investigation related to Ms. Walker's concerns?

_____

_____

Why did Gloria visit during the morning shower time?

_____

_____

What challenges might an ombudsman encounter when visiting early mornings, nights or weekends?

_____

_____

Identify other ways Gloria could approach the investigation of this complaint.

_____

_____

When Ms. Walker expressed her concern about not wanting to be identified with this complaint and said residents have been discharged due to sharing their concerns, what else could Gloria have said in response to her statement?

_____

_____

What does Gloria do to protect Ms. Walker's confidentiality, and what are some other things she could do to ensure Ms. Walker isn't identified as the complainant unless she is ready?

_____

_____

What concerns did you hear Ms. Walker express in this scenario? Were all of them addressed?

_____

_____

Why didn't Gloria review Ms. Walker's care plan to check her preferences about showers?

_____

_____

Effective Communication Skills Exercise: Use the chart below to identify some of the open-ended and close-ended questions you heard Gloria ask and describe what information she was trying to obtain with those questions.

OPEN ENDED	CLOS ENDED	INFORMATION GAINED

Exercise: In the table, list an approach for each emotional or uncooperative response.

Witness's Response	Ombudsman Approach
Crying	Empathize or offer a glass of water and tissues
Pacing	
Slamming things	
Pointing fingers	
Eye rolling	
Lack of eye contact	
Screaming or yelling	
Folder arms or other body language	
Excessive talking	

Giving the same response to every question	
Sarcasm	
Cursing	
Blaming	
Avoiding	
Other:	

Chapter 10: Resolving Complaints

Trainee Name: _____

Date Completed: _____

The difference between a position and an interest is: _____

_____

When negotiating with management, separate the _____ from the problem.

Video: Long-term Care Ombudsman Casework: Advocacy and Communication Skills, Scenario #2 Brashear

INSTRUCTIONS: Watch the video and answer the following questions. Be prepared to discuss your responses with your trainer.

Note: Some questions seek specific examples from the scenarios so it may be helpful to review the questions before watching the video to understand what you will be asked to identify.

What concerns did you hear Mr. Brashear's expressing in this scenario? Were all of them addressed?

_____

_____

_____

_____

What is the PEP method? _____, _____,

_____.

How did Gloria address Mr. Brashear's concerns in relation to his rights and the other residents' rights when speaking with Mr. Cook? Was that effective? Explain your answer.

_____

_____

_____

_____

How did Gloria ensure her complaint investigation was resident-directed while reminding Mr. Cook of the need for resident-directed care and quality of life? How did this impact her credibility with Mr. Brashear? With Mr. Cook?

_____

_____

_____

_____

As it states in the video, LTCO need to remain "calm, objective and in control" at all times, especially when a situation has escalated. When speaking with Mr. Cook what techniques did Gloria use, both verbal and nonverbal, to maintain her professionalism and remain calm, but assertive?

_____

_____

_____

_____

In the follow-up conversation with Mr. Brashear and Mr. Cook, how did Gloria demonstrate her support of Mr. Brashear when facilitating that conversation? Why was that important?

_____

_____

_____

_____

Resident-directed advocacy means the ombudsman should:

_____

_____

Exercise: Brainstorm possible solutions, potential obstacles, and suggestions to overcome obstacles below.

Ms. Garcia wants to stay up late at night. An evening charge nurse knows her preference and will accommodate her. This nurse doesn't work every night. How can a lasting solution be reached?

Possible Solutions: _____

Potential Obstacles: _____

Suggestions to Overcome Obstacles: _____

_____

_____

Possible Solutions: _____

Potential Obstacles: _____

Suggestions to Overcome Obstacles: _____

_____

_____

Possible Solutions: _____

Potential Obstacles: _____

Suggestions to Overcome Obstacles: _____

_____

_____

Possible Solutions: _____

Potential Obstacles: _____

Suggestions to Overcome Obstacles: _____

_____

_____

Before taking action to resolve, be sure you know what the _____ wants.

Close a case when you have done all the _____ you can reasonably do.

Exercise: Case Studies

Case Discussion: "Show me the Money"

Ms. James lost several clothing items. Her sister Ms. Martin visits often. On the last visit, Ms. James was wearing clothes that did not belong to her. She told her sister

some clothes had been taken out of her dresser. When Ms. Martin asked, the administrator said Ms. James is confused.

Ms. Martin heard that her sister should be able to keep some money out of her check each month. Ms. James doesn't know about this. Ms. Martin suggests the administrator use the money to buy a new dress for her sister. He says there isn't any money left after bills are paid each month. When Ms. Martin asked where the money was kept, staff replied that only the legal guardian could have that information. Other residents report their funds are not accounted for. The administrator reports:

- Because of theft, personal needs allowances are given on an as-needed basis.
- At admission, every resident signs a form authorizing the facility to administer funds for security purposes. For residents who have a diagnosis of dementia, a family member is asked to agree to this procedure by signing the form.

Step 1: Identify the problem and research statutory support

_____

_____

Step 2: Consider causes and scope

_____

_____

Step 3: Explore ways to resolve and take action

_____

_____

Case Discussion: "Discharge – Unable to Meet Needs"

Lacey Dalton is married and 45 years old. Her husband lives in their home and she lives in a nursing home. The administrator issued her a 30-day discharge notice stating they cannot meet her needs.

The facility contacted Mr. Dalton numerous times to discuss his wife's behaviors, but he changed his phone number and address. Mrs. Dalton reportedly gave her husband Power of Attorney when she was in the hospital, but the facility does not have a copy. The facility reports Mrs. Dalton is noncompliant with treatment and has placed her health at risk. Mrs. Dalton says her husband cannot take care of her. She calls the ombudsman to help her stay in the nursing home.

Step 1: Identify the problem and research statutory support

_____

_____

Step 2: Consider causes and scope

_____

_____

Step 3: Explore ways to resolve and take action

_____

_____

Case Discussion: "No Food Choices Appropriate for Diabetes"

Jerry Smith lives in Happy Hills Assisted Living. He recently shared his concern about the facility's lack of food choices appropriate for a person with diabetes. Mr. Smith states he inquired about appropriate menus for diabetes before moving into Happy Hills. At that time, the executive director told Mr. Smith they always have two entrée choices at each meal and that he could choose the best option that serves his dietary needs. Mr. Smith showed the monthly menu to the ombudsman. He had highlighted the entrée choices which did not meet his dietary needs. Many lunches and dinners listed two high carbohydrate options such as chicken spaghetti and tuna noodle casserole. No sugar free desserts were indicated.

Mr. Smith said he recently told the executive director and the nurse about his dietary concerns. He said the executive director told him the facility disclosure indicates the assisted living serves a liberalized diet.

Step 1: Identify the problem and research statutory support

_____

_____

Step 2: Consider causes and scope

_____

_____

Step 3: Explore ways to resolve and take action

_____

_____

Chapter 11: Staying Connected

Trainee Name: _____

Date Completed: _____

Every certified ombudsman is required to earn ____ hours of continuing education each year.

Staff ombudsmen report daily and volunteers report every _____.

Consultation provides all ombudsmen the support they need while ensuring they follow procedures to protect residents' rights and the _____ of the ombudsman program. Consultation is required when ombudsmen are asked to disclose confidential _____ and _____ from the resident, resident's LAR, or complainant cannot be obtained.

Exercise: Find the Best Complaint Code

Use the list of 133 complaint codes to assign the best code to describe a complaint. Circle the complainant in each complaint.

Example: An ombudsman observed a resident with fingernails and hair that appeared dirty. The best complaint category and code is: F 45, personal hygiene.

____ 1. A resident tells you "A CNA is mean. I get nervous when she comes to my room."

____ 2. A daughter reports the nursing home is moving her Mom to make room for a special rehabilitation unit. She has lived in the same room for two years and doesn't want to move. She says, "The social worker is harassing us."

____ 3. A resident says, "My roommate hollers out and keeps me up at night. I want him moved."

____ 4. A facility staff tells you, "Breakfast looks awful. The pancakes are rubbery, the eggs are powdered, and the coffee is cold." You ask residents and they agree.

____ 5. A resident reports the facility held her care plan meeting without her.

____ 6. The social worker reports, "Mr. Jones is going into resident rooms and stealing."

____ 7. A resident reports, "Rehab has stopped physical therapy because they say I am no longer improving enough, but I know I can progress with more therapy."

____ 8. The daughter said, “Mom called me very upset. The blouse and pants they put on her are not hers.”

____ 9. The ombudsman observes the bathroom in a resident’s room has feces, standing water, and live roaches.

____ 10. The ombudsman notices several call lights are not within residents’ reach in bed.

____ 11. The daughter of a resident says, “My mother is allergic to fish and she couldn’t eat what was served. No one told her she could order something else so she went to bed hungry.”

____ 12. The facility called the ombudsman for assistance. They report a resident wants to go home but the nursing home does not think he can live safely at home.

____ 13. An ombudsman is aware a resident is diagnosed with an anxiety disorder. The resident’s son calls and reports to the ombudsman that he was not informed his father’s doctor ordered two psychotropic drugs. The son is concerned after reading about serious side effects.

____ 14. The ombudsman notices the facility’s living room smells of smoke. The smoking area is off the living room and has a large ashtray full of cigarette butts in the corner.

____ 15. A resident’s daughter says, “Every time I visit my mother, she is sitting in the wheelchair in the hall staring at the walls.”

____ 16. An ombudsman observes a resident looks very thin and does not eat lunch. The resident calls out for milk, but no one gets it for her.

____ 17. A resident reports, “My dentures got lost three months ago. I am still waiting for them to be replaced.”

____ 18. The ombudsman learns a resident is Spanish speaking, but none of her caregivers understand or speak Spanish.

____ 19. A resident says, “I’m in terrible pain. The nurse is giving me Tylenol but it doesn’t help. I told her but no one pays attention.”

____ 20. A resident says, “Last evening I called the CNA to use the bathroom. The CNA said, “I’m busy now. Go in your diaper.”

____ 21. A resident tells you she has left messages for her MCO service coordinator, but none of her calls are returned.

____ 22. A resident’s customized power wheelchair is broken and the facility says the MCO will not agree to get it fixed.

Exercise: Practice Completing a Monthly Report

Use the ombudsman's notes provided below to complete a May 2012 Ombudsman Activity Report.

May 1, 2012 (2.5 hours)

- Ms. Green reports it is too noisy at night and she can't sleep. Reported to administrator and discussed changes in nighttime supervision.
- Mr. White says his roommate keeps his light on until midnight and it keeps him awake. His sheets have not been changed in a week. Housekeeping changes sheets while I am there. Visited 29 residents.

May 10 (2 hours)

- Mr. Mustard tells me, "I don't know why I am here, I want to go home." We speak with the social worker who calls the relocation contractor for an assessment.
- Ms. Scarlet reports never having a water pitcher and says she is thirsty. Three other rooms do not have water available and two hallways have only one CNA working.
- Attended Family Council meeting in p.m. Visited with 9 family members.

May 13 (1 hour)

- Ms. Brown wants to get outdoors but says everyone is too busy. Activities assistant helps her outside while I am there.
- Mr. White and I discuss his relationship with his roommate who was sent to the hospital last night. He reports several housekeeping staff quit. Trash cans are full and the restroom needs attention. Requested housekeeping services.

May 14

- Called Mr. White. Housekeeping cleaned his room yesterday afternoon.

May 21 (1.5 hours)

Followed up with all residents on complaints. Visited with 10 residents and 2 families.

- Ms. Green says nights are quieter. Other residents report the same. I reported to the administrator improvements and thanked her for intervention.
- Mr. Mustard hasn't seen the relocation contractor for an assessment. Asks me to call and find out the status of his request.
- Ms. Brown reports not getting outside since last week. Calendar includes no outdoor activities. Activity director is not available to talk; left a note for administrator to call me.
- Mr. White's roommate has returned from the hospital and is sleeping more. Room has been quiet at night, but he feels it is temporary.
- Observed water pitchers being distributed to each resident. Ms. Scarlet reports she has received water every day since I reported it. Close case, but watch for how often water is replenished and if solution lasts next month.
- Housekeeping still looks behind – beds not made at noon. Trash overflowing.

Supplement 11-A – Researching Statutory Support

Use the links below to find the rule. The first one has been completed for you. To shorten you search, you can use "Ctrl F" to complete a word search.
Nursing Facility Requirements for Licensure and Medicaid Certification Handbook:
http://www.dads.state.tx.us/handbooks/nfr-lmc/
Licensing Standards for Assisted Living Facility Handbook:
http://www.dads.state.tx.us/handbooks/ls-alf/

Nursing Home

1. Can medications be released to residents?
   Reference §19. 507(a)(b)__

   [Hint: Find Subchapter P, Pharmacy Services, 19.507 Drug Release]

2. Who prepares the comprehensive care plan?
   Reference §19. _____

3. What is the facility's responsibility for enforcement of smoking policies?
   Reference §19. _____

4. What is the maximum time period between meals?
   Reference §19. _____

5. Must the facility provide physician-ordered medical transportation to medical services outside the facility? Reference §19._____

6. Can a resident administer his or her own medications?
   Reference §19. _____

7. Name four of five types of information that must be conspicuously and prominently posted in a licensed facility? Reference §19._____

8. Does the resident have to be provided access to representatives of the ombudsman program? Reference §19. _____

9. In 19.307, where does it discuss accessibility of resident call cords?
   Reference §19.307_____

10. When is it appropriate to have locks on bedroom doors?
    Reference §19. _____

Assisted Living Facilities

1. What criteria are used to determine if a resident is placed appropriately in a Type A assisted living facility? Reference 92._____

2. Does the resident service plan have to be approved and signed by the resident or resident's responsible party for making health care decisions? Reference 92._____

3. May a resident self-administer medications? Reference 92._____

4. In an assisted living facility, which staff can administer medications to a resident and what training does he or she need? Reference 92.

5. The assisted living facility must keep supplies of staple foods for a minimum of _____ day period and perishable foods for a minimum of a ____ day period. Reference 92._____

6. Does the resident have to be provided access to representatives of the ombudsman program? Reference 92._____

7. Name six of the nine required postings that an assisted living facility must prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees, and visitors Reference 92._____

8. Can a facility discharge a resident because covert electronic monitoring is being conducted by or on behalf of a resident? Reference 92._____

9. Does an assisted living have to give a 30 day discharge notice? Reference 92._____

10. Can an assisted living facility provide skilled nursing services? Reference 92. _____

Supplement 11-B - Consistency in Reporting Case Work

2. A resident tells the ombudsman she used her call light twice today. Each time, she had to wait 20 minutes before someone came to help. She asks the ombudsman for help. The ombudsman asks the resident to push the call button and checks the nurses' station. The call light works. The ombudsman asks who worked the morning shift. A new CNA started yesterday. Staff said they would focus training on call lights. During a follow up visit, the resident says she doesn't have to wait long for someone to respond to the call light. The ombudsman closes the case.

Number of complaints:
Complainant:
Complaint(s) verified: Yes __ No __
Complaint code(s):
Disposition:

2. A resident complains his home only offers one alternative meal at dinner and he would like two. He would also like to have a larger screened TV in the lounge closest to his room. He requests to remain anonymous and asks the ombudsman to investigate. The facility says the small lounge rooms are too small for a big screen TV, but there is a big screen TV in the main lounge. Staff arranges two alternative meals during the week but cannot offer two on weekends. The resident is satisfied with alternative meals during the week, because his family often brings special treats on the weekends. But, he is not happy about the TV. The ombudsman closes the case.

Number of complaints:
Complainant:
Complaint(s) verified: Yes __ No __
Complaint code(s):
Disposition:

3. A daughter complains that her mother needs to move closer to the nurse's station. The daughter has MPoA (An MPoA (medical power of attorney) allows the agent to make health decisions for the principal if the principal (mother) is incapacitated.) for her mother. The resident agrees she would feel safer in one of two rooms near a nurse station. The ombudsman investigates and finds no empty beds in either room. The daughter insists that her mother needs to move. The ombudsman visits the resident twice and both times, she says she wants to forget the whole thing. Her current room is OK, and all the commotion about moving is upsetting her. The ombudsman closes the case.

Number of complaints:
Complainant:
Complaint(s) verified: Yes __ No __
Complaint code(s):
Disposition:

4. The ombudsman observes roaches in three resident rooms. This is the fourth complaint opened concerning roaches in the past year. Each time, the ombudsman contacts the local health department and corporate office. The facility addressed the problem temporarily, but the roaches return. This time, after contacting the health department and corporate office, the ombudsman refers the case to Regulatory Services. (For this exercise, assume there is nothing more the ombudsman can do.) Regulatory staff doesn't find any roaches the day they inspect the facility so they do not substantiate the complaint. The ombudsman closes the case.

Number of complaints:
Complainant:
Complaint(s) verified: Yes __ No __
Complaint code(s):
Disposition:

5. A resident's son calls the ombudsman with a complaint about food. Meat is often tough to cut and chew, and his mother rarely eats most of her dinner. He visits his mother most dinner meals. The ombudsman offers to investigate by speaking with the complainant's mother on a future visit. The ombudsman visits the nursing home and discreetly visits the resident to ask about food quality, temperature and taste. The resident doesn't report any concerns. The ombudsman tells the resident about her son's call and his concern that sometimes the meat is tough. The resident says her son "worries too much" and she doesn't mind the food. The ombudsman watches the evening meal and asks eight residents about the meal. No concerns are noted. By phone, the ombudsman informs the son that as a resident advocate, she takes action based on resident interests. The son is dissatisfied to learn the ombudsman will not work the complaint further. The ombudsman closes the case.

Number of complaints:
Complainant:
Complaint(s) verified: Yes __ No __
Complaint code(s):
Disposition:

6. A Resident Council president makes a complaint about the amount of the Personal Needs Allowance (PNA) for Medicaid residents. Invited to the next council meeting, the ombudsman explains the Texas Legislature determines the PNA. The residents ask the ombudsman's help to present this issue to an advocacy organization to lobby on behalf of residents. The ombudsman meets with an advocacy organization representative, and the organization agrees to lobby for a PNA increase during the next legislative session. The ombudsman closes the case.

Number of complaints:
Complainant:
Complaint(s) verified: Yes __ No __
Complaint code(s):
Disposition:

7. On June 1, the ombudsman observes seven call buttons out of reach of residents:

- 3 residents told the ombudsman they didn't realize the call buttons were out of reach.
- 1 resident said he would call out if he needed anything.
- 3 residents were unable to express their needs and didn't seem to be able to use the call button.

The ombudsman visited 25 rooms and contacted 40 residents. Some beds with call buttons out of reach were made while others were not, indicating housekeeping may have misplaced the call buttons. For the remaining rooms, the ombudsman talks with a nurse and two CNAs. The nurse reports it is a mistake and places the buttons within residents' reach. Both CNAs report they check more frequently on the residents who cannot use the call buttons. The ombudsman reports the concern to the administrator who states she will talk with the housekeeping supervisor and in-service direct-care staff on proper placement of call buttons. The ombudsman suggests more frequent checks on residents by a CNA seems a good strategy to help meet all residents' needs. The ombudsman keeps the case open.

On July 14, the ombudsman monitors the original seven residents and others who did not have access to their call buttons. Housekeeping has cleaned each room, and all buttons are within the residents' reach. The male resident says it works to call out for help. CNAs report making frequent checks on residents who cannot use a call button. The ombudsman interviews another nurse who goes into a resident's room and asks, "Do you know how to use the call light?" The resident replies, "yes," but the ombudsman suspects the resident may not be capable. The ombudsman reports to the administrator: CNAs appear to have a good protocol; housekeeping appears to have made adjustments; but nurses appear to not recognize how to best meet the residents' needs. The administrator says she can't do more than provide another in-service. The ombudsman offers to assist, but the administrator declines. The ombudsman closes the case.

Number of complaints:
Complainant:
Complaint(s) verified: Yes __ No __
Complaint code(s):
Disposition:

Chapter 12: Resident Records

Trainee Name: _____

Date Completed: _____

Residents have the right to review all medical and financial records pertaining to them.

_____ True (T) or False (F)

Obtain resident consent to access a _____ record.

Exercise: Name the Medical Record Section

In which section of the medical record would you find the following?

1. What care does the morning shift need to give following the night shift?

   _____

2. Who did the resident name as her Medical Power of Attorney?

   _____

3. What kind of rehab does the resident need and how often?

   _____

4. When was the last x-ray to check whether the hip healed?

   _____

5. When did the resident return from the hospital?

   _____

6. What is the resident's working diagnosis?

   _____

7. Did the physician prescribe Ativan?

   _____

8. When does the facility plan to discharge the resident?

   _____

Chapter 13: Regulators and Resources

Trainee Name: _____

Date Completed: _____

The purpose of a survey is to _____ whether facilities meet licensing standards and whether _____ meet standards for participation in Medicare or Medicaid.

Ask the Trainer: Enforcement

Which enforcement action have you seen most commonly taken? _____ _____

All nursing homes and assisted living facility employees must be determined employable. Operators must check what two registries?

1. _____
2. _____

Exercise: Help! – Identify the Right Resource

Write the program or the best person to help solve each problem. To take action on a resident's behalf, you always need resident consent. For this exercise, assume you obtained consent from the resident.

1. Mrs. Cash moved to a new nursing home. She asks for her personal funds deposited with the home and is told no money is available.
   _____
2. When Mr. Rich moved in, he was private pay. Now he has spent down to a total of $2,000 in his accounts. Where does he apply for Medicaid?
   _____
3. You notice numerous residents are restrained. Facility staff says they use physical restraints to prevent falls, but they want to learn best clinical practices to keep residents safe.
   _____

4. Mr. Brown's bill hasn't been paid for the past three months. His dementia got worse and his son started paying. The business office manager believes the son is paying his own house payments out of his dad's money.

   _____

5. Each time you visit Julie Morrow, she talks about moving out of the nursing home because everyone is old and she believes she could live in an apartment.

   _____

6. The nursing home sent Alex Chang a 30-day discharge notice that they cannot meet his needs. He doesn't understand because other residents are in the same condition. He wants to stay.

   _____

Chapter 14: Resident-centered Care

Trainee Name: _____

Date Completed: _____

Exercise: Suggest how traditional words could be replaced with words that emphasize the person.

1. Nursing facility _____
2. Staff _____
3. Resident _____
4. Hallway/unit_____
5. Nourishment _____
6. Pet therapy _____
7. Activities room _____
8. Resident council _____
9. Therapy room _____
10. Meal tray _____

How can person-directed care improve quality of life in nursing homes and assisted living facilities?

_____

_____

List two differences between traditional care practices and person-directed care practices.

1. Traditional _____

   Person-directed _____
2. Traditional _____

   Person-directed _____

Mystery Game: Discussion in class only

CMS Video: Answer the following questions about CMS *Hand in Hand Module 4*.

1. All behaviors or actions are a form of _____. We must try to understand their world.

2. List three possible reasons behind the actions or reactions of an individual with dementia:

   d) _____

   e) _____

   f) _____

3. Medications can contribute to changes in a resident's actions. Any change in a resident's behavior or condition should be _____immediately.

4. In the *I Want to Go Home* video clip, why might Mrs. Caputo say she wants to go home?

   a) _____

   b) _____

   c) _____

5. In coming up with ways to respond to actions and reactions, what are the three 'P's' you should think about? Define the three P's.

   a) _____

   b) _____

   c) _____

What can an ombudsman do to help a facility implement person-centered care planning?

_____

Exercise: Practice Connecting Regulatory Compliance with Resident-directed Care
Directions:

Review the following regulations for nursing homes (§19, F-tags) and assisted living facilities (Texas Administrative Code, §92) then answer the correlating questions to practice promoting resident-directed care.

Introduction

List some practices a facility can do to promote dignity and choice?

- Build relationships with residents, families, and physicians to understand residents as individuals and provide care according to resident preferences.
- Enable residents to self-administer medications if they want to and it is safe.
- _____
- _____

Notice of Rights and Services

How can a care provider support resident-directed care, including the right to refuse care?

- Learn the person's cultural and spiritual practices and how they may affect treatment decisions.
- Determine exactly what service a resident is refusing and why.
- _____
- _____

Grievances

How can the right to complain be assured?

- Empower residents to feel comfortable voicing complaints to the ombudsman, facility staff, and family members to find a solution to their complaints.
- Empower resident and family groups to help resolve conflicts, grievances, and complaints, thus keeping problems close to their source.
- _____

Privacy and Confidentiality

How can privacy be respected and allow residents to thrive?

- Teach staff that only persons directly involved in providing treatments, delivering care, or to whom the resident has given consent can be present during care.
- Ensure privacy when residents go to the bathroom and receive other hygiene care.
- _____
- _____

Ombudsman Access

How can ombudsmen respect residents' privacy?
In rooms:

_____

Visiting a resident with a complaint:

_____

Investigating a complaint:

_____

Accessing resident's medical records:

_____

Quality of Life

Suggest some changes in facility environments to enhance quality of life.

- Furnish the home with personal items, such as pictures and furnishings that belong to the residents.
- Offer parties, dinners, and celebrations.
- Provide a variety of spiritual opportunities, such as speakers, services, and music.
- _____
- _____

Dignity

How can resident dignity, respect, and individuality be enhanced?

- Get resident input before choosing a radio or television station.
- Offer choice of paint colors to decorate rooms.
- _____
- _____

Activities

How can a home provide meaningful activities that offer interesting activity for all?

- Incorporate lifelong interests into activity options.
- Consider male and female, all ages, and various cultures and religions.
- _____
- _____

Quality of Care

How can care practices help a person attain physical and mental well-being?

- Ensure direct care staff recognize and know how to report changes in a resident's condition.
- Develop a staff training program with opportunities for interactive learning and resident participation.
- _____

Food

How can food taste and appear better to residents?

- Kitchen staff can be trained on cooking methods that enhance tastiness.
- During meals, observe whether food is attractive and eaten.
- Routinely survey all residents about their opinions of food served.
- Make fresh fruits and vegetables readily available.
- _____
- _____

Chapter 15: Systems Advocacy

Trainee Name: _____

Date Completed: _____

A resident council discusses their home's cutting back van travel on weekends. Identify one individual and one systems advocacy approach to resolve this problem.

Individual - _____

_____

Systems - _____

_____

How does the successful relocation of the person described above depend on a systems change? _____

_____

Find two system advocacy activities in the example above in which ombudsmen can participate in: _____

_____

List two ways you can help the public and lawmakers understand the needs of people who live in assisted living facilities.

3. _____
4. _____

Exercise: Future Advocacy

Brainstorm ideas for systemic culture change in your assigned facility. Consider the following areas:

- Meal service: _____
- Bathing and hygienic experiences: _____

- Social activities: _____
- Intimacy: _____

In general, what is one change that could provide all residents with an opportunity to exercise more choice and control?
_____

Name the training material that ombudsmen can deliver to long-term care staff. CMS _____ _____ _____.

Name one thing Town and Country changed or implemented in their nursing home to reduce the use of antipsychotics.

_____

_____