

The Role of Long-Term Care Ombudsmen In Nursing Home Closures And Natural Disasters

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INTRODUCTION

One very social resident, curled up into a ball in the new home and died. She never got out of bed.¹

Over the last several months, long-term care ombudsmen have experienced the problems, frustrations, and deaths of residents that are manifested when nursing homes have to move residents due to voluntary or involuntary nursing home closures. The unprecedented financial problems of nursing homes have recently brought national attention to the issue of nursing home closures, the need for a state plan, and transfer trauma. Information has been sent from the Health Care Financing Administration (HCFA) to state survey agency directors with guidelines on developing a state plan. The Administration on Aging (AoA) has disseminated indicators for ombudsmen to consider in identifying nursing homes that are having financial problems. All of this is an attempt to better prepare individuals in the event they are faced with a nursing home closure or natural disaster that ultimately will mean residents will experience some form of transfer trauma.

Long-term care ombudsmen have been and should be intimately involved in the movement or potential movement of residents from their nursing home. Ombudsmen play a vital role in supporting residents' rights, quality of life, and quality of care, during a move or closure. Ombudsmen work to help prevent or minimize any compromise in these areas. In addition, ombudsmen know that the resident's best interest is the overriding issue that must be addressed. Ombudsmen may need to be the 'default' party to initiate discussions if the licensure/certification/surveying or other legislatively authorized agency fails to do so. As such, the ombudsman may be the one individual who can and should urge dialogue among the different parties involved to ensure that there is a state and local plan to deal with closures and natural disasters that will also protect residents. Subsequently, the ombudsmen role in the meeting would be to represent the resident's interest.

Even more important, local and state ombudsmen have the ability to be proactive and work toward preventing nursing home closures along with other community agencies and individuals. Ombudsmen understand that the nursing home is the resident's home and that residents, like all people, should not be forced to leave their home unless it is absolutely necessary. Once there is a closure, everyone involved becomes reactive rather than proactive.

To avoid being placed in a reactive mode, ombudsmen need to:

- fight for alternatives to closures,
- be system advocates for changes in laws, regulations, etc.,
- encourage nursing home owners or the state licensing and certification agency to change management when problems persist or urge the use of temporary managers, and

¹ John MacDonald, Flood Slowly Taking Toll on Residents of Nursing Home, St. Louis Post Dispatch, Nov. 1 1997, at 1.

- be catalysts for these changes in their state in order to protect the residents who end up paying the highest price.

However, if the closure is imminent, then the role of ombudsman needs to be one of full participation with all parties involved.

The purpose of this paper is to identify the multiple roles of state, local, and volunteer long-term care ombudsmen in nursing home closures and natural disasters. Much of the information is relevant to board and care facilities as well. The information provided herein will assist ombudsmen in their efforts to:

- develop state and local closure plans,
- educate all parties involved in a closure on the issues/problems that residents encounter when faced with a transfer,
- better understand how transfers impact residents and family members, and
- promote a smooth transition.

Each of the six sections (Overview, Transfer Trauma, Nursing Home Closures, Role of State Long-Term Care Ombudsmen in Closures, Role of Local Long-Term Care Ombudsmen in Closures, and Natural Disasters) may be used independently of the other sections. These stand-alone sections allow the reader to target a specific section for information depending on the needs or interest at the time. Most importantly, care has been taken to include the viewpoints of residents and their family members regarding their experiences when faced with a nursing home closure or natural disaster. Their stories, problems, and suggestions are given so that the focus on residents and how closures and transfers affect them is never forgotten.

The **Overview, Section I**, explains why ombudsmen should be involved in a nursing home closure or natural disaster evacuation and pinpoints specific residents' rights that are more susceptible to being compromised. **Transfer Trauma, Section II**, defines this important issue and identifies resident related characteristics. Testimony from family members, ombudsmen, and staff explain the impact transfer trauma has on residents. In addition, the section explains measures to minimize trauma by developing a facility plan, help the resident once relocated, and deal with natural disasters.

Section III – Nursing Home Closures - looks at the issue of closures. The types of closures (voluntary and involuntary) are defined and comments are provided from HCFA staff. Residents and family members give their perspectives on how nursing home closures affected their lives. Indicators of possible nursing home problems that may signal an imminent closure are listed.

The role of state and local long-term care ombudsmen in nursing home closures is explored in sections IV and V. **Section IV, Role of State Long-Term Care Ombudsmen in Closures**, deals with the proactive role of state ombudsmen to prevent nursing home closures, perspectives from state ombudsmen on prior closures, the coordination effort needed with local ombudsmen, and an outline for developing a state nursing home closure “PLAN.” A recap of HCFA’s proposed criteria for a state plan and model state plans are provided. **Section V, Role of Local Long-Term Care Ombudsman in Closures**, takes another look at residents’ rights, provides perspectives from local ombudsmen on prior closures, and details a plan for developing a local nursing home closure “KIT” (Keep It Together).

Natural Disasters are discussed in **Section VI**. Ombudsmen requested that natural disasters be addressed because of the commonality of issues between disasters and closures. Natural disasters can involve a closure and will often involve a transfer. This section recounts perspectives of state and local long-term care ombudsmen who have experienced a natural disaster and provides measures to minimize transfer trauma. An outline for developing a state and local “EVACUATION STRATEGY” and a recap of model state and local evacuation plans are included.

OVERVIEW

Six residents were sent to facilities that were substandard.²

Long-Term Care Ombudsman Program Involvement

The relocation or potential for relocation of residents due to a nursing home closure or a natural disaster impacts the resident's quality of life and quality of care, if even for a short period of time. As the individual designated in the Older Americans Act of 1965 to advocate for residents in nursing homes, ombudsmen should play a pivotal role in closures and evacuations to ensure that the rights of residents are protected.

Another reason involvement of ombudsmen is critical is that they are the individuals who are sensitive to state and local issues. Ombudsmen have a broad perspective of the issues involved from licensing, regulations, staffing, and quality of care which all affect the residents. They are the individuals who can be "outside the box" in thinking since their primary role is to represent residents' needs and interests. As such, they do not have a prescribed role, as do the regulators or nursing home owners/managers. The other parties involved have more of a singular mission, adherence to specific regulations affecting funding or management objectives in the overall operation of a facility respectively, which may or may not take into full consideration the rights and needs of residents.

Since local ombudsman programs have responsibility for several homes, they cross facility lines and are able to see the big picture. They become catalysts to get others to fulfill their responsibility to residents. In addition, ombudsmen are able to identify patterns of care issues when residents are transferred from one out of compliance home to another.

Ombudsmen are typically the individuals with expertise regarding transfer trauma. Therefore, the ombudsman is the person who can help facilitate communications on this issue with the nursing home staff, regulatory staff, family members, and temporary managers (terminology varies by state, i.e. trustee, substitute administrator, third party administrator, state administrator, receiver, temporary manager, etc.). When all parties involved are educated, the resident's risk of transfer trauma is minimized.

Ombudsmen visit nursing homes frequently and become familiar with individual resident needs and the staff who provide the resident's care. These regular visits give ombudsmen a unique look at the operation of the facility that is extremely important when dealing with a closure. Most importantly, ombudsmen can follow-up with residents who are transferred, assess the impact that the transfer has on the resident, and work to ensure the appropriate level of care for the transferred resident.

² Local Ombudsman comment

As the advocate for nursing home residents, ombudsmen receive continuous training in issues that affect residents. This includes how to address and resolve conflict between a resident and staff. Conflict is apt to occur during a closure. This expertise in conflict management can help all parties involved in the process.

To recap, involvement of ombudsmen is necessary and beneficial because they:

- (1) are the individuals designated as advocates for residents in nursing homes;
- (2) are sensitive to state and local issues;
- (3) see the big picture;
- (4) have expertise regarding transfer trauma;
- (5) visit nursing homes on a regular basis; and
- (6) have expertise in conflict management.

In addition, ombudsmen are:

- (7) involved in monitoring the political climate in their state and/or region;
- (8) a central source of information on nursing homes; and
- (9) maintain a relationship with all parties who serve the aging population.

Individually or collectively, these nine reasons make ombudsmen a valuable and necessary partner in dealing with closures.

Ombudsmen have to be aware of and able to respond to circumstances concerning a potential closure or evacuation with little to no advance warning. Many ombudsmen have had the unexpected problem of dealing with a nursing home closure and/or the evacuation of residents due to a natural disaster. Their insight into the problems they encountered, what should have occurred, or what they would like to see in place in the future enables other ombudsmen to gain from their experiences. Although each circumstance will have its own peculiarities, this paper reflects general understandings of the issues involved in closures based on numerous interviews with state, local, and volunteer ombudsmen, family members, residents, Administration on Aging staff, HCFA staff, Area Agency on Aging (AAA) staff, and other individuals in the aging profession. The ultimate goal is to be prepared through the development and use of a State Ombudsman “**PLAN,**” to “**KEEP IT TOGETHER**” through a local ombudsman “**KIT,**” and to be prepared with a state and local “**EVACUATION STRATEGY.**”

It is recognized, however, that each state has its own dynamics, issues, and constraints that ombudsman programs must work within daily. As such, there may not be opportunity to do as much as each program would like. This in no way diminishes the efforts of ombudsmen or should cause any concern when reading the ideas presented here. Small steps or large endeavors are all important in the on-going effort to make life better for residents in nursing homes.

Residents' Rights

Residents do not lose rights simply because their nursing home is closing or they have to leave the home due to a natural disaster. However, several of the rights may be compromised and should be monitored more closely.

- ***Be treated with respect, dignity, and consideration***

Respect and dignity may vary based on the circumstances at the time as is evident in the next case.

During the relocation of residents due to flooding, open bed pick-up trucks were used to evacuate the residents. National Guard personnel lifted the residents into the truck. The weather was warm and sunny. One resident, who always kept her hair up in a bun, was seen in the back of a red pick-up truck with her flowing white hair going down the road. The ombudsman's first reaction was how horrible for the resident. However, when talking to the resident, the ombudsman learned that the resident thought it had been a good experience. She said it was "really fun." This could just as easily have been a lack of dignity or respect issue. This is a reminder of the importance of always using the resident's viewpoint and of checking to be sure the ombudsman understands the resident's perspective.

Another scenario, evicting residents in the middle of the night due to a voluntary or involuntary nursing home closure, would be a lack of respect, dignity, and consideration (exception would be the case of a natural disaster).

- ***Exercise rights as residents***

Residents have the right to choose where they will go if they are transferred. This is not the facility's or family's choice, when the resident is competent and there is no guardian in place.

- ***Freedom from mental, verbal, and physical abuse and restraints***

Residents should be carefully monitored during a relocation to avoid both chemical and physical restraints. As discussed later in the Transfer Trauma Section, the nursing home staff may utilize restraints inappropriately in response to resident hostility, a normal reaction to transfer trauma.

- ***Freedom of association and communication***

Residents need to know how to contact ombudsmen (state and local), key state regulators, HCFA, legal services, and other who can help. This information should be readily available and is included in the Local Ombudsmen "KIT."

- ***Not to be transferred without notice***

Proper notice is required. Residents are to be notified of a transfer/relocation/evacuation with as much advance notice as possible including options available to them so they can choose where they want to go. As soon as the relocation information is available, the facility should share it with residents and families. Withholding this information due to its potential for increasing stress on residents and families is not justified. Information withheld probably increases the stress more than

having the information in order to make appropriate plans. There should be timely updates throughout the relocation process of the time frames for the relocation and it is important to stick to that time frame, barring the need for a more immediate evacuation. During a closure, once a timetable is set, residents and families need to be able to rely on that schedule when making arrangements for transfer to another facility.

In addition, fast closures are not the best for residents. Having the opportunity to visit other facilities and make appropriate choices is easier on the resident and minimizes transfer trauma.

- ***Make complaints and express grievances***

Residents need to have an outlet available to them to express their anger at the closure, at having to leave their “home,” or simply to ask questions.

In one state, several residents refused to leave the nursing home when the home was ordered to evacuate. They wanted to stay and ride out the storm. They had lived in the area all their lives and in the nursing home for many years. Their request was not granted; however, they were allowed to complain and the facility talked about the evacuation regularly. Since then, evacuations are discussed regularly and practiced in case of a future evacuation.

- ***Keep possessions***

Information residents need to be kept aware of includes: where personal belongings are located, who has them, whether they are to be transported with the resident at the time of the closure, and how they are protected during a disaster. During the relocation, residents have the right to retain personal property and arrangements need to be made to safe guard their possessions.

TRANSFER TRAUMA

A wave of disorientation and despair so intense that it can kill.³

Several courts and the Administration on Aging have recognized transfer trauma as a viable problem. One statute defines transfer trauma as “the combination of medical and psychological reactions to abrupt physical transfer that may increase the risk of grave illness or death.”⁴ The terminology to identify the effects of relocation has been referred to by many names such as translocation syndrome, transfer stress, transfer shock, transfer anxiety, or transfer trauma. In 1992, a formal nursing diagnosis was approved, ‘relocation stress syndrome,’ and is defined as “physiologic and/or psychosocial disturbances as a result of transfer from one environment to another.”⁵

Transfer trauma is described as a “wave of disorientation and despair so intense that it can kill.” Stability of familiar people, surroundings, and routine are important elements for sustaining life for people of advanced age and, thus, minimizing trauma. That first move to a nursing home is almost always traumatic; a subsequent move can be deadly.⁶

Ombudsmen, state regulators, nursing home staff, and all other parties involved with residents who may be transferred from a nursing home due to a disaster or closure need to understand transfer trauma. However, there are many in the field who minimize the importance or discount transfer trauma entirely. As the resident’s advocate, ombudsmen are the ideal people to educate individuals on this life threatening issue. To assist in this education, a discussion of the characteristics of transfer trauma, its impact on residents, and ways to minimize transfer trauma follows.

Characteristics

The response to the stress caused by a transfer or relocation may include depression, manifesting as agitation, increase in withdrawn behavior, self-care deficits, falls, and weight loss.⁷ The increase in falls doubled after relocation to a new facility according to one study. Those individuals who were ambulatory or wheelchair mobile had the most significant risk of increased falls.⁸

In residents with cognitive impairment due to dementia or Alzheimer’s, the symptoms are more exaggerated and may include hallucinations and delusions. The reason for the trauma is

³ Pamela S. Manion & Marilyn J. Rantz, Relocation Stress Syndrome: A Comprehensive Plan for Long-Term Care Admissions, 16 Geriatric Nursing, May/June 1995 at 108.

⁴ Me.Rev.Stat.Ann. title 22, section 7932 (West 1983).

⁵ Pamela S. Manion & Marilyn J. Rantz, Relocation Stress Syndrome: A Comprehensive Plan for Long-Term Care Admissions, 16 Geriatric Nursing, May/June 1995 at 108.

⁶ Matt Smith, Diagnosis: Eviction, (visited Oct. 23, 1999) <<http://www.sfweekly.com/1999/060999/feature1-2.html>>

⁷ Susan M. Lander et al, Intrainstitutional Relocation Effects on Resident’s Behavior and Psychosocial Functioning, Journal of Gerontological Nursing, April 1997 at 35.

⁸ Susan M Friedman et al, Increased Fall Rates in Nursing Home Residents After Relocation to a New Facility, Journal of American Geriatrics Society, November, 1995 at 1237.

that the elderly have little flexibility left in their physical or psychological make up, the inability to adjust due to chronic conditions, and the accumulation of losses (physical/psychological, family, home, and nursing home). The transfer is the “final blow.”⁹

Confusion is the most frequently experienced symptom of residents (60% of residents during the first 28 days after relocation). Resident behavior ranges from withdrawal, crying, and sadness to hopelessness and helplessness in the “resigned resisters.” The “forceful resisters” behavior is anger, distrust, noncompliance, aggressiveness, and physical or verbal abuse to staff.¹⁰

The characteristics identified as relocation stress syndrome are:¹¹

- anxiety
- depression
- weight change
- sad affect
- dependency
- gastrointestinal disturbances
- increased verbalization of needs
- unfavorable comparison of post/pre-transfer staff
- verbalization of being concerned/upset about transfer
- verbalization of unwillingness to relocate
- apprehension
- loneliness
- insecurity
- restlessness
- lack of trust
- increased confusion
- vigilance
- withdrawal
- sleep disturbance
- change in eating habits

By understanding that transfer trauma will occur when there is a transfer or evacuation or even the potential for such a move, the ombudsman can be attuned to residents whose behavior reflects a characteristic and educate others about the problem to minimize the risk to residents. Even minor changes in routine can, emotionally and physically, upset the elderly because they frequently have established routines and preferences that provide security for them.

Impact On Residents

Once notified by the state of non-compliance issues, the facility attempted to evict the residents during the night. One woman was a Holocaust survivor. The staff put her things in a black plastic bag and told her “they were coming to take her away.” When the ambulance drivers arrived in the middle of the night to move the residents, once the drivers saw what was happening, they refused to transport.¹²

The impact of a closure on residents is illustrated by the fact that “the elderly rank changes in living conditions and residence as requiring significantly higher magnitudes of adjustment than the normative group. No matter what the condition of the individual, the nature

⁹ Sarah Greene Burger & Harriet Fields, Signs of Transfer Trauma, May 3, 1993.

¹⁰ Pamela S. Manion & Marilyn J. Rantz, Relocation Stress Syndrome: A Comprehensive Plan for Long-Term Care Admissions, 16 Geriatric Nursing, May/June 1995 at 108.

¹¹ Id.

¹² Matt Smith, Diagnosis: Eviction, (visited Oct. 25, 1999) <<http://www.sfweekly.com/1999/060999/feature1-5.html>>

of the environment, or the degree of sophisticated preparation, relocation entailed higher than acceptable risk to the majority of those who moved. In one study, during the relocation, within the first ten weeks of residence, 96% of the involuntary group died, whereas only 2.6% of the voluntary group died.”¹³

The following cases illustrate the different characteristics of transfer trauma and the affect it had on residents who were involved in a nursing home closure as expressed by relatives, nursing home staff, ombudsmen, and regulators.

Anxiety, Insecurity, Increased Confusion, and Hallucinations: My mother had Multiple Sclerosis (MS) but was cognitively alert. Once moved, she became confused, and thought she was in a donut shop. When stressed she would have spasms in her legs. After the move, the spasms increased. She was afraid of being dropped, asked where other residents were that she had befriended, and had to remember new staff members names. (daughter of resident)

Depression, Withdrawal, Death, and Change in Eating Habits: We were told that some of the residents being moved would not survive but that the move was for the best. Never in my imagination did it occur to me that my father would die. He was eating, drinking, walking, and doing OK prior to the move. After the move, he became more fidgety, wringing his hands, hands shaking more, then he got sick and refused to eat. I wonder how many more died. (daughter of resident who died 18 days after transfer)

Withdrawal, Depression, Death, Loneliness, and Weight Change: He survived the flood but was dead in two weeks, his spirit utterly broken. The whole thing was just not very pleasant for him. The activities director believed he died from a broken heart. Seven months after fleeing floodwaters in Minnesota, 15 of the 47 evacuated residents were dead. Typically two or three residents would have died in the same period. Officially the deaths were from natural causes and age-related illnesses but stress, loneliness, and despair were the real killers according to the director of nursing. The residents became withdrawn, despondent, lost weight and suffered one ailment after another.¹⁴

Withdrawal, Death, and Change in Eating Habits: The evacuation of Georgia nursing homes due to a hurricane resulted in two deaths while residents were in transit. The nursing homes, where the deceased residents had lived, reported that they were both very frail but felt that the move had exacerbated the problem. The relocation had an effect even on those residents able to return to their nursing home. A couple of weeks later, the nursing home staff was reporting that the residents were still not back to “normal.” The ones who had been communicative were more quiet and withdrawn and there was a lack of eating as normal. (local ombudsman)

Change in Eating Habits, Withdrawal, Death, and Depression: Within three months, ten residents were dead. At least eight were possible victims of transfer trauma according to the Marin County Department of Health and Human Services. The residents, when forced from their homes and routines, became so distraught that they simply gave up on living. Other residents withdrew, stopped eating, or willed themselves to die. One resident who was very fragile but

¹³ Mary Thomasma et al, Moving Day: Relocation and Anxiety in Institutional Elderly, 16(7) Journal of Gerontological Nursing, 1990 at 18.

¹⁴ John MacDonald, Flood Slowly Taking Toll on Residents of Nursing Home, St. Louis Post Dispatch, Nov. 1, 1997, at 1.

very, very social, getting out of her room and greeting people at her first home, curled up into a ball in the new home and died. She never got out of bed.¹⁵

The potential impacts of a transfer should not be minimized. Residents may experience a delayed response, responding more slowly to a crisis than others, and often not fully understanding the magnitude of their loss, injury, or potential dangers.¹⁶ Even if only one resident dies prematurely, it is too many. The move may be only a mile from the other facility, but if the spouse cannot drive, moving the resident even a mile away may mean the difference in seeing the resident daily (because she could previously walk to the facility) to only when she can find someone to drive her. Residents, like all other people, do better if they are given time to visit the new facility, move with their roommate, and particularly, when they are asked what they want. Closing facilities fast does not minimize transfer trauma. Only a slow closure with appropriate measures to assist the resident helps to decrease transfer trauma.

Measures To Minimize Trauma

During relocation, other members of the community may be used to help with the needs of the residents (Emergency Medical Technicians [EMT], bus drivers, volunteers, etc.). It is important that these individuals are trained in the needs of the chronic and frail population to minimize the trauma of relocation. In addition, paramedics and general hospital staff, who may have to fill a staffing gap during the relocation, are not generally versed in this type of medical management.

Residents with pre-existing medical problems or cognitive impairment tend to be more susceptible to post-traumatic stress disorder. The temptation by nursing staff is to restrain, physically or pharmacologically, which will only lead to further complications. An alternative is an adequately/well staffed locked unit so that residents may ambulate freely and safely both inside and outside the facility under proper supervision.¹⁷ A locked unit should only be a short-term alternative in a crisis and in lieu of physical or pharmacological restraints; the immediate safety of the resident is at issue. Once the crisis is over, the resident should be assessed and moved to the most appropriate environment. The main issue to assess on a locked unit is that the staff is well trained and that there is enough staff.

A comprehensive relocation plan with timely notification is needed to ensure a smooth transition and to minimize the negative effects and stress on the residents.

*The facility plan for closure might include:*¹⁸

- Weekly meetings by staff with residents or with resident council, family council, and ombudsmen as far in advance as possible

¹⁵ Matt Smith, Diagnosis: Eviction, (visited Oct. 23, 1999)
<<http://www.sfweekly.com/1999/060999/feature1-2.html>>

¹⁶ Evacuation Considerations for the Elderly, Disabled and Special Medical Care Issues (visited Oct. 11, 1999)
<<http://www.sema.state.mo.us/elderly1.htm>>

¹⁷ Transfer Trauma Minimizing the Impact on Community Based and Institutional Elders (visited Sept. 9, 1999)
<<http://www.aoa.dhhs.gov/aoa/disaster/manual/gran.html>>

¹⁸ Susan M. Lander et al, Intra-institutional Relocation Effects on Resident's Behavior and Psychosocial Functioning, *Journal of Gerontological Nursing*, April 1997 at 35.

- Nursing staff interviews with residents and family members, guardians, or legal representatives and review of medical records
- Discussions with the ombudsman to determine the needs and concerns of the residents and suggested placement
- Written updates on bulletin boards that can be seen by residents in wheelchairs and distributed to all residents and family members
- Frequent notices on the status of the relocation
- Once relocated, frequent monitoring of the residents by staff and/or ombudsmen
- In the new facility, increases in staffing and lighting until the resident is more familiar with his or her new environment

*Some suggested general staffing (and ombudsman) principles of care for the relocated residents are:*¹⁹

- Work to develop a level of trust
- Present an optimistic, favorable attitude about the relocation
- Anticipate that anxiety will occur
- Do not argue with the resident
- Do not give orders
- Do not take the resident's behavior personally
- Use praise liberally
- Use humor, find out what makes the resident laugh
- Include the resident in assessing problems
- Encourage staff to introduce themselves to residents
- Encourage family participation
- Encourage the resident to talk about expectations, anger, and/or disappointment

Natural Disasters – Transfer trauma is an issue regardless of why the resident is being relocated. Some specific steps the facility can take to minimize transfer trauma during a natural disaster are:²⁰

- Prepare a specific plan and conduct a yearly review
- Designate all critical staff
- Make a detailed contingency evacuation plan
- Designate key personnel, establish and coordinate chain of command
- Confirm third party support agreements
- Coordinate with county and state disaster plans
- Prepare a required task list of all assignments to be completed (water heaters, water proofing computers)
- Develop a command center
- Develop interdisciplinary teams
- Develop security
- Plan on using hand-held radios, secure battery operated radios – cell phones

¹⁹ Pamela S. Manion & Marilyn J. Rantz, Relocation Stress Syndrome: A Comprehensive Plan for Long-Term Care Admissions, 16 Geriatric Nursing, May/June 1995 at 108.

²⁰ Transfer Trauma Minimizing the Impact on Community Based and Institutional Elders (visited Sept. 9, 1999) <<http://www.aoa.dhhs.gov/aoa/disaster/manual/gran.html>>

- Order critical supplies
- Order dietary orders
- Staff pharmacy with extra personnel and medications
- Physical plant have working generators – donated generators
- Fuel all vehicles during watch phase
- Have chainsaws available
- Photograph and document all property damage
- Develop a person transfer log with a resident picture. Prepare a necklace tag with important information. Inadequate resident identification is a big issue as the caregiver may disappear and no one may know the resident's medication and care needs.
- Have cash on hand
- Follow infection control procedures
- Ensure services are available for emotional support of residents
- Provide disaster education to all staff on continuing basis
- Conduct disaster alert simulations

NURSING HOME CLOSURES

If the home closes, we'd be in deep trouble. I'm 79 years old, can't go traipsing all around to visit my husband of 37 years who has Alzheimer's. I'm the one that's maintaining what he has left."²¹

Why Is This An Issue?

There were 1.6 million residents in 18,900 nursing homes in 1999. In many of the largest for-profit nursing home chains, there is financial instability. For example, in 1999: Vencor, the sixth largest nursing home chain with approximately 300 homes in 46 states, filed for bankruptcy protection in September; Sun Healthcare Group, with 385 facilities, filed for bankruptcy protection in October; Lenox Healthcare, Inc. filed for Chapter 11 bankruptcy protection in November; HCR ManorCare, with 298 nursing homes, reported in June a \$34.2 million drop in revenues for the second quarter; Mariner Post-Acute Network, with 400 facilities, reported a third quarter loss in June of \$405 million; Integrated Health Services, Inc. lost \$1.8 billion in the third quarter; and Beverly Enterprises, the largest chain with more than 500 nursing homes in 30 states, reported a second quarter loss of \$115 million.²²

These unprecedented financial problems by corporations have brought national attention to the closure issue. The central focus is the need to ensure that all parties involved are fully prepared in the event of a closing. In order to more fully understand nursing home closures, this section of the paper covers the different types of closures, HCFA staff perspectives, residents and residents' family perspectives, and a list of possible indicators of nursing home problems.

Types Of Closures

The advent of a nursing home closure is stressful and traumatic to all involved. However, once notification has been made and steps to close undertaken, it is possible that the closure may not actually happen. This may be due to another party buying the facility and maintaining operations as a nursing home. However, the impact of a potential move on residents will still be traumatic. A discussion of the types of closures follows.

Voluntary Nursing Home Closure

A voluntary closure is when the owner decides, for some reason, to close the facility. This is generally the easiest type of closing as the facility usually is more willing to work with the residents in ensuring that they are transferred to an appropriate facility. More notice is normally given by the facility to its employees and residents, which avoids the problem of employees just walking out. Many facilities provide severance pay to their employees to help in maintaining continuity of care during the phase out period. A voluntary closure may be due to bankruptcy, receivership, going out of business, choosing to close rather than deal with

²¹ Julie Appleby, Not-so-golden years, USA Today, Sept. 30, 1999, at 2B.

²² Julie Appleby, Not-so-golden years, USA Today, Sept. 30, 1999, at 1B, 2B; David S. Hilzenrath, Health Firm in Survival Struggle, (visited Nov. 19, 1999) <<http://www.washingtonpost.com/wp-srv/business/feed/a21354-1999-nov19.htm>>; Message from Steven A. Pelovitz, HCFA Acting Director Survey and Certification Group, CMSO (Nov. 9, 1999).

deficiencies, a buy out, or selling the business. However, even a bankruptcy or receivership does not automatically mean that the facility will close.

One example of the inherent problem in voluntary closures occurred in Connecticut. The owners and the creditors decided to close the facility because “they could realize a greater financial gain by forcibly evicting the residents and selling the building and the certificates of need for the beds than they could if they sold the occupied facility to a new operator. At least six residents died and at least two required psychiatric hospitalization during a very rapid and decidedly involuntary discharge process.”²³

There are varying theories on why nursing homes are having financial problems that may result in closure including: reduction in Medicare reimbursement, ill considered expansions and related debt (large lease vs. owning the facility outright), investing heavily in nursing home and ancillary-service businesses, and/or mismanagement.²⁴ For example, one company with financial problems acquired 36 homes in 1996 and 17 more in 1997.²⁵ The reason for the closure may or may not be clearly evident but the end result is that residents will be affected.

Some of the terms that may be encountered by residents, family members, and ombudsmen when there is a voluntary nursing home closure are defined below.²⁶

- Bankrupt – the state or condition of a business that is unable to pay its debts as they are or become due. As such the company is entitled to take the benefit of the federal bankruptcy laws.
- Bankruptcy Code – a federal law for the benefit and relief of creditors and their debtors in cases in which the debtor is unable or unwilling to pay their debts.
- Debtor – one who owes a debt to another who is called the creditor.
- Creditor – a person to whom a debt is owed by another person, the debtor.
- Chapter 11 Bankruptcy – Business Reorganizations - when a debtor business realizes it will become insolvent or unable to pay its debts, it can petition for reorganization under Chapter 11 of the Bankruptcy Code. The business normally is permitted to continue its operation under court supervision until the reorganization plan is approved by two-thirds of the creditors. If an agreement cannot be reached, then the court supervises liquidation proceedings.
- Chapter 7 Bankruptcy – Straight Bankruptcy – a proceeding designed to liquidate the debtor’s property and pay off the creditors. It can be either voluntary (started by the debtor) or involuntary (started by the creditors).
- Chapter 9 – Adjustment of debt of a municipality.
- Receivership – A proceeding where a person is appointed to preserve the property of an insolvent corporation, partnership, or individual whenever there is danger that the property may be lost, removed, or injured. The protection of the assets is for the ultimate sale and distribution to creditors.

²³ Memorandum from Edward Dale, Connecticut Legal Services to Stephanie Edelstein, ABA (Nov. 29, 1999).

²⁴ Thomas J. Cole, [Awash in Red Ink](http://www.abqjournal.com/health/nursing/1nursing08-03-99.htm) (visited Oct. 18, 1999) <<http://www.abqjournal.com/health/nursing/1nursing08-03-99.htm>>

²⁵ Matt Smith, [Diagnosis: Eviction](http://www.sfweekly.com/1999/060999/feature1-5.html), (visited Oct. 25, 1999) <<http://www.sfweekly.com/1999/060999/feature1-5.html>>

²⁶ Black’s Law Dictionary 147, 148, 1269 (6th ed.1990).

Involuntary Nursing Home Closure

An involuntary nursing home closure is one where the state licensing and certification agency²⁷ or HCFA²⁸ has determined that due to the lack of substantial compliance, funding is being terminated and/or the state is revoking the facility's license. In these types of closures, more problems normally arise, as the management is unhappy with the regulators. The rights of the residents and their welfare may become secondary. At this time, the state may appoint a temporary manager, if one is available, to oversee the closing of the facility. One concern expressed by ombudsmen is that temporary managers may not have the interest of the residents as their number one priority and false information is prevalent.

HCFA & Closures

Staff members at the national HCFA office provided information on nursing home closures regarding clarification on the decision-making process involved, statistical information on closures, temporary managers, and their thoughts on the ombudsman's role.²⁹ As Helene Fredeking stated at NCCNHR's 1999 Annual Meeting when discussing the role of ombudsmen and surveyors, "there is a need to define each other's role." The roles of these parties have become "fuzzy over the last several years."³⁰

HCFA or the state decides which facilities will be involuntarily closed based on the type(s) of federal funds that the facility receives. If the facility is receiving Title XVIII (Medicare) or both Title XVIII and Title XIX funds (Medicaid), then the federal regulators make the final decision. For those facilities receiving only Title XIX funds, the state decides. The state-surveying agency that contracts with HCFA makes a recommendation to the regional HCFA office and through discussions a decision is made. The state agency can recommend a temporary manager in lieu of closure. The funding source also determines who decides whether to place a facility on fast tract following the state surveying agency's report of non-compliance to the regional HCFA office. (Fast tract is a timetable, usually around 23 days, that is followed with the end result being potential decertification if the facility is still out of compliance at the end of the time period.)

The following are the number of voluntary and involuntary closures for the last four fiscal years:

- Voluntary closures – Statistics on voluntary closures are divided into merger/closure, dissatisfaction with reimbursement, risk of involuntary closure, and other. On review of the statistics, the majority of closures were under the category of merger/closure, with a few under the category of other. The HCFA staff does not feel that this is accurate and is probably due to a lack of understanding on coding. Therefore, only total voluntary closures for each time period was provided.

²⁷ Facility is a Medicaid, Title XIX provider.

²⁸ Facility is a Title XVIII recipient, Medicare, or receives both Medicaid and Medicare funds.

²⁹ Information provided by Helene Fredeking, Technical Director Division of Outcomes and Improvement; Fred Gladden, Health Insurance Specialist; and Nora Castro, Health Insurance Specialist, HCFA National Office.

³⁰ Comments provided at NCCNHR's 1999 Annual Conference, "Strategies to Prevent and Monitor Nursing Home Closures" Intensive, Oct. 31, 1999.

July 1, 1995 to June 30, 1996	148
July 1, 1996 to June 30, 1997	164
July 1, 1997 to June 30, 1998	199
July 1, 1998 to June 30, 1999	334*

*(This increase in closures from the prior year was surprising to HCFA staff and will be evaluated to determine why.)

- Involuntary closures:

July 1, 1995 to June 30, 1996	32
July 1, 1996 to June 30, 1997	32
July 1, 1997 to June 30, 1998	39
July 1, 1998 to June 30, 1999	45

The Code of Federal Regulations (CFR)³¹ establishes parameters regarding a temporary manager. A state agency could provide this service providing the staff meets the parameters. This is usually not feasible due to staffing constraints.

HCFA staff at the national level has urged the state surveying agencies to coordinate their response to involuntary closures with the long-term care ombudsman program.³² After a termination, there needs to be an orderly transfer process for residents. The state licensure and certification unit may work with the ombudsmen regarding this transfer. The specifics of the process are left up to the individual state agency and the ombudsman program to develop. The main focus should be the safe and orderly transfer of the residents.

Resident And Family Perspective

The following are stories and thoughts from residents and relatives on how nursing home closures affected their lives. They are included here to promote discussion and understanding of the resident and family perspective.³³

Family Member Observations: The state did not and does not care. The state killed my father. The cruelty shown by the state should be punished. The state lied to us. We were told we would have six months, then a few days passed and the plug was pulled. There was a lack of communication by the team that took over the facility. The state should be able to maintain the facility if they can come in and close it. Residents were wandering the halls and weeping. We need standards that take into consideration the people. The state needs to help fix the problem. Put the money into a trust, not accessible by the owner, and fix the facility. The facility never assisted in the transfer nor sent the medical records. What the state did was the same as what they cited the owner for, only worse. Don't let the problem get so severe; don't wait to amputate the leg. (daughter of resident who died 18 days after transfer)

The state did nothing with the issues that were brought to their attention regarding the problems in the facility. Once HCFA became involved, instead of helping to fix the problem, the

³¹ Temporary Manager, 42 C.F.R. pt. 488.415 (1999).

³² Letter from Sally K. Richardson, Director HCFA, to State Survey Agency Directors, (July 15, 1999).

³³ Comments provided by residents and family members in Florida, Washington, DC, Texas, and Michigan

facility was closed down. The state administrator was not helpful. They told us no one would have to move until proper arrangements could be made. I had made arrangements to move my mother, then, the facility called on a Thursday and told me that if I left my mother in the facility over the weekend, they could not guarantee staffing. (Her mother had to make a temporary move for a couple of days until the bed was available in the pre-arranged facility.) The medical records were never transferred. They should have sent the records, not just a cover sheet. The new facility did not have my mother's history. I do not think my mother would have died this early but for the move. (daughter of resident)

Resident Concern about if Closure was Needed: Little things all add up to important things. The move is hard on residents. The nursing home we are in is where we want to be, close to kids and friends. (resident of nursing home that was closed)

Resident Observation on Impact of Move: The move affected the high functioning residents the most. We were used to being around each other, we lost friends in the move. We felt thrown away. Closing is an easy way out. The resident council needs to be more proactive. A nursing home is not a place to go and die, but to get quality care. We were talked down to, not given credit for our information. The ombudsmen get caught up in the problem and think that closing is better for the residents. Transfer trauma is the issue, the new environment may be worse. People need to listen to the residents. Nobody cares. They are only out for the money, not for the resident. There needs to be a strong resident and family council, the eyes and ears of the facility. (resident of nursing home that was closed)

Relocation Benefited Resident: At first, I didn't want my husband to have to move. Later, I realized that the new facility provided better care; care I hadn't even realized was possible at the first facility. The move, however, was not easy on either of us. We did get to choose where my husband was going to be moved to but it is farther away for me to visit. (wife of resident moved to a new facility)

Family Councils and Relocation: There needs to be a strong family council. Families banded together are powerful. We can impact decisions made by the facility. Closure simply holds the residents hostage. (family member who was instrumental in preventing a nursing home from closing)

Possible Indicators Of Nursing Home Closure/Problems

“When they start running out of supplies, you know there’s something wrong.”³⁴ (a resident’s observation that proved to be true)

An ombudsman is an advocate for the resident. The following indicators might give the impression that the role is switching to one of regulator or surveyor. This is not the intent or desire. However, the reality is that ombudsmen are in nursing homes normally on a weekly basis whereas the regulatory staff is generally only in the facility once a year. Therefore, local and/or volunteer ombudsmen can assist the state regulatory agency by notifying them when a nursing home appears to be having problems. That does not mean that there is a problem, only the potential for one. Long-term care ombudsman programs need to develop a consistent policy regarding when and how to notify the regulatory agency. Ombudsmen almost always give the facility the first opportunity to correct problems, working within the facility to achieve results. Ombudsman programs need to consider: At what point does the ombudsman contact the regulatory agency? What is the responsibility of the ombudsman to gather some facts, observations, before saying the facility is potentially on the brink of financial difficulties?

When the ombudsman begins to notice changes that may signal a problem, the local ombudsman should contact their State Ombudsman, local and state regulators, and/or HCFA. Ombudsmen always want to be careful to avoid any perception of stirring or carrying rumors or of carrying out someone else’s agenda other than that of residents.

Several indicators that may suggest that the nursing home is having problems are:³⁵

- Failure to meet payroll or late payroll
- High levels of staff walkouts or rumors of walkouts, resignations, “no-call, no-show”
- Failure to make needed repairs or urgent capital improvements, including roof repairs, furnace/boiler repairs, backup generator repairs, fire/smoke detection system repairs
- Dramatic increase in number or seriousness of resident/family/staff complaints, including neglect, staffing, or withholding of care and services
- Major reductions in services or programs provided to residents, such as elimination of most activities programs
- Elimination or reduction of snacks and substitution of less costly and appealing food products with concurrent elimination or reduced availability of more expensive food items, such as: no longer offering residents nutritional drink supplements that are rather expensive
- Increased emergency room (ER) admissions Adult Protective Services referrals or deaths due to negligent care such as malnutrition, dehydration, etc.

³⁴ Julie Appleby, Not-so-golden years, USA Today, Sept. 30, 1999, at 2B.

³⁵ Letter from Sue Wheaton, Ombudsman Program Specialist, Administration on Aging, to State Ombudsmen (July 13, 1999).

or use of ER as the primary physician provider in order to save on physician costs

- Reports in the community or directly to ombudsmen that a facility is not paying its bills (laundry, supplies, and other purchases/services)

ROLE OF STATE LONG-TERM CARE OMBUDSMEN IN CLOSURES

The state ombudsman is in an oversight role to look at the states plan and advocate for residents.³⁶

State Ombudsman Involvement

The State Long-Term Care Ombudsmen Program is uniquely positioned to address nursing home closure issues. State Ombudsmen are responsible for overseeing the local ombudsmen programs within each state including training, daily assistance, and support to local ombudsmen who are on the front lines when a facility closes. The state ombudsman typically monitors the political climate within the state, maintains relationships with other state agencies, entities and programs that serve the aging population, and may participate as a team member with these other groups. In addition, the state ombudsman is a central source for information throughout the state and provides the assistance needed by local ombudsmen when nursing home violations need to be addressed at the state level. Most importantly, state ombudsmen are able to share important information on transfer trauma with other individuals and programs involved in nursing home closures.

The state ombudsmen role should be as proactive as possible, based on the individual state mandates. In providing leadership on facility closures, state long-term care ombudsmen might consider:

- working to ensure that a state and local ombudsman closure plan and the ombudsman role with other agencies are in place,
- developing processes to provide information and training to all local ombudsmen (local and volunteer ombudsmen),
- serving as an advocate with any corporation that is experiencing problems to minimize the trauma to residents through a smooth transition,
- sharing information with other long-term care ombudsmen, particularly with others in their federal region regarding companies that are experiencing having problems, and
- advocating for notice to be sent to all residents, family members and/or legal representatives when immediate jeopardy has been called in a facility.

As an aid in developing or improving a state plan on closures, this section of the paper provides perspectives regarding state ombudsman experiences with closures, the coordination effort needed with local ombudsmen, criteria for developing a state closure plan, HCFA's proposed criteria for a state plan, and sample model plans.

Proactive Role

Ombudsmen, families, residents, and regulators all agree that there has to be a better way of dealing with nursing home problems than the involuntary closure of the facility. One observation was that it is much easier for management to make corrective changes than for

³⁶ State Ombudsman comment.

residents to adjust to a new home. Other observations posed were: For those facilities with financial problems, should HCFA be monitoring the financial health of organizations that are receiving federal funds to minimize bankruptcies? Should HCFA look at corporate ownership when one nursing home is involved, guarantees of solvency, finding new owners, or bringing temporary managers in earlier?

Once a facility is targeted for closure, the process becomes reactive by all parties involved. One way to avoid this is by having a plan on closures that emphasizes proactive involvement in nursing homes as soon as problems are identified. The main goal of such a plan is to save the homes through improved care and correction of problems. This can be accomplished by utilizing outside assistance (temporary managers) when needed and providing the funds necessary to accomplish the intended goal of keeping the facility open. There needs to be a range of expertise to correct the nursing home's problems. Once the facility is headed toward closure, it is too late.

Ways that state ombudsmen can be proactive might include their being:

- part of the training for temporary managers,
- a member of, or encouraging the development of, an adverse action committee/task force meeting (surveying agency or other legislatively designated agency responsible for the care of residents in nursing homes that discusses problem facilities),
- a catalyst in getting a receivership/temporary management program in place and promoting an adequate number of temporary managers being available,
- a voice for legislation that requires a 90 day notice when a facility is closing voluntarily,
- an advocate for strong and effective enforcement systems,
- an advocate for adequate funds available in the state trust fund to deal with multiple closures, if necessary working to make such funds available,
- part of a grass-roots committee of concerned advocates who are committed to working on preventing closures,
- a catalyst for regular meetings with HCFA regional office staff members,
- active with elected officials/legislators and encouraging them to see what life is like in a nursing home,
- the agent to help local ombudsman cultivate and/or strengthen resident and family councils,
- an advocate for nursing homes that are providing individualized care, publicizing what should be expected in a facility, level of care, and what is not acceptable care,
- a voice for residents with nursing home corporate officers and trade associations,
- a speaker at public forums or civic organizations discussing nursing home issues so that the community has a sense of ownership for vulnerable residents, or
- an advocate for a state 'talking paper' so that all parties involved are saying the same thing when it comes to nursing homes and closures.

Barriers that may hamper state ombudsmen from being proactive include:

- the relationship with licensing/certification/surveying agency,
- not receiving timely notification of nursing home closures or identified problems,
- poor communications between the ombudsman program and state surveying agency, and/or
- the position/role that the ombudsman program has in the state.

Ombudsmen need to remember that they may not always be successful in their efforts to be proactive. However, ombudsmen must continue working, even if only small steps can be accomplished at any given time. The larger picture will develop as the smaller pieces are put into place. In many states, the state and/or local ombudsman may not be in a position to take the lead role in being proactive. Other parties may be more appropriate, such as the surveying/licensure agency or social services. The ombudsman in these states can still promote the idea of being proactive and work to be involved in developing this concept.

Proactive plans to prevent nursing home closures can be implemented on a state and/or local level. A recap of several types of proactive plans/information follows with copies located in the Appendix.

✠ Temporary Managers, Directed Plans of Correction, and Follow-Up: In Michigan a committee of concerned parties embarked on a mission to solve a mutual problem in long term care, “how to make the process better in a less punitive way.” The state found that fines did not improve care and were not collected due to ongoing litigation. From July 1995 to April 1998, the state department levied \$5.5 million in fines but only collected \$1.6 million. Of the 179 penalties assessed, 91 were involved in litigation.³⁷ The state surveying and Medicaid agency developed a plan, the Resident Protection Initiative, utilizing a quasi-governmental organization the Michigan Public Health Institute (MPHI). The goal was remediation services through education, clinical, and administrative advisors. This organization has been functioning as temporary manager but is only in the beginning stages of development in this area. Facilities may be directed to MPHI by the appropriate state agency when deficiencies are identified or they may contact the organization on their own for assistance and expertise. The organization develops a plan of correction for the facility and does appropriate follow-up. The facility pays the cost for the services in lieu of civil monetary penalties (CMP). If the facility refuses, then CMP’s are imposed. The contract for the program is presently being renegotiated.³⁸

Suggesting for improving this type of program are:

- (1) make the quasi-agency independent of the state,
 - (2) require the state to pay for the monitoring if the facility refuses,
 - (3) establish an early time frame for intervention, and
 - (4) withhold vendor payments in the required amount if the facility refuses to pay.
- (Appendix A)

³⁷ C.I.S. Lauds Improvement With New Nursing Home Oversight, Michigan Report #65, April 7, 1998.

³⁸ Comments regarding MPHI program obtained from Carl Gibson, Sherry Jansen, Beth Bakin, & Mike Connors who have worked with or are staff of MPHI.

- ✦ Fact Sheets for Consumer Action: The Michigan state ombudsman developed a fact sheet with information for family members on how to contact nursing home owners. The sheet explains who runs nursing homes, who owns nursing homes, when to contact the owner, and the right to complain. This information gives consumers corporate information that can be used to improve a facility. It enables families to work to change the corporation in order to prevent a potential closure. (Appendix B)

- ✦ Regional Task Force: A regional ombudsmen program in Michigan is involved in a long-term care task force that is focusing on being proactive. Initially established when they were faced with three homes being in jeopardy, the group has evolved into meeting monthly trying to (1) ensure continual quality of care for the residents, (2) assist all parties involved in solving their individual problems (i.e. expediting police checks of new staff), (3) develop a cohesive group to respond in an emergency (i.e., team response to explosion in nursing home that killed residents and staff), (4) provide feedback to residents and family members on issues of concern, and (5) identify and preserve community resources. The group is composed of representatives from social services, guardians, mental health, legislative representatives, Area Agencies on Aging, licensure/certification, legal services, hospital center for gerontology, sheriff, local ombudsmen, and a disability agency. Nursing home administrators are invited to attend quarterly. A questionnaire was sent to facilities to elicit the type of assistance the facility could provide in the event of a closure. The lead agency in this group is social services due to an interagency agreement that specifies their role as being responsible for residents that have to be transferred out of a nursing home.³⁹ (Appendix C)

Copies of the following companies and their proactive program may be obtained by contacting the Ombudsman Resource Center.

- Proactive Monitoring is a program offered by a private sector individual. This is an alternative plan to closure. The emphasis is on training all parties - internal and external to the facility - on what to look for in poor performing facilities and how to properly care for residents. An outplacement component assists in reducing or eliminating transfer trauma. The facility would pay for the monitoring, in lieu of penalties.
- Rehabilitation Care Consultants is a temporary management service provided to states and/or companies. The company deals with crisis intervention, interim management, policy resource, and expert legal support services. They provide an extensive array of services to the long-term care community.
- Survey Solutions provides temporary management services. They offer consulting services to nursing homes in training, mock surveys, turnarounds, interim management staffing, and strategic advice.

³⁹ Comments provided by the local ombudsman and Douglas Williams and Howard Bearup with Genesee County Family Independence Agency.

State Ombudsman Perspectives

The following are comments from state long-term care ombudsmen who have experienced a nursing home closure. They summarize the problems they experienced, how they view their role, and suggestions for future closures.⁴⁰

Temporary Managers: The state prefers to close the facility rather than attempt to correct the problem. Temporary managers are needed to try to turn the facility around in three months. During that time they can identify where the problems are and the needs of the residents.

State Funds: Have ample state funds to deal with a closure. There are too many closures due to old physical plant problems. There needs to be one person within the state with resources available and authority to make decisions. If the facility is to be closed, the first priorities should be making the residents happy. The state must make a commitment to take as long as necessary.

Ombudsman Program: The long-term care ombudsman program needs to be involved in legislative issues regarding ways to prevent closure and issues that lead to closure. Support local ombudsmen and keep them informed of what is happening in developing proactive measures as well as when facilities seem to be encountering difficulties that could lead to closure. Assist local ombudsmen with violations that need to be addressed at the state level.

Collaboration Efforts: The long-term care ombudsman and other agencies in the state need to work as a team on closure issues: prevention, developing alternatives, developing a plan to deal with closures, and transitions when closure is the only option. The ombudsman and HCFA need to inform and sensitize state agencies to transfer trauma so that personnel understand it from a resident's perspective. HCFA needs to encourage agencies to take the time needed for residents.

Coordination With Local Ombudsmen

Under the state closure plan, there should be guidance on the role of the local ombudsmen and their role in closures. The State Ombudsman needs to work with local and volunteer ombudsmen to ensure that they have the expertise and tools available to support residents and families during a closing.

Some of the areas that State Ombudsmen need to address include:

1. **PLAN:**

- Development of a local ombudsman plan for each local program area
- Support for residents' rights without compromise
- Guidance regarding a follow-up program for ombudsman visits with residents in their new facility
- Arrangements to work on preventing residents from being transferred to out of compliance homes through maintenance of current bed availability and survey data. Provide bed availability information to consumers, families, and residents

⁴⁰ Comments provided by state ombudsmen in Michigan, Georgia, Wisconsin, Missouri, Texas, Oklahoma, Florida, North Carolina and Louisiana.

- Guidance on how to deal with the media including the messages the long-term care ombudsman wants to get across: move the owners, not the residents; use temporary managers and keep them there until care improves and ensure the next administration will continue the effective practices; more money for surveyors; etc.
 - A mechanism for the transfer of the complete medical records, personal fund accounts with complete accounting of funds, family information, legal papers, burial information, and personal property inventory list at the time of the move, not afterwards
- 2. TRAINING:**
- Provide training to local and/or volunteer ombudsmen on nursing home closures, indicators of potential problems, transfer trauma, and working with residents, families, the media, and the public, if a closure occurs
- 3. VOLUNTEER OMBUDSMEN:**
- Assess the ability of and how volunteers can be utilized effectively
 - Develop programs to deal with volunteer frustration, loss of, and recruitment of volunteers

State Ombudsman Role In A Nursing Home Closure Plan

State ombudsmen need to assess their state's needs, the HCFA State Operations Manual, and what may already be in place that may need to be modified, amended, or changed. It is important that a plan for nursing home closures be in place prior to an actual closure and that all parties are aware of their role. This avoids problems and uncertainty. As one ombudsman stated, “when the third home was closed, everything ran smoothly.” Unfortunately, the prior two closings had been horrible and residents suffered due to the lack of advance planning.

Several state nursing home closure relocation plans are recapped at the end of this section and may be obtained by contacting the Ombudsman Resource Center. Tips from state long-term care ombudsmen on putting together a state plan follow.

- 1. Who To Involve:**
- Establish a plan involving all appropriate agencies/programs and citizen advocacy groups. State parties/agencies to include might be:

▪ State and Local Ombudsmen	▪ Department on Aging
▪ Regulatory Agency	▪ Regional HCFA Office
▪ Governor’s Office	▪ Medicaid/Medicare Agency
▪ Health Department	▪ Mental Health Agency
▪ Mental Retardation Agency	▪ Nursing Home Organization
▪ Adult Protective Services	▪ Public Health
▪ Transportation Providers	▪ Protection & Advocacy Services
 - Exchange emergency numbers, home, cell, beeper numbers and email addresses of all parties who will be involved in the plan

2. What Components To Include:

- Evaluate the present plan, if applicable, and HCFA State Operations Manual guidance
- Determine who is responsible, the lead agency, and areas of responsibility of each agency through the development of a master checklist
- Establish a plan of communication for holidays and after hour notification
- Hold regular meetings to keep up to date, make revisions to the plan
- Determine what kind of notification timetable is appropriate for the closing (voluntary closure – 90 to 30 days, involuntary closure – 14 to 21 days) and the type of notification to the different parties including notification to residents and families (If time permits, written notice by the ombudsman program and state regulatory agency addressing: why the facility is closing, residents’ rights, resource information, list of beds available, etc. If time does not permit, a party such as the ombudsman, in addition to the facility, should contact the residents, family members and/or legal representatives regarding the closing.)
- Provide a central source to disseminate information regarding the closure, name a “point” person responsible for overall coordination of all transfer issues
- Work to have an active role for ombudsman in closures included in state law or regulations
- Determine the remedy in court for receivership to be appointed to keep a home open if problems can be corrected without jeopardy to residents (sample receivership statutes available from the Ombudsman Resource Center)
- Work to ensure the safety of all individuals in the facility
- Ensure that appropriate money is available to handle expenditures during a closing, i.e. utilize civil monetary penalties to pay for transferring residents (see Louisiana model under Model State Plans)
- Review current certificate of need (CON) legislation, or consider adding CON legislation, to determine how it affects bed availability. Two primary considerations are: increasing the likelihood that residents will not be transferred to an out of compliance facility and avoiding deterrents to enable facilities with reputations for quality care to add beds. (See Connecticut revision to certificate of need legislation under Model State Plans.)
- Determine which agency will disseminate information on bed availability (male/female beds, Medicare beds, etc.)
- Develop procedures to ensure that residents are transferred to facilities without ongoing problems/deficiencies
- Develop an informational pamphlet for residents and family members identifying and providing telephone numbers to key players such as local and state ombudsmen, local and state regulatory staff, legal services, HCFA, how to access and use the grievance process, their options, terminology, who to contact, what to do if care deteriorates, and residents’ rights explained (sample under Local Ombudsman Nursing Home Closure “KIT” section)

3. What Educational Needs To Address:

- Everyone who will potentially be involved in a nursing home closure needs to understand or be knowledgeable about transfer trauma and residents’ rights

- Everyone related to closure needs to understand the long-term care ombudsman program and the role of ombudsmen in closure
- Legislators need to be informed about sensitive issues regarding residents and transfers. The state long-term care ombudsman and/or local ombudsmen may need to directly provide this information.

4. The Role and Responsibilities of a Temporary Manager:

- Establish clear guidelines about the qualifications of a temporary manager, i.e., someone who is fully educated on state and area laws, regulations, procedures, culture, residents' rights, and transfer trauma
- Establish very clear and specific guidelines for this role covering all aspects of the job: who selects, who the manager reports to, payment procedures for the manager's salary, the responsibilities, available resources, decision-making authority, amount of budgetary control, communication with residents and families, and decision criteria for ending this responsibility
- Have clear procedures to ensure accountability regarding the treatment and relocation of residents if the temporary manager reports only to the courts
- Include a role for the long-term care ombudsman program to actively participate in training temporary managers on the ombudsman program, residents' rights, and transfer trauma

5. Nursing Home Factors:

- Develop a mechanism to ensure that complete medical records, personal fund accounts with complete accounting of funds, family information, legal papers, burial information, and personal property inventory list be transferred with the resident at the time of the move, not afterwards
- Ensure that medicines within the facility are transported with the resident or that the new facility has been able to obtain needed medications so that medication distribution is not delayed
- Include a provision that the receiving facility will not charge the resident for a prorated day that was paid to the facility the resident is leaving
- Develop a comprehensive discharge plan for each resident

HCFA Proposed Criteria For A State Plan

HCFA sent the State Survey Agency Directors a letter in July 1999 with points to include in a state plan for facility closures. A recap of these points follows.⁴¹

- Assessment of each resident's care needs
- Plan for communicating with staff/unions
- Continuation of appropriate staffing levels and pay
- Provision for supplies and identification of sources
- Availability of beds/facilities should transfer be necessary
- Quality of care rendered by alternate facilities
- Process for relocation of residents
- Management of facility
- Responsibility of facility's administrator

⁴¹ Letter from Sally K. Richardson, Director HCFA, to State Survey Agency Directors (July 15, 1999).

- Oversight of those managing the facility
- Role of other organizations
- Sources of supplemental funding to keep facility open until sold or residents transferred safely
- Plan for communicating with:
 - residents and families
 - press and general public
 - elected officials
 - other interested parties (HCFA)
- Role of the Administration on Aging and the long-term care ombudsman
- Identification of new owners
- Assessment of potential impact on survey agency should there be widespread problems
- Safety of state surveyors going into facilities

Sample State Plans

Several states have plans in place; others are in the process of developing a plan or modifying their existing one. Oftentimes the state plan on closures is based on the state emergency plan. A recap of some of the different types of plans follows. Copies of these plans may be obtained by contacting the Ombudsman Resource Center. A nursing home closure survey of long-term care ombudsman programs and nursing home closure information discussed at NCCNHR's 1999 Annual Meeting is also available from the Center.

- ⊕ Arizona – 7-29-99 – Joint document that outlines a contingency plan for nursing facilities experiencing financial problems. Includes the State Medicaid agency, department of health, licensure, and ombudsman program.
- ⊕ Connecticut – Proposed CON legislation to change existing statute. Proposes that certificate of need be forfeited when a facility is closed as a result of misadministration. Clarifies the role of receiver who is presently charged with conflicting responsibilities to the creditors and the residents.
- ⊕ Washington, DC – Receivership legislation that allows the long-term care ombudsman, or any other resident advocate, to file a request for a nursing home receivership
- ⊕ Louisiana – 1-20-96 – Regulation that expands/modifies use of civil monetary penalties. Regulation earmarks funds for relocation expenses due to a closure. Some of the areas that might be covered are transportation costs, new phone line, and lost belongings. The problem is that the money has never been tapped, as the regulation is too limited. One suggestion by the State Ombudsman is to liberalize the purposes to include quality incentive programs and lost items (i.e. glasses, hearing aids, false teeth). Louisiana has a separate sanction law and all of those monies go in the fund.. The fund, in place for at least eight years, had over \$287,000 in it in 1999.
- ⊕ Massachusetts – Receivership legislation allows “any interested person” to petition for a receiver. Presently the ombudsman program does so only through the health department or Attorney General’s office.
- ⊕ Michigan – 1-10-94 - Interagency agreement that includes the Aging office and the roles of each department.

- ⊕ North Dakota – 8-18-99 – Relocation plan for long term care residents by the Department of Human Services. Aging Services Division is lead agency for implementation of the plan.
- ⊕ Ohio – 1-94 – Defines roles of parties' involved, pre-location procedures in non-jeopardy and jeopardy situations, relocation process, master relocation sheet, and 30-day termination letter.
- ⊕ Tennessee – 8-19-99 – An onsite monitoring protocol for the survey agency
- ⊕ Texas – 7-13-98 & 5-4-92 – A cooperative general program coordination agreement between the Department of Aging and the state surveying agency and a memorandum of understanding between AOA and HCFA in Region VI (does not presently address closures but provides base for inclusion)
- ⊕ Wisconsin – 12-1-98 – Memorandum of Agreement between Department of Health and Family Services and the Board on Aging and Long Term Care. Covers all areas of mutual responsibility relating to nursing homes.

ROLE OF LOCAL LONG-TERM CARE OMBUDSMEN IN CLOSURES

There is one type of intervention being used, decertification.⁴²

Local Ombudsman Involvement

Local and/or volunteer long-term care ombudsmen often provide a regular presence in nursing homes to assist residents in understanding and executing their rights. They become well acquainted with the residents, employees, and workings of the facility, and work to empower residents to resolve issues. Ombudsmen typically know which facilities are having problems concerning quality of care and quality of life issues that impact residents. As the program given the mandate under the Older Americans Act of 1965 to visit residents, monitor residents' rights in facilities, and to serve as a consumer advocate, ombudsmen have a wealth of information that is invaluable during a nursing home closure. Ombudsmen are also often knowledgeable in the area of transfer trauma.

The role of volunteer ombudsmen depends on how the long-term care ombudsman program defines their role, the training and support provided, and the level of expertise of the volunteer. In addition, some programs utilize more volunteers than others. One ombudsman stressed that volunteers who were not certified ombudsmen could help by answering the phones, copying documents, running errands, or just being a friendly visitor to ease some of the apprehension felt by residents during the relocation process. Each program needs to assess these individual talents and, if needed, provide additional training to those who would be able to help during a nursing home closure.

To assist local ombudsmen in dealing with a nursing home closure, this section includes a review of residents' rights that are most apt to be compromised, perspectives from local ombudsmen who have experienced a closure, and suggested criteria for developing a local plan and a "KIT" (KEEP IT TOGETHER) to take to a closing.

Residents' Rights

Residents should not lose any rights simply because their nursing home is closing. However, several of the rights may be compromised and should be monitored more closely.

- ***Be treated with respect, dignity and consideration***
Residents should not be evicted in the middle of the night due to a voluntary or involuntary nursing home closure (exception would be in the case of a natural disaster). Proper notice and appropriate transfers are important.

⁴² Local Ombudsman comment.

- ***Exercise rights as residents***
Residents have the right to make the choice of where they will be transferred. This is not the facilities or families choice, when the resident is competent and there is no guardian in place.
- ***Freedom from mental, verbal and physical abuse and restraints.***
Residents should be carefully monitored during a relocation to avoid both chemical and physical restraints. As discussed in the Transfer Trauma Section, because of transfer trauma characteristics, such as hostility, the nursing home staff may utilize restraints inappropriately.
- ***Freedom of association and communication***
Residents need to know how to access the ombudsmen (state and local), key state regulators, HCFA, legal services, etc. This information should be readily available and is included in the local ombudsmen “KIT.”
- ***Not to be transferred without notice***
Proper notice is required. Residents are to be notified of a transfer/relocation/evacuation with as much advance notice as possible including options available to them so they can choose where they want to go. As soon as the relocation information is available, the facility should share it with residents and families. Withholding this information due to its potential for increasing stress on residents and families is not justified. The information withheld probably increases stress more than having the information in order to make appropriate plans. There should be timely updates throughout the relocation process of the time frames for the relocation and the time frame should be maintained if possible. During a closure, once a timetable is set, residents and families need to be able to rely on that schedule when making arrangements for transfer to another facility.

In addition, fast closures are not the best for residents. Having the opportunity to visit other facilities and make appropriate choices is easier on the resident and minimizes transfer trauma.

- ***Make complaints and express grievances***
Residents need to have an outlet available to them to express their anger at the closure, at having to leave their “home,” or simply to ask questions.
- ***Keep possessions***
Information residents need to be kept aware of includes: where personal belongings are located, who has them, whether they are transported with the resident at the time of the closure, and how they are protected during a disaster. During the relocation, the residents have the right to retain personal property and arrangements need to be made to safe guard their possessions.

LOCAL OMBUDSMAN PERSPECTIVES

One common comment among ombudsmen has been that there has to be a better way than closing homes, particularly for financial reasons, due to the unnecessary hardship on the residents. What role ombudsmen feel they should play in a closure varies by state, community and by individual ombudsman.

The following is a compilation of various comments from local long-term care ombudsmen that illustrate the different roles ombudsmen see themselves in, the problems they experienced during a nursing home closure, and what they would do in the future if they were involved in a closing.⁴³

Ombudsman Role: The areas to focus on are: monitoring and protecting residents' rights, providing technical assistance to the facility, investigating complaints, and monitoring care.

The first task is to establish the role of ombudsmen with all the parties involved. Ombudsmen may need to be in the home seven days a week during the process of closure, which is a significant drain on ombudsmen and diverts attention from other facilities' residents. The ombudsman cannot meet everyone's preferences nor prevent residents from being transferred to facilities that are having problems. The ombudsman role has to be done quietly as not to add to the chaos.

Ombudsmen should provide technical assistance to the families. Ombudsmen should train the families and residents on how to make a valid complaint, criteria to use, keeping good records, and identifying unmet needs.

In retrospect, I should have gotten a list of where the residents went so that I could have done follow-up.

My role was not to implement the relocation plan. My role was to ensure that it was being implemented in a way that was respectful of the residents and not infringing on their rights.

Temporary Managers: The state appointed administrator lied to staff about when the nursing home would close. He stated in a month but told me after the meeting they would be out of there by Friday. The state administrator had no plan for transferring the residents or a list of other facilities with available beds. He had a low opinion of the ombudsman program. The state appointed administrator needs to understand the ombudsman program.

With a voluntary closing, there is no panic. But when the facility is being closed due to deficiencies, the rights of the residents are out of the window according to the state administrator.

Our has never used a temporary manager because there is no one available to choose from. The state will not assume this role; they see this as a third party role. The state position is that they are only regulators.

Nursing Home Concerns: In a facility that was for sale, the administrator had been asked by the corporation to transfer residents to a sister facility in another county to beef up their census.

The facility had a lot of potential; however, after ten years with three different owners there were too many changes and times when nothing was done. The state health department

⁴³ Comments provided by local ombudsman in Michigan, Maryland, North Carolina, Texas, Washington, DC, Pennsylvania, and Georgia.

could have been more involved in fixing the problem. The state survey agency gave a list of potential homes to families. They used a cut-off point for deficiencies that was appropriate.

Residents' Rights: The state wants the guardian to decide where the resident is transferred even if it is a poor facility. Six residents were sent to facilities that were sub-standard. The guardian was only concerned with where the resident could be moved with short notice, not the quality of the home.

The letter notifying families said take your time; the facility will close at the end of the month. The time period was changed and a resident had to be moved twice. We need to know the criteria for closing; it seems to change from day to day.

Resident Care: Safety became a real issue during the closure. Many staff had quit and temporary help had to be brought in to prepare meals and to distribute medications. Numerous errors were being made and several of the residents kept saying that they had not gotten the right medicine. Eventually, a team of staff from the hospital and health department was brought in to stabilize the facility and things went more smoothly.

I was concerned because so many people were in and out of the facility, including the media. The residents seemed quite baffled and were not sure at times who they were talking to (media, protective services, temporary staff brought into the facility, etc.)

State Issues: There are not enough beds in our area to absorb the residents from a closure, much less to provide any choice in facility. The residents had to go where there was a bed available. Many were relocated 150 miles away. Even though the facility had provided terrible care, the residents wanted to return. It is similar to any other type of abuse syndrome, they become familiar with the environment and that is their home.

The state should be the responsible party.

In our state, there is a low census so finding a bed is not difficult; finding a facility that provides quality care is a different story.

Communications: The state did not follow up with the promises made to the residents and families. Who is responsible after the building is closed? Residents lost their supplemental insurance because the premium, which came due at the same time as the closure was occurring, was not paid and there was no accounting for the funds.

The state and county could have saved the facility. Families who were lied to by state, federal, and local regulators became distrustful and were disillusioned. There is no support from the federal, state or local level. The problem is only getting worse; however, we are not doing anyone a favor by closing the facility down. (volunteer ombudsman who became dissatisfied and quit the program)

Local Ombudsman Nursing Home Closure “KIT”

The following are suggested criteria regarding the process of developing a local area plan, the content of the plan, and a “KIT” (KEEP IT TOGETHER) to develop and use when responding to a closure. Be sure the local plan is compatible with any state plan for closure.

Local Plan Development: When developing a local plan for nursing home closures, the following are tips to consider that other ombudsmen did, or wish they had done, before or during a closure:

1. Who to Involve:

- Establish a local agreement with other agencies/programs and citizen advocacy groups who should be involved in a nursing home closure. Parties to include might be:
 - State/Local Ombudsmen
 - Adult Protective Services
 - Mental Health Association
 - Mental Retardation Association
 - Local Regulators
 - Nursing Home Industry
 - Media
 - Guardians/Probate Courts
 - Public Health
 - Transportation Providers
- Exchange home, cell, beeper, and other secondary numbers and email address among all the key players

2. What Components to Include:

- Determine who is responsible – the lead agency and the areas of responsibility of each agency through development of a master checklist
- Establish a plan of communication for holidays and after hour notification
- Hold regular meetings to keep up to date, make revisions to the plan
- Determine what kind of notification timetable is appropriate (voluntary closure – 30 to 90 days, involuntary closure – 14 to 21 days) and the type of notification to the different parties including notification to residents and families (If time permits, written notice by the ombudsman program and state regulatory agency addressing: why the facility is closing, residents’ rights, resource information, list of beds available, etc. If time does not permit, a party such as the ombudsman, in addition to the facility, should contact the residents, family members and/or legal representatives regarding the closing.)
- Provide for a central source to disseminate information regarding the closure
- Determine what remedies are available in court for receivership to keep the home open if problems can be corrected without jeopardy to residents (sample receivership statutes available from the Ombudsman Resource Center)
- Provide for immediate notification to families, guardians and the local probate of the pending closure
- Consider which parties are involved when the residents are told of the pending closure – ombudsmen need to be included
- Provide for the Lead agency be responsible for observing residents for a day before having decision making authority

3. WHAT EDUCATIONAL NEEDS TO ADDRESS:

- Lead agencies educate the temporary manager and public guardian about the local plan
- Local ombudsmen provide training on the ombudsman program, transfer trauma, and residents’ rights to all parties involved

4. NURSING HOME FACTORS:

- Determine how personal belongings will be transported, phones re-established and who will pay for this (if the nursing home, the resident will have to get in

line with the other creditors), can/should the state provide assistance? (See innovative use of civil monetary penalties under State Ombudsman Section, Model State Plans - LA)

- Establish a procedure to ensure the transfer of medical records with the resident – all of the families stated that this was a big problem, that records were not transferred, sometimes even months after the transfer
- Develop a mechanism to ensure that personal fund accounts with complete accounting of funds, family information, legal papers, burial information, and personal property inventory list be transferred with the resident at the time of the move, not afterwards
- All consent forms are completed
- Letters distributed to all residents and family members
- Medications are transferred with the resident. For residents with mental health problems it is important that the medication history accompany the resident so that the new staff will not have to experiment with changing the medication and causing the resident to go into crisis or end up in a psychiatric unit
- Development of a tracking sheet to help locate residents once they are moved
- Develop a comprehensive discharge plan for each resident

Local Ombudsman Plan: The following are suggested areas that ombudsmen need to include in their part of the local plan. A recap of an internal closing document developed by a Michigan ombudsman and a Florida family council program follows. In addition, information on closures presented by two local ombudsmen from Pennsylvania and Texas was distributed during the nursing home closure intensive presentation at NCCNHR's 1999 Annual Meeting. Copies of all of these documents are available from the Ombudsman Resource Center.

1. Information:

- Develop an informational pamphlet for residents and family members identifying and providing telephone numbers to key players, i.e. local and state ombudsmen, local and state regulatory staff, legal services, HCFA, how to access and use the grievance process, their options, terminology, who to contact, what to do if care deteriorates, and residents' rights explained (sample "KIT" follows)

2. Referral:

- Residents and families are given options to placement (New facilities tend to come in wanting to pick and choose the "best" residents for their facility.)
- Try to prevent residents from being transferred to sub-standard homes
- Obtain information on bed availability in the area, current survey information, and status of receiving nursing home
- Provide placement information/resources available to residents/families regarding other nursing homes, how to make an informed decision, and a list of local resources such as Alzheimer's Association, Mental Health and Mental Retardation organizations, and Adult Protective Services

3. Resident and Family:

- Promote resident rights at every opportunity
- Encourage and support development and use of resident and family councils

- Attend resident and family council meetings regularly, weekly meetings might be suggested
- Conduct regular visits to residents in the new location
- Communicate with other local ombudsmen, notifying them of residents who have been transferred into their region
- Increase visitation to facilities where closure is indicated or has been announced
- Initiate meeting with all interested parties to talk about each agency's role with residents, family members and/or legal representatives
- Advocate for roommates or groups of friends who want to be together be transferred to the same facility

4. Local Issues:

- Develop a tracking sheet in order to follow up with relocated residents, ask facility for list of where each resident was transferred
- Use volunteers – their involvement may include copying, placing calls, running errands, friendly visits, and visiting residents once relocated
- Provide training to volunteer long-term care ombudsmen and the public on transfer trauma and nursing home closure indicators
- Determine the role of the state ombudsman and communicate frequently
- Evaluate the safety of ombudsmen in the facility
- Establish a training program to be conducted by ombudsmen for all parties who may be involved on residents' rights and transfer trauma, i.e., bus drivers, EMT staff, volunteers (if utilized), etc.
- Be part of the agenda to educate temporary managers and staff on the ombudsman programs, residents' rights, and transfer trauma
- Continually work to establish community resources

Michigan – Based on a closing in one of the local regions, the local ombudsman developed an internal guideline to assist in future closings. It gives times lines, involvement by local ombudsmen, and a copy of a letter sent to residents from the Department of Social Services explaining why residents were moved.

Florida – Due to a potential closing, the families in this home banded together. Two members would represent the group and talk with the facility staff. All other members were anonymous to prevent potential retaliation to the family member's resident. The care of the residents whose families were vocal actually got better. The group put out a newsletter, giving information and education on the laws involved. Information on how they see a family council operating and copies of their newsletter is available from the Ombudsman Resource Center.

“KIT” On The Go: As the ombudsman walks out the door to a closure, the following **“KIT” (KEEP IT TOGETHER)** is suggested to be used as a checklist to ensure that each ombudsman has all the information needed once they reach the nursing home. Depending on the type of closing - immediate, emergency, disaster, or planned - some of the information may need to be modified to the circumstances. (A copy of an emergency plan used in Indiana is available from the Ombudsman Resource Center.)

LOCAL LONG-TERM CARE OMBUDSMAN “KIT”

CHECKLIST FOR RESIDENTS/FAMILY MEMBERS/LEGAL REPRESENTATIVES:

- _____ Informational Pamphlet on contact people
- _____ Abbreviations/Terminology Sheet
- _____ Residents’ Rights Pamphlets
- _____ Placement options (Provide residents, family members and/or guardians with information about facilities and who to contact regarding other nursing homes in the area, recent survey information, etc.)
- _____ Placement alternatives to nursing home (Provide residents and family members with information and whom to contact regarding other types of placement such as board and care, personal care facilities, home health, etc.)
- _____ Letter informing each party (resident/family member/guardian/physician/legal representative/responsible party) of what is happening, if possible
- _____ Hold meeting(s) with residents/family members/legal representatives to inform of what is happening DATE(S): _____
- _____ Explain to each resident the reason for the relocation and the steps involved in the process
- _____ Items to be transferred with the resident are:
 - _____ All medications
 - _____ Complete medical record
 - _____ Personal funds with full accounting
 - _____ Family information
 - _____ Legal papers
 - _____ Burial information
 - _____ Personal property with inventory list – how will the property be transferred, who will pay the cost, phone service changes, if applicable, etc.
 - _____ Consent forms completed
 - _____ Identification with the resident

NEED FROM NURSING HOME ON ARRIVAL:

- _____ List of all residents, family members, and legal representatives with telephone numbers
- _____ Date(s) of resident/family meetings _____
- _____ Date notification of closure sent to residents and family members _____
- _____ Copy of facility grievance procedure

FOLLOW UP NEEDS:

- _____ Daily/weekly updates from facility
- _____ Roster of new home where residents are transferred
- _____ Hold on-going meeting with residents and families to explain what is happening
- _____ Maintain on-going presence in the facility
- _____ Visit residents in new home or make arrangements for follow-up visits

OTHER:

- _____ Contact numbers of Lead Agency & others included in closure plan (cell phone numbers, e-mail addresses, night numbers will help in an emergency)
- _____ Contact numbers of State Ombudsman
- _____ Cash for meals and incidentals (closure may involve long hours in the facility)
- _____ Cell phone (facility phones are often tied up during these crisis situations)

RESIDENT AND FAMILY INFORMATIONAL SHEET

Important People And Telephone Numbers:

	<u>Name(s)</u>	<u>Telephone #</u>
Local Ombudsmen	_____	_____
State Ombudsman	_____	_____
Local Regulatory Staff	_____	_____
State Regulatory Staff	_____	_____
Legal Services	_____	_____
Regional HCFA office	_____	_____
National HCFA office	_____	1-800-HIT HCFA
Local Representative(s)	_____	_____
State Representative(s)	_____	_____
Temporary Manager	_____	_____
Adult Protective Services	_____	_____
Mental Health Assoc.	_____	_____
Mental Retardation Assoc.	_____	_____
Alzheimer's Assoc.	_____	_____
After Hours Contact(s)	_____	_____
Other Contacts	_____	_____

[Decide which other parties are to be contacted if care deteriorates and add to list]

ABBREVIATIONS/TERMINOLOGY

The following abbreviations/terms are provided to help clarify and define often used terms in nursing homes and that may be encountered during a closure.

Abbreviations

HCFA	Health Care Financing Administration
AoA	Administration on Aging
AAA	Area Agency on Aging
Title XVIII	Medicare
Title XIX	Medicaid

[Add all state abbreviations, i.e. state regulatory agency, ombudsman office, health department, etc]

Voluntary Closure Terminology⁴⁴

- Bankrupt – the state or condition of a business that is unable to pay its debts as they are or become due. As such the company is entitled to take the benefit of the federal bankruptcy laws.
- Bankruptcy Code – a federal law for the benefit and relief of creditors and their debtors in cases in which the debtor is unable or unwilling to pay their debts.
- Debtor – one who owes a debt to another who is called the creditor
- Creditor – a person to whom a debt is owed by another person, the debtor
- Chapter 11 Bankruptcy – Business Reorganizations - when a debtor business realizes it will become insolvent or unable to pay its debts, it can petition for reorganization under Chapter 11 of the Bankruptcy Code. The business normally is permitted to continue its operation under court supervision until the reorganization plan is approved by two-thirds of the creditors. If an agreement cannot be reached, then the court supervises liquidation proceedings.
- Chapter 7 Bankruptcy – Straight Bankruptcy – a proceeding designed to liquidate the debtor's property and pay off the creditors. It can be either voluntary (started by the debtor) or involuntary (started by the creditors).
- Chapter 9 – Adjustment of debt of a municipality.
- Receivership – A proceeding where a person is appointed to preserve the property of an insolvent corporation, partnership, or individual whenever there is danger that the property may be lost, removed, or injured. The protection of the assets is for the ultimate sale and distribution to creditors.

[Add state terminology, text of appropriate legislation, etc.]

⁴⁴ Black's Law Dictionary 147, 148, 1269 (6th ed. 1990).

NATURAL DISASTERS

We found out about the explosion through the media. The facility did not contact anyone. It was a holiday, which only made communications harder.⁴⁵

Natural disasters can range from lightning, smoke, windstorm, hail, explosion, collapse of building, toxic fumes, gas leak, earthquake, tornado, fire, flood, labor force strike, or hurricane. Upon the occurrence of one or more of these types of events, residents may have to be evacuated from the nursing home for an indeterminate period of time, perhaps permanently. The following provides insight from ombudsmen who have experienced a natural disaster, measures to minimize transfer trauma, suggested criteria in developing a state and local Evacuation Plan, and a recap of sample evacuation plans.

State And Local Long-Term Care Ombudsman Perspectives

The following are stories provided by state and local ombudsmen who have experienced some type of natural disaster. In some situations the residents were able to return to their home, in other cases, the home was completely destroyed.⁴⁶

Transportation: The major issue in the recent hurricane evacuation was transportation for nursing homes without pre-arranged contracts. One nursing home in Georgia paid \$30,000 for private transportation. Nursing homes without pre-arranged transportation used mainly school buses that did not have safety belts or bathrooms. Sheets and duct tape were used for safety devices. Incontinence was a real problem. Residents were on the buses from 12 to 16 hours. Two residents died in transit. There was no availability of ambulances or stretcher vans.

Ombudsmen and the nursing home arranged transportation when the tornado hit. The state did not and should not play a part.

Emergency Management System: The emergency management agency needed to do a better job of communicating and coordinating the timing of the evacuation. The agency needed to be educated on the needs of this population. The bus drivers were not trained to deal with the elderly population. A family member that went on the bus with her husband was pleased with how the nursing home dealt with the problem under the circumstances. Not anticipating the length of time on the bus, the medications and other supplies were not split up very well. Ombudsmen should network with all the parties, but the emergency management agency should coordinate the evacuation.

The regions of the state that deal with the potential for emergencies were well-prepared, other areas were not.

Ombudsman Role: Ombudsmen are the ones who understand transfer trauma. We care about the shock and loss that residents feel when relocated. As ombudsmen, we need to ensure that: there are adequate staff in the facilities, the residents can find their families, medications are taken with the resident, there is a central information source, personal

⁴⁵ Local Ombudsman comment.

⁴⁶ Comments provided by state and local ombudsman in Michigan, Georgia, Florida, and North Carolina.

belongings are protected, beds are available, transportation needs are met, and there is coordination with mental health/grief counselors. If the resident does not want to return to the facility, then we need to assist the resident with new placement.

The nursing home was the lead and the ombudsmen provided support. Ombudsmen could be the lead if there was a clear plan in place.

The ombudsman's staff helped to find facilities where there were beds available. We checked on the residents before and after the hurricane.

Communications: We need to attempt to contact families on behalf of residents to let them know where the resident is located. Ombudsmen should try to visit the resident in the temporary setting or contact other ombudsmen in the new region of the transferred resident.

Due to communication problems, we provided information to the state offices and relayed information from the state to the local parties involved. We helped locate beds and have followed up with residents. The residents seemed to fare better than any one else. We are still monitoring the issue of transfer trauma, particularly with those residents whose home was completely destroyed.

One problem was how to keep families informed.

We contacted the gas and electric companies to make sure that they knew where all of the facilities were located. In retrospect, we should have done this before the disaster occurred.

Some of the ombudsman volunteers went as quickly as they could to the facilities; they were so motivated by their concern for the residents that no communication was needed to get them to the scene.

Facility Information: Medical records were a big issue. It was 48 hours after the explosion before we could obtain the records. Some residents went without psychotropic drugs for three days. If the Minimum Data Set (MDS) can be sent electronically to the state agency, why can't it be sent to the receiving home? At least then the receiving home would have some information on the resident. Grief counselors were not readily available for the residents or the staff (residents and staff were killed).

Measures To Minimize Transfer Trauma

Transfer trauma is an issue regardless of why the resident is being relocated. Some specific steps the facility can take to minimize transfer trauma during a natural disaster follow.⁴⁷

- Facility prepare a specific plan and conduct a yearly review
- Designate all critical staff
- Make a detailed contingency evacuation plan
- Designate key personnel
- Confirm third party support agreements
- Coordinate with county and state disaster plans
- Establish and coordinate chain of command
- Prepare a required task list of all assignments to be completed (water heaters, water proofing computers)
- Develop a command center

⁴⁷ Transfer Trauma Minimizing the Impact on Community Based and Institutional Elders (visited Sept. 9, 1999) <<http://www.aoa.dhhs.gov/aoa/disaster/manual/gtran.html>>

- Develop interdisciplinary teams
- Develop security
- Plan on using hand-held radios, secure battery operated radios – cell phones
- Order critical supplies
- Order dietary orders
- Staff pharmacy with extra personnel and medications
- Equip the physical plant with working generators – donated generators
- Fuel all vehicles during watch phase
- Have chainsaws available
- Photograph and document all property damage
- Develop a person transfer log with a resident picture. Prepare a necklace tag with important information. Inadequate resident identification is a big issue as the caregiver may disappear and no one may know the resident's medication and care needs.
- Have cash on hand
- Follow infection control procedures
- Ensure services are available for emotional support of residents
- Provide disaster education to all staff on continuing basis
- Conduct disaster alert simulations

State/Local Evacuation Strategy

An Evacuation Strategy and coordination of services is important at the local and state level. An overall state perspective is needed to assist in the development of a local plan. The following outlines suggest areas that should be included in a state strategy and the areas to cover in a local strategy.

State Evacuation Strategy Development: Areas that the state strategy needs to address are:

1. Who To Involve:

- Establish a state evacuation task force to develop a plan in the event of a natural disaster. Establish which agency will be in charge of coordinating the evacuation plan. Agencies, other parties, and community advocacy groups to consider including:
 - Emergency management agency – lead agency
 - Public Health Department
 - Nursing home association and administrators
 - State transportation department
 - Hospital association and administrators
 - State regulatory agency
 - Transportation companies – ambulance and tour bus companies – establish contracts
 - Law enforcement agency – is a police escort possible/necessary
 - State/Local ombudsmen
 - Volunteer organizations and local advocacy groups – members available to assist, AARP

- Media – how information is to be generated to the public
- Church and school officials – availability of rooms within their building
- Red Cross/Salvation Army/other relief organizations
- Nursing home staff unions
- Mental Health and Mental Retardation organizations
- Vendors identified who can/will donate food and other supplies
- Mental Health/Grief Counselors
- All parties’ exchange home numbers, beeper numbers, and cell phone numbers as disasters happen after hours and on holidays

2. What Components To Include:

- Who should maintain a roster of residents and where they are being transported to, expected arrival time, length of stay
- Who and how to notify individuals/agencies on holidays
- Who notifies the family members prior to and after evacuation about where residents are located?
- Alternative modes of communication in the event of outages – cell phones, can/should an 800 number be established
- Who will handle phone calls, disseminate information on location of residents
- Governor sign certificates of appreciation for staff and volunteers who assisted during the disaster

3. Resident Needs:

- Development of criteria/triage system with the assistance of the hospital association to determine the most critical nursing home residents at the time of the evacuation in order that those residents can be assured transportation by ambulance or stretcher van
- Responsible party for ensuring medical data is available on each resident throughout the evacuation, status of personal belongings, food and other supplies are available to the residents during the evacuation – agency identify the local entity to coordinate this function

4. Evacuation Logistics:

- Who decides where residents will go when they are evacuated
- Should the ombudsmen give out information about alternative facilities where beds may be available
- Locations identified where residents could be taken – schools, churches

Local Evacuation Strategy Development: Areas that the local strategy needs to address are:

1. Who To Include:

- Establish a local evacuation task force to develop a plan in the event of a natural disaster. Establish which agency will be in charge of coordinating the evacuation plan. Agencies, other parties, and community advocacy groups to consider including:
 - Emergency management agency – lead agency
 - Local Health Department

- Nursing home association and administrators
- Local transportation department
- Hospital association and administrators
- Local regulatory agency
- Transportation companies – ambulance and tour bus companies – establish contracts
- Law enforcement agency – is a police escort possible/necessary
- Local ombudsmen
- Volunteer organizations – members available to assist, AARP
- Media – how information is to be generated to the public
- Church and school officials – availability of rooms within their building
- Red Cross/Salvation Army/other relief organizations
- Nursing home staff unions
- Mental Health and Mental Retardation organizations
- Vendors identified who can/will donate food and other supplies
- Mental Health/Grief Counselors
- All parties’ exchange home numbers, beeper numbers, and cell phone numbers as disasters happen after hours and on holidays

2. What Components To Include:

- Roster of residents and where they are being transported to, who maintains, expected arrival time, length of stay
- Who and how to notify individuals/agencies on holidays
- Who notifies the family members prior to and after evacuation; Where residents are located
- Alternative modes of communication in the event of outages – cell phones, can/should an 800 number be established
- Who will handle phone calls, disseminate information on location of residents
- Role of volunteers, i.e. run errands, copying, visibility afterwards, answering phones
- Access to copy machines
- Who will handle phone calls, disseminate information on location of residents
- Family members and guardians are notified of evacuation
- Ombudsmen follow up with residents in temporary facilities and upon return to home facility

3. Resident Needs:

- Development of criteria/triage system with the assistance of the local hospital/hospital association to determine the most critical nursing home residents at the time of the evacuation in order that those residents can be assured transportation by ambulance or stretcher van
- Responsible party for ensuring medical data is available on each resident throughout the evacuation, status of personal belongings, food and other supplies are available to the residents during the evacuation – agency identify the local entity to coordinate this function

4. Evacuation Logistics:

- Who decides where residents will go when they are evacuated
- Who should give out information on alternative facilities where beds may be available
- Locations identified where residents could be taken – schools, churches, other nursing homes
- Nursing home staff and volunteers who will accompany the residents
- Identified parties (ombudsmen, nursing home staff) call other facilities to acquire information on bed availability and report to the emergency management agency – (ombudsman is not a referral agency, only providing information)
- Drivers have information regarding the most direct route to their destination

Model State/Local Evacuation Plans Recapped

Two state plans are recapped below. Copies of these plans may be obtained from the Ombudsman Resource Center.

- North Carolina
 1. Legislation to allow nursing homes to be designated as emergency shelters, receive reimbursement, allowing the State Medicaid agency and licensure authority to increase beds beyond certificate of need under emergency provisions, memorandum of interpretation, sample county emergency ordinance, sample proclamation of county state of emergency, proclamation terminating state of emergency, and comments on ordinance.
 2. Local Hurricane Checklist – pre-planning conditions, coping and getting prepared.
 3. Local County Special Needs Disaster Sheltering Program (New Hanover) - in the process of revising plan based on new legislation
- Tennessee – Establishes roles of ombudsmen program in the event of an emergency, notice to families of contingency plan, and of transfer.

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RESOURCE LIST

Copies of the following plans/programs/statutes are available from the Ombudsman Resource Center.

SECTION IV – Role of State LTC Ombudsmen in Closures – Proactive Role, page 26

1. Proactive Monitoring
2. Rehabilitation Care Consultants, Inc.
3. Survey Solutions

SECTION IV – Role of State LTC Ombudsmen in Closures – Model State Plans Recapped, page 36

1. Arizona
2. Connecticut
3. Washington, DC
4. Louisiana
5. Massachusetts
6. Michigan
7. North Dakota
8. Ohio
9. Tennessee
10. Texas
11. Wisconsin

SECTION VI – Natural Disasters – Model State/Local Evacuation Plans Recapped, page 58

1. North Carolina
2. Tennessee

APPENDICES

Copies of the following plans/information follow.

- Appendix A Michigan MPHI
- Appendix B Michigan Fact Sheet
- Appendix C Michigan Local Long-Term Care Task Force