LEVEL I
TRAINER'S
MANUAL

ILLINOIS STATE LONG-TERM CARE OMBUDSMAN PROGRAM

As mandated by the Older Americans Act, the mission of the Long-Term Care Ombudsman Program is to seek resolution of problems and advocate for the rights of residents of long-term care facilities with the goal of enhancing the quality of life and care of residents. The Illinois Long-Term Care Ombudsman Program was expanded to include advocacy on behalf of participants in the same manner in which advocacy is provided on behalf of residents.

Adapted from the NASOP Mission Statement,
Adopted May 2004

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ACKNOWLEDGMENTS

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The 2018 revisions of this manual were completed by Jamie Freschi, State Ombudsman and Jessica Belsly, Ombudsman Support Specialist.

The primary sources for this training are the Illinois State Long-Term Care Ombudsman Policies and Procedures; the State Operations Manual Appendix PP – Guidance to Surveyors for Long-Term Care Facilities; the Illinois Act on the Aging; and the many useful resources available through the National Ombudsman Resource Center (NORC) website (www.ltcombudsman.org). Footnotes and the bibliography identify as many of the original source materials as possible. Special thanks to Connecticut State Long-Term Care Ombudsman Program for sharing the "Courage to Speak" video with Illinois Long-Term Care Ombudsman.

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ABOUT THE TRAINER'S MANUAL

TRAINER'S NOTES *appear in red italics throughout the text. Trainer's notes are based on the suggestions of experienced professional Ombudsmen, resources from the National Ombudsman Resource Center, the Illinois Long-Term Care Ombudsman Program Policies and Procedures Manual, The Illinois Act on the Aging, and the Older Americans Act.*

The intent of standardized training materials is to assure that new volunteers and paid staff are trained in a consistent manner across regions. However, as the training progresses into problem solving techniques, you are encouraged to share information from your own experiences and casework in your Region. This sharing brings the training alive for participants and helps put the training material in context.

Before the training, read through the modules and review the PowerPoint Presentation provided with this manual. You will not be able to cover every detail in this manual. The PowerPoint slides provide you with an outline of critical training points and can help guide you through the material. However, you must be familiar with the text so that you can present a coherent overview of the material.

To help assure that you are on the right PowerPoint slide, each slide uses a title that corresponds with a heading or subheading in the text. Next to the title on each PowerPoint slide, you will notice two numbers in parentheses with a slash mark between them, [i.e., (12/7)]. The first number corresponds with the page numbers on which the material appears in the Trainer's Manual. The second number corresponds with the page number on which the material appears in the Participant's Manual.

If you are looking at your Trainer's Manual and want to be sure that you are on the right PowerPoint slide, the corresponding slide number appears in parentheses next to each subheading, [i.e., (PPS 1)]. To help you guide participants through their manual during the training, the page number on which material appears in the Participant's Manual also appears in parentheses next to each topic heading or subheading, [i.e. (PM Pg. 10)]. A complete example of this formatting looks like this: Training Requirements (PPS #) (PM Pg. #)

Set up your training site early. If your training room is in the same building as your office, it is a good idea to set up your computer, speakers, DVD, etc. the night before training. Go ahead and play a couple of minutes of the training DVD's to assure that the DVD plays correctly and that the volume control is set correctly.

TRAINING MATERIALS

To conduct the Level 1 Training, you will need the following materials:

- *WiFi*
- *DVD Compatible Laptop*
- *Projector*
- *PowerPoint Presentation (provided)*
- *DVD: "Advocating for Residents' Rights: The Older Americans Act Long-Term Care Ombudsman Program"*
- *DVD: "The Courage to Speak"*
- *One display board, easel or wall upon which you can tack or tape 4x6 index cards for the "What Does an Ombudsman Do?" activity*
- *One set of "What Does an Ombudsman Do?" word cards (see the activity instructions on page 34 for more specific details)*
- *One trainer's manual for each trainer*
- *Participant's materials as listed below*
- *Snacks and meals as local convention dictates*

Add the following information to your training materials as needed:

- *Local program information (page 9)*
- *Local applications, (Appendix G)*
- *Local forms for documentation (Appendix H)*

For each participant you will need the following materials:

- *One copy of Level 1 Training Participant's Manual*
- *One copy of the Level 1 Pre-Test*
- *One copy of the Level 1 Post-Test*
- *Copies of local program brochures (Can be inserted in Appendix G)*
- *Paper and pens*

MANAGING THE TRAINING ENVIRONMENT

As a trainer, you must cover a lot of material in a limited period of time. You may find that participants have questions that seem pressing at the moment but that are covered later in the training. You may also find that participants who have worked in nursing homes, or who have had a loved one in a nursing home, want to share their personal experiences during classroom training. Left unchecked, this sharing can dominate the training day. It is easier to assure that you cover all the necessary material if you are able to have some control over the number of questions and personal experiences participants share during the training. Some tactful ways to limit participant interruptions include:

- *Explaining that information included in the training may answer some of their questions about long-term care as well as home and community based services.*
- *Suggesting that the case studies contained in the training provide effective ways to discuss specific problems in nursing homes in more general way.*
- *Asking participants to hold their questions until the end of a module when you can have a short question and answer session.*
- *Offering to meet with participant(s) after the training to discuss any specific questions.*

The ability of a participant to separate their own experiences from the information provided during the training and the participant's responses to case studies can give you important insight into the participant's ability to become an effective Ombudsman. You may find that you need to counsel some participants out of the program before they receive a badge. This counseling should occur in a private setting.

AGENDA

(PPS #4 & 96) (PM Pg. 5)

TRAINER'S NOTE: *Provide an overview of the topics being covered today. Sharing the agenda will:*

- *Give participants some idea what content to expect.*
- *Help participants make good decisions about holding questions until certain topics have been covered.*
- *Show participants that the Level I training program requires a commitment of at least 2 days of classroom training and four hours of mentoring visits.*
- *If you are providing the training over four half day sessions, train modules 1-4 on Day One, Modules 5-8 and administrative tasks on Day Two, Modules 9-12 on Day 3, Modules 13-15 on Day 4.*

Day One (PPS #4) (PM Pg. 5)

9:00-9:30	Introductions and Pre-Test
9:30-9:45	Module 1 – Becoming an Ombudsman
9:45-10:15	Module 2 – Program History and Overview
10:15-10:30	BREAK
10:30-11:15	Module 3 – Ombudsman Roles & Responsibilities
11:15-11:45	Module 4 – Confidentiality and Ethical Practice
11:45-12:15	LUNCH *(If using a half-day training schedule, end Day 1)*
12:15-1:15	Module 5 –Residents' Rights
1:15-2:00	Module 6 – Ombudsman Communication Skills
2:00-2:15	BREAK
2:15-3:00	Module 7 – Empowering Self-Advocacy
3:00-3:45	Module 8 – Your First Visit
3:45-4:00	Administrative tasks: ● Complete applications, confidentiality agreement ● Photos for badge ● Distribute temporary name badges ● Schedule first supervised mentoring visit
4:00	Dismiss *(If using a half-day training schedule, end Day 2)*

Day Two (PPS #96) (PM Pg. 5)

9:00-9:45	Module 9 – Complaint Intake
9:45-10:30	Module 10 – Complaint Investigation & Verification
10:30-10:45	BREAK
10:45-11:30	Module 11 – Planning, Intervention & Resolution
11:30-12:00	Module 12 – Conflict and Negotiation
12:00-12:30	LUNCH *(If using a half-day training schedule, end Day 3)*
12:30-1:15	Module 13 – Questions of Capacity and Competence
1:15-1:45	Module 14 – Responding to Resident Abuse, Neglect and Exploitation
1:45-2:15	Module 15 – Introduction to Documentation
2:15-2:30	BREAK
2:30-3:00	Module 16 – Putting it all together: A final case study
3:00-3:15	Post-Test
3:15	Closing activities
	Dismiss *(If using a half-day training schedule, end Day 4)*

PRE-TEST
(PPS# 5) (PM Pg. 6)

TRAINER'S NOTE:

- *The Pre-Test is not included in the Participant's Manual.*
- *Both the Pre-Test and the Post-Test are in Appendix I of the Trainer's Manual.*
- *Pass out one copy of the Pre-Test to each participant. Do not pass out the Post-Test until the end of Day 2.*
- *Tell participants that the Pre-Test is two pages long.*
- *Give participants 10 minutes to complete the Pre-Test.*
- *Do not review the Pre-Test with participants until they have completed Level I Training and taken the Post-Test.*

Before you begin training, you will be asked to complete a Pre-Test. You will have 10 minutes to complete the test. At the end of day two, you will be asked to take a Post-Test. The Pre-Test and Post-Test are designed to assure that the training gave you the knowledge you need to become an effective Ombudsman. Your trainer will discuss the content of the test at the end of Day Two of your training.

MODULE 1

BECOMING AN OMBUDSMAN

You will find a great sense of satisfaction in helping residents regain some of the autonomy they lost when they moved into the nursing home.

TRAINER'S NOTE: *Before you begin, introduce yourself, other trainers, and guests (i.e. the State or Deputy State Long-Term Care Ombudsman). Allow participants to introduce themselves and share their most recent work history with the group. Do not encourage participants to engage in an in-depth discussion of their experiences with long-term care. Review the training agenda, share the break schedule and tell participants where they can find refreshments and restrooms.*

Becoming an Ombudsman

(PPS #7) (PM Pg. 8)

Being an Ombudsman is one of the most challenging and rewarding professional or volunteer positions you may ever experience. Ombudsmen share many personal and professional characteristics that are vital to both personal success as an advocate and to sustaining a strong advocacy network across the state of Illinois.

Personal Characteristics

(PPS #8) (PM Pg. 8)

Having a desire to help others is only the first step to becoming a successful Ombudsman. You will also need strong communication skills, effective problem-solving skills, a firm commitment to resident directed care and advocacy, and an understanding of the long-term care system.

Legal Requirements

(PPS #9) (PM Pg. 8)

Chapter 300, Section 303 of the Illinois Long-Term Care Ombudsman Program Policies and Procedures outlines the minimum requirements for certification of a Long-Term Care Ombudsman. To become an Ombudsman, you must:

- be at least 18 years of age,
- submit to a criminal background check and not have a disqualifying criminal conviction,
- be free from conflicts of interest (discussed later in this training), and
- be recommended by a Regional Ombudsman for certification.

The State Ombudsman makes the final determination on certification.

Training Requirements

(PPS #10) (PM Pg. 8)

To assure that all Ombudsmen meet the same standards for professional conduct and engage in similar problem-solving techniques across all regions, every Ombudsman is required to complete a standardized training program consisting of:

- Level I training and
- at least four (4) hours of mentoring.

Once certified, you are required to complete Level II training and additional in-service hours based upon Policies and Procedures and your local program. Through training and mentoring, you will learn about:

- Culture change and person-centered care;
- Federal and state agencies ;
- Federal and state regulations;
- Working with the Illinois Department of Public Health;
- When residents threaten to harm themselves;
- Resident assessment and care planning;
- Advance Planning;
- Medicaid and Medicare
- Financial exploitation and medical fraud
- Transfer or discharge; and
- Documentation

Despite the length of the required training, it is impossible to cover all information needed to be an effective Ombudsman. Your understanding of the Ombudsman Program and your ability to advocate for residents will be greatly enhanced by taking the time to read the training modules at home.

Assessment & Supervision

(PPS #11) (PM Pg. 9)

TRAINER'S NOTE: *Becoming an Ombudsman may not be the best fit for every person wanting to help residents. Explain that completion of Ombudsman training does not assure that every individual will be selected to become a certified Ombudsman.*

While the Ombudsman Program provides in-depth training and a strong network of supervision, some individuals learn that the Program's mandate to provide resident directed advocacy conflicts with their personal values. Should you discover, at any point, that your values conflict with the values of the Program, please do not hesitate to discuss your concerns with your Regional Ombudsman or Volunteer Coordinator.

During your training, and throughout your career as an Ombudsman, the Regional Ombudsman will assess your ability to empower residents and to engage in resident directed advocacy and problem-solving activities. Should you become unable to develop a commitment to resident empowerment and resident directed advocacy, you may be asked to discontinue training. If you are unable to maintain a commitment to program values in the field, the Regional Ombudsman may recommend decertification to the State Ombudsman.

The Rewards

(PPS #12) (PM PG. 9)

As a certified Ombudsman, you will become a voice for residents' rights and for systemic improvements in long-term care. It is not always easy, but you will find that helping residents maintain a sense of dignity, quality of life, and independence is quite rewarding.

MODULE 2

PROGRAM HISTORY & OVERVIEW

The Ombudsman role is often described as one of getting service providers, regulators, and others to fulfill their responsibilities to residents.

Sara Hunt, Consultant,
National Ombudsman Resource Center

What is a Long-Term Care Ombudsman?

(PPS #14-16) (PM Pg. 12)

Say the word "Ombudsman" to most people, including residents and you will get a blank look. The word "Ombudsman" is a Swedish word meaning "citizen's representative." Long-Term Care Ombudsmen are *advocate* Ombudsmen working on behalf of residents of long-term care facilities to improve the long-term care system from the perspective of the resident. Long-Term Care Ombudsmen try to influence the long-term care health system so that it is more responsive to the individual needs and preferences of the resident.

As described in the Long-Term Care Program Policies and Procedures, Chapter 100, Section 101 General Authority and Mission

TRAINER'S NOTE: *Forward to PPS #15*

"The Program protects and improves the quality of care and quality of life for residents of long-term care facilities in Illinois through individual and systemic advocacy for and on behalf of residents, including representing interests of residents before governmental agencies, reviewing and commenting on existing and proposed laws, seeking out and responding to media requests, the promotion and cultivation of best practices within long-term care services, and through the promotion of family and community involvement in long-term care facilities."

TRAINER'S NOTE: *Forward to PPS #16*

Mention that the word "participant" refers to individuals living in their home eligible for Home Care Ombudsman advocacy, which will be discuss in more detail later.

"The Program is a resident and participant centered advocacy program. The resident or participant is the program's client, regardless of the source of the complaint or request for service. The Ombudsman will make every reasonable effort to assist, empower, represent, and intervene on behalf of the resident or participant."

TRAINER'S NOTE: *Forward to PPS #??*

Don't get bogged down on this section. Everything will be discussed in more detail later in the training sessions.

According to the Older Americans Act, the Ombudsman shall:

1. Identify, investigate, and resolve complaints that are made by or on behalf of residents and relate to action, inaction or decisions that may adversely affect the health, safety and welfare of the residents of long-term care facilities;
2. Provide services to assist residents in protecting the health, safety, welfare, and rights of residents;
3. Inform residents on ways of obtaining services for which they are entitled;
4. Ensure that residents have regular and timely access to the services provided through the Office and that the residents and complainants receive timely responses from the Office to complaints;

5. Represent the interests of the residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;
6. Analyze, comment on, and monitor the development and implementation of federal, state, and local laws, regulations and other governmental policies and actions, that pertain to the health, safety, welfare, and rights of long-term care residents with respect to the adequacy of long-term care facilities and services in the State. Ombudsmen recommend changes in such laws, regulations, policies and actions as appropriate and facilitate public comment;
7. Promote the development of and provide assistance to citizen advocacy groups that want to protect the well-being and rights of residents;
8. Provide technical support for the development of resident and family councils to protect the wellbeing and rights of residents.

Long-Term Care Ombudsman Program History
(PPS #17-18) (PM Pg. 13)

TRAINER'S NOTE: *Do not attempt cover all dates provided in this timeline. The PowerPoint slides highlight dates that should be covered.*

The Long-Term Care Ombudsman Program is authorized and regulated through Title VII, Chapter 2 of the Older Americans Act and through Section 4.04 of the Illinois Act on the Aging. The following timeline[1] offers a brief history of the development of the program.

1965 – Medicare and Medicaid programs begin to provide public funding for long-term care.

1970 – Publicity about poor care, abuse, neglect, and substandard living conditions in nursing homes lead to Congressional Hearings which identify a breakdown in licensing and certification systems meant to protect vulnerable individuals.

1971 – Dr. Arthur Flemming, a well-respected public servant committed to improving health care systems and the lives of the elderly, proposes an "Ombudsman" program based on a Swedish model to then President Nixon for inclusion in his nursing home agenda. The model introduced is intentionally structured to operate outside the licensing and certification systems.

1972 – A Presidential directive authorizes states to establish specialized units to respond to the complaints made by or on behalf of individual nursing home residents, leading to the creation of Ombudsman demonstration projects in five states. The Public Health Service provides for federal oversight of the projects, four of which are located in state agencies while a fifth project tests a non-profit program model. The goal of each project is the same – complaint resolution.

1974 – Administrative authority for the Ombudsman program transfers to the Administration on Aging, a part of the Department of Health and Human Services.

1975 – Amendments to the Older Americans Act authorize the Administration on Aging to provide grants to all states "to enable the State Agencies to develop the capabilities of the Area Agencies on Aging to promote, coordinate, monitor, and assess nursing home Ombudsman activities within their service areas." Every state except Oklahoma and Nebraska receive grants and hire a Nursing Home Ombudsman Specialist.

1978 – Amendments to the Older Americans Act require all states to operate a Nursing Home Ombudsman Program using a program framework that relies heavily on volunteers to provide local services to resolve the complaints of individual nursing home residents. Amendments also help define the Ombudsman's role in providing systemic advocacy by identifying significant, widespread problems, and by monitoring federal, state and local laws and policies that affect long-term care residents.

[1] *State Long-Term Care Ombudsman Programs: A Primer for State Aging Directors and Executive Staff. National Ombudsman Resource Center. May 2010.*

1981 – Ombudsman responsibilities expand to include complaint resolution for residents of board and care facilities. The program name changes to the Long-Term Care Ombudsman Program.

1987 – Amendments to the Older Americans Act, require states to assure that Ombudsmen are granted access to residents and to their medical records. Ombudsmen are granted immunity from prosecution for good faith performance of their duties.

1992 – Amendments require all states to create an Office of the State Long-Term Care Ombudsman and encourage a more coordinated approach by Ombudsmen, elder abuse caseworkers, legal assistance workers, and benefits advisors to help the vulnerable elderly understand and exercise their right to access assistance when they are having problems.

2000 – The Older Americans Act reauthorizes the Ombudsman program through 2005. Financial conflicts of interest are more clearly defined. Ombudsmen are prohibited from making any financial gain as a result of actions taken by or on behalf of long-term care residents. Ombudsman programs are required to coordinate their efforts with state and local law enforcement agencies and with the court system.

2006 – The Ombudsman Program is reauthorized through fiscal year 2011. Assisted living facilities are added to the definition of "long-term care facility."

2010 – The Administration on Aging creates and staffs the position of National Ombudsman. Additional consumer protections, Ombudsman responsibilities and abuse prevention requirements are included in health care reform legislation.

2011 – The Older Americans Act, including the Long-Term Care Ombudsman Program, is reauthorized.

2016 – Federal Ombudsman Rule implemented

Over time, amendments to the Older Americans Act changed the Long-Term Care Ombudsman Program. However, those changes always strengthened the program by clarifying the role of the Ombudsman as an independent advocate for vulnerable adults living in long-term care settings. As long as residents experience substandard care as a result of poor regulation, enforcement, and care delivery, Ombudsmen will continue to have a role to play in long-term care facilities.

"Advocates for Residents' Rights: The Older Americans Act Long-Term Care Ombudsman Program" Video

Your trainer will now show "Advocates for Residents' Rights: The Older Americans Act Long-Term Care Ombudsman Program" an introduction to the Ombudsman Program featuring Dr. Arthur Flemming.

TRAINER'S NOTE: *Forward to PPS #18. Show the Arthur Flemming video now. Be sure to explain that while the DC facility in the video was shut down, it is not the goal of the Ombudsman to close facilities. Explain that Ombudsman work to resolve individual and systemic concerns. Process the video by asking the following questions:*

What is the core message you received from the video?
Is there anything that surprised you?
Are you starting to understand the role of the Ombudsman?

Program Administration
(PPS #19) (PM Pg. 15)

TRAINER'S NOTE: *This section is most easily trained by directing participants to the flow chart on the next page. Explaining program administration gives you an opportunity to introduce participants to the idea that many agencies, including the Administration for Community Living, have an interest in Ombudsman activities. This knowledge can be used to help encourage Ombudsmen to complete documentation so that information is reported correctly to other entities.*

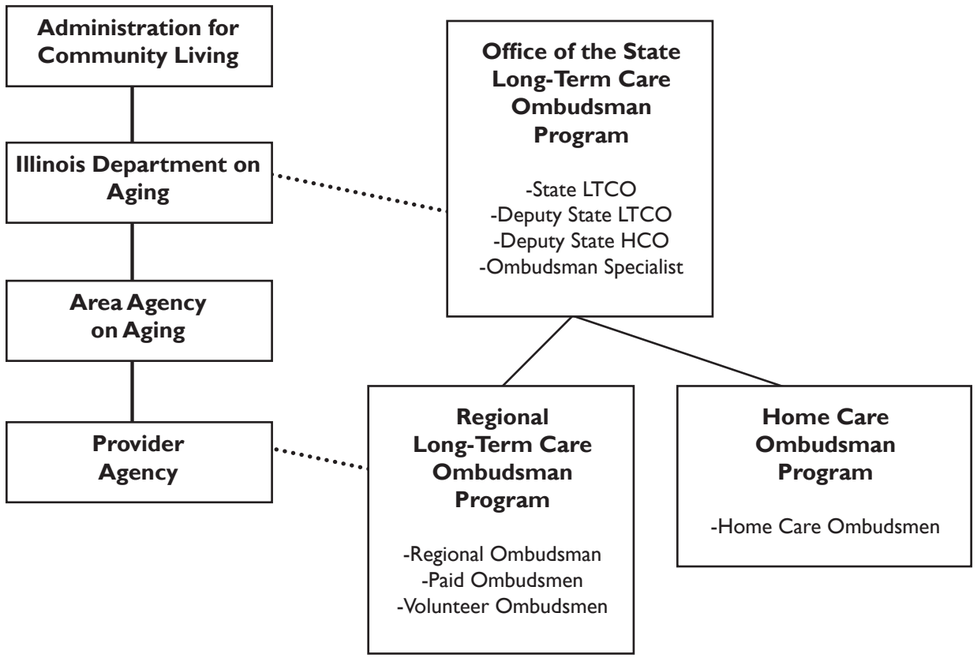
Providing effective long-term care Ombudsman services requires the cooperation of many agencies and individuals on federal, state, regional and local levels. The flow chart on the next page shows how responsibilities spelled out in the Older Americans Act, the Illinois Act on the Aging, and the Long-Term Care Ombudsman Program Policies and Procedures Manual are delegated.

The Administration for Community Living delegates responsibility for the Long-Term Care Ombudsman Program to the Illinois Department on Aging. The Office of the State Long-Term Care Ombudsman sits at the Department on Aging. The Office houses the State and Deputy State Ombudsmen as well as the Home Care Ombudsman Program.

The Illinois Department on Aging delegates administrative responsibilities for Regional Ombudsman Programs to local Area Agencies on Aging. In some areas, a separate provider agency may oversee the day to day operations of the Regional Ombudsman Program. However, the Area Agency on Aging maintains responsibility for fiscal oversight of the program. Whether the Provider Agency is the Area Agency on Aging or another organization, the State Ombudsman designates the Ombudsman Providers.

Regional Ombudsman programs are responsible for providing direct services to residents. Regional Ombudsmen work with supervision and technical assistance provided by the State and Deputy State Long-Term Care Ombudsmen. In most areas, the Regional Ombudsman depends on a small staff of paid Ombudsmen and/or Volunteer Ombudsmen to assist with regular presence visits, activities, and casework.

Figure 1. Illinois Long-Term Care Ombudsman Program Administration
(PPS #19) (PM Pg. 16)



Program Funding
(PPS #20) (PM Pg. 17)

TRAINER'S NOTE: *This section is most easily trained by using the flow chart on the next page. It may be helpful to briefly define general revenue funds, provider funds (from the bed tax), and in-kind donations. Explaining funding sources reinforces the idea that many organizations are interested in program activities that are reported through Ombudsman documentation.*

Regional Long-Term Care Ombudsman Programs depend on funding from many sources to assure that they can meet program requirements set forth by the Older Americans Act.

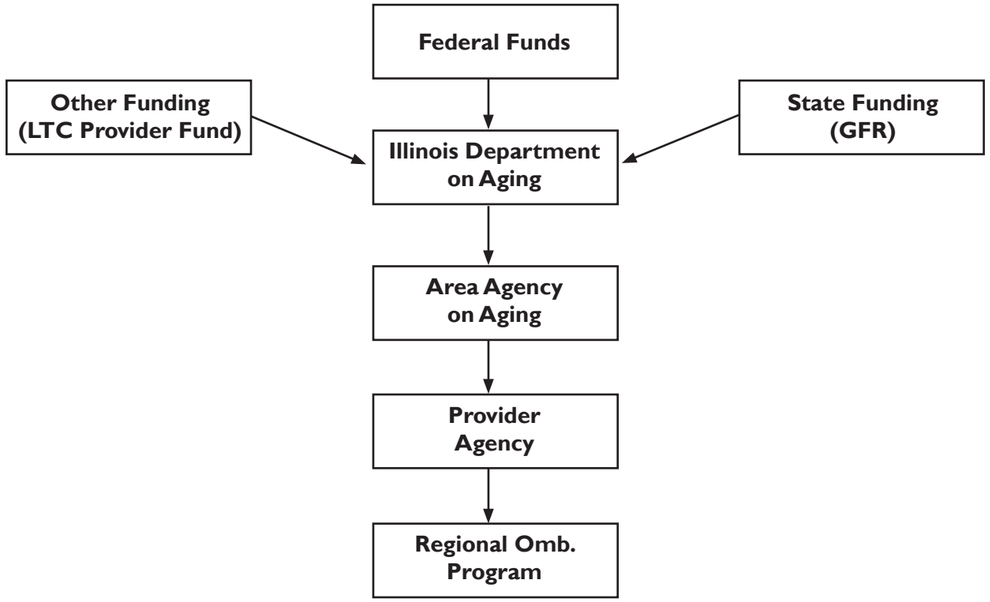
As shown on the next page, federal funds and state general revenue funds are combined with other funding such as provider funds (bed tax) to provide support for the Long-Term Care Ombudsman Program.

Funding for the Long-Term Care Ombudsman program is allocated to the Department on Aging which, in turn, allocates funding to the Area Agencies on Aging (AAAs) for administration of the program. If the regional program is housed in a separate provider agency, the AAA allocates funding for day-to-day operations to the provider agency.

Some AAAs provide local fundraising efforts to supplement federal and state funding. Provider agencies may also engage in fundraising or provide in-kind donations or actual monetary support to Regional Ombudsman Programs that operate under their sponsorship.

Program funding can vary widely from year to year depending on federal, state, and local funding.

Table 3. LTCOP Funding Sources **(PPS #20) (PM Pg. 18)**



Types of Facilities Visited by Ombudsmen

Skilled Nursing Facilities (SNF): Licensed under the Nursing Home Care Act, skilled nursing facilities provide services that require licensed nursing staff for administration (i.e. IVs or wound care), or provide rehabilitation services (therapy) to residents who are expected to return to the community. The cost of some care may be covered by Medicare.

http://www.ilga.gov/commission/jcar/admincode/077/07700300sections.html

Intermediate Care Facilities (ICF): Licensed under the Nursing Home Care Act, Intermediate care facilities provide services and some nursing supervision in addition to help with eating, dressing, walking or other personal needs. Medicaid may pay for intermediate care but Medicare never does. Some intermediate care facilities are private pay only facilities.

http://www.ilga.gov/commission/jcar/admincode/077/07700300sections.html

Intermediate Care Facilities for the Developmentally Disabled (ID/DD): Licensed under the ID/DD Community Care Act, ID/DD facilities provide custodial care for individuals with developmental disabilities who are mobile adults and need physical, intellectual, social and emotional assistance. Residents are often out of the building during normal business hours as they attend "workshops" that provide them with an opportunity to earn a small income. Facility staff and workshop staff work together to provide appropriate behavioral training and interventions for residents. Residents may receive Social Security or Medicaid benefits that help pay for room and board.

http://www.ilga.gov/commission/jcar/admincode/077/07700350sections.html

Assisted Living and Shared Housing Establishments (ALF): Licensed under the Assisted Living and Shared Housing Act, assisted living and shared housing establishments are community-based residential care homes that provide care for residents who do not need the services of a nurse but who do need some help with activities of daily living (i.e. meal preparation, getting dressed), personal, supportive and intermittent health-related services available 24 hours a day. Assisted living and shared housing establishments are private pay and are not certified to accept Medicaid or Medicare.

http://www.ilga.gov/commission/jcar/admincode/077/07700295sections.html

Supportive Living Facilities (SLF): Established under Public Aid §.01a 5/5-5.01a. Supportive living facilities program, supportive living facilities were developed in Illinois as an alternative to assisted living and nursing homes for low-income older persons and persons with physical disabilities under Medicaid. Supportive living facilities are similar to assisted living establishments in terms of the care provided. The Department of Healthcare and Family Services (HFS) has obtained a waiver to allow for services that are not routinely covered by Medicaid. The resident is responsible for paying the cost of room and board at the facility. HFS is the regulatory agency for supportive living facilities. A supportive living must designate which population it will serve: Persons age 22-64 with a physical disability or persons age 65 or over.

http://www.ilga.gov/commission/jcar/admincode/089/08900146sections.html

Sheltered Care Units and Facilities (SHL): Sheltered care facilities provide personal care, supervision, oversight and a suitable activity program. Provisions are made for periodic medical supervision and other medical services as needed. Some sheltered care facilities are similar to assisted living facilities, accepting only residents who are 65 and older while some admit individuals of any age with mental illness diagnoses.

http://www.ilga.gov/commission/jcar/admincode/077/07700330sections.html

Specialized Mental Health Rehabilitation Facilities (SMHRF): Facilities licensed under (210 ILCS 49/) Specialized Mental Health Rehabilitation Act of 2013 provide rehabilitation, triage as well as crisis stabilization to inpatient hospitalization, provide stabilization for those in post crisis stabilization, and provide transitional living assistance to prepare those with serious mental illness to reintegrate successfully into community living settings.

http://www.ilga.gov/commission/jcar/admincode/077/07700380sections.html

Medically Complex for the Developmentally Disabled (MC/DD): Facilities licensed under the MC/DD Act provide medically complex, personal care, and nursing to individuals of any age. However, Ombudsman who visit MC/DD licensed homes do not have the authority to advocate on behalf of residents who are under the age of 18, unless the complaint is systemic in nature and affects residents who are 18 and older.

http://www.ilga.gov/legislation/publicacts/99/099-0180.htm

Your Regional Ombudsman Program
(PPS #21) (PM Pg. 21)

TRAINER'S NOTES: *Share a brief history of your local program and discuss specific ways your provider agency supports your program (i.e., monetary support or in-kind donations such as volunteer hours, office space, etc.) You may also want to share the following information with attendees.*

Your trainer or Regional Ombudsman can provide you with information about the history of your local program as well as ways that your Area Agency on Aging or provider agency supports your local program.

Total number of facilities served:

- Nursing Facility (Skilled and/or Intermediate): ____
- Supportive Living: ____
- Assisted Living and Shared Housing Establishment: ____
- Sheltered Care: ____
- Intermediate Care for the Developmentally Disabled: ____
- Specialized Mental Health Rehabilitation Facilities: ____
- Medically Complex for the Developmentally Disabled: ____

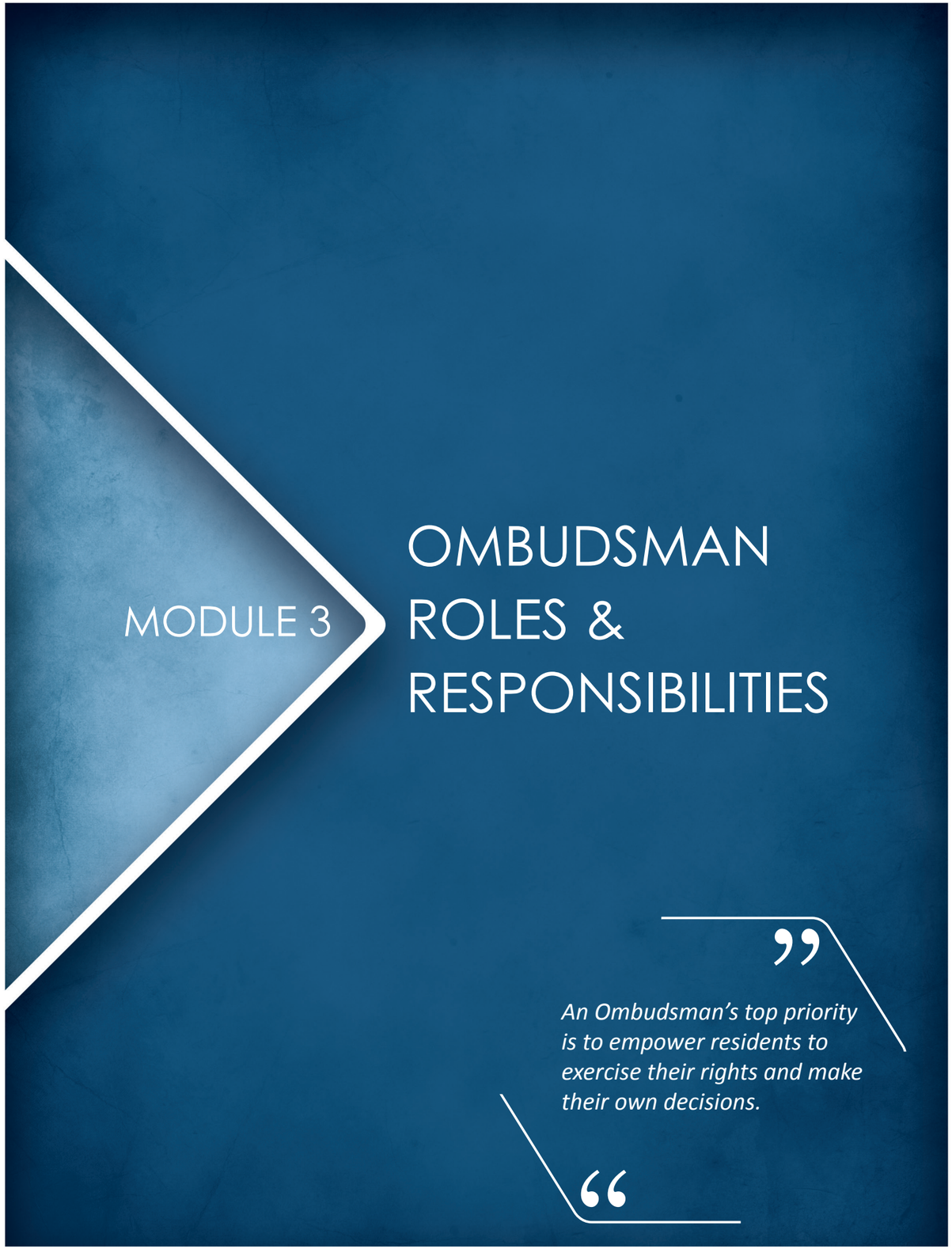
Approximate number of beds in your service area: ____

Total Activities for the most recent reporting year: ____

- Facility Visits: ____
- Consultations to Individuals: ____
- Consultation to Facilities: ____
- Resident Council Meetings: ____
- Family Council Meetings: ____
- Other: _____
- Local staffing:

  Paid Ombudsmen: ____ Volunteer Ombudsmen: ____

TRAINER'S NOTE: *Before moving on, offer an opportunity for questions and answers on the material covered up to this point.*



What Do Ombudsmen Do?

TRAINER'S NOTE:

Materials needed:
4x6 White, Green, Yellow, Pink Index Cards
Black Marker
Push Pins, Tape, or Adhesive Putty
Display Board, Chalk Board, Easel or other upright, flat surface

Before training day:
1. Using three white index cards and a black marker, create the following header cards:
   - Describes
   - Might Describe
   - Does Not Describe

2. Use the black marker to write the following words on your green index cards:
   - Facilitator
   - Investigator
   - Open-minded
   - Advocate

3. Use the black marker to write the following words on your yellow index cards.
   - Mediator
   - Activist
   - Trainer

4. Use the black marker to write the following words on your pink or red cards:
   - Police
   - Enforcer
   - Regulator
   - Companion
   - Neutral
   - Impartial
   - Judge
   - Friend

5. Shuffle the cards together so that colors are well mixed and words are in no particular order.

On Training Day:
1. Set up a display board, easel, or another upright flat surface.
2. Create three (3) columns on your board or wall by attaching the white "header" cards at the top of what will become columns.
3. Place push pins, tape, or adhesive putty near the display board, chalk board, or easel. If you are using a wall, be sure that you use a tape or adhesive putty that will not damage the wall.

4. As participants arrive at the training, give them each at least one card. If you have a small class, you may want to give each participant two or more cards. Alternately, you may pass the colored cards around the room so that each participant has an approximately equal number of cards. No participant should be holding all green cards, all yellow cards, or all pink/red cards.
5. Ask participants to think about each of the words they have been given and, using a push pin, tape or adhesive putty, place the word under the header card that they feel best describes the role of an Ombudsman.
6. Allow participants five (5) minutes to place their cards on the board.
7. Ask participants to take their seats.
8. Do not review the exercise at this time. You will review it at the end of this module.

Activity (PPS #23) (PM Pg. 24)
What Do Ombudsmen Do?

To begin this module, your trainer will guide you through an exercise designed to help you think about the roles and responsibilities of an Ombudsman. At the end of the module, you will be asked to revisit your answers.

Ombudsman Roles[2]

(PPS #24,25) (PM Pg. 24-25)

Federal and state laws direct Ombudsmen to identify, investigate and resolve complaints, and work toward improving the quality of care and quality of life both individually and systemically. However, providers, regulators and case managers, for example, may not understand exactly what Ombudsmen do. Below are some common misconceptions about the role of the Ombudsman followed by explanations of the Ombudsman's true role.

Myth: **Ombudsmen work in the best interest of the residents.**

Fact: **Whenever possible, Ombudsmen advocate for what the resident wants, even if that is not in the resident's best interest.**

While Ombudsmen may attempt to work with others to resolve resident concerns, the resident is the person who directs the Ombudsman in which avenues to pursue regarding the complaint(s). An Ombudsman's top priority is to empower residents and participants to exercise their rights and make their own decisions.

Myth: **Ombudsmen may talk freely with family members and facility staff in an effort to resolve concerns.**

Fact: **Ombudsmen are bound by strict rules of confidentiality.**

Ombudsmen are required to maintain resident confidentiality. Without the consent of the resident or complainant, Ombudsmen are not permitted to share information with third parties.

Myth: **Ombudsmen just provide social interaction for residents.**

Fact: **Ombudsmen are not just friendly visitors.**

Simply visiting with residents may be rewarding and beneficial, but it is not the Ombudsman's primary function. Federal and state law specifies that Ombudsmen are to identify, investigate, and resolve complaints made by or on behalf of residents. Ombudsmen seek resolutions to both individual and systemic problems affecting the lives of residents who otherwise would have little power or influence within the long-term care system.

Myth: **Ombudsmen are neutral third parties.**

Fact: **Ombudsmen are not neutral.**
The Ombudsman Program is designed to represent resident concerns and interests. Ombudsmen are neutral while they are investigating a complaint and gathering information, but the information they gain must be used to advocate for the outcome that the resident is seeking.

[2] *Adapted from the Oregon State Long-Term Care Ombudsman Certification Manual.*

TRAINER'S NOTE: *Forward to PPS #25.*

Myth: **Ombudsmen just stir up trouble.**

Fact: **Ombudsmen seek to resolve problems on behalf of residents.**

Often, residents feel more comfortable discussing concerns with Ombudsmen than they do complaining to facility staff or even their own family members. This may lead to the misperception that Ombudsmen are creating problems when, in fact, the problems were there all along. When residents give Ombudsmen permission to advocate, Ombudsmen can begin to resolve concerns before they lead to more complicated problems or even a compliant to the regulators.

Myth: **Ombudsmen do not understand the pressures and financial constraints involved in running a long-term care facility.**

Fact: **Ombudsmen must advocate for residents, not long-term care facilities.**

Ombudsmen understand the problems facing long-term care providers. However, the role of the Ombudsman is to make the long-term care system more responsive to resident needs. Ombudsmen cannot allow provider concerns to limit their advocacy.

Myth**: Ombudsmen are volunteers who do not have the professional background or training necessary to understand the difficult medical issues affecting long-term care residents.**

Fact: **Ombudsmen serve as a consumer presence in long-term care.**

Ombudsmen function as change agents, providing a routine check and balance to bureaucratic power while reinforcing government policy that works. Ombudsmen serve in long-term care facilities because they are concerned about the residents of those facilities. While an Ombudsman's investigation may cause them to learn about a resident's medical condition, the Ombudsman's primary concern is always whatever concerns the resident.

Ombudsman Responsibilities

(PPS #26-36) (PM Pg. 26-27)

There are five major components to Ombudsman responsibilities:

1. regular presence in long-term care facilities;
2. investigative services;
3. consultations and community education;
4. issue advocacy; and
5. resident and family council support.

Regular Presence Visits (PPS #27) (PM Pg. 26)

TRAINER'S NOTE: *If your program standards for regular presence visits exceed state standards, this is the time to discuss your expectations for regular presence visits.*

Although Ombudsmen are not regulators and cannot impose any kind of sanctions on long-term care facilities, you are responsible for identifying, investigating and resolving complaints made by or on behalf of residents. Therefore, you are required to make regular presence visits to one or more assigned facilities so that residents and family members can get to know you and identify you as someone who can help them solve problems.

Ombudsmen are required to conduct quarterly visits in each long-term care facility. Keep in mind that these are *minimum* requirements. Ombudsmen are encouraged to visit facilities as often as possible to assure that residents know about the program and have access to Ombudsman services. Some Regional Program standards for regular presence visits exceed the state requirement.

TRAINER'S NOTE: *Forward to PPS #28.*

Chapter 400, Section 403 of the Long-Term Care Ombudsman Program Policies and Procedures Manual requires that you make unannounced visits at intervals that prevent the facility from anticipating your visit. You are also required to:

- assure that residents have adequate access to posters and brochures that explain the Ombudsman program and provide contact information;
- introduce yourself to residents and talk with them about the program;
- attempt to meet with the resident council president and any new residents; and
- document your observations.

While you may talk with family members and facility staff during your visits, it is important to keep in mind that the resident is always your client.

TRAINER'S NOTE: *Forward to PPS #29.*

Your activities on visits should complement the five categories of Ombudsman service by:

- building professional helping relationships with residents;
- providing residents with an opportunity to meet with someone who is not a representative of the facility or a family member;
- providing residents with information and assistance to help them engage in empowered self-advocacy;
- receiving, investigating and resolving complaints from or on behalf of residents; and,
- attending and supporting resident and family council activities.

Regular presence visits will be given a more in-depth treatment in upcoming training modules and during your mentored visits.

Investigative Services (PPS #30) (PM Pg. 27)

Chapter 400, Section 402 of the Long-Term Care Ombudsman Program Policies and Procedures Manual requires that every Ombudsman Program shall: "receive, investigate and resolve complaints made by or on behalf of residents. Relating to actions, inactions, or decisions of providers, or their representatives, of long-term care services, of public agencies, or of social service agencies, which may adversely affect the health, safety, welfare, or rights of such residents." Once complaints are received, Ombudsmen should attempt to empower residents to engage in self-directed problem solving. If resident empowerment fails, or if the resident asks the Ombudsman to advocate on their behalf, Ombudsmen are directed to follow a well-defined investigative process that includes:

- identifying relevant issues raised by the complainant;
- assembling all the necessary facts;
- determining the validity of the complaint; and,
- seeking resolution of the complaint.

You will learn much more about investigations and problem solving in upcoming training modules and during your mentoring visits.

Consultations and Community Education (PPS #31) (PM Pg. 27)

Chapter 400, Section 404 of the Long-Term Care Ombudsman Program Policies and Procedures Manual spells out the responsibilities of Ombudsmen for providing information about long-term care issues and the needs and rights of residents of long-term care facilities.

Consultations are information and assistance provided to individuals which do not involve investigating and working to resolve complaints.

Community education may be provided by any Ombudsman who may use a wide range of resources to provide the community with information about several topics such as:

- residents' rights
- the Long-Term Care Ombudsman Program
- resident and family Councils
- abuse, neglect, financial exploitation
- how to select a long-term care facility

Issue Advocacy (PPS #32) (PM Pg. 28)

Issue Advocacy is any activity that supports and promotes issues that benefit or advance the health, safety, welfare, or rights of residents. Chapter 400, Section 405 of the Policies and Procedures Manual establishes the program's mandate to "assure that the interests of residents and participants are represented to governmental agencies and policymakers."

Every year the State Ombudsman selects a state-wide initiative and every Regional Program is charged with establishing actions towards meeting the state-wide initiative.

The State Office works to advocate for the modification of laws, regulations or policies that effect residents in any way.

The Illinois Association of Long-Term Care Ombudsmen (IALTCO) is an association made up of Regional Ombudsmen. The Association works on issue advocacy and other systemic concerns throughout the state.

Resident & Family Council Support (PPS #33) (PM Pg. 28)

Chapter 400, Section 406 of the Long-Term Care Ombudsman Program Policies and Procedures Manual spells out the responsibilities of the Program by providing technical assistance to resident and family councils. This may take the form of:

- providing information about the purpose of the Program;
- providing literature on resident and family councils;
- assisting with the development of resident and family councils; and
- providing a list of topics the Ombudsman is prepared to present if requested.

Resident and family councils can become effective when investigating and resolving systemic problems.

Documentation (PPS#35) (PM Pg. 28)

In addition to the responsibilities discussed above, the Illinois Long-Term Care Ombudsman Program Policies and Procedures Manual requires Ombudsmen to document all activities conducted on behalf of the program. The data gathered from documentation helps local, regional, and state programs demonstrate the program is meeting its mandate, develop programs to target specific areas of concern, and with resource and fiscal planning. In addition, documentation helps assure continuity of advocacy and may serve as a legal record in a court of law.

What Do Ombudsmen Do?
(PPS #36) (PM Pg. 28)

TRAINER'S NOTE: *Before closing the module, review the "What do Ombudsmen Do?" activity. Move words to the most appropriate columns, explaining why words fit better in one column than in another. Discuss reasons that terms may fit in more than one column. The paragraphs below can help guide your review.*

At the beginning of this module, you were encouraged to take part in an activity exploring the roles and responsibilities of Ombudsmen. Now that you are at the end of the module, would you change your responses?

Ombudsmen Do...

*First and foremost, Ombudsmen serve as **advocates** for residents of long-term care facilities Ombudsmen must be **open-minded** and understand that residents may make decisions that others feel are not in the resident's best interest. Ombudsmen serve as **facilitators**, helping residents engage in self-directed and self-empowered advocacy. This can be accomplished by using professional knowledge (**expertise**) about residents' rights and long-term care to **teach** residents and their family members how to negotiate solutions that fulfill the wishes of the resident. As residents and family members engage in self-advocacy, Ombudsmen continue to provide ongoing **support** and **evaluate** the response of facility staff to resident concerns. If there is no response to resident or family advocacy efforts, and the resident gives his or her consent, Ombudsmen may begin **investigating** resident concerns and engaging in a well-defined problem-solving process.*

Ombudsmen Might...

*Ombudsmen may serve as **mediators** between residents of equal standing and cognitive ability, but are never mediators between a resident and facility staff, or residents of unequal standing. Because Ombudsmen attempt to change a system to meet the needs of individuals instead of trying to make individuals fit the system, it could be said that each of us who engage in advocacy on behalf of residents in long-term care settings are **activists**.*

Ombudsmen Don't...

*Ombudsmen are never **neutral** or **impartial** in their work with residents' family members, or facility staff. Our work always favors the expressed wishes of the resident. While we should attempt to develop "unconditional positive regard" for our clients, we must also remember that our relationships with residents are professional in nature. Therefore, we must avoid being perceived to be a companion or friend to the resident.*

*While Ombudsmen do attempt to motivate nursing home staff and family members to involve residents in decisions about their care and to provide care and services that fulfill the wishes of the resident, we are not **regulators, enforcers, or law enforcement authorities**. No Ombudsman has the authority to levy fines or to discipline facility staffs or administration in any way.*

*While Ombudsmen could be said to be consumer advocates, our sustained effort is on helping residents, not on exposing the nursing home industry to public scrutiny. Therefore, the Ombudsman program is not a **watchdog** program and Ombudsmen do not serve as **referees** between parties with an interest in long-term care.*

TRAINER'S NOTE: *Before ending the module, offer participants an opportunity to ask questions about the materials covered in this module.*

MODULE 4

CONFIDENTIALITY & ETHICAL PRACTICE

The Ombudsman shall conduct himself/herself in a manner that will strengthen the statewide and national Ombudsman network.

NASOP Code of Ethics

Confidentiality
(PPS #38) (PM Pg. 30)

Confidentiality is the cornerstone of your work as an Ombudsman. In many cases, residents of long-term care facilities are afraid that facility staff will retaliate against them if they complain. Residents and family members who think that you will share their concerns with facility staff without their permission won't discuss problems with you. Maintaining confidentiality is the only way that Ombudsmen earn and keep the trust of residents and assure that Ombudsman services are resident-directed.

Chapter 800, Section 803 of the Illinois Long-Term Care Ombudsman Program Policies and Procedures Manual requires that you have the verbal or written consent of a resident before sharing any information that could disclose the identity of a resident, participant or complainant. When you open a case, you should work with the resident to identify key individuals such as family members, physicians, or staff who work for the providers whom the resident believes can help resolve the problem. You must obtain permission to talk to anyone else about the resident's concerns.

From time to time, a family member or friend will call with a concern about an individual in a long-term care facility or in the community. It is a good idea to explain the rules about confidentiality to family and friends who share concerns with you.

1. You must have the complainant's permission to be identified. Some individuals prefer to remain anonymous or to not have their identifying information shared.

2. You must have the resident's permission to report back to the original complainant. When you talk to the resident you may find that they would prefer you not share any information about their situation with the original complainant.

3. You must honor the complainant's and the resident's confidentiality.

In a long-term care facility, residents may share concerns with you and ask you to advocate for them as an "anonymous" complainant. In this situation, it is important to let the resident know that you will not disclose any identifying information. However, explain that facility staff may know by the nature of the concern who filed the complaint. You should also explain that any concern that requires you to access records during your investigation will reveal the resident's identity.

Occasionally you will need to identify a resident who is unknown to you and who is not in his or her room. Your approach in this situation will depend on the circumstances surrounding your visit. If you have been told not to approach the resident in a group setting or not to draw the attention of staff, you will need to return at another time. If you are seeking out a resident to discuss a concern or complaint that involves another person who lives or works in the facility, there may be a higher risk of retaliation against the resident because of your visit. In this case,

you should return to the facility at a time when the resident is more likely to be in his or her room. On the other hand, if you need to talk with a resident about interactions with an agency or individual from the community, and the resident is unlikely to suffer retaliation from facility staff, it is okay to ask facility staff to help you identify the resident.

If a resident refuses to give you the consent necessary to pursue a case on their behalf and you have reason to believe it may be a systemic problem, you may, without naming the original complainant, ask other residents if they share a similar concern or you may look for activity that supports the anonymous resident's complaint. If you gather enough information to support opening a case, you may do so, but you must protect the privacy of any resident who does not wish to be identified in your casework.

Confidentiality Dos & Don'ts (PPS #39, 40) (PM Pg. 31)

Confidentiality mandates apply to verbal communications, written records and your actions. The following table offers some "Dos & Don'ts" of confidentiality.

Confidentiality DOs (PPS #39)	Confidentiality DON'Ts (PPS #40)
Treat the resident as your client no matter who made the complaint. If a resident is able to direct, only take direction from the resident. If a resident is unable to give consent, you may follow the direction of the representative. Act only with resident's consent. Volunteers should turn in the entire case file, including notes, correspondences, etc. to the Regional Program when the case is closed. Volunteers should delete any case notes from his/her personal computer, laptop or other electronic device after they have been submitted to the Regional Program. Keep the identity of the complainant confidential. For example, you cannot tell a resident that you received a call from a family member who was concerned about x, y, or z unless that family member has given you permission to share that information.	Divulge anything to anyone without the permission of the resident or complainant. Tell facility staff which resident you are visiting. Allow facility staff to follow you on your visits. Mention a resident's or complainant's name or aspects of a complaint to anyone other than an Ombudsman unless you have permission to do so. Show paperwork or case notes to anyone other than an Ombudsman without the consent of the resident. This includes family members and facility staff, even when they are the original complainants. Take case files containing client information into a facility unless there is a specific reason to do so. Keep copies of case files after case work has been completed. Read a resident's chart that is offered to you by facility staff or attempt to access a resident's chart without the consent of the resident or representative.

Release of Information (PPS #41) (PM Pg. 31)

Program records are the property of the State Ombudsman and are to be kept confidential. The Office of the State Long-Term Care Ombudsman is the only entity designated to release Ombudsman records. If a resident has given permission to release records or part of a record from the Ombudsman Program to another entity, then written consent to release information is strongly encouraged. Oral permission may be obtained, provided the Ombudsman documents such permission in the case file.

If a resident has signed a release of information form for the Ombudsman to refer the individual for legal services with regards to an appeal of a decision or an facility-initiated discharge, the Ombudsman may provide the information stated on the release of information form. In addition, if a resident has signed a release of information document for the Ombudsman to share information with IDPH regarding a compliant, then the Ombudsman may provide the information stated on the release of information form.

If the Ombudsman does not have permission to release information but receives a request to release information, regardless of the source, please refer the individual to put their request in writing to the Office of the State Long-Term Care Ombudsman.

Occasionally, a Regional Program will receive a court order for a request for records. These requests should be immediately sent to the State Ombudsman.

Conflict of Interest (PPS #42) (PM Pg. 32)

TRAINER'S NOTE: *The "Conflict of Interest" PowerPoint slide provides only bullet points. You should give examples of conflicts of interest or describe situations that create a conflict of interest, to help Ombudsman candidates identify any areas of concern.*

Ombudsmen must be free to represent the wishes of residents or participants, therefore must be free from conflicts of interest. In general, this means that a provider agency, individual Ombudsmen, and the immediate family members of Ombudsmen must not be in a position to profit or receive compensation of any kind from long-term care facilities, Home and Community Based Services (HCBS) or managed care organizations, or long-term care services providers. The provider agency, individual Ombudsmen and the immediate family members of Ombudsmen cannot be involved in the ownership, management or governance of long-term care facilities, providers of long-term health care services, or Home and Community Based Services or managed care organizations. Members of the board of directors, administrators, or employees of long-term care facilities, HCBS or managed care organizations, or other long-term care services providers cannot be Long-Term Care Ombudsmen.

Individuals who wish to be Ombudsmen cannot be agents of any organization involved in the certification or licensure of facilities or provide services that conflict with the role of the Long-Term Care Ombudsman such as: adult protective services; discharge planning; serving as

a guardian, agent under power of attorney or other surrogate decision-maker for a long-term care resident in the service area; pre-admission screening, managed care coordinator, or a case management for long-term care residents.

You may not serve as a Long-Term Care Ombudsman in a facility in which a family member resides or in which a family member is employed.

If you or someone in your immediate family is engaged in one of the activities listed above, please disclose the conflict as soon as you become aware of it. After review, the conflict may be cleared by the Office of the State Long-Term Care Ombudsman. If your conflict is cleared, you may be allowed to serve as an Ombudsman.

The Ombudsman Code of Ethics
(PPS #43) (PM Pg. 33)

TRAINER'S NOTE: *The Code of Ethics helps participants understand that the Ombudsman Program has a defined set of expectations for individuals who advocate for seniors and adults with disabilities under the auspices of the program. You may train the Code by asking participants to go around the room with each person reading the next item in the Code. Let participants know that it is okay to say "pass" if they would prefer not to read aloud. Continue going around the room until the Code of Ethics has been read in its entirety. Ask participants if they have any questions about the Code of Ethics.*

As you have seen, engaging in resident-directed advocacy is a multi-faceted endeavor. Every Ombudsman is expected to accept direction from residents, and supervision from State and Regional Ombudsmen to empower residents to engage in self-advocacy and to sort through the many barriers to resolving complaints. As with any other form of social or human service, it is helpful to be guided by a professional code of ethics. The National Association of State Ombudsman Programs developed a Code of Ethics to help guide Ombudsmen in their advocacy efforts. Illinois has adopted the Code of Ethics and has included language to fit the individuals also served under the Home and Community Ombudsman Program.

1. The Ombudsman provides services with respect for human dignity and the individuality of the client[3], unrestricted by considerations of age, social or economic status, personal characteristics or lifestyle choices.
2. The Ombudsman respects and promotes the client's right to self-determination.
3. The Ombudsman makes every reasonable effort to ascertain and act in accordance with the client's wishes.
4. The Ombudsman acts to protect vulnerable individuals from abuse and neglect.
5. The Ombudsman safeguards the client's right to privacy by protecting confidential information.
6. The Ombudsman remains knowledgeable in areas relevant to the long-term care system, especially regulatory and legislative information, and long-term care service options.

[3] *In the Code of Ethics, client refers to the range of consumers served by LTCO such as residents, their family members, and individuals who are seeing information about long-term care facilities.*

7. The Ombudsman remains knowledgeable in areas relevant to home and community based waiver services and managed care.
8. The Ombudsman acts in accordance with the standards and practices of the Long-Term Care and Home Care Ombudsman Program and with respect for the policies of the sponsoring organization.
9. The Ombudsman provides professional advocacy services unrestricted by his/her personal belief or opinion.
10. The Ombudsman participates in efforts to promote a quality, long-term care system
11. The Ombudsman participates in efforts to maintain and promote the integrity of the Ombudsman Program.
12. The Ombudsman supports a strict conflict of interest standard that prohibits any financial interest in the delivery or provision of nursing home, board and care services, or other long-term care services that are within their scope of involvement.
13. The Ombudsman shall conduct himself/herself in a manner that will strengthen the statewide and national Ombudsman network.

Activity: Appropriate or Not?

TRAINER'S NOTE: *This activity can be done individually or in a small group setting. If doing it in a small group setting, break individuals into groups of 3-4 people, ask them to assign someone to report back to the group and give them 10-15 minutes to complete. If you are running short on time, you may divide up the questions equally among the groups.*

For each of the situations, determine whether the situation is or is not appropriate for an Ombudsman. Choose YES if you feel this is an appropriate Ombudsman situation. If you do not believe this an appropriate behavior for an Ombudsman, choose NO.

If you have any comments or questions about the situation, jot it down in the comments section for discussion.

1. A resident in a wheelchair wants to talk to Joe the Ombudsman. But, they are in a very noisy community room, so Joe pushes the resident to a quiet corner so he can hear the resident.

   Yes _____
   No _____

Comments: **TRAINER'S NOTE:** *No, an Ombudsman should never push a resident in a wheelchair. With consent, the Ombudsman could ask a staff member to push the resident to the corner.*

2. Mrs. O'Reilly, a resident, tells the Ombudsman she would like to go to church in town each week for mass. The resident states that she heard "The Ride" program takes two fellow residents, but she needs assistance to fill out the application and submit it. With resident's permission, the Ombudsman asks the social worker to help the resident complete the application.

   Yes _____
   No _____

Comments: **TRAINER'S NOTE:** *Yes, it is appropriate. If the social worker won't assist with completing the application, the Ombudsman could assist with the application.*

3. Sean's wife works with a group of women making shawls for charity. They often bring them to the Activity Directors at local nursing homes for distribution. Her group asks him to take them to the nursing home that he visits as the Ombudsman.

   Yes _____
   No _____

Comments: **TRAINER'S NOTE:** *No, it is not appropriate for Sean to take the shawls to the facility. Residents could perceive this as favoring some residents over other residents. It is okay for his wife's group to do it if Sean isn't involved.*

4. Jim, an Ombudsman, visits resident Joan Connelly four weeks in a row to follow up with her on an issue about her dentures.

   Yes _____
   No _____

Comments: **TRAINER'S NOTE:** *Yes. If the Ombudsman is meeting with the resident to investigate and resolve the denture issue, it is appropriate.*

5. The ABC Nursing Home has some younger long-term residents. One of them, Margie, has told Tricia, the Ombudsman that her DVD player no longer works, and she really misses watching her collection of movies. She does not have the funds to replace it. Next week, Tricia brings her an old DVD player that her own son no longer uses.

   Yes _____
   No _____

Comments: **TRAINER'S NOTE:** *No, however, it is okay if the Ombudsman facilitates a referral to get someone to provide a DVD player for the resident but it is not appropriate for the Ombudsman to fill that need.*

6. Mary, the Ombudsman, has been visiting the nursing home for four years and has gotten to know both residents and staff well. In fact, she and one of the aides have become quite friendly. Today, that aide invites Mary to dinner at her home and Mary is delighted to accept the invitation.

Yes _____
No _____

Comments: **TRAINER'S NOTE:** *No, it is important that Ombudsmen maintain a professional relationship with staff and residents. An Ombudsman should be friendly, but not friends with the staff at the facility. The Ombudsman must have boundaries when visiting facilities. Developing a friendship with a staff member is crossing the boundaries of a professional relationship.*

7. Resident Mrs. Smith lets the Ombudsman know she is concerned about changes in her medications. The Ombudsman offers to ask the nurse to stop by and explain the changes to the resident, and the resident says that would be great.

Yes _____
No _____

Comments: **TRAINER'S NOTE:** *Yes, an Ombudsman is facilitating communication between a staff member and a resident. Resident gave permission for the Ombudsman to speak to the staff.*

8. Lisa, the Ombudsman, chatted for a few minutes with the social worker and asked if she knew where she could find Ms. Jones because Ms. Jones had called the Ombudsman program about some issues.

Yes _____
No _____

Comments: **TRAINER'S NOTE:** *No, the Ombudsman violated confidentiality by disclosing who the Ombudsman is there to visit and the Ombudsman doesn't have consent to provide that information to staff.*

9. The resident council is holding a raffle to raise some funds. The top prize is a brand-new television. Judy the Ombudsman buys a few tickets.

Yes _____
No _____

Comments: **TRAINER'S NOTE:** *No, the Ombudsman needs to maintain professional boundaries and should not be purchasing tickets. In addition, the Ombudsman would not be able to accept the prize.*

10. Carole, the Ombudsman, observes a large bruise on the nose of one of the residents she visits. When Carole asked where the bruise came from, the resident said it was from her glasses which are broken and don't fit her very well. She has difficulty seeing without her glasses and wants to know if Carole can help her get them fixed or replaced.

Yes _____
No _____

Comments: **TRAINER'S NOTE:** *Yes, this would be a case that the Ombudsman can work to resolve. The Ombudsman should facilitate discussions with the staff to get them to make the appropriate appointments and referrals for follow up on getting the glasses repaired.*

11. After working her entire career in hospitals and long-term care, Ana retires and becomes an Ombudsman. Six months later, two of her former co-workers, who are also good friends of Ana, join the staff of the home she visits as the Ombudsman. She is happy to see them, and continues her Ombudsman work at that home.

Yes _____
No _____

Comments: **TRAINER'S NOTE:** *No, it is a conflict as it may be difficult for the Ombudsman to remain objective if facing issues involving her friends. It may also be difficult to maintain confidentiality when talking to the friends.*

12. Sally the Ombudsman often visits the nursing home at noon and eats lunch with the residents.

Yes _____
No _____

Comments: **TRAINER'S NOTE:** *No, eating lunch with someone is a social activity and Ombudsmen are not there to socialize. It is similar to an Ombudsman joining in an activity. One could argue that residents may be more likely to "open up" in a less formal setting, but it is not professional and it could look like favoritism if the Ombudsman eats with the same group each time.*

13. A resident tells the Ombudsman that when she went into the hospital, she assigned her brother as power of attorney over her finances. When she came to this nursing home her brother and sister-in-law emptied out her account. She tells you she is almost well enough to go back home but now does not have any savings to pay for rent. She asks the Ombudsman to help get her money back.

Yes _____
No _____

Comments: **TRAINER'S NOTE:** *Yes, this would be a financial exploitation case.*

14. While visiting Mary, a resident, Mary asks the Ombudsman to help her put her sweater on because she is chilly, so the Ombudsman assists her.

Yes _____
No _____

Comments: **TRAINER'S NOTE:** *No, it is not the Ombudsman role to assist in this manner. An Ombudsman's response should be, "I'd be happy to get someone to assist you with your sweater." Helping the resident with her sweater could inadvertently cause harm to the resident.*

15. A resident complains to the Ombudsman that her meals that are served in the room are cold, and invites the Ombudsman to sample the food to see if she agrees. The Ombudsman finds a clean fork and takes a sample of the mashed potatoes and meatloaf and agrees with the resident.

Yes _____
No _____

Comments: **TRAINER'S NOTE:** *No, the perception of the Ombudsman doesn't matter. What matters is the resident's perception of the food. If it is too cold for the resident, it is too cold. Not to mention what would happen if staff saw an Ombudsman eating a resident's food!*

16. Betty the Ombudsman stopped by to drop off a book for her aunt who happened to be a resident of ABC home. After dropping off the book and visiting with her aunt for thirty minutes, Betty proceeded to continue her Ombudsman visit of the ABC home.

Yes _____
No _____

Comments: **TRAINER'S NOTE:** *No, it is a conflict of interest to serve as the Ombudsman in a facility where a family member resides.*

17. A resident's daughter sees Chuck, the Ombudsman in the hall and asks for his help. She says her mother needs to be fed. Since she arrived three months ago, she has lost a lot of weight. The daughter can't be here at meal times and wonders if the staff is feeding her. Every time she visits, her mother complains about being hungry. She asks the Ombudsman what he can do to get help for her mother.

Yes _____
No _____

Comments: **TRAINER'S NOTE:** *Yes, this would be a complaint the Ombudsman could help to resolve.*

TRAINER'S NOTE: *Before ending the module, offer participants an opportunity to ask questions about the materials covered in this module.*

Activity: Going Once, Going Twice, Gone[1] (PPS #45) (PM Pg. 40)

TRAINER'S NOTE: *Give participants about ten minutes to complete this activity. When they have completed the questionnaire, poll the group to see which areas of care and which "privileges" were most important to the group then ask them why this activity is important. Make sure you mention our rights and privileges as citizens.*

If you moved into a long-term care facility and could only have great care in three of the following areas, which three would you choose?

1. Helping me maintain the ability to bathe and dress independently.
2. Helping me maintain bladder control.
3. Helping me maintain the ability to walk without assistance.
4. Helping me remain free of respiratory problems.
5. Helping me remain free from pain.
6. Helping me avoid falls.
7. Helping me avoid skin problems.
8. Helping me maintain my current cognitive abilities.

You make decisions every day about how to live your life. If you moved into a long-term care facility, choices you take for granted today might suddenly become "privileges." For this exercise, choose five "privileges" that you would want to keep if you were in a nursing home. If an important "privilege" is not listed, you may add two choices by writing them in the space marked "other." Count your "other" choices as part of the final list of five.

1. The privilege of taking frequent trips, and visiting with family and/or friends outside the nursing home.
2. The privilege of engaging in some gainful activity every day, similar to what I did in my home or apartment.
3. The privilege of keeping pictures of my family and small treasured mementos close.
4. The privilege of defining my own schedule, i.e. making noise, staying up late, not getting dressed in the morning, etc.
5. The privilege of being considered a sexual being and of being able to entertain friends in sufficient space and with privacy.
6. The privilege of keeping and preparing food any way I please.
7. The privilege of bringing favorite pieces of furniture from my home or apartment and of having my living space be a reflection of my personality (including not being particularly neat).
8. The privilege of having a pet.
9. The privilege of living in a heterogeneous community where I regularly come into contact with people of different ages and races, including children.
10. The privilege of monitoring my own health; to keep, take, or refuse to take medications.
11. The privilege of making totally independent decisions, with myself and my close family and friends as the only people's opinions to consider.
12. The privilege of taking a bath or shower with privacy and water the temperature I choose.
13. The privilege of choosing how I will spend my time.
14. The privilege of having space and supplies to work on my hobby.
15. The privilege of having a private telephone number and privacy to conduct telephone conversations.
16. The privilege of listening to the radio station or TV program of my choice.
17. The privilege of being alone and having absolute peace and quiet.
18. The privilege of grieving for loss of home and independent living status.
19. The privilege of receiving considerate, respectful care, with my privacy and need for independence uncompromised.
20. The privilege of living in an environment where it is okay to talk about and discuss my fears and feelings about aging, life, and death.
21. The privilege of practicing my religion as I choose.
22. The privilege of having a beer, cocktail, or glass of wine in the evening.
23. The privilege of smoking cigarettes or chewing tobacco.
24. Other:
25. Other:

Legislative Mandates
(PPS #46) (PM Pg. 42)

TRAINER'S NOTE: *In this section, it is more important to discuss the actual rights of residents than the pieces of legislation that assure those rights.*
People do not lose any rights just because they are admitted to a nursing home. In fact, they actually gain many rights related to their care and safety. The Older Americans Act of 1965, the Omnibus Reconciliation Act of 1987, the Illinois Nursing Home Care Act, and Illinois Administrative Codes all combine to address issues related to both quality of care and quality of life in long-term care facilities.

In 2001, the Centers for Medicare and Medicaid Services (CMS) developed the Nursing Home Quality Initiative to promote measurable change in provider practices and consumer education. Since that time, CMS has worked with Quality Improvement Organizations to improve quality of care, to promote resident directed care, and to address workforce practices. As a resident advocate, you should be familiar with measurable characteristics that can help you identify quality care. In 2016, the federal nursing home regulations were revised to include additional detail on how facilities are mandated to honor residents' rights.

Quality of Care
(PPS #47) (PM Pg. 42)

A study conducted in 2005 by Abt Associates, Inc. for the RAND Corporation confirmed that several CMS quality indicators have high levels of validity when measuring resident-based outcomes of presumed quality of care. Residents receiving better care usually:

- Experience improvements in their level of activities of daily life (ADLs) functioning;
- Improve their ability to perform early-loss ADLs (dressing and hygiene) or remained completely independent in early-loss ADLs;
- Experience improvements in their pain status or are pain free (based on the MDS pain scale);
- Do not experience shortness of breath or respiratory infections;
- Improve their balance or remain free from balance impairment between their 5-day and 14-day assessments;
- Walk as well or better on day 14 as on day 5 of their stay;
- Show improvement in level of locomotion functioning or remain completely independent in locomotion functioning;
- Have fewer incidences of delirium.

Although you can research a facility's performance in these areas using the "Find a Facility" function on the Medicare website (http://www.medicare.gov), Ombudsmen usually become aware of care problems when a resident expresses a concern or a family member contacts the program with a concern. In some cases, the Ombudsman can empower the resident or family member to engage in self-advocacy to improve care. In other cases, Ombudsmen become involved in

problem-solving for the purpose of improving care. When care concerns are very serious, Ombudsmen may encourage the resident or resident's representative to contact the Illinois Department of Public Health Central Complaint Registry, also referred to as the nursing home hotline, (1-800-252-4343). You will learn more about the techniques used by Ombudsmen in these situations as your training progresses.

Quality of Life
(PPS #48) (PM Pg. 43)

Today, some facilities are moving toward person-centered or resident-directed care models. In order to provide person-centered care, facilities must embrace the core values of choice, dignity, respect, self-determination, and purposeful living. By embracing these values, facilities create a home-like environment that encourages both autonomy and social engagement. This in turn helps residents maintain life-long routines and create a sense of community in long-term care settings.

TRAINER'S NOTE: *Forward to PPS #49.*

Measurable signs that a facility provides person-centered care include:

- Consistent staff assignments allowing residents and caregivers to get to know one another and providing caregivers with an opportunity to anticipate the needs of residents under their care;
- Flexible bedtimes and wake up times, based on the wishes of the resident rather than the needs of the facility or staff;
- A wide range of food selections at every meal;
- Resident choice about bath routines (i.e. a.m. vs. p.m.; shower vs. sponge bathing, etc.);
- Opportunities for spontaneous activities; caregiver involvement in providing "on the spot" activities; opportunities for activities at night and on weekends; residents spend less time in bed or in a chair;
- A high level of resident involvement in the day-to-day operations of the facility, usually accomplished through weekly meetings between residents, staff, family members, etc.;
- Low staff turnover, fewer "call offs" and sick days.
- High staff morale as expressed through surveys and informal communication with other staff members;
- Facility does not use "agency" or "temporary" staff;
- Facility frequently "surveys" staff to assure that they feel respected and supported;
- Staff are self-motivated, have a strong knowledge of person-directed care principles and are empowered to use person-centered principles to solve problems;
- Staff are recognized and rewarded for providing excellence in resident directed care;
- Facility frequently "surveys" residents to assure customer satisfaction and listens and responds positively to informal critiques of care;
- Fewer signs of physical or chemical restraint, pressure sores, agitation, weight loss;
- Emphasis on developing relationships and a sense of community that helps reinforce a home-like or family-like environment.

You may become aware of quality of life concerns through your own observations or during casual conversations with residents or family members. As advocates for residents, Ombudsmen often provide facilities with suggestions that will help them provide person-centered care. To learn more about person-centered care visit the Pioneer Network website (http://www.pioneernetwork.net) or the Illinois Pioneer Coalition website (http://www.illinoispioneercoalition.org/).

Residents' Rights
(PPS #50) (PM Pg. 44-47)

TRAINER'S NOTE: *The "Residents' Rights" PowerPoint slide provides an outline of the rights listed below. You will need to provide a more in-depth overview either by discussing* ***some of*** *the points below or by discussing OBRA '87 Residents' Rights.*

As an advocate for residents, you must understand and have a strong commitment to residents' rights. The information shared here is only an introduction to residents' rights. Once you have completed the classroom portion of this training, you will continue to work with your mentors and Regional Ombudsman to assure that you learn the finer points of residents' rights. For a more in-depth understanding of Residents' Rights, you may want to read through the residents' rights section of OBRA "87.

1.Residents have the right to safety and good care.

- The facility must provide services to keep residents' physical and mental health, and sense of satisfaction with themselves, at their highest practical levels.
- The facility must be clean and stay at a healthy temperature.
- The facility must keep residents free from restraints.
- Residents may only be given psychotropic medications as part of an overall plan designed to change or remove the problems for which the medications are given and may only be used with the resident's consent.

2. Residents have the right to participate in their own care.

- The facility must develop a written care plan which states all the services the facility will provide the resident and everything the resident is expected to do.
- The facility must make reasonable arrangements to meet the resident's needs and choices.
- The resident may attend the care plan conference where the care plan is discussed and finalized.
- The resident may choose to have family, friends, or a representative participate in the care plan meeting.
- The resident may choose their own doctor. However, the resident will have to pay the doctor bill out of pocket unless it is covered by Medicare, a private insurance plan, or Medicaid.
- The facility must tell the resident the name and specialty of each doctor responsible for his or her care, and how to contact that doctor.
- The resident has the right to be in charge of taking their own medicine if the care plan team and the resident's physician say that they are able to do so.

- The resident may refuse any medical treatment. When a resident refuses medical treatment, the facility must make the resident aware of the consequences of refusing treatment and must tell the resident about other treatment options.
- Residents have the right to complete information about their medical condition and treatment in a language that the resident can understand.
- Residents have the right to make a Living Will or Durable Power of Attorney for Health Care so that the facility will know the resident's wishes if he or she is no longer able to speak for themselves.
- Residents may refuse to participate in any experimental treatment and may refuse to allow anyone to use information about them without their permission.
- The facility must allow a resident to access their medical records within 24 hours of the resident's request. Residents may purchase a copy of part or all of the record at a reasonable copy fee with two days advance notice.
- The facility may not require residents to work.
- The resident has a right to move out of the facility after giving the administrator, nurse, or doctor written notice of their plan to move.

3. Residents have the right to privacy.

- Residents have the right to privacy when medical examinations and personal care are being provided.
- Facility staff must knock before entering residents' rooms.
- The facility may not give information about a resident or the resident's care to unauthorized persons without the resident's permission, unless the resident is being transferred to a hospital or to another health care facility.
- Residents have the right to private visits at a reasonable hour. The only exception is if the resident's doctor has ordered limited visits for medical reasons.
- Residents may ask any visitor to leave their personal area at any time.
- Residents have the right to make and receive phone calls in private.
- The facility must deliver resident mail promptly and promptly send mail out for residents. The facility may not open resident mail.
- If a resident is married, the resident and his or her spouse have the right to share a room unless no room is available or the resident's doctor has said the couple cannot share a room for medical reasons.

4. Residents have personal property rights.

- The resident may keep and wear their appropriate clothing.
- The resident may keep and use their own property, including some furniture if there is enough space, unless it interferes with the health and safety of other residents.
- The facility should provide a safe, accessible place for small valuables.
- The facility must try to keep resident property from being lost or stolen. If property is missing, the resident must try to find it. The facility is not required to replace missing items.

5. Residents have the right to manage their own money.

- The facility may not ***require*** that residents let the facility manage their money or be the resident's Social Security representative payee.
- If the resident asks the facility to manage their personal money, the facility must do so. (Medicare and Medicaid certified facilities only.)
- If the facility manages the resident's money, it may spend money only with the resident's permission.
- The facility must provide an itemized written statement at least once every three months of all the money put into a resident's account and all the money taken out of the resident's account.
- If the facility manages the money for a resident who receives Medicaid, the facility must tell the resident if his or her savings comes within $200 of the amount Medicaid allows residents to keep. Money saved over that amount can be used to pay for the resident's care in the facility.
- Within 30 days of a resident's death, the facility must provide the resident's family, or whoever is in charge of distributing the resident's property, a final accounting of all money left in any account which the facility managed for the resident.
- The resident has the right to see his or her financial record at any time.
- If the resident is paying for some or all of his or her care at the facility, the facility must provide a contract that states what services are provided by the facility and how much they cost. The contract must say what expenses are included in the regular rate.
- The facility may not require anyone else to sign an agreement saying they will pay the resident's bill if the resident cannot pay it themselves. The only person, other than the resident, who can be required to pay a resident's bill is a court appointed guardian or someone else who is handling the resident's money.
- The facility must provide the resident with information about how to apply for Medicaid and Medicare along with rules about "spousal impoverishment." Spousal impoverishment rules allow the resident to give money and property to his or her spouse and still be eligible for Medicaid.
- The resident has the right to apply for Medicaid or Medicare to help pay for his or her care. The facility cannot make a resident promise not to apply for Medicaid or Medicare.
- If the resident receives Medicaid, the facility cannot make the resident pay for anything that Medicaid pays for. The facility must provide a written list of what items and services Medicaid pays for, and the items and services for which residents will be charged.

6. The resident has the right to stay in the facility.

- A resident has the right to continue to live in the facility unless:
    - the resident's welfare and needs cannot be met in the facility, as documented in the clinical record by the resident's physician;
    - the resident's health has improved sufficiently so that he or she no longer needs the services provided by the facility, as documented in the clinical record by the resident's physician;

    - the resident is a danger to the health or safety of other individuals in the facility, as documented by a physician in the resident's clinical record;
    - the resident has failed, after reasonable and appropriate notice, to pay for his or her stay at the facility; or the facility ceases to operate.
- If the facility wants a resident to move from the facility, it must provide a written notice, called a *Notice of Involuntary Transfer or Discharge Pursuant to the Nursing Home Care Act*. The notice must:
    - include the reason the facility wants the resident to move;
    - include procedures for appealing to the Illinois Department of Public Health;
    - include a blank *Request for Hearing* form to be used for requesting an appeal;
    - include a stamped and addressed envelope to mail the request for appeal;
    - be received 30 days prior to the day they want the resident to move from a Medicare or Medicaid certified facility; or
    - be received 21 days prior to the day they want the resident to move from a State licensed facility.
- Residents have the right to be told in advance if their room or roommate is being changed.

7. Residents do not lose their rights as citizens just because they live in a long-term care facility.

- Facilities must provide residents with access to all inspections conducted by the Illinois Department of Public Health from the last five years and the most recent survey conducted by the Illinois Department of Public Health along with any plans for correcting deficiencies provided to surveyors.
- If the resident has a court appointed legal guardian, the guardian may exercise the resident's rights.
- If the resident has named an agent under a Durable Power of Attorney for Health Care, the resident's agent may exercise the resident's rights.
- Residents have freedom of religion. The facility may not force a resident to follow any religious beliefs or practices and cannot require a resident to attend any religious services.
- Residents have the right to vote for the candidate of their choice.
- Residents have the right to participate in social and community activities that do not interfere with the rights of other residents.
- Residents have the right to participate in the Resident Council. The facility must respond to concerns raised by the council.
- Residents have the right to meet with the Long-Term Care Ombudsman, community organizations, social service groups, legal advocates, and members of the general public who come to the facility. Representatives of these groups may come to the facility to provide services or to help residents assert their rights.
- Residents have the right to present grievances to the facility or to outside organizations and advocates (such as the Long-Term Care Ombudsman).
- The facility may not threaten or punish a resident in any way for asserting his or her rights or for presenting grievances either to facility staff or to outside organizations and advocates.

Other Resources (PPS #54) (PM Pg. 47)

To make residents' rights easy for residents to understand, the Illinois Department on Aging publishes residents' rights booklets for residents of nursing homes, supportive living facilities, assisted living facilities, and intermediate care facilities for the developmentally disabled.

To help assure that you have access to information that can help inform your study of residents' rights, links to legislation and administrative codes regulating long-term care facilities appear in Appendix C of this manual. The Illinois Act on the Aging can be found at: http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=224 .
In your work with residents, keep in mind that any right a resident had prior to entering the nursing facility he or she maintains as a resident of the facility. Final Ombudsman Rule can be found at: http://ltcombudsman.org/uploads/files/library/2015-01914.pdf

Common Residents' Rights Violations
(PPS #55) (PM Pg. 48)

TRAINER'S NOTE: *The "Common Violations" PowerPoint slide provides an outline of the violations listed below. You will need to provide a more in-depth overview by discussing some of the situations below.*

As an Ombudsman, you will often see residents' rights problems associated with violations of the resident's right to:

- **safety and good care** – sometimes presenting as a decline in physical or mental health as the result of low staffing or fewer opportunities to engage in preferred forms of socialization or activity.
- **choose their physician** – may be caused by the refusal of the facility to provide transportation to doctor's appointments. May also occur when a resident is on Medicaid and their preferred physician does not accept payment from Medicaid or when a preferred physician does not visit nursing homes.
- **refuse medical treatment** – may occur when a facility consults with a representative (POA, etc.) instead of the resident or when the facility takes the direction of a representative over the direction of a resident who is competent to make medical decisions.
- **participate in decisions about their own care** – may occur when there is a failure to share information about medical conditions and treatments in a language the resident can understand or when facility staff call a resident's representative (POA, etc.) about changes in medical condition or treatment without sharing information with the resident.
- **privacy** – may occur when facility staff do not knock before entering resident rooms or when facility staff fail to close doors or pull privacy curtains when providing care that could compromise resident dignity. May also occur when the facility fails to assure that the resident has private access to community organizations, social service groups, legal advocates, Ombudsmen, and other members of the public who come into the facility.

- **manage their own money** – may occur when the resident or representative signs a form authorizing the facility to "bank" the resident's personal needs allowance or other cash assets. This often occurs at the time of admission and is presented as a way to help prevent theft. Violations may also occur when a resident who is able to provide direction is not informed of past due bills or if a resident is told that they are "required" to let the facility be the representative payee for social security checks.
- **safety of personal belongings and property** – most often seen in the form of lost laundry. Sometimes cash or small valuables also come up "missing." Although the facility is not required to replace lost items, the facility should have a protocol for investigation theft. This protocol should include procedures for both an internal investigation and contacting law enforcement.
- **contract for services** – can occur when someone other than a competent resident or a court-appointed legal guardian are asked to sign an agreement stating that they will pay for the resident's care;
- **remain in the facility** – sometimes seen in the form of "suggestions" to family that the facility can no longer provide the care that the resident needs. These suggestions put pressure on the family to find other placement without due process.

Ombudsman Access (PPS #56) (PM Pg. 49)

The Older Americans Act, the Illinois Act on the Aging, and the Illinois Administrative Code all assert that residents have the right to meet with an Ombudsman in a private setting. Some nursing homes are very cooperative in assuring that you have access to residents while others attempt to circumvent this requirement.

Efforts to learn who you are working with or what you are discussing with residents can take many forms. Some common ways that nursing homes make it impossible for you to provide private and confidential services include:

- having staff come into the room you are visiting to provide care;
- having staff hover outside the door of the room you are visiting; or,
- asking if they can "help" you find a resident.

When this happens, you have a wonderful opportunity to educate staff about your role in protecting residents' rights and to suggest that your presence in the facility can actually help them identify problems before they get out of hand.
Chapter 600, Section 601 of the Long-Term Care Ombudsman Program Policies and Procedures Manual also offers appropriate responses in the event you are denied access to a facility or to a resident by a facility employee or agent.

First, ask the facility administrator or highest ranking available employee why you are being denied access. If the denial seems reasonable, (e.g., the resident is being bathed), accept the explanation and return to the facility at your earliest opportunity. If the explanation does not seem reasonable, or if access is being denied arbitrarily, inform the facility administrator or highest ranking available employee of your legal authority to visit the facility and to communicate with residents. It may be helpful to show the administrator or staff person the Ombudsman

access authority printed on the back of your Ombudsman badge. If facility staff continue to deny you access to the facility or to a resident, contact your Regional Ombudsman for assistance. The Regional Ombudsman shall follow the protocol spelled out in Chapter 600, Section 601(E).

While a facility is required to give you access to the facility and to residents, you also have a responsibility to follow state policies and procedures. When exercising the authority to visit residents, you are required to:

- wear your badge;
- inform staff member of your presence upon entering the building and/or sign in if required;
- respect the privacy and convenience of the resident;
- knock and receive permission to enter a resident's room
- introduce yourself and explain the Ombudsman Program and its services to the resident, family members, and staff; and
- terminate a conversation or visit with a resident who has expressly declined or withdrawn consent in a direct conversation with you.

Never seek to intimidate, coerce, or deceive the resident, a family member, or staff into a communication or conversation and do not visit with residents on confidential matters during meal time, activities, therapy sessions, etc.

If you would like to visit your facility during "off hours," please consult with your Regional Ombudsman before making the visit. Off hours visits may alarm facility staff, resulting in a call from facility staff or administration to your Regional Ombudsman.

If you would like to make an "official" visit to a facility not ordinarily assigned to you, talk with your Regional Ombudsman prior to doing so. He or she will make a courtesy call to the Long-Term Care or Regional Ombudsman who ordinarily serves that facility letting them know that you have asked to make a visit.

You may visit friends or family members in nursing homes not assigned to you. However, you are not acting as an Ombudsman in such facilities and should NOT wear your Ombudsman badge when making personal visits.

Activity: Name That Right[2] (PPS #57) (PM Pg. 50)

TRAINER'S NOTE: *Choose a few of the cases below for review and discussion. Cases 4, 6, and 10 may be especially useful. In addition to discussing which rights are being violated, be sure to discuss how you would attempt to resolve these problems.*

Your trainer has now discussed residents' rights, culture change and the Ombudsman's role in supporting resident self-determination. Review the scenarios below and decide which resident right(s) is being violated:

1. Andrew is his father's power of attorney. When Andrew requested to review his father's medical records and care plan, he was told by facility staff that it was not customary for family to review resident's records.
   TRAINER'S NOTE: *Access to medical information. Requires discussion of a competent resident's right to deny access to his medical record.*

2. Facility staff routinely walk into Mrs. Carlisle's room without knocking and they often leave the door open while attending to her personal needs.
   TRAINER'S NOTE: *Privacy issues, dignity concerns.*

3. June is a Volunteer Ombudsman. She is concerned about Mrs. Abbott, who was recently admitted to the facility June visits. Before she goes to speak with Mrs. Abbott, she requests to look at her medical record and care plan and the charge nurse obliges.
   TRAINER'S NOTE: *Inappropriate attempt to access to medical information.*

4. Mr. Carter is a disabled man living in a nursing home. He is very active in the Resident Council and not shy about bringing problems to the attention of facility staff. On Friday, facility staff informed him that they could no longer meet his needs and he would be discharged the following Monday.
   TRAINER'S NOTE: *Threat of retaliation for voicing his concerns.*

5. Mr. Norman is on Medicaid. He receives a $30 personal needs allowance to spend on personal items. Mr. Norman's son Herman takes money from his father each month and buys items for his new apartment.
   TRAINER'S NOTE: *Resident's right to control his own money, possible financial exploitation.*

6. Mr. Pine's nephew, Stephen, is loud and obnoxious, but Mr. Pine enjoys his visits. Facility staff does not like Stephen and informs Mr. Pine that Stephen can no longer come to visit because he might upset the other residents.
   TRAINER'S NOTE: *Resident's right to have guests of his choosing. Balancing the rights of one resident against the rights of other residents.*

7. Mr. Smith got angry during dinner one night and threw his plate on the floor. Dining room staff immediately took him back to his room and told him that he would not have dinner that night and could not eat in the dining room until he learned to behave himself.
   TRAINER'S NOTE: *Isolation, punishment, dignity issues, not meeting nutritional needs.*

8. Mr. Wilson is a Vietnam veteran. He often orders personal items through the VA commissary to be delivered to him at the nursing home where he lives. When he receives the items, the boxes are already opened.
TRAINER'S NOTE: *Privacy, mail tampering.*

9. Mrs. Waters is reliant on a wheelchair and cannot get herself around very well. On Tuesday the Activities Director invites her to attend a sing-along in the main dining room. Mrs. Waters is feeling a bit under the weather and declines the invitation. The Activities Director says, "Oh, you'll enjoy it once you get there" and pushes her down to the dining room anyway.
TRAINER'S NOTE: *Right to participate in activities of one's own choosing.*

10. Ms. Stamper has lived in a local nursing facility for 4 years and has paid privately. Recently her money ran out and she became eligible for Medicaid. Facility staff informed her that she would have to change rooms and move to one of their Medicaid beds.
TRAINER'S NOTE: *Explain that Illinois certifies Medicare and Medicaid beds so that each facility has a set number of beds which can be used for Medicare residents and a set number of beds that are available to Medicaid residents. These beds are certified by bed location rather than the payer sources of the resident occupying the bed. If a resident is in a Medicare certified bed, when they are no longer receiving Medicare benefits, they are often forced to change rooms.*

11. Peter's mother is a resident in a local nursing home. Peter works 2 jobs and is only able to visit his mother after 9:00pm Facility staff told Peter and his mother that he must visit during the posted visiting hours: 10:00am – 5:00pm.
TRAINER'S NOTE: *Resident's right to have visitors at any time of the day.*

12. Three days after admission, Mrs. Miner's engagement ring disappears off her finger. When she reports it to the facility, she is shown her admission contract and the paragraph that states that the facility is not liable for lost or stolen items.
TRAINER'S NOTE: *Security of personal items. The facility should have a protocol in place for internal investigations and for contacting law enforcement or allowing the resident to contact law enforcement when items are lost or stolen. The facility is not required to pay for or replace the ring.*

13. Upon admission, facility staff told Mrs. Clinton that her family doctor could not be her doctor at the nursing home, she would have to choose one of the staff physicians.
TRAINER'S NOTE: *Right to choose one's own physician. Discuss how transportation, Medicaid reimbursement, and other issues can impede the resident's right to choose a physician.*

14. When Mrs. Brown goes to bed at night, the nursing aides tuck her blankets around the bed so tight that Mrs. Brown can barely move her legs.
TRAINER'S NOTE: *A form of restraint.*

TRAINER'S NOTE: *Before ending the module, offer participants an opportunity to ask questions about the materials covered in this module.*

MODULE 6

OMBUDSMAN COMMUNICATION SKILLS

Listen for the "problem behind the problem." Sometimes a resident will be hesitant to reveal what is really bothering them. The specific problem may be hidden behind a generalized sense of hopelessness or a set of generalized complaints.

Communications
(PPS #59) (PM Pg. 54)

The ability to communicate effectively with residents in long-term care facilities is one of the most valuable skills an Ombudsman can possess. The most common form of problem identification and information gathering you will use during your career as an Ombudsman will be the resident interview.

Successful Resident Interviews (PPS #60) (PM Pg. 54)

When preparing for an interview with a resident, it is helpful to consider several factors:

- **Setting** – is the meeting area comfortable, quiet and private?
- **Time allotted** – will the interview be rushed?
- **Timing** – will there be interruptions such as meals, activities, therapy, etc.?
- **Goals** – what are the goals of the interview? List these.
- **Biases** – what possible biases do you have? What preconceived ideas might the interviewee have? How might biases and preconceived notions affect the process and the outcome of the interview?

TRAINER'S NOTE: *Forward to PPS #61.*

During the interview, you can improve the likelihood of success by:

- **Establishing rapport** before trying to address problems.
- **Identifying yourself and your role as an Ombudsman.**
- **Explaining the purpose of the interview.**
- **Using open-ended questions to help gather general information or opinions.** Open-ended questions start with phrases like, "What happens when..." or "What is it like..."
- **Using closed-ended questions to gather facts or if the resident is having a hard time communicating.** For example, you might ask, "Who responded to your call light?" "Who came when you called for help?" "How long did it take for someone to help you?"

TRAINER'S NOTE: *Forward to PPS #62.*

- **Using easy to understand language.** Help assure that people at the table understand one another. If medical or technical terms are used, ask for explanations and clarifications.
- **Keeping in mind that residents may use colloquialisms, or slang, to describe medical conditions.** For example, "spells" may be a word used to describe a set of conditions that a physician would describe as a heart condition while "vapors" might be a word used by a resident to describe a set of conditions that would be identified by a physician as respiratory problem. You may have to ask the resident more specific questions about their symptoms to understand what is happening to them.
- **Maintaining objectivity.** Don't assume that all information or answers are valid.
- **Guiding the interview toward the desired goals but be flexible enough to follow up on new, relevant information that might come up during the interview.**

TRAINER'S NOTE: Forward to PPS #63.

- **Explaining how the information you gather will be used and other steps anticipated in conducting the investigation and resolving the complaint.** This is a good time to discuss confidentiality and to explain your role as a resident-directed advocate.
- **If you have a systemic case open, letting the resident know that others share their concerns and that you are trying to help resolve those concerns.**
- **Getting the resident's consent to proceed** before beginning the problem-solving process or before adding their name to the list of complainants in a systemic case.
- **Being aware of body language.** Such things as tone of voice and inflection, a glint in the eye, gestures and general behavior can be as informative as the words that are actually being spoken.

TRAINER'S NOTE: Forward to PPS #64.

- **Determining whether the complainant is glossing over some fact that they think will detract from their position.** Explain that you need to know all facts so that you give them the best help possible.
- **Being comfortable with silence.** Don't try to fill in the gaps. Use this time to organize what you have already heard.
- **Distinguishing facts from hearsay, opinions, characterizations, or the evaluations of others.** For example, if someone calls a resident "hostile," find out what specific resident behaviors lead to this characterization.
- **Remembering that you are the interviewer.** Turn questions into statements and reflect them back. For instance, if someone asks you if you think a facility is short staffed you may want to say, "It sounds like you think that there is not enough staff, I'd like to know what leads you to that conclusion."
- **Listening for the "problem behind the problem."** Sometimes a resident is hesitant to reveal what is really bothering them. The specific problem may be hidden behind a generalized sense of hopelessness or a set of generalized complaints.
- **Sticking to your interview agenda.** Don't be deflected or distracted by collateral issues. Avoid debates.
- **Staying focused on the current issue.** Avoid discussion of past grievances.
- **Being flexible enough that the resident is able to bring up new concerns.**

Taking Notes (PPS #65) (PM Pg. 55)

During your interview, ask the resident if it is okay for you to take notes. Notes provide you with a record of the interview and help you remember important information. This will help you work with the resident and a supervising Ombudsman to develop a plan of action for resolving the issue at hand. Be sure to gather the following information:

- Names and positions of everyone present and if they spoke during the interview
- Consent given or not given to act and specific permissions given by the resident
- Date, time, and location of the interview

- Narrative account of the content of the interview
- Plan of action – who is going to do what?
- Goals that were accomplished
- Goals that were not achieved
- Any new avenues to explore

Overcoming Barriers to Communication

Hearing Impairment (PPS #68) (PM Pg. 56)

Many residents in long-term care facilities have moderate to severe hearing loss. Some are less able to hear high frequency sounds while others are less able to hear low frequency sounds. You may have to experiment a little bit to see what works best for communicating with each individual resident. Some tips include:

- Stand 3-6 feet away and directly in front of the resident.
- Speak loudly and clearly. You may have to slow down your normal speaking pace. If this does not work, ask the resident which ear works best. Then move closer to that ear.
- If you must get next to the resident's ear to speak, try a "low and slow" tone and pace first. You can increase volume if you find that the resident still cannot hear you. If you start at a high volume close to the head you run the risk of having the resident become annoyed that you are "yelling" at them.
- Ask the resident if you can move to a location with less background noise.
- Write if necessary. Depending on other physical conditions, the resident may be able to answer you verbally or may also need to write their answers. You should be aware that writing will not always work. Some residents have other impairments that limit their ability to read.
- If you are unable to communicate with a resident who has hearing impairments, ask staff how they communicate with the resident. They may have a certain technique, or you may learn that the resident has hearing aids that are not in use for some reason.

Visual Impairment (PPS #69) (PM Pg. 56)

Many residents in long-term care facilities have visual impairments such as macular degeneration or cataracts. You may only become aware of these conditions if the resident tells you or if you notice that the resident's body language suggests they cannot see you. Individuals with macular degeneration may continue to wear prescription glasses but may turn their head to the right or left to get you in their field of vision. Individuals with cataracts may also continue to wear eye glasses, but may seem less able to focus on you.

You may learn that a resident has a visual impairment when you offer to leave them a program brochure. If this is the case, offer to share the information contained in the brochure or to leave

the brochure for family members. You can also ask the resident if they read Braille, and if so, would they like a Braille brochure. Here are some techniques you can use to help improve your communications with visually impaired residents.

- Identify yourself to the resident.
- Ask the resident where they would like for you to stand so that they can best see you.
- Let the resident know who else is in the room.
- If you are moving about the room, explain everything that you are doing as you are doing it.
- If documents must be signed, increase lighting or do anything else that will help the resident see better. Don't assume anything. Ask the resident what is most helpful.

Memory Loss (PPS #70) (PM Pg. 57)

Some of the residents you visit will have some degree of dementia caused by Alzheimer's disease or other disease processes. Some residents remember long ago quite well but have difficulty remembering what happened to them yesterday. Other residents remember the recent past very well but have a hard time with long ago events. The monotony of day-to-day life in a long-term care facility can also contribute to a sense of days running together and a certain degree of forgetfulness.

Greg Kyrouac, of the Southern Illinois University School of Medicine Center for Alzheimer's Disease and Related Disorders, offers some useful tips for working with elders who have memory loss.

- Get the person's attention.
- Make eye contact.
- Introduce yourself to the resident each time you meet them.
- Expect repetitive questions and behaviors. You may have to re-introduce yourself or answer the same questions several times during the course of a single conversation.
- Speak slowly and clearly, maintain a calm tone.
- Use good manners. Be respectful.
- Allow the resident to maintain dignity.
- Avoid sarcasm or teasing, the resident will not understand these forms of humor.
- Give the resident ample time to process information and develop an answer to your question (up to a minute may be necessary).
- Provide reminders when needed.
- Ask simple questions that can be answered with a "yes" or "no."
- When possible, answer questions with a simple "yes" or "no."
- Be conscious of body language (yours and theirs).
- If there are distractions, ask if it is okay to go somewhere quieter.

- Visit in the morning. People with memory loss are often better able to interact and have better recall in the first half of the day.
- Always thank the resident for taking the time to meet with you.

There are also a few specific communication "Don'ts" when working with individuals with cognitive impairments: Don't

- ask the resident if they remember you. Behave as if this is your first meeting.
- try to convince.
- try to explain reality.
- argue or try to use reason.
- raise your voice, frown, or scold.
- use language that could be misinterpreted as romantic or sexual.
- corner or crowd the individual.
- talk about the person as if he or she were not there.
- ignore the person's feelings.
- be offended by language or behaviors coming from the resident.

Aphasia (PPS #71) (PM Pg. 58)

Aphasia is a condition causing either partial or total loss of the ability to communicate verbally or in writing. It is a common side effect of strokes and brain injuries. Individuals can have varying degrees of aphasia. Some may only have a slur while others have to stop to find and pronounce words and still others are completely unable to speak. Some tips for working with residents with aphasia include:

- Be patient. Aphasia is very frustrating for residents who are affected by it.
- Many people with aphasia understand you but are unable to respond.
- If the resident is unable to speak, ask the resident if they can respond to "yes/no" questions with hand gestures, by blinking, or by moving their eyes up and down or side to side. As you mention each form of response, watch to see if the resident is using that technique at that moment.
- If you are unable to find a way to communicate with the resident, ask facility staff how they communicate with the resident and use the same method. If resident staff tell you that the resident is completely non-communicative, you may want to spend some time observing the resident and talking with them a little to see if you are able to detect any movement that would suggest the resident understands you or is trying to communicate with you.
- To learn more about how effectively the facility meets the needs of the resident, you may also want to ask facility staff how they know when the resident needs something.

Languages other than English (PPS #72) (PM Pg. 58)

If you learn that a resident does not speak English, seek out an interpreter. To help assure that the resident is getting all of the information that you are trying to provide in a completely accurate fashion, avoid using family members or facility staff as interpreters unless absolutely necessary.

Psychological Barriers (PPS #73) (PM Pg. 59)

At some point in your career as an Ombudsman, you will probably meet a resident who has a psychological condition that affects their ability to interact with others. Unless a resident with a mental illness feels intimidated or threatened, they are more likely to be depressed and withdrawn than agitated and aggressive. Here are a few tips for working with people with mental illnesses.

- Introduce yourself and attempt to engage the resident in conversation just as you would any other resident.
- If the resident does not appear to be in any danger and does not want to talk with you, don't force the issue.
- If the resident is unusually agitated but wants to talk with you about whatever is upsetting them, make sure that you can move to safety or call for help if the resident becomes physically aggressive.
- Avoid confrontation. Be firm about your boundaries, explaining what you can and cannot do for the resident but do not argue with the resident.
- If you are familiar with the resident, watch for changes in mood and behavior. Is the resident more agitated than usual? Does the resident appear to be more depressed than usual? Be sure that you can clearly describe the behaviors and body language that lead you to this conclusion.
- If you notice a change in behavior, try to get the resident's consent to talk with the Director of Nursing about your observations or about any information the resident shares which would help guide treatment.
- If the resident threatens to harm themselves or others, contact your Regional
- Ombudsman or the Office immediately. There is additional training provided in Level II to address this concern.

When all else fails (PPS #74) (PM Pg. 59)

If you have concerns about the care of resident who is completely unable to communicate with you, ask facility staff to provide you with the contact information of the resident's representative. In these cases, you will be making a "cold call" and will have to introduce yourself and the program to the resident's representative. You may then ask if they have any concerns about the care of the resident. You may follow the direction of the representative with permission. Sometimes you will find that a resident's representative either does not have any concerns or is unwilling to pursue a concern for fear that the resident will experience some form of retaliation, that resident care will suffer or that the resident may be discharged if they complain. You must respect the representative's wishes.

If the resident is unable to guide you and the resident's representative is unavailable, unresponsive, or causing the complaint or concern, you may act in good faith, assuming that the resident would want good care and a high quality of life. These cases should be handled with the direction of the Ombudsman's supervisor.

Case Studies

(PPS #75) (PM Pg. 60)

Working through Communication Barriers

Read the following case studies. How might you attempt to communicate with these residents?
You introduce yourself to a resident and offer her a pamphlet about the Ombudsman program. She tells you she is blind. **TRAINER'S NOTE:** *Interventions include - Describe the Ombudsman program and resident's rights. Offer to leave copies of the Ombudsman and/or Residents' Rights pamphlets for family or friends that might visit her. Explain to her that friends or family members can help her contact the Ombudsman program. Also explain that facility staff must help her reach the Ombudsman program if she asks them to do so. Ask the resident if she can read Braille and if so, provide her with a copy of the brochure in Braille.*

You notice a resident in a reclining wheel chair crying loudly. You approach her and ask her how she is. She continues to cry loudly. You have not witnessed anyone approach her. Her crying does not change and she does not acknowledge you. **TRAINER'S NOTE:** *Interventions include - Ask the resident "yes/ no" questions. Ask the staff how they communicate with the resident and try that. If you are still not able to communicate with her and she seems distressed or you notice problems, ask staff members for the name and phone number of the residents' representative. Encourage staff to intervene to soothe the resident.*

You approach a resident and ask him specific questions about a complaint you have received from his daughter. He can communicate through the pleasantries, but when you start asking specific questions he begins sentences, but stutters and becomes stuck on words before he is able to finish the sentence. **TRAINER'S NOTE:** *Interventions include - Ask the resident "yes/ no" questions. Ask the staff how they communicate with the resident and try that. If you are still not able to communicate with him and he seems distressed or you notice problems, ask staff members for the name and phone number of the residents' representative.*

MODULE 7

EMPOWERING RESIDENTS FOR SELF-ADVOCACY

If you are able to teach residents how to solve problems for themselves, you actually give them the tools they need to improve their own lives on a day-to-day basis with minimal assistance from others.

TRAINER'S NOTE: *This module requires use of the "Courage to Speak" DVD. Before beginning the module prepare your projector and sound systems to show the DVD.*

Empowering Residents for Self-Advocacy

Long-Term Care Ombudsmen are drawn to the program by a desire to help others, especially frail elders. You will often be inclined to solve problems for residents. However, your first goal should be to empower residents to engage in self-directed problem-solving activities. Teaching residents how to solve problems for themselves gives them the tools they need to improve their own lives on a day-to-day basis with minimal assistance from others. By empowering those residents who can help themselves, you will also have more time to devote to residents who are unable to engage in any form of self-advocacy.

Barriers to Self-Advocacy (PPS #77) (PM Pg. 62)

TRAINER'S NOTE: *The "Common Barriers" PowerPoint Slide only lists the three primary categories of barriers. You will need to read selected barriers from the lists below to help participants understand the scope of barriers to self-advocacy.*

There are three main categories of barriers that limit resident's abilities to engage in problem solving activities in the facility. These are:

PSYCHOLOGICAL & PSYCHOSOCIAL BARRIERS	
Fear of retaliation	Fear of upsetting the family
Sense of isolation	Belief that this is the best that it can be
Lethargy	Sense of hopelessness and/or despair
Disorientation	Inability to question authority
Loss of confidence	Mystique about medical issues
Depersonalization	Lack of familiarity with staff
Disdain for the label "complainer"	Lack of experience with being assertive, particularly for women
Social pressures to conform	Stereotypes, fears about age
	Sense of weakness resulting from illness

PHYSICAL & MENTAL BARRIERS	
Hearing loss	Inaccessibility of staff
Loss of speech	Impaired vision
Immobility	Diminished physical strength
Memory loss or other impairments in cognitive functioning	Effects of medications
	Depression

INFORMATION BARRIERS	
The resident lacks information concerning:	• rights, entitlements, benefits; • authority within the facility; • legal and administrative remedies; • alternatives; • how to improve the situation; • the right to complain and how to advocate for change.

Overcoming Barriers to Self-Advocacy (PPS #78) (PM Pg. 63)

TRAINER'S NOTE: *Only those steps needing explanation at this point in the training appear on the PowerPoint slides. In the interest of time, use the slides to guide your discussion.*

Resident empowerment can only begin when you visit the resident and learn their concerns, the ideas they may have for resolving those concerns, and actions they may have already taken to address the concern.

In the early stages of problem solving, it is appropriate to engage in activities that empower the resident to engage in self-advocacy. Some specific steps you can take include:

- educating residents about their rights;
- explaining which facility staff can most effectively address specific problems;
- encouraging residents to participate in care plan meetings;
- encouraging residents to participate in resident councils;
- encouraging family members to participate in family councils;
- explaining how to file effective complaints with the Illinois Department of Public Health;
- encouraging residents and family members to call local authorities when there is a medical emergency or a law is being broken in the facility (i.e. rape, assault, theft, financial exploitation).

Each of these options is discussed below. You will also learn more about these options through training, mentoring, and your own experiences in the field.

Familiarizing Residents with Their Rights (PPS #78) (PM Pg. 63)

As you have seen, residents of long-term care facilities do not lose any of their rights when they move into a nursing home. You may find that you need to reinforce this information and teach residents and/or family members about the resident's new rights to quality of care and quality of life in the facility. It is a good idea to carry several Residents' Rights brochures with you on each visit to the facility. The brochures give you a way to introduce yourself, the Ombudsman program, and the concept of residents' rights to residents.

TRAINER'S NOTE: *It may be helpful to share a local case in which familiarizing a resident with their rights resulted in a successful outcome for the resident.*

Identifying Staff Members Who Can Solve Specific Problems (PPS #79) (PM Pg. 64)

TRAINER'S NOTE: *In the interest of time, do not attempt to share the complete list of staff members. Those staff members appearing on the PowerPoint slides have the most power to create change in the day-to-day lives of residents.*

You may find that you need to explain the administrative structure of the nursing home to the resident or representative. This can help them identify who might best solve their problem.

Nursing home staff members have specialized roles to play in providing care for residents. It is helpful for you to know the responsibilities of each staff member so that you can quickly identify the staff member who can help the resident address a concern.

Governing Body/Board of Directors/Trustees/Owners/Corporate Office. The owner or governing body of a facility has the overall responsibility for the operation of the facility. The governing body meets periodically to set policies and to adopt and enforce rules and regulations for the care and safety of residents. When facility staff are unable to resolve concerns, Regional Ombudsmen may contact corporate offices for clarification of corporate policies or to engage in problem solving with appropriate corporate staff. Volunteer and Community Ombudsmen should have the permission of the resident and seek supervision from their Regional Ombudsman before contacting a corporate office.

Administrator. Operates and manages the nursing home on a daily basis. The administrator is hired by the governing body and must be licensed by the State of Illinois. The administrator is ultimately responsible for supervising the work of all the employees and assuring that the facility meets state standards for quality of care, quality of life, and facility safety and cleanliness.

Medical Director. A physician who is contracted with the facility or corporation to assist in the development and implementation of policies and procedures based on current standards of practice. The medical director may also serve as the physician for residents or may act as a consultant to the resident's physician if asked to do so by the facility to help address a specific medical problem experienced by a resident.

Corporate Nurse or Nursing Consultant. Some multi-facility chains have a highly trained registered nurse or nurse practitioner on staff. This corporate nurse uses federal regulations and state administrative codes to develop corporate policies and procedures for nursing care. The corporate nurse then serves as a consultant to local facilities, helping to assure that care standards are met. When there is not a corporate nurse or another nursing consultant provided through a corporate office, the Director of Nursing may be responsible for developing policies and procedures for nursing staff.

Director of Nursing (DON). The DON is responsible for assuring that the nursing care provided by other Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants meets both federal and state standards for care. While some Directors of Nursing are very involved in the lives of residents and carefully supervise day-to-day interactions between staff and

residents, others may "manage" nursing staff from a distance leaving direct supervision of staff to the Assistant Director of Nursing or other front-line staff.

Assistant Director of Nursing (ADON). The assistant director of nursing helps the DON with his or her duties. In some cases, the ADON may have more contact with front line staff than the DON.

Charge Nurse. The charge nurse is a Registered Nurse or a Licensed Practical Nurse who supervises nursing care during a given shift. Depending on the size of the facility, there may be more than one charge nurse. Larger facilities may have a charge nurse assigned to each unit or section of the facility. Most facilities are required to have at least one charge nurse on duty at all times. The charge nurse is an excellent resource for answering questions or for immediately addressing care concerns that are not being adequately addressed by Certified Nursing Assistants or unit aides.

Registered Nurse (RN). A facility may hire RNs to conduct nursing assessments and coordinate individualized care. These RNs may serve as Care Plan Coordinators.

TRAINER'S NOTE: *Forward to PPS #80.*

Care Plan Coordinator. The care plan coordinator works with other licensed nurses to conduct nursing assessments and coordinate individual nursing care. They may also work with other department heads to assure that interventions are coordinated appropriately across departments (i.e. nursing, dietary, physical therapy, etc.) The care plan coordinator is usually a registered nurse (RN). Care plan coordinators are often responsible for scheduling care plan meetings. Therefore, residents, family members or Ombudsmen should talk with the care plan coordinator to find out when a resident will have the next care plan meeting or to arrange a care plan meeting between scheduled meetings.

Licensed Practical Nurse (LPN). Licensed practical nurses often serve as charge nurses. In addition to mid-level supervisory duties, LPN's may dispense medications, provide treatments and provide direct nursing care to residents.

Certified Nursing Assistant (CNA). Certified nursing assistants provide most of the personal care residents receive each day. CNA's assist residents with activities of daily living such as grooming, dressing, toileting, showers, and ambulation. CNA's will almost always be the highest percentage of nursing staff in a facility.

Pharmacy Consultant. The pharmacy consultant reviews the drug regimens of each resident and assures that medications are dispensed to the facility to meet the needs of residents. Like the nurse consultant, the pharmacy consultant may be employed by an outside vendor working under contract with the corporate office to provide oversight to multiple facilities.

Physical, speech and occupational therapists. The staff of the therapy department provides rehabilitative services to help residents reach a higher level of functioning. Like nurse and pharmacy consultants, therapists may be assigned to one or more facilities under a contract between the corporate office and an outside vendor.

Social worker or social services director. The facility social worker provides medically related social services and acts as a liaison between residents and/or family members and staff. The facility social worker should be familiar with local resources so that they can provide referrals

to outside agencies or services to meet needs that cannot be met by facility staff. Many social services directors have access to more experienced social workers who serve as consultants to the facility. In some cases, the social worker or social services director may also serve as an admissions coordinator.

Admissions Coordinator. The admissions coordinator works closely with nursing staff, social services staff, or the facility administrator to decide which residents will be admitted to the facility from the hospital, another facility, or the community. The admissions coordinator helps residents and family members transition into the nursing home by guiding them through the admissions process, directing them to their assigned room, and assuring that the resident has assistance from housekeeping, maintenance, etc. to help them settle in to the facility.

TRAINER'S NOTE: *Forward to PPS #81.*

Activities Director. The activities director plans and implements an activities program designed to meet the needs of residents. Ideally, an activities program provides enough variety to meet the individualized needs of facility residents. The activities director may also be called upon to develop one-on-one activities programs for individuals who are unable to participate in group activities. When the facility is large enough to justify the employment of activities assistants, the activities director provides supervision. In some facilities, the activities department may hold responsibility for making resident appointments and coordinating transportation for residents.

Dietary Manager/Director of Food Services. The dietary manager provides oversight for the preparation of meals to meet the individualized dietary needs of residents. The dietary manager usually follows a corporate menu and is responsible for the receipt and storage of food supplies. If the facility dietary manager is not a dietician, he or she must receive consultant services from a registered dietician.

Director of Housekeeping. The director of housekeeping manages the housekeeping department and is ultimately responsible for assuring that the facility and resident rooms are clean. Housekeepers should be consulted when there is a spill or if a resident is concerned about the cleanliness of their room.

Maintenance Supervisor. The maintenance supervisor is responsible for maintaining the facility's physical plant, equipment, and grounds. The maintenance department may be responsible for the upkeep of facility wheelchairs.

Other personnel in the facility may include medical records staff, a business manager or bookkeeper, and a chaplain.

TRAINER'S NOTE: *It may be helpful to discuss a local case in which explaining the role of individual staff members helped a resident engage in empowered self-advocacy.*

Meeting with Staff Members (PPS #82) (PM Pg. 66)

You can further empower the resident by suggesting that they meet the staff person you have identified as a problem solver. When you suggest this meeting, it can be helpful to offer to "go along." Your presence can give the resident or representative increased confidence that their concern will be heard and addressed appropriately. If you find yourself accompanying the resident on a meeting with staff, it is important that you not to dominate the conversation. It may be helpful to discuss possible reactions that staff will have to the resident's request and what approaches to resolution are acceptable to the resident prior to the meeting. When in the meeting, allow the resident to state their concern and the desired solution. If the staff person is resistant to meeting the resident's goals, it may be helpful for you to offer suggestions that can help staff accommodate the resident's wishes. Keep in mind that you are there to promote resident empowerment, not to bring the resident's wishes in line with facility preferences.

TRAINER'S NOTE: *It may be helpful to discuss a local case in which assisting a resident in meeting with staff members helped a resident engage in empowered self-advocacy.*

Encouraging Residents to Attend Care Plan Meetings (PPS #83) (PM Pg. 67)

When a care concern arises, Ombudsmen may talk with the resident or the resident's representative about arranging a care plan meeting to assure that the resident is getting care that meets both medical and psychosocial needs. Care plan meetings are held on a regularly scheduled basis or whenever there is a significant change in resident condition. Prior to the care plan meeting, representatives of each department in the facility collect information on the resident using an instrument called the Minimum Data Set (MDS). The MDS helps staff identify areas of concern that may need additional intervention. At the time of the meeting, representatives of each department gather to discuss the needs of the resident. Once all interventions are discussed, staff members sign off on the care plan and it is added to the resident's record. A care plan meeting involves representatives of each department in the facility. The resident and family member should receive a notice whenever a care plan meeting is being held. An Ombudsman may attend a care plan meeting at the request or with the consent of the resident. Sometimes, Ombudsmen attend care plan meetings, serving as a trusted advocate for the resident's right to self-determination, quality care, and quality of life.

TRAINER'S NOTE: *It may be helpful to discuss a case in which encouraging a resident to attend a care plan meeting resulted in a successful outcome for the resident.*

Encouraging Participation in Resident or Family Councils (PPS #84) (PM Pg. 67)

Another way you may become involved in empowering residents and their family members is through developing, supporting and/or strengthening resident councils and family councils. One of the rights guaranteed by federal nursing home regulations is the right to organize and participate in resident councils and family councils. Nursing homes are required to establish a resident council. Other licensed facilities, such as assisted living establishments, are required to allow family and friends to form a family council should they so choose. With all councils, the residents and family members have a right to meet without interruption from staff. Facilities are required to provide resident and family councils with private meeting space and a designated

staff member to assist the council. Facility staff are required to respond to written requests from the group and address grievances and recommendations that come to them from resident and family councils.

One of the ways that you can empower residents and family members is to assure that their council truly reflects their concerns. As an Ombudsman, you may attend meetings at the invitation of a member of the council (a resident or family member, *not* facility staff). Often you will find that a facility staff member facilitates the resident council meetings and, at least to some degree, controls the topics of discussion in the meetings. You may also find that facility staff take notes and type up the minutes of the meeting. In some facilities a resident is asked to review the minutes of the meeting before they become official. When staff members control a council meeting or type up minutes that fail to accurately reflect the concerns of council minutes, the council is said to be "compromised."

Because resident councils may be compromised, it is a good idea to work closely with your mentor or Regional Ombudsman when engaging in advocacy through a resident council. You may be asked to help draft letters or assist the council president in taking issues to administrative staff. As always, you should seek guidance and consent from council members before acting on any concern that arises in a council meeting. Be sure to consult with your mentor or Regional Ombudsman so that you don't overstep appropriate Ombudsman boundaries.

TRAINER'S NOTE: *It may be helpful to discuss a case in which Ombudsman assistance with a resident or family council, or encouraging residents and family members to participate in a council, led to a successful outcome for residents.*

Reporting to Regulators (PPS #85) (PM Pg. 68)

Many residents and family members have only a vague notion that they can report concerns about nursing care or resident safety to the Illinois Department of Public Health. As an Ombudsman, you can assist them in the complaint process by sharing the phone number, fax number, on-line complaint form, and e-mail address of the Central Complaint Registry (IDPH Hotline) and by explaining the most effective process for assuring that complaints are investigated.

Complaints about Supportive Living Facilities should be directed to the Illinois Department of Healthcare and Family Services.

TRAINER'S NOTE: *It may be helpful to discuss a case in which helping a resident file a report with IDPH resulted in a successful outcome for the resident.*

Contacting Local Authorities (PPS #86) (PM Pg. 68)

Although facilities are responsible for the safety of residents and their personal possessions, illegal drug use, thefts, assaults, and even rapes occur in nursing homes. Section 1150B of the Social Security Act now requires that any individual who is an owner, operator, employee, manager, agent or contractor of a long-term care facility receiving at least $10,000 annually in Federal funds under the Affordable Care Act ***must*** report any reasonable suspicion of a crime committed against an individual who is a resident of, or receiving care from, a long-term care facility to at least one local law enforcement entity and the State Survey Agency (the Illinois Department of Public Health).

If you believe a crime has occurred in a facility, ask the resident if the facility has reported the incident to local authorities and/or to the Illinois Department of Public Health. Ask for permission to contact the authorities or to assist the resident with contacting the authorities.

TRAINER'S NOTE: *Make it clear to participants that calling local authorities is one of many options available to residents, family members, and Ombudsmen. If law enforcement agencies in your region have trained Elder Services Officers, explain the ESO program to participants. If you have worked with an ESO, share that experience with participants. Share a case in your area where local law enforcement investigated a crime in a nursing home. You may want to share a situation in which law enforcement should have been involved but local law enforcement agencies were reluctant to investigate or where a nursing home was reluctant to involve law enforcement when there was a concern that a crime had been committed.*

Overcoming Fear of Retaliation (PPS #TK) (PM Pg. 68)

Fear of retaliation is one of the biggest obstacles to any form of advocacy in long-term care settings. Retaliation can take many forms including verbal abuse and slower response to call lights. Residents can usually tell you the forms of retaliation they have seen against those who "stir the pot." It may be helpful to explain that discrimination, retaliation or reprisal against any person who shares information with an Ombudsman is a business offense punishable by a fine of up to $501.

The Connecticut Long-Term Care Ombudsman developed "Courage to Speak," a program featuring residents of long-term care facilities talking about the importance of overcoming the fear of retaliation to engage in self-directed problem solving. As you watch the program, think about how you might use this information to encourage residents to engage in problem solving activities.

TRAINER'S NOTE: *Show the "Courage to Speak" DVD now. Before ending the module, offer participants an opportunity to ask questions about the materials covered in this module.*

MODULE 8

PREPARING FOR YOUR FIRST VISIT

As an Ombudsman I receive great personal satisfaction when the resident feels they received fair treatment and their voice was heard regarding the problem they asked us to assist them with.

Carol Keiemelmeyer,
Wisconsin Long-Term Care Ombudsman

Your First Visit

Now that you understand the mission of the Ombudsman program, you can prepare for your first mentoring visit to a long-term care facility. During these visits you will observe the problem-solving process used by Ombudsmen across Illinois. After you have completed a minimum of four hours of mentoring visits, you will be asked to return to the classroom where you will have an opportunity to learn how to apply the Ombudsman problem solving process to your own cases.

Before You Go: Protect Yourself & Others from Illnesses and Infections
(PPS #89) (PM Pg. 70)

Residents of nursing homes may have compromised immune systems. An illness that might only be an inconvenience for a relatively healthy person can become a serious health concern for a frail senior. Furthermore, because of the close living quarters experienced by nursing home residents, infections and illnesses can travel from one resident to another quickly. There are a few precautions that you should always take to protect yourself and residents from unnecessary illnesses.

- If you think you may be coming down with a cold, flu or other illness, do not visit the facility. Contact your supervising Ombudsman to let him or her know if you are not going to be able to make a visit within the required timeframe.
- Avoid carrying germs into or out of the facility by using a hand sanitizer or washing your hands thoroughly with antiseptic soap before and after each visit. If you are shaking hands with or touching residents, it is a good idea to use hand sanitizer between individual resident visits.
- Do not enter an isolation room without taking precautions to assure your own safety. Isolation rooms usually have a sign that says, “Please report to the nurses’ station before entering” or “Isolation.” Some isolation signs will give you instructions for entering the room. If you do not see isolation instructions, ask a nurse what steps you need to take to prevent infection. You may be required to wear a gown, mask, and gloves.
- Do not confuse an oxygen sign with an isolation sign. You may enter rooms with oxygen in use unless an isolation sign is also present or the resident declines the visit.

Entering the facility (PPS #90) (PM Pg. 70)

When you enter a facility, it is a good idea to stop by the front desk or business office to ask for a recent room roster. If the facility requires visitors to sign in, please do so. However, do not indicate who you are visiting. Checking in at the front desk will alert staff to your presence in the building and the roster will help you locate residents you need to visit or to keep track of the residents you visited while in the facility.

Observation (PPS #90) (PM Pg. 70)

Although the most important information you gather comes from conversations with residents, your first impressions of a facility are based on your personal observations. Observation is the second most common form of Ombudsman information gathering. Use your own senses to think about what it might be like to live in the facility. By sharpening your senses, you can join in

the experience of the day to day life of facility residents. The following tips will help you make accurate observations:

When observing conditions in a facility, use all the senses (sight, hearing, smell, touch). You are most likely to detect loud noises and strong odors during the first few minutes of your visit, before you begin to become acclimated to the environment.

- Look for Ombudsman posters and IDPH survey results
- Approach the situation with an open mind, try to understand what is going on.
- Be as impartial as possible. If you are looking only for evidence that fits a preconceived notion or theory, you may miss or misinterpret other evidence.
- Although you are not a regulator, familiarity with regulations can help you judge which observations are most relevant to your case.
- Record your observations as soon as possible. This helps eliminate errors caused by memory bias (i.e. what you expected to see vs what you really saw).
- Remember, you may address problems that you observe without the consent of a resident. However, when you do this, you do not have the right to use any resident’s name when talking to facility staff.

Case Study
Anne Walker

This video was developed, funded and produced by the Texas Department of Aging and Disability Services, Media Services Department in coordination with the Texas Long-Term Care Ombudsman Program.

TRAINER’S NOTE: *Play the Texas Long-Term Care Ombudsman Casework: Anne Walker Video, stopping at the 2:27 mark, before the narrator begins to set up the next scene.*

The first segment of the video gave an over-all view of investigation, discussed later in Level I. Because the points are key to an investigation, let’s go over the highlights of the video while it is still fresh in our minds.

Investigation tips:

1. Name the three things an Ombudsman investigation should be:
TRAINER’S NOTE: *timely, thorough, and objective*

2. Ombudsman collect information during an investigation through what three main actions?
TRAINER’S NOTE: *observation, interview, and record review.*

3. To protect the integrity of the program what must you always do?
TRAINER'S NOTE: *Resident directed and always ask permission to act, understand what matters to the resident, and maintain confidentiality.*

Arrival to the facility:
What did Gloria the Ombudsman observe on her way into the building?
TRAINER'S NOTE: *Someone was at the front desk. The entry way was unobstructed.*

What did Gloria do (and not do) when notifying the facility staff of her arrival? Why is this important?
TRAINER'S NOTE: *Gloria wore her badge. She introduced herself to the woman at the reception desk, but she did not sign in on the facility visitor log. It is important to announce your visits to maintain a professional relationship and have open facility staff (e.g. notification of arrival, a primary contact person, signing facility visitor log).*

Discuss relevant LTCO program policies and procedures regarding LTCO communication with the facility staff.

The video stated an Ombudsman should plan ahead but be flexible. Why is that important?
TRAINER'S NOTE: *An Ombudsman should have a plan of who needs a follow up visit from the Ombudsman, what staff may need to be interviewed and what observations may need to be made based on cases and past consultations. However, an Ombudsman must be flexible to allow for new concerns to be addressed.*

Over the next few weeks, you will be given opportunities to accompany experienced Ombudsmen on visits to long-term care facilities. You must complete a minimum of four (4) hours of supervised visits before attending Day 2 of Level 1 Training. On Day 2 of Level 1 Training, you will learn more about complaint intake, resolution, verification and documentation.

TRAINER'S NOTE: *This ends Day 1 of Level 1 Training. Before ending the module, offer participants an opportunity to ask questions about the materials covered in this module. Before dismissing participants be sure that the participants:*

- *have completed their application to the Program.*
- *have completed their background check or know where to go for the background check.*
- *have given the Regional Ombudsman a signed confidentiality agreement so that they can go on monitoring visits.*
- *have had their photo taken for a badge.*
- *have received a temporary name badge (prepared in your office) for use on monitoring visits.*
- *have established a time and date for the first monitoring visit.*
- *know the date of Level I day 2.*

TRAINER'S NOTE: *Since this module begins on a new day, ask participants if they have questions or comments from the last training session before you proceed to Module 9. Review any necessary housekeeping items, such as lunchtime, etc.*

The Ombudsman Problem-Solving Process
(PPS #98) (PM Pg. 74)

As a representative of the Long-Term Care Ombudsman Program, you will address the concerns of residents of long-term care facilities using specific protocols set forth in Illinois Long-Term Care Ombudsman Program Policies and Procedures Manual.

During your mentoring visits, you will begin to apply the Ombudsman problem solving processes described in Chapter 500 of the Illinois State Long-Term Care Ombudsman Program Policies and Procedures Manual. In this and the upcoming modules you will learn the established protocols for:

- complaint intake,
- complaint investigation,
- complaint verification,
- planning and investigation,
- complaint resolution,
- referral to other agencies,
- addressing issues related to decision making capacity,
- working with cases of abuse or neglect, and
- documentation of investigative services.

Intake

Sources of Information (PPS #99) (PM Pg. 74)

Intake is the first step in the investigative process. Complaints may come from anyone who has knowledge of an action, inaction, or decision that may adversely affect the health safety, welfare or rights of residents. Ombudsmen may initiate complaints when they become aware of actions, inactions, or decisions by the facility as a response to natural disasters, evacuations, facility relocations, involuntary change of management, facility closures or other unusual events.

Information Collected at Intake (PPS #100) (PM Pg. 74)

Regardless of the source of the complaint, your intake efforts should include learning:

- what has occurred or is occurring;
- when the problem occurred and whether the problem is ongoing;
- where the problem occurred;
- who was involved;
- the effect of the incident on resident(s);
- reason(s) for the occurrence;
- what steps the resident or complainant has already taken to resolve the problem;

- what, if anything the facility or other interested parties have done in response to the problem; and,
- the resident's wishes with regard to complaint resolution.

As part of the intake process, you should explain the Ombudsman's role as a *resident-directed* advocate, explaining that the *resident* is your client regardless of the source of the complaint and that your investigation may only proceed with the express consent of the *resident*. If you are receiving the complaint from anyone other than the resident, explain to the complainant that you will not be able to report back to them without the permission of the resident.

When you meet with the resident, determine the resident's perception of the complaint or problem, and the outcome the resident would like to achieve. Advise the resident of his or her rights and work with the resident to develop a plan of investigation and action that conforms to the resident's wishes and to the Ombudsman Program's empowerment mission.

Timely Response (PPS #101) (PM Pg. 75)

Ombudsmen are required to respond to complaints in a timely manner. The "standard of promptness" varies from situation to situation. Use the following table to help you determine how quickly you need to respond to a complaint.

COMPLAINT RESPONSE	
If a complaint involves…	***Then the standard of promptness for an Ombudsman response is…***
• abuse or gross neglect, and the Ombudsman has reason to believe that a resident may be at risk • actual or threatened transfer or discharge from a facility within two (2) calendar days • use of restraints	• within the next working day from the receipt of the message or information by the Regional Program
• abuse or gross neglect, and the Ombudsman has no reason to believe that a resident is at risk (i.e., the resident has left the facility for home or a hospital) • actual or threatened transfer or discharge from a facility where a "Notice of Involuntary Transfer or Discharge" is issued	• within three (3) working days from the receipt of the message or information by the Regional Program
• other types of complaints	• within 7 - 21 working days or less depending upon severity of complaint

Resident Consent (PPS #102) (PM Pg. 76)

As an Ombudsman, you are a *resident-directed* advocate. You may not take action on a resident's concern without resident consent. The time will come when a resident shares a concern with you but insists that nothing be said or done to help address their concern. You may also work with a resident who gives you permission to work on a case and then withdraws consent. In either case, you must honor the resident's wishes. However, you may still be able to engage in problem solving strategies that do not disclose the identity of the resident. The following table can help with your decision-making process.

If the resident...	*Then the LTCO shall...*
• refuses to consent to LTCOP work on the complaint, or • withdraws consent before the LTCO has verified the complaint	• discontinue work on the complaint; and • follow steps below.
• withdraws consent after the LTCO has verified or partially verified the complaint	• discontinue investigation and resolution activities on the complaint; • determine whether the complaint is recurring. • If the problem is recurring, develop problem-solving strategies that would not disclose the identity of the resident (i.e. filing an Ombudsman generated complaint or presenting the issue to a resident or family council); and, • follow the steps below.

When a Resident Withdraws Consent (PPS#103) (PM Pg. 76)

Sometimes a resident with good decision-making capacity and the ability to understand the consequences of their actions refuses to give, or withdraws, consent to investigate a concern or allegation of abuse or neglect. If this happens:

- Attempt to determine why the resident does not want to proceed.
- Let the resident know that they can contact the Ombudsman program about concerns at any time in the future.
- Be sure to provide the resident with a business card or brochure that provides them with contact information.
- Inform your mentor or Regional Ombudsman, especially in cases involving allegations of abuse or neglect.

Consent and Residents with Diminished Capacity (PPS #104) (PM Pg. 77)

Some residents have limited decision making capacity. The Long-Term Care Ombudsman Program Policies and Procedures Manual gives you options for working with residents with diminished decision-making capacity.

If you are working with a resident who can communicate with you in some way but has limited decision making capacity and is unable to provide consent, you should advocate for the resident's wishes to the extent that the resident is able to express them.

If the resident is unable to direct you at all, you should seek evidence from family, friends, and other sources to try to determine what the resident would have wanted if they were able to direct you. You may then work toward addressing the situation in such a manner that the past values of the resident are actualized. It is always safe to assume that the resident would want his or her health, safety, welfare and rights to be protected.

A more thorough explanation about working with residents with diminished capacity appears in Module 13.

When the Resident Has Passed Away (PPS #105) (PM Pg. 77)

If the resident has already passed away when you learn of the abuse or neglect you should determine if the situation involved systemic abuse or neglect against other residents, in which case you can open a systemic case. If there is not a systemic case needing Ombudsman intervention, explain to the complainant that there is no client for which an issue can be resolved. When the complaint involves abuse, neglect or exploitation as the result of action or inaction on the part of the facility, you may refer the complainant to the Illinois Department of Public Health Central Complaint Registry.

Anonymous Complainants (PPS #106) (PM Pg. 77)

Sometimes a complainant will not give you permission to use their name while investigating or problem-solving. You must respect the complainant's right to confidentiality. However, you should explain to the complainant that complete anonymity can make it very difficult for you to broach the subject of concern with the resident or with staff who could help resolve the issue. It is also a good idea to explain to anonymous complainant that, in some cases, facility staff will know who the resident or complainant is simply by the nature of the complaints.

All Concerns Are Not Cases (PPS #107) (PM Pg. 77)

Complaints may not be appropriate for Ombudsman intervention if they do not directly impact a resident or former resident of a long-term care facility, are outside the scope of the program, or if they would create a real or perceived conflict of interest between an individual Ombudsman or the Ombudsman program and the interests of a resident or residents of long-term care facilities.
In some cases, residents do not want your assistance but just need to voice their concerns to someone who does not live or work in the facility. You can serve as a valuable sounding board while also letting residents know that you are available to assist if they choose to open a case.

Case Study
Anne Walker – Intake

TRAINER'S NOTE: *Play the Texas Long-Term Care Ombudsman Casework: Anne Walker Video, starting at the 2:34 mark and stopping at the 7:37 mark, before the narrator begins to set up the next scene. It may be helpful to have resources regarding residents' rights and nursing home requirements available for reference.*

What was the first thing Gloria did when she went to enter Ms. Walker's room?
TRAINER'S NOTE: *The Ombudsman knocked on the door, announced herself and asked for permission to enter her room.*

When Ms. Walker expressed her concern about not wanting to be identified with the complaint and said residents have been discharged due to sharing their concerns, what else could Gloria have said in response to her statement?
TRAINER'S NOTE: *Gloria assured Ms. Walker that she wouldn't reveal her name without her consent. Additionally, Gloria could have informed Ms. Walker that she has the right to make a complaint, is protected from retaliation and has rights related to discharge.*

What concerns did you hear Ms. Walker expressing in this scenario? Were all of them addressed?
TRAINER'S NOTE: *Her shower time is too early in the morning. She feels the staff are not listening to her and respecting her preferences. She said staff rush her out of bed in the morning and rushed her during and after her shower. Staff have not answered her questions about the shower schedule and one aide treats her like a child.*

Did the Ombudsman explain the resident's rights pertaining to her concerns?
TRAINER'S NOTE: *Yes*

Did the Ombudsman and the resident work on a plan of action together?
TRAINER'S NOTE: *Yes*

What examples of empowerment did you observe?
TRAINER'S NOTE: *By explaining her rights and explaining that by expressing her concerns she may be helping other residents.*

Is the anything that you would have done differently?
TRAINER'S NOTE: *You may want to use this as an opportunity to discuss not sitting on resident's beds.*

Effective Communication Skills:
Gloria used both open-ended and closed-ended questions during her complaint intake.
Use the chart below to identify some of the open-ended and closed-ended questions you heard Gloria ask during both scenarios and describe what information she was trying to obtain with those questions.

QUESTION	TYPE OF QUESTION (OPEN-ENDED OR CLOSED-ENDED)	INFORMATION GAINED
What time do they come to your room?	Closed-ended	What time the aides arrive to take Ms. Walker to the shower.
Why do you think they started coming so early?	Open-ended	Gather more information about the changes in shower time and Ms. Walker's understanding of the changes
When you're in the showers is there anyone else in the area?	Closed-ended	To see if anyone else is in the shower and if so, identify other potential residents to speak with regarding the shower schedule.

MODULE 10

COMPLAINT INVESTIGATION & VERIFICATION

The more dependent we are on the mercy of others, the more waiting we have to endure. Dependence and waiting become synonymous.

Wendy Lustbader

Complaint Investigation
(PPS #110) (PM Pg. 80)

The next step in the Ombudsman problem-solving process is investigation. The purpose of your investigation is to verify the complaint and gather information that will help you resolve concerns.

At a minimum, your investigation must include:

- a face-to-face meeting with the resident(s)
- direct contact with the complainant either by face-to-face meeting, telephone call or letter (unless the complaint is received from an anonymous complainant, the complainant does not wish to be contacted, or the resident phoned in the complaint and agreed that a face-to-face meeting is not needed).

Ombudsmen often receive complaints from residents while making regular presence visits, therefore you will usually meet the requirements for a face-to-face meeting with the resident during your intake process.

Ombudsmen who receive complaints through phone calls to the program office may ask Volunteer Ombudsmen to make a face-to-face visit with the resident.

Ombudsmen may also work with the resident on the phone to resolve problems when a resident is facing a facility-initiated discharge due to nonpayment or if the resident has a concern involving a Medicaid application. If you are a Volunteer Ombudsman and become aware of a situation involving a facility-initiated discharge or a question about a Medicaid application note the request in your case notes and let the Regional Ombudsman Program know of the request as soon as possible.

In addition to the steps listed above, complaint investigation may also require you to:

- conduct an unannounced visit to the facility;
- personally observe the situation;
- interview staff, administration, physicians, other residents and families having knowledge of the problem;
- identify and interview staff from other agencies who have knowledge of the problem or can provide information that would help resolve the problem;
- research relevant laws, rules, regulations, and policies for insight into appropriate responses or solutions to the problem;
- examine relevant clinical, medical, social, financial and other records as approved by your Regional Ombudsman;
- review any other pertinent information that becomes available to you;
- consider if the current problem is part of a larger systemic problem in the facility, corporation, agency or program.

Case Study
Anne Walker – Investigation

TRAINER'S NOTE: *Begin at the 7:37 mark and end at the 13:50 mark*

Why was it important for Gloria to contact her supervisor, Diane, after speaking with Ms. Walker?
TRAINER'S NOTE: *She was considering visiting at an unusually early hour to observe the showering schedule and speak with residents, so she needed to consult her supervisor before her next visit. In speaking with her supervisor, Gloria received additional advocacy tips and Diane's support of her advocacy strategy. Also, since Gloria's informed Diane that she wanted to visit at an unusual time Diane will be prepared in case the facility staff contacted her with a complaint about Gloria's visit.*

Discuss relevant LTCO program policies and procedures regarding LTCO communication and consultation with LTCO supervisors (e.g. required consultation in cases involving abuse, neglect or exploitation or in situations when the LTCO may need to take action outside of routine LTCO procedures).

After talking to her supervisor, what did Gloria do to begin her investigation?
TRAINER'S NOTE: *Observations, interviews, record review (shower schedule)*

How did Gloria use her senses to gather evidence during her visit and complaint investigation related to Ms. Walker's concerns?
TRAINER'S NOTE: *She looked in the showers for evidence of use and observed residents and staff during her early morning visit.*

Why did Gloria visit during the morning shower time?
TRAINER'S NOTE: *She visited during the morning shower time to observe the shower process. Visiting at that time of day can show the Ombudsman the early morning experience, including staffing, from a resident's perspective.*

What challenges might an Ombudsman encounter when visiting early mornings, nights or weekends?
TRAINER'S NOTE: *Staff may pay more attention to Gloria during her visit to see where she goes and which residents she visits and ask questions about why she is visiting at that time. Or the facility may be short staffed making it difficult to enter the facility if the front door is locked or to find staff to respond to questions. Finding managerial staff outside of weekday, daytime shifts may be a challenge or delay the problem-solving process. Communication with facility decision-makers may not occur face-to-face unless the ombudsman also visits during weekday, daytime hours.*

Identify other ways Gloria could approach the investigation of this complaint.
TRAINER'S NOTE: *Gloria could have interviewed other residents about their showering experience and reviewed the shower schedule first then visited during the morning shower time if necessary.*

What does Gloria do to protect Ms. Walker's confidentiality, and what are some other things she could do to ensure Ms. Walker isn't identified as the complainant unless she is ready?
TRAINER'S NOTE: *Gloria visits with residents other than Ms. Walker and when asking them about the bathing schedule and their experience, she does not disclose that a complaint was made or by whom. Gloria does not look at Ms. Walker's medical records.*

Why didn't Gloria review Ms. Walker's care plan to check her preferences about showers?
TRAINER'S NOTE: *In addition to the fact that Ms. Walker's identity would be revealed if Gloria asked for her records, Gloria would need Ms. Walker's permission prior to reviewing her care plan and other records. Since Ms. Walker did not want Gloria to disclose her identity during the initial investigation, she used other strategies such as interviewing other residents and reviewing the shower schedule to gather information.*

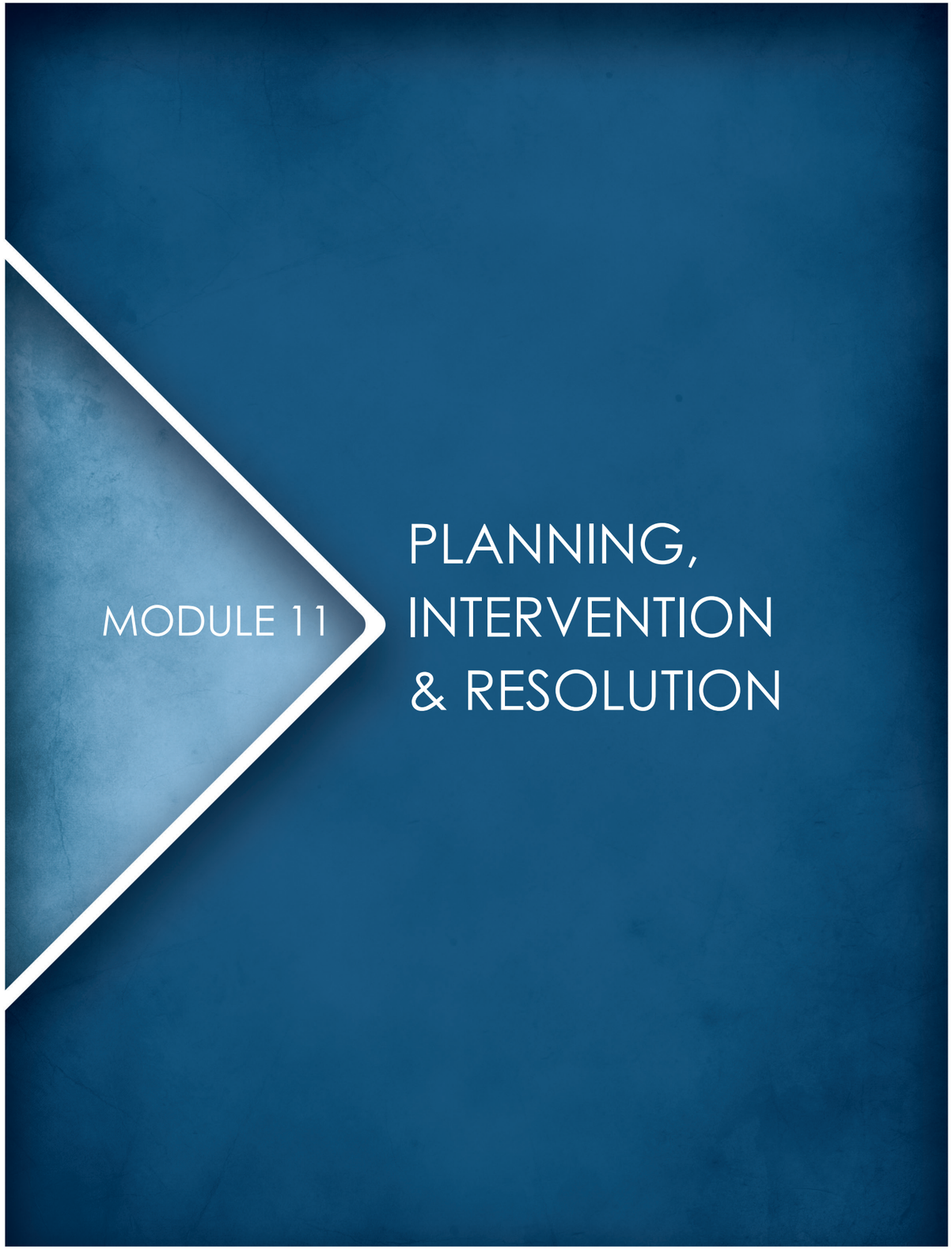
Discuss the Older Americans Act requirements regarding disclosure of LTCO records, access to resident records and relevant LTCO program policies and procedures regarding LTCO access to resident records and the confidentiality of LTCO program records (e.g. how to document cases, what to do with case notes, copies of resident records, and what is considered part of LTCO program records).

Verification of Complaints
(PPS #111) (PM Pg. 81)

You are not required to independently verify a complaint before seeking resolution on behalf of a resident. In your role as a resident-directed advocate, the resident's perception that a problem exists ***and*** the resident's consent to work with you, or to allow you to advocate on their behalf, is all you need to begin the problem-solving process.

Once you have completed your investigation, you will determine whether or not the complaint was "verified." A complaint is "verified" if the investigation found that the circumstances described in the complaint were generally accurate. A complaint is "not verified" if the investigation found that the circumstances described in the complaint were not accurate. Complaints may also be "withdrawn" if the resident requests that the investigation be terminated or if the resident dies and no further investigation is required.

TRAINER'S NOTE: *Before ending the module, offer participants an opportunity to ask questions about the materials covered in this module.*



Planning

Planning Considerations **(PPS #114) (PM Pg. 84)**

When a complaint is verified, you will work with the resident or, if the resident is unable to provide direction, the resident's representative to develop a plan for resolving the complaint. When developing the plan of action, consider the following issues:

- the scope and nature of the complaint;
- the history of the facility with respect to resolution of other complaints;
- available remedies and resources for referral;
- the individual or agency best able to resolve the complaint; and
- the likelihood of retaliation against the resident or complainant.

TRAINER'S NOTE: *Forward to PPS #115.*

Several questions may be helpful as you develop a plan of action:

- Is there a "hidden" or "root" problem that is leading to the current concern?
- What outcome does the resident want?
- Is the resident willing to participate in the problem-solving process? If so, how?
- Who else (besides you and the resident) needs to be involved?
- What are some possible solutions to the problem?
- Of the possible solutions, which one do you want to try first and why?
- What objections might the facility (or others) have to your proposed solution?
- How will you respond to those objections?
- What actions (approaches) will you take to resolve the problem?
- How will you know the problem is resolved?

Planning Outcomes **(PPS #116) (PM Pg. 84)**

The results of your investigation combined with the response of facility staff to the complaint and the satisfaction of the resident with the information gathered during investigation can help you identify a number of problem solving approaches that may be available to the resident.

- Once the facts surrounding the complaint have been investigated and the circumstances surrounding the events described in the complaint have been explained to the resident, you may both agree that no further intervention is necessary.
- If your investigation verifies that the resident's or complainant's concern requires further action, you are required to explain legal, administrative or other remedies that are available to help resolve the problem.

- If the findings of your investigation lead to the conclusion that something must change, you may work with or on behalf of the resident to negotiate an agreement with facility staff or other relevant parties to resolve the problem to the resident's satisfaction. However, you must be careful to never negotiate in a way that will diminish a resident's rights.
- If the complaint involves residents or family members with equal status, you may serve as an impartial mediator to help conflicting parties reach an agreement that resolves the complaint. Because facility staff and family members often have more power than residents, you cannot mediate between a resident and facility staff or family members. An Ombudsman should never mediate a resident's rights away. In other words, do not negotiate a settlement that would reduce or minimize the rights of the resident.
- You may be instrumental in helping a resident assert their right to a fair hearing in cases of facility-initiated transfer or discharge or when appealing the findings of an investigation conducted by the Department of Public Health.
- You may also coordinate referrals to agencies such as the Illinois Department of Public Health, Public Aid, the Centers for Medicare and Medicaid Services, or the Office of Civil Rights. In some cases, you will need to assist the resident by filing a complaint on the resident's behalf.

If a case requires changes to long-term health care policy or to nursing home standards in order to achieve resolution, contact your Regional Ombudsman to learn how your program engages in issue advocacy.

Intervention

(PPS #117) (PM Pg. 85)

TRAINER'S NOTE: *The "Intervention" Power Point slide offers a bullet list of the following interventions. You will need to take the time to describe each intervention to participants.*

Intervention is, quite simply putting your plan of action to work. Your interventions on behalf of a resident may include:

Direct advocacy. Unless the resident helps you identify a better problem-solving strategy, your first action step will be advocating on behalf of the resident with the facility staff person or family member who is the source of concern for the resident. To help achieve resident empowerment, it is useful to ask the resident to accompany you to any meetings with facility staff or family members and to give the resident ample opportunity to express their concern in their own terms. It may be necessary for you to encourage facility staff and/or family members to hear the resident out. Once again, you are not mediating in these situations but are serving as a support system for the resident.

Contacting your Regional Ombudsman. Your Regional Ombudsman should be directly involved in complicated cases involving other agencies, legal action or issue advocacy. Having the Regional Ombudsman involved assures that every appropriate means for representing the resident is employed. You should contact your Regional Ombudsman in each of the following cases before proceeding with problem solving.

- If a request for appeal has been filed in the case of a facility-initiated transfer or discharge.
- If the results of an investigation conducted by the Department of Public health are being appealed.
- If the complaint involves systemic issues that put resident health and safety at risk.
- If the resident has agreed to allow you to make referrals to other agencies.
- When a problem cannot be resolved through any means other than changes in law, policy, or practice.
- When a complaint involves a deficiency related to state or federal laws or the rules or regulations of a government agency.
- When a criminal offense such as theft or assault occurs in a facility.
- In cases where a certified or licensed facility employee (i.e., C.N.A., L.P.N., R.N., Administrator, or licensed social worker) harms or allows a resident to be harmed.
- If negotiations with the facility or referrals to the appropriate government agency fails to resolve a complaint or if the practices, policies, and procedures of a facility or government agency adversely affect the health, safety, welfare or civil or human rights of a resident or class of residents.

Many of the advocacy options for these problems require the assistance of a Regional Ombudsman and/or the Office of the State Long-Term Care Ombudsman. Appropriate management of complicated cases requires:

- Regular and thorough case reviews with your Regional Ombudsman;
- Ongoing communication with the resident or complainant to update the plan of action and to assure that the resident or complainant is interested in pursuing options that involve regulatory agencies, law enforcement, or the possibility of legal action.

Referrals and Joint Investigations. Chapter 500, Section 506 of the Illinois Long-Term Care Ombudsman Program Policies and Procedures Manual provides guidelines for referrals. As a general rule, you will make a referral when:

- the resident asks for a referral
- another agency offers a service that the Ombudsman program does not offer (i.e. finding housing in the community)
- the action to be taken and the complaint is outside of the Program's authority and/or expertise (i.e., Department of Public Health or Department of Healthcare and Family Services takes enforcement actions); or
- an Ombudsman needs additional assistance to achieve resolution of the complaint

Referrals to regulatory agencies. As part of your efforts to empower residents or complainants to engage in self-directed advocacy, you may encourage them to file a complaint with the appropriate regulatory agency. To help assure that complainants file effective complaints, familiarize yourself with and/or refer individuals to the Illinois Department of Public Health Website http://dph.illinois.gov/topics-services/health-care-regulation/complaints.

Information needed to file a complaint

The Illinois Department of Public Health needs to know the who, what, when, where and how.

Who is the resident? Who are the employees involved? Who is the complainant?
What happened to the resident? What are the specific allegations (abuse/neglect, acquired infections or medication error)?
When did this incident occur (date of incident, admission or treatment)?
Where is the facility located (name and city)? Where in the facility did the incident occur (room number, unit, or department)?
How was the resident harmed or potentially harmed?
How was your complaint addressed by the facility?

As an Ombudsman, you may also file complaints with regulatory agencies if you are a *witness* to abuse or neglect by facility staff. Keep in mind that you cannot name a resident, family member, or staff member in your complaint without their permission or consent. All Ombudsman reports to regulatory agencies should be submitted electronically via, e-mail or on IDPH's prescribed form on their website. If you must contact the agency by phone, confirm the referral in writing.

It is important that you help residents or family members focus the narrative of their complaint on a specific failure by the facility and the unacceptable consequences of that failure. At the very least, a complaint to IDPH must also include:

- The date of the report
- The name and phone number of the complainant
- The name and address of the facility
- The nature of the concern, broken down into two statements, repeating these steps until each concern has been addressed in the complaint.:
    - Begin with the first statement with: "The facility failed to...." followed by a brief description of the problem.
    - Begin with the second statement with: "As a result of this failure...." followed by a brief description of consequences to the resident.
- Keep narrative concise so that IDPH intake staff can quickly identify the area of concern.

Referrals to legal services. If a resident is requesting, or in need of, legal advice and representation, the Ombudsman shall assist the resident in finding appropriate legal services. With consent from the resident or representative, the Ombudsman may make a referral to Older Americans Act-funded legal services agencies, Legal Services Corporation-funded legal services agencies, and/or Equip for Equality. If none of these services are able to provide assistance, the Ombudsman may refer the resident or complainant to the local bar association or provide them with a list of at least three private attorneys. An Ombudsman should not recommend an individual private attorney or law practice.

Referrals to other Ombudsman programs. If a resident who is receiving Ombudsman services moves to a different service area they should be referred to the Regional Long-Term Care Ombudsman Program serving that area. The Ombudsman in the receiving service area will follow up with the resident to assure that appropriate Ombudsman services have been received and the original complaint has been resolved.

Joint investigatory activities. At times Ombudsmen are invited to participant in or assist with joint investigations by a regulatory or law enforcement agency. Participation in joint investigatory activities requires that:

- the Ombudsman can fulfill the role of a resident advocate during the investigation;
- the Ombudsman does not to attempt to regulate a facility or take actions that could lead others to assume that the Long-Term Care Ombudsman Program is a regulatory agency;
- the Ombudsman explains to facility administration and residents that his or her role is to advocate for the health, safety, welfare and rights of residents, not to enforce regulations.

Remember, your actions are limited by the consent given to you by the resident. However, in some cases, facility staff, family members or other concerned individuals may contact agencies other than the Ombudsman Program to seek remedies. For instance, any individual can file a complaint with the Illinois Department of Public Health or the Illinois Department of Professional and Financial Regulation. Family members may also choose to call law enforcement or to seek legal counsel without the involvement of an Ombudsman.

Case Study
Anne Walker – Planning and Intervention

TRAINER'S NOTE: *Begin at the 13:50 mark and end at the 20:09 mark*

What options did the Ombudsman give to the resident for resolution?
TRAINER'S NOTE: *Either to address the concern at the Resident Council meeting or to meet with Carol Lee, the Director of Nursing.*

Was Gloria effective in facilitating the conversation between Ms. Walker and the DON, Ms. Lee? Explain your answer.
TRAINER'S NOTE: *Yes, Gloria waits until Ms. Walker gives her a nonverbal cue to share her concerns and then provides an overview of Ms. Walker's concerns. Once Ms. Walker feels comfortable speaking she shares her perspective with Gloria's support. Gloria makes sure all of Ms. Walker's points are addressed, stresses her rights and guides the conversation to a resolution Ms. Walker appreciates.*

How did the Ombudsman respond to the DON's pushback on changing the bathing schedule?
TRAINER'S NOTE: *The Ombudsman treated the DON with professional respect, reiterated the resident's wishes and reminded the DON of Mrs. Walker's right to have her showers at her preferred time.*

Is there anything you would have done differently in this scenario?

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TRAINER'S NOTE: *Highlight how Gloria focused her advocacy on Ms. Walker's preferences and empowered Ms. Walker to share her experience as she facilitated the meeting between Ms. Walker and Ms. Lee. Gloria's decision to advocate for the changes Ms. Walker wanted instead of focusing on the written care plan is an effective strategy as it may be less threatening to staff to hear directly from the resident. Gloria focused on what was most important in this situation: the current shower situation, Ms. Walker's wishes, how the aides interact with Ms. Walker and how to ensure that her bathing preferences are upheld in the future.*

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Resolution
(PPS #118) (PM Pg. 89)

When all work has been completed on a complaint and you are ready to close the case, you will need to code each complaint. Ideally the complaint is resolved or partially resolved, but there are some instances in which all resources have been exhausted and yet the resident is not satisfied or there is no resolution. Volunteers do not have to code complaints. Staff Ombudsmen will learn how to code complaints with documentation training and with technical assistance from the Regional Ombudsman.

- A complaint is "resolved" if the problem was addressed to the satisfaction of the resident or, if the resident was unable to direct, the complainant.
- A complaint is "partially resolved" if the resident or, if the resident is unable to direct, the complainant, is partially satisfied with the results of your casework but some problem remains.
- A complaint is classified as "no action needed" when action is neither needed nor appropriate.
- A complaint is classified as "withdrawn" when the resident or, if the resident is unable to direct, the complainant, asks you to stop work on the complaint prior to resolution or if the resident dies prior to resolution.
- A complaint is classified as "not resolved" when you took action but for some reason the problem was not resolved to the satisfaction of the resident or, if the resident is unable to provide direction, the complainant, or the Ombudsman.

- A complaint is classified as “regulatory or legislative action required” when the complaint is not resolved and resolution would require a change of regulation or law.

A case can be closed when:

- the complaint has been resolved to the resident’s satisfaction;
- you have completed your investigation and determined that the complaint either could not be verified, was not made in good faith or would require additional case work that would not create a satisfactory conclusion, or the complaint is not appropriate for Ombudsman activity;
- you do not anticipate any further response regarding the complaint from the agency to which you referred the complaint; or,
- the resident has asked you to stop working on the problem.

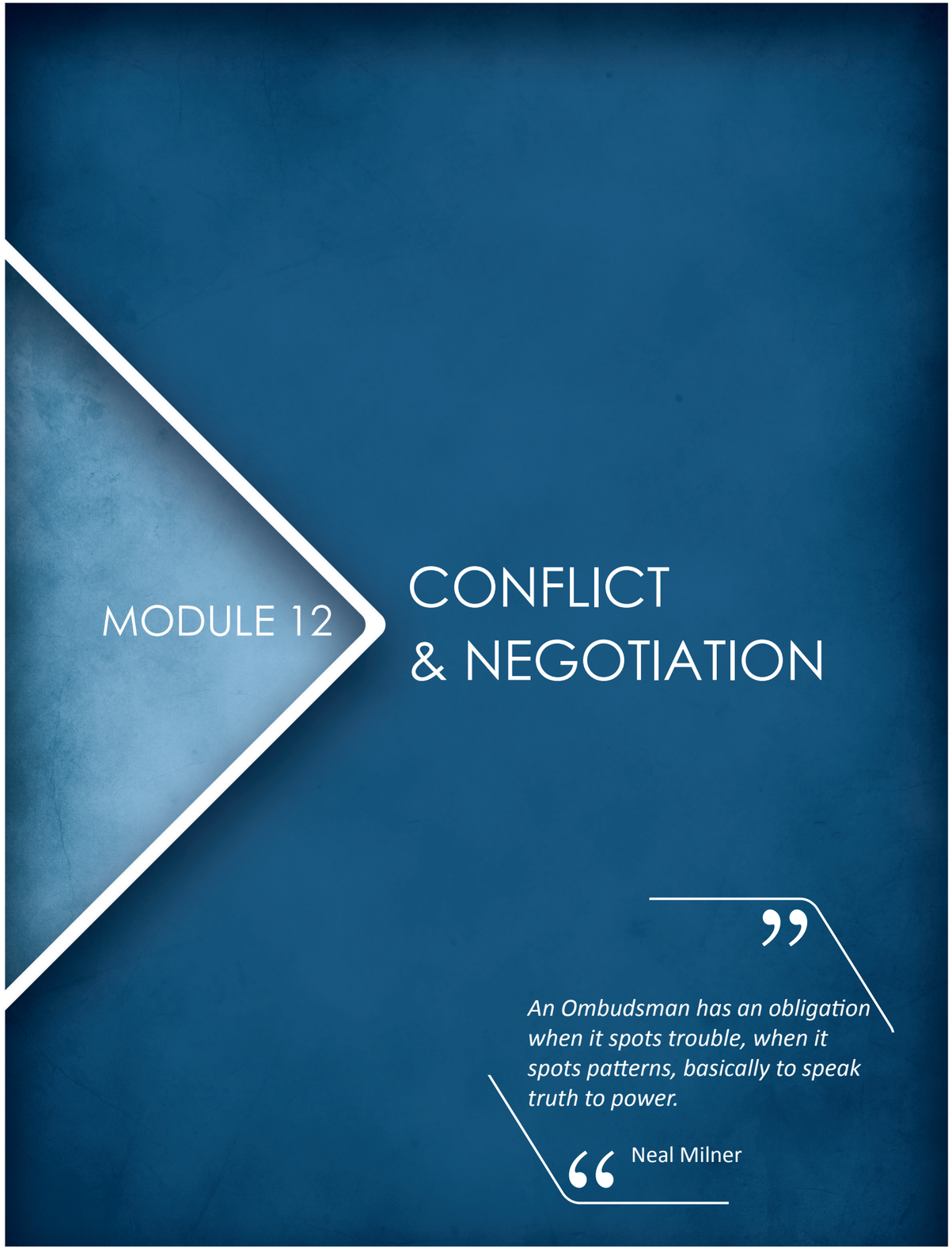
Case Study
Anne Walker - Resolution

TRAINER’S NOTE: *Begin at the 20:09 mark and end at the 20:56 mark*

As you can see from the video, Gloria follows up with resident, Anne Walker to assure her complaints have been resolved. The best way to determine resolution is to go back and visit the resident to see if the concerns have been taken care of. If the resident cannot communicate his or her wishes, then the Ombudsman should seek input from the resident’s representative and/or the complainant to determine if resolution has been met.

TRAINER’S NOTE: *Address the mistake that Gloria made when walking arm in arm with the resident at the end of the video. Ombudsmen should not physically support a resident while walking.*

TRAINER’S NOTE: *Before ending the module, offer participants an opportunity to ask questions about the materials covered in this module.*



Case Study
Brian Brashear

This video was developed, funded and produced by the Texas Department of Aging and Disability Services, Media Services Department in coordination with the Texas Long-Term Care Ombudsman Program.

TRAINER'S NOTE: *Play the Texas Long-Term Care Ombudsman Casework: Brian Brashear Video all the way through and ask the following questions.*

1. What concerns did you hear Mr. Brashear's expressing in this scenario? Were all of them addressed?

Mr. Brashear wants his friends to be able to visit him at any time and he feared being discharged from the facility since the Administrator, Jack Cook, told him he may want to consider moving. He also said that some nurses were ignoring him.

2. What is the PEP method? Point, Evidence, Repeat Point

3. How did Gloria address Mr. Brashear's concerns in relation to his rights and the other residents' rights when speaking with the Administrator, Mr. Cook? Was that effective? Explain your answer.

Gloria was very clear about Mr. Brashear's right to visitors and asserted that Mr. Brashear and his guests understood that they should not interfere with his roommate and other residents' rights. She also recognized, however, that Mr. Brashear's roommate indicated that he also enjoyed the visits by Mr. Brashear's friends. Yes, it was effective as she demonstrated that Mr. Brashear and his visitors were respecting the rights of others, yet Mr. Brashear's rights to visitors was not supported by the staff.

4. How did Gloria ensure her complaint investigation was resident-directed while reminding Mr. Cook of the need for resident-directed care and quality of life? How did this impact her credibility with Mr. Brashear? With Mr. Cook?

Gloria informed Mr. Brashear of how she wanted to proceed and asked for his permission before speaking with the Administrator. She invited Mr. Brashear to come with her to talk to Mr. Cook. She encouraged Mr. Cook to speak directly with Mr. Brashear to assure him he wasn't being discharged. Her ability to remain objective and resident-directed enhanced her credibility with both Mr. Brashear and Mr. Cook.

5. As it states in the video, LTCO need to remain "calm, objective and in control" at all times, especially when a situation has escalated. When speaking with Mr. Cook, what techniques did Gloria use, both verbal and nonverbal, to maintain her professionalism and remain calm, but assertive?

Gloria kept her hands in her lap and looked relaxed. She did not raise her voice or interrupt the Administrator. She was professional and courteous, but directly stated Mr. Brashear's concerns, his rights and her concerns with the facility response. She acknowledged the challenges Mr. Cook deals with in running a long-term care facility and that they both have the same goal, to meet the needs of residents.

6. In the follow-up conversation with Mr. Brashear and Mr. Cook, how did Gloria demonstrate her support of Mr. Brashear when facilitating that conversation? Why was that important?

To open the follow-up conversation, Gloria clearly stated Mr. Brashear's concerns and paraphrased her previous conversation with Mr. Cook. After Mr. Brashear shared his perspective, Gloria reiterated that she shared his concern about Mr. Cook's suggestion about moving out and persisted until Mr. Cook assured him that he would not be discharged and his rights to visitors would be supported. Gloria's obvious support was important since the LTCO is the resident advocate and her support encouraged Mr. Brashear to share his perspective.

7. Is there anything you would have done differently in this scenario?

In addition to discussing the other concerns, Gloria could have asked more questions about the night nurse that ignored Mr. Brashear to see if that happened often and if other staff did the same thing in order to address the attitude of staff members towards Mr. Brashear.

Gloria should have gone back to the resident to receive permission to bring the administrator back to the resident's room particularly because the resident made it clear in their initial conversation that he did not want to meet with the administrator.

8. What are your "take away" points from this segment?

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TRAINER'S NOTE: *Emphasize how critical it is for LTCO to "do their homework and build their case" before moving to resolution. Remind the trainee that LTCO staff are available to support them when they need assistance (e.g. consultation regarding a case before meeting with residents, family members or staff). Prior to speaking with Mr. Cook, Gloria made sure she had the information she needed. She understood the residents' rights and facility requirements involved in this situation and based on Mr. Brashear's direction she knew what she wanted to accomplish during the meeting. Due to her preparation, she was confident, stayed on track during the meeting and was an effective advocate.*

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MODULE 13

QUESTIONS OF CAPACITY AND COMPETENCY

As an Ombudsman it is your mission to recognize and expand a resident's self-autonomy as much as possible. This effort requires you to support the right of the resident to make decisions without coercion or restraint as long as those decisions do not impose on the rights of others.

The Ombudsman Program is built on the basic principle of resident empowerment. Some residents will not complain about their quality of life or quality of care because they do not know their rights, they do not think it would do any good to complain, or they fear retaliation. However, other residents may lack the decision-making capacity, or even the legal competence, to effectively participate in decisions about their own health care and quality of life.

As an Ombudsman it is your mission to recognize and expand a resident's self-autonomy as much as possible. This effort requires you to support the right of the resident to make decisions without coercion or restraint (called *decisional autonomy*) as long as those decisions do not impose on the rights of others. You must also be able to work around obstacles that impede the resident's ability to carry out their decisions (called *autonomy of execution*).

Decision Making Capacity & Competence

This section will explain the differences between decision making capacity and competence.

Decision Making Capacity (PPS #122) (PM Pg. 96)

One of the most frequent obstacles you will encounter to resident autonomy is the perception by medical professionals, facility staff, and family members that the resident lacks *decision making capacity*. Therefore, it is important that we discuss what is meant by the terms *decision making capacity* and *legal competence*.

As used here, decision making capacity is a term used to describe the ability of a person to make an informed decision. At a minimum, decision making capacity depends on:

- the ability of the individual to understand information relevant to the choice at hand;
- the ability to think about choices in the context of their own personal values and goals; and
- the ability to communicate decisions to caregivers through verbal or nonverbal means.

Extending Decision Making Capacity (PPS #123) (PM Pg. 96)

Ombudsmen can help stretch the limits of decision making capacity by assuring that:

- *all* of the choices and their consequences are presented in language that the resident can understand;
- *all* choices and their consequences are discussed fairly and evenly;
- the resident is given additional information to help him or her understand difficult concepts;
- the resident is given an opportunity to consult with any individual they would normally consult when making important life decisions;
- the resident is given ample time to consider every alternative; and
- the resident is not being unduly influenced by medical professionals, facility staff, or family members to choose one alternative over another.

Fortunately, lacking complete decision-making capacity does not necessarily mean that a resident does not have the capability – and the right – to participate to some extent in decisions about issues that affect their quality of life. Ombudsmen should help residents exercise as much decision-making power as possible. If you are unsure about a resident's decision-making capacity (or the status of the resident's legal competence, explained below), consult your mentor or Regional Ombudsman for guidance.

Competence (PPS #124) (PM Pg. 97)

It is also important to understand the term incompetent as it is used here. A person may be deemed legally incompetent (to a greater or lesser degree) through the legal procedures usually done in connection with a guardianship hearing, which is described in greater detail below. A person deemed incompetent by a court loses some or all of their legal rights to make decisions for themselves.

Advocating When Decision Making Capacity is Unclear (PPS #125) (PM Pg. 97)

In cases where the resident has not been deemed legally incompetent, but where the decision-making capacity of a resident is unclear, you will have to make a good faith judgment as to a resident's ability to participate in decisions based on the issue the resident is facing. For example, a resident may not know what year it is, but might still be able to indicate a preference whether or not they want to visit a specific friend or family member.

If a resident lacks decision making capacity and you have concerns about their care or quality of life or what direction to take, understand that Ombudsmen still advocate for and follow the resident's wishes to the extent that the resident can express them, even if the resident has limited decision making capacity.

You may also ask facility staff to provide you with the name and phone number of the resident's legal representative (this could be a health care agent, a court appointed guardian, or a health care surrogate as described below) for further direction.

Legal Representatives

This section will explain the differences between agents under a power of attorney, court-appointed guardians, and health care surrogates.

Powers of Attorney (PPS #126) (PM Pg. 97)

An *agent under a power of attorney* is appointed by the individual his or herself (in this role called the "principal"), and holds shared or delegated authority. The Illinois Power of Attorney Act (755 ILCS 45/1-1 *et seq.*) describes the breadth of authority and fiduciary duties of the agent under such a document.

An agent under a power of attorney can only be appointed by the principal if the principal retains sufficient decisional capacity to understand what they are doing (e.g., has decision-making capacity).

With the execution of the power of attorney document (which may be for health care or property), the principal is voluntarily sharing decision making authority with an agent, unlike a guardianship, where a court has removed some or all of the person's own decision-making authority. This is the key difference between the authority of an agent and that of a guardian.

There is often confusion over when the decision-making authority of the agent under a power of attorney takes effect. Unless the document spells out a later date or event (such as "when the physician has determined I lack the capacity to make my own health care decisions"), the authority of the agent starts immediately. However, as long as the principal can make and communicate their own decisions, that principal has the right to overrule either the health care or property agent.

Once a power of attorney document takes effect, the agent has the obligation to make decisions in accordance with the principal's wishes and belief systems. The agent must first look to specific instructions (some of which might be contained within the document itself), the principal's own moral values and philosophy, and then, finally, if the agent cannot determine the answer based on those, what is in the principal's best interest.

The principal retains the right to revoke a health care power of attorney at any time regardless of their physical or mental condition (this is not true of property powers of attorney). However, while a resident who is incapacitated may revoke a health care power of attorney, a lack of decisional capacity may, under the law, prevent them from naming a new health care agent.

Obviously, if a person has declined in terms of decision making capacity to the point where that person cannot validly appoint an agent, then the only recourse for family or caregivers is to go to court ask the judge to appoint a guardian.

Guardians (PPS #127) (PM Pg. 98)

The guardianship statute (Article 11a of the Probate Act, 755 ILCS 5/11a-1 et seq.) provides that the court may appoint a *guardian* for individuals who have been determined to be incapable of managing their own affairs. This is a process that involves the submission of a written medical statement, sometimes testimony from physicians or others, reports from a guardian *ad litem* (GAL), and the determination by the court as to whether the individual (the "alleged disabled adult") needs a decision maker appointed.

Unlike an agent under a power of attorney, the guardian is appointed by the court and assumes (to a greater or lesser extent) the decision-making authority of the "alleged disabled adult," who (upon the appointment of a guardian) is then referred to as the "ward."

The guardian is authorized, either on a limited basis or (more often) on a plenary (broad) basis to make decisions for the ward. The guardian may be a "guardian of the person" or a "guardian of the estate" (sometimes the same person is appointed to be both). The guardian of the person handles the health care and personal care needs of the ward and the guardian of the estate handles property and financial matters.

Only a court can appoint a guardian of the person or a guardian of the estate for an individual; thereafter the guardian is responsible to the court for as long as the guardian is exercising authority.

The guardian statute provides that any "reputable person," the alleged disabled adult him or herself, or the court (on its own motion) may initiate the petition to have a guardian appointed for the alleged disabled adult (755 ILCS 11a-3(a)). While the statute allows essentially any person to initiate a guardianship petition, it does impose several restrictions on which person or entity may be actually appointed the guardian (755 ILCS 11a-5(a)). These include that the guardian must be at least eighteen years of age, not adjudicated an alleged disabled adult, not a felon (although this can be waived by the court), and capable of making a suitable plan of care and protection to the alleged disabled adult. Certain not-for-profit organizations may be appointed as guardians; a bank trust department may be appointed as a guardian of the estate. However, a facility providing residential care to the alleged disabled adult, such as a nursing home, may not be appointed as a guardian (755 ILCS 11a-5(b)).

When a judge has signed a guardianship order appointing a plenary guardian for a resident, that guardian holds the full range of decision making authority for that resident. Sometimes courts issue limited guardianship orders, where the authority of the guardian is narrower, but these are much rarer.

Health Care Surrogates (PPS #128) (PM Pg. 99)

Finally, a *health care surrogate* is a person designated by an attending physician, pursuant to the Health Care Surrogate Act (755 ILCS 40/1 et seq.), to make health care decisions for an individual lacking decisional capacity to appoint an agent, has no court appointed guardian, and yet needs someone to make health care decisions.

A health care surrogate is a person designated by an attending physician, in concert with at least one other physician, to make decisions for a person who can no longer make decisions. The Illinois Health Care Surrogate Act itself defines a hierarchy of individuals who may be designated by the physicians to make legally binding decisions for the incapacitated person.

Working with a Legal Representative (PPS #129) (PM Pg. 99)

You will often work with clients who have either an agent under a power of attorney, a guardian, or a health care surrogate. While you will learn more about working with these clients and their representatives, it is important even at the entry level that you understand who has the power to make decisions on behalf of residents.

Residents who have a legal representative with decision-making power may still retain some capacity to participate in their own care. In other cases, you will have to weigh the resident's decision-making capacity. You may also find that you must work with an agent, guardian, or health care surrogate to assure that the resident maintains as much autonomy as possible.

Either you or the Regional Ombudsman may call the resident's representative to learn if the resident's representative shares your concerns and would accept Ombudsman assistance in resolving those concerns. The Illinois Long-Term Care Ombudsman Program Policies and Procedures Manual also allows you to ask legal representatives and family members what the resident's preferences would have been in each situation.

Based on the information you receive, you may begin advocacy on the resident's behalf. If you are unable to get clear direction from the resident's representative, you may assume that the

resident would want you to advocate for their health, safety, and welfare as well as the protection of their rights.

It is always the goal of the Ombudsman Program and individual Ombudsmen to assure that residents exercise as much power over their own lives as possible. We are not advocates for the best interest of the resident; we are resident-directed advocates.

Case Study
Mrs. Smith[3]
(PPS #130) (PM Pg. 100)

You are visiting a nursing facility when a resident, Mrs. Smith, stops you in the hall. She is dressed in clothing that is too big and the colors of her skirt and blouse clash. You remember her from previous encounters. She always seems to have a series of "problems." No one in the facility takes her seriously.

After asking you if you've been in the facility before, she emphatically tells you that she can't tolerate her roommate. She wants another one; the home will just have to find somewhere else to move the lady who is in Mrs. Smith's room now!

There's one more thing Mrs. Smith wants you to know: the nurse is trying to force her to take drugs that dope her up. She has managed to outsmart the nurse so far, but she doesn't know how much longer she can continue before the nurse starts trying to slip the pill in her food! Mrs. Smith mumbles something about the nurse claims her doctor ordered the pill for the pain in her leg.

Mrs. Smith asks if you can help her with these problems.

Is the staff treating Mrs. Smith as if she were had decision making capacity? If no, in what ways?
TRAINER'S NOTE: *By not taking Mrs. Smith seriously, staff may be signaling that they believe her requests are unrealistic or that her decision-making capacity is questionable. Staff failure to discuss care preferences with Mrs. Smith may also be a signal that they feel she has limited decision making capacity. Mrs. Smith is doing her best to resist taking medications that make her feel "doped up."*

How might you decide whether Mrs. Smith has decision making capacity?
TRAINER'S NOTE: *By having a more in-depth conversation with Mrs. Smith In any case, it is the Ombudsman's role to support Mrs. Smith's autonomy to the greatest extent possible.*

Are any of Mrs. Smith's rights being violated?
TRAINER'S NOTE: *The right to have her concerns addressed, to be treated with dignity and respect, and the right to be informed of or refuse medical treatment.*

How do you balance Mrs. Smith's rights and the rights of other residents?
TRAINER'S NOTE: *Ask for Mrs. Smith's permission to talk with her roommate to determine how to best address both Mrs. Smith's rights and the rights of her roommate. Often, the resident who complains about a roommate is the resident who is moved to another room.*

Do you see any ethical dilemmas or concerns in this case?
TRAINER'S NOTE: *Those associated with residents' rights violations.*

Case Study
Mrs. Jones
(PPS #131) (PM Pg. 101)

Mrs. Jones has Alzheimer's disease and lives in a nursing home. Her daughter, Mary, who is also her Agent under a Power of Attorney for Healthcare, is concerned that her mother is being over-medicated. The facility says that Mrs. Jones is "sundowning," that she is agitated and strikes out at others. They have told Mary that her mother is a danger to other residents. Mary disagrees. The facility says that if Mary does not consent to drug treatment for her mother, Mrs. Jones will have to leave.

Is the staff treating Mrs. Jones as if she had decision making capacity? Why or why not?
TRAINER'S NOTE: *No. Dealing with the Agent instead of the resident. Possible overmedication.*

How might you decide whether Mrs. Jones has decision making capacity?
TRAINER'S NOTE: *An Ombudsman should visit Mrs. Jones to determine her level of decision making capacity.*

Are any of Mrs. Jones rights being violated? Which ones?
TRAINER'S NOTE: *Yes. The right to refuse treatment and her right to stay in the facility. This concern should be care-planned. If Mrs. Jones is incapacitated, her Agent has the right to make medical decisions for her.*

How do you balance Mrs. Jones rights and the rights of other residents?
TRAINER'S NOTE: *Mrs. Jones does have a right to stay in the facility and to be free from treatment with psychotropic medications. The facility should work with the Agent to determine why the resident has become agitated, when and where it is occurring and exactly what is occurring. Once an assessment is done, the Agent and the facility should determine appropriate interventions. However, the facility must also protect the safety of other residents. Again, this issue should be care-planned and part of the plan should include keeping the other residents safe.*

Do you see any ethical dilemmas or concerns in this case?
TRAINER'S NOTE: *Overmedication, threat to discharge, protecting other residents.*

TRAINER'S NOTE: *Before ending the module, offer participants an opportunity to ask questions about the materials covered in this module.*

MODULE 14

RESPONDING TO RESIDENT ABUSE, NEGLECT, AND EXPLOITATION

I felt trapped, scared, used and frustrated. When a man feels helpless, it's terrible.

Mickey Rooney testifying at a 2011 congressional hearing on elder abuse

Responding to Resident Abuse, Neglect and Exploitation
(PPS #133) (PM Pg. 137)

The Illinois State-Long-Term Care Ombudsman Program Policies and Procedures Manual provides standards for engaging in advocacy around issues of abuse and neglect.

Ombudsmen Are Not Mandated Reporters (PPS #133) (PM Pg. 104)

Keep in mind that you, as an Ombudsman, are the resident's representative. Therefore, you may only report abuse, neglect, or exploitation if the resident:

- understands the facts;
- is expressing free choice;
- understands the risks and benefits both of reporting and of failing to report suspected abuse and neglect;
- agrees to allow you to release his or her name and any other information that would help assist with investigation of the complaint.

When a complaint or investigation reveals that a resident may be experiencing abuse, neglect, or exploitation, it is important for you to encourage the resident, complainant or any witnesses to the event to call the Illinois Department of Public Health (IDPH) and law enforcement immediately. You may offer assistance to anyone who wants to report abuse.

If the complainant is a mandated reporter, instruct them to file a complaint with the appropriate authority under Illinois law (Abused and Neglected Long-Term Care Facility Residents Reporting Act, [210 ILCS 30/4]) This statute mandates many categories of persons having contact with residents of long-term care facilities to report suspected abuse or neglect.

When a Resident Refuses to Report (PPS #134) (PM Pg. 104)

If a resident who is able to provide direction refuses to give you permission to report suspected abuse, neglect, or exploitation you should try to figure out why the resident is refusing to let you report the situation. It may help you understand the resident's wariness if you are able to learn more about:

- the facility's past response to complaints;
- the resident's relationship with staff;
- the resident's past experiences with filing complaints in this or other long-term care facilities.

If the resident continues to refuse to file a report or allow you to file a report on their behalf, you may not do so. However, if the complaint has the potential to affect other residents in the building, your Regional Ombudsman may direct you to open a systemic case and ask you to interview other residents to determine if anyone else is at risk.

When a Resident is Unable to Report Abuse (PPS #135) (PM Pg. 105)

If the resident is unable to report the abuse themselves, ask the resident's representative for permission to report the abuse to the appropriate agency or authorities.

If the resident is unable to direct you, you should:

- check to see if the resident has a guardian or another representative;
- encourage the guardian or representative to report the abuse or ask for consent to report the abuse;
- remind anyone who has knowledge of the abuse about the reporting requirements set forth by Illinois law.

If there is no guardian or representative and the Ombudsman has reason to believe that the resident is a victim of abuse, neglect and/or exploitation, contact the Office to discuss the case, seek guidance and get approval to take further action.

Financial Exploitation & Facility-Initiated Discharges
(PPS #137) (PM Pg. 105)

Ombudsman are often alerted to the possibility of financial exploitation when the resident's bill is not being paid and the facility issues a notice of a facility-initiated transfer or discharge. These cases can be quite cumbersome and time-consuming. For the Ombudsman to approach a resident to offer assistance, the resident should be informed by the facility staff that there is a problem with the bill. It is never the job of an Ombudsman to notify a resident about a facility-initiated transfer or discharge.

If you learn that a resident who is incapable of providing direction is being financially exploited, encourage the complainant to notify the facility and to contact law enforcement. Next, consult with the Regional Ombudsman to ascertain additional steps such as contacting the resident's representative, facility staff or making a referral.

Case Study
Financial Exploitation
(PPS 138) (PM Pg. 105)

Mrs. Baker was admitted to ABC Nursing Home in July for physical therapy following hip replacement surgery. By September, it became clear that Mrs. Baker was unable to progress any further and her physical therapy was discontinued. As a result, Medicare is no longer paying for Mrs. Baker's stay at the facility. Mrs. Baker's son, Jack, was supposed to manage Mrs. Baker's money while she is in the facility. It is now January and Mrs. Baker has an overdue bill of $15,423. On your most recent visit to the facility, the social services director, Amy, asked you for advice. In the course of your conversation with Amy, you learn that Jack has not paid any of Mrs. Baker's bill and has not made any attempt to apply for Medicaid. Amy tells you that Mrs. Baker owns

a large farm with land currently in production. Although Mrs. Baker is facing a facility-initiated discharge for non-payment, neither Amy nor the facility administrator has discussed the overdue bill with Mrs. Baker.

What should the Ombudsman do?
TRAINER'S NOTE: *The Ombudsman should tell the Social Services Director to discuss the concern with the resident and could offer to go with her to talk to the resident. However, it is not the responsibility nor the role of the Ombudsman to break the news to the resident. The resident has a right to know about her finances and the right to choose a new agent under a POA or another person to assist her with her finances. This could be resolved before and IVD is issued.*

If Mrs. Baker has been given a notice of a facility-initiated transfer or discharge, the Ombudsman should visit to assure that Mrs. Baker knows that she has the right to appeal. If Mrs. Baker chooses to appeal, the Ombudsman can help assure that the appeal is filed properly. The Ombudsman can also talk with Mrs. Baker about naming a new power of attorney. If Mrs. Baker says that she would like to name a new POA, the Ombudsman can facilitate by working with facility staff or helping Mrs. Baker contact an attorney of the resident's choice.

What should the facility do?
TRAINER'S NOTE: *The administrator or his/her designated representative should discuss the bill with Mrs. Baker. In addition, Mrs. Baker needs to know that she can change her Agent under a Power of Attorney for Property. If she chooses to do this, facility staff can provide assistance. It is very unlikely that Mrs. Baker would qualify for Medicaid, but facility staff could explain this option as well.*

TRAINER'S NOTE: *Be sure to explain that Ombudsmen must have resident consent to contact law enforcement. However, facility staff may contact law enforcement without resident consent.*

Criminal Activities in Long-Term Care Settings
(PPS #139) (PM Pg. 106)

As you learned earlier, long-term care facilities are not always free of crime. Sometimes Ombudsmen become aware of a crime or a pattern of criminal activity in a long-term care setting because residents or family members disclose such concerns.

Section 1150B of the Social Security Act requires that any individual who is an owner, operator, employee, manager, agent or contractor of a long-term care facility receiving at least $10,000 annually in Federal funds under the Affordable Care Act report any reasonable suspicion of a crime committed against an individual who is a resident of, or receiving care from, a long-term care facility to at least one local law enforcement entity and the State Survey Agency (the Illinois Department of Public Health). With proper permission, Ombudsmen may work with the resident, the resident's legal and facility staff to assure that criminal activities are appropriately reported to local authorities and the Illinois Department of Public Health.

Case Study
Criminal Activity
(PPS #140) (PM Pg. 106)

TRAINER'S NOTE: *Use the following case study to discuss how Ombudsmen should respond to allegations of criminal activity in nursing homes.*

What should the Ombudsman do?

TRAINER'S NOTE: *The Ombudsman should explain the program, including confidentiality, resident-directed advocacy, and the facility's obligation to report and investigate all allegations of abuse or injuries of unknown origin. The Ombudsman should then ask Mrs. Jackson to take the Ombudsman to the resident's room to confirm she is not able to provide direction. If the resident is not able to provide direction, offer to accompany Mrs. Jackson to the administrator's office to discuss her concerns and to find out what, if anything, the facility has done to address the complaint. Inform the complaintant of her options to file a complaint with IDPH and to request a care plan meeting.*

During a regular presence visit to a facility, you meet Mrs. Jackson, who tells you that she believes her mother, Mrs. Brown, (who is noncommunicative and non-ambulatory) was sexually assaulted. Mrs. Jackson has noticed that Mrs. Brown has become agitated when staff are providing personal care.

Furthermore, Mrs. Jackson explained that she was in the room yesterday when staff were changing Mrs. Brown's clothes. At that time, she noticed that Mrs. Brown had substantial bruising on her upper and inner thighs. Mrs. Jackson has shared her concern with the facility social service director and the facility administrator but they have not been willing to discuss the allegation of abuse.

TRAINER'S NOTE: *Before ending the module, offer participants an opportunity to ask questions about the materials covered in this module.*

MODULE 15

INTRODUCTION TO DOCUMENTATION

Factual documentation is vital because it paints a clear picture of the resident's concern and the steps the Ombudsman took toward resolution of the issue.

Jessica Belsly,
Illinois Ombudsman Specialist

Documentation Requirements
(PPS #142) (PM Pg. 108)

TRAINER'S NOTE: *Although you may have provided documentation training during your supervised facility visits, it is a good idea to discuss the importance of documentation with Ombudsman candidates. This module also gives you an opportunity to discuss any local documentation requirements that may not have been covered in the field or classroom.*

During your mentoring visits, you may have been introduced to local forms that are used to gather information about your activities and visits. Illinois Long-Term Care Ombudsman Program Policies and Procedures, require that Ombudsmen regularly enter activity data and case documentation into a program called "PeerPlace." Volunteer Ombudsmen are required to provide written reports that are used by staff Ombudsmen to enter volunteer information into PeerPlace, thus meeting reporting requirements.

All program records are the property of the State Ombudsman. All program records are confidential. Only certified Ombudsmen are allowed access to program records. Program records include all files, records, correspondence, documentation, case notes and communications related to a specific case or resident. Program records collected in PeerPlace are used to generate reports that provide a record of all Ombudsman Program activities and cases. Reports, such as the Benchmark Report, are created by the State Office and are provided to your Area Agency on Aging, provider agency, and to the Regional Ombudsman Programs.

An annual report of state-wide data is collected from PeerPlace and submitted to the Administration for Community Living (ACL).

Ultimately, the compiled data is used to demonstrate problems in long-term care facilities, to develop programs that target areas of particular concern in long-term care facilities and to engage in resource and fiscal planning for Ombudsman programs.

On a more practical level, providing documentation and engaging in regular case reviews with your supervising Ombudsman makes it easier for Ombudsmen to work together to develop appropriate plans of action for case resolution. Sharing information also helps assure continuity of advocacy should you become ill or unable to perform your duties as an Ombudsman.

Information Collected (PPS #143) (PM Pg. 108)

TRAINER'S NOTE: *The "Information Collected" PowerPoint slide only provides a list of terms. You will need to explain each of the categories of information collected as described below.*

Activities. There are a wide variety of activities entered into the documentation system. Those activities include, but are not limited to, consultations, continuing education, facility in-service training, and community education. All activities must be entered into the system within 15 days of occurrence.

Consultations. Consultations are the provision of information and assistance to individuals regarding long-term care facilities and resident services which does not involve investigating

and working to resolve complaints (i.e., a consultation is not a case). A consultation may include when the Ombudsman refers someone with a concern to another agency and is not actively involved in investigating and working to resolve the problem.

Consultations are usually discussions with residents, family members, facility staff or the public in which we answer questions about the Ombudsman Program, residents' rights, advance directives, complaint process, choosing a nursing home, Medicare/Medicaid, community services and more.

Cases. Cases are defined by ACL as an "inquiry brought to, or initiated by the Ombudsman on behalf of a resident or group of residents involving one or more complaints which requires opening a case and includes Ombudsman investigation, strategy to resolve, and follow up."

Complaints. Complaints are defined by ACL as, "a concern brought to, or initiated by, the Ombudsman for investigation and action by or on behalf of one or more residents of a long-term care facility related to health, safety, welfare or rights of a resident. One or more complaints constitute a case."

There are several complaint codes in PeerPlace. These codes provide a system to track the types of complaints received by Ombudsmen and the rate of success Ombudsmen have in resolving those problems.

Case Documentation. PeerPlace provides a centralized location for case documentation. All information pertaining to a case must be entered into the system within 30 days of occurrence.

Verification Codes. Staff Ombudsmen must code each complaint as either "verified" or "not verified", based on interviews, observation, and investigation.

Disposition Codes. As you learned earlier, complaints may be resolved, partially resolved, not resolved, withdrawn, or referred for other action. Sometimes the disposition code is "no action needed or appropriate". The final status, or disposition code of each complaint within a case is entered into PeerPlace. Disposition codes include:

- Complaint resolved to the satisfaction of the resident.
- Case partially resolved but some problem still exists
- Complaint not resolved to the satisfaction of the resident or complainant
- Complaint withdrawn by the complainant or resident died before the case could be resolved.
- Complaint referred to another agency
- No action was needed or appropriate
- The need for policy or regulatory changes to resolve the complaint.

Training Requirements **(PPS #144) (PM Pg. 110)**

Level I
Before becoming a certified Ombudsman, and individual must complete Level I Training and at least four hours of mentoring in long-term care facilities by an experienced Ombudsman.

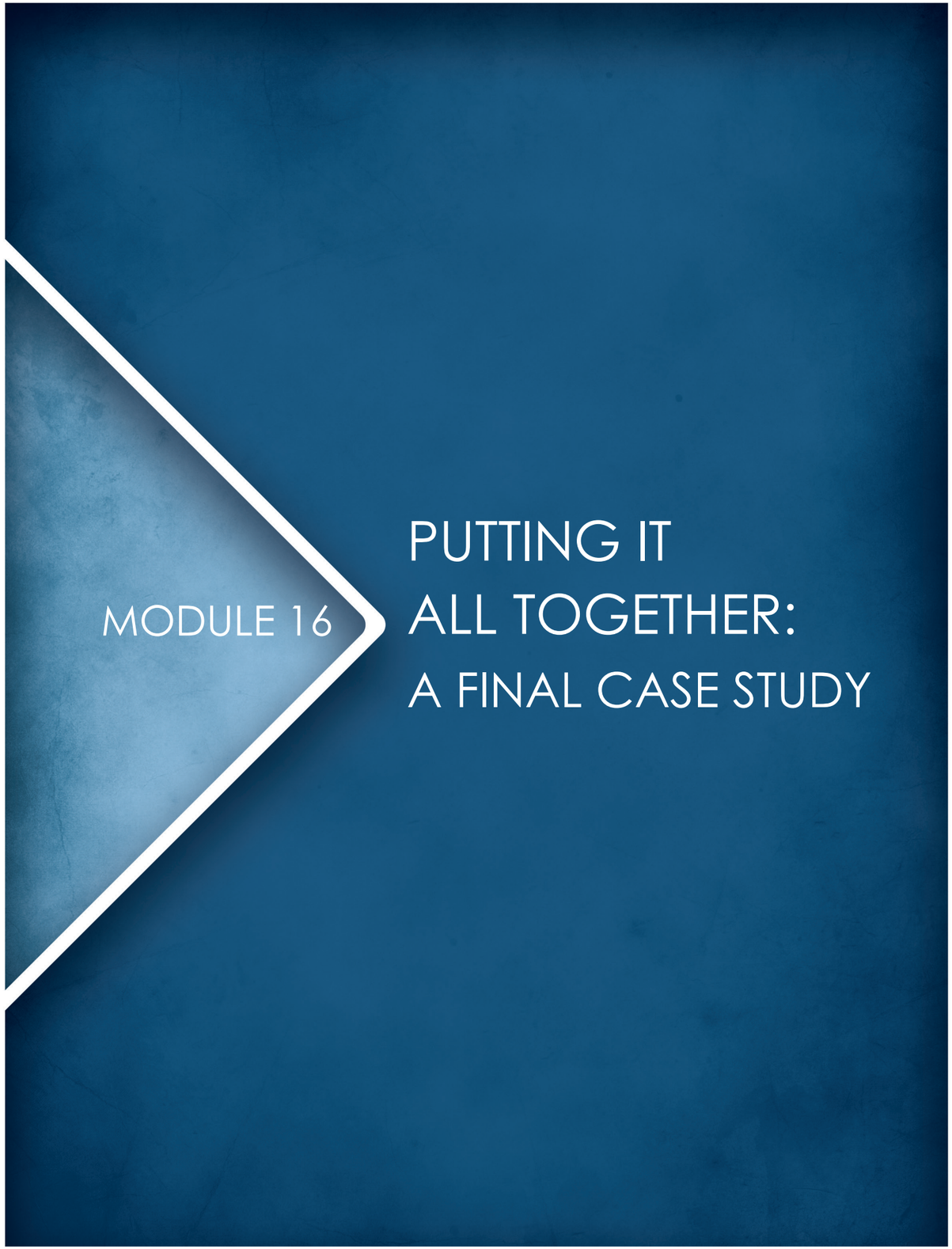
Level II
Within eighteen months of certification, all Ombudsmen must complete Level II Training.

Continuing Education
Regional Ombudsmen must complete eighteen hours of continuing education per each federal fiscal year.

Staff Ombudsmen must complete ten hours of continuing education per each federal fiscal year. Volunteer Ombudsmen must complete six hours of continuing education per each federal fiscal year.

All continuing education must be documented in PeerPlace.

TRAINER'S NOTE: *Take some time to discuss local forms and to share your expectations about documentation. If your program provides documentation training during supervised facility visits, this is a good time to fill in any gaps that may have occurred in documentation training in the field. Before ending the module, offer participants an opportunity to ask questions about the materials covered in this module.*



Case Study
Jack Smith

Intake:

Sandra Peters makes a call to the Regional Ombudsman Program saying that her father, Jack Smith, is living at ABC Nursing Home. According to Sandra, after Jack's wife died 6 months ago, Jack was no longer able to care for himself at home. He began to wander through other people's yards saying that he was looking for his wife. He received Meals on Wheels but still was not eating regularly. He often complained of dizziness and had several falls in his home. Sandra made sure that Mr. Smith had help in the home but he still seemed unable to manage his medications. After several hospitalizations, Mr. Smith's doctor insisted that he be placed in a nursing home. According to Sandra, when she visits, she often finds Mr. Smith unkempt, agitated and angry. She stated that when she tries to help clean him up, he becomes "even more agitated". Sandra stated that her father also refuses to eat meals in the dining room with other residents. Sandra indicates that she has tried to talk with the CNAs about Mr. Smith's care but he never seems to have the same aide from day to day. Furthermore, every time she has tried to talk with the Administrator or Director of Nursing, they are either dealing with a crisis in the building or unavailable. According to Sandra, the nursing home staff recently told her that she should visit less often. Sandra has given the Ombudsman permission to tell Mr. Smith that she called and that she is concerned about him.

Investigation:

With permission, the Ombudsman visited with Mr. Smith in his room. The Ombudsman observed the resident to have uncombed hair, dirt under his fingernails and stains on his shirt. There was a urine odor in the room. The Ombudsman explained the Ombudsman Program and stated she is visiting today because Mr. Smith's daughter called her with concerns that he wasn't eating with the other residents, that there are different aides all of the time and that it seems he isn't getting bathed regularly. Mr. Smith stated that he has crippling arthritis and is unable to control his bladder at times. Mr. Smith stated he is embarrassed by his unkempt appearance and incontinence. He stated he was doing fine at home, despite his falls and difficulty managing his medications. Mr. Smith stated he misses his wife and prefers to keep to himself. He stated he has not really enjoyed eating since his wife passed away and finds that food "just doesn't seem to taste good anymore". He stated that he would rather risk the consequences of going home than live a longer life with the indignities he faces at the nursing home. The Ombudsman asks Mr. Smith if he wishes for the Ombudsman to assist him with his concerns. Mr. Smith responded, "if you can get me out of here, then yes". The Ombudsman asks Mr. Smith's permission to discuss his wishes with his daughter, Sandra and with staff at the facility. After some hesitation, Mr. Smith was agreeable. The Ombudsman stated that several factors are involved with discharging a resident back into the community, then asked if in the meantime, there was anything that could be done to make his quality of life better at the nursing home. He indicated that he would prefer to shower by himself rather than to be treated like a baby. Mr. Smith gave the Ombudsman permission to talk to the DON about his shower, but to no one else.

Intake

- Who filed the initial complaint?
- What complaints did the complainant disclose?
- Does the Ombudsman have the complainant's permission to tell the resident that she contacted the Ombudsman Program?
- According to the complainant, when did the concerns begin?
- Are the concerns ongoing?
- Where do the concerns occur?
- Who is involved?
- What are the reasons for the concern?
- What steps has the complainant taken to resolve the concern?
- What has the facility done in response to the problem?
- What does the complainant hope to achieve?
- To meet Ombudsman Standards of Promptness, how soon should the Ombudsman visit Mr. Smith?

Investigation

The investigation may require several steps. The first step should be to visit to Mr. Smith.

- Does Mr. Smith seem to have decision making capacity?
- Does Mr. Smith have the same perception of the concern as the complainant?
- What are Mr. Smith's concerns?
- Does Mr. Smith give consent to discuss his concerns with the complainant?
- Does Mr. Smith give consent to advocate on his behalf?
- Has Mr. Smith given permission to contact outside agencies?
- What are the resident's wishes about complaint resolution?
- Does Mr. Smith seem to fear of retaliation?

Following the visit with Mr. Smith, there are other factors to consider.

- Did the Ombudsman and the resident develop a plan of action?
- Who should the Ombudsman speak with next?
- Should the Ombudsman identify and interview staff from other agencies who may have knowledge of the concerns or who can provide information that would help resolve the problem?
- Should the Ombudsman research relevant laws, rules, regulations, and policies for insight into appropriate responses or solutions to the problem?
- Are there relevant clinical, medical, social, financial and other records you should examine?
- Who should approve Ombudsman access to resident records?
- What other pertinent information might be available?

Verification
Based on what you currently know, which complaints are verified and which complaints are not verified?

Planning

- At this point, does the Ombudsman understand the scope and nature of the complaint?
- Are there multiple verified complaints? If so, what are they?
- What are the available remedies and resources for referral?
- Which individual or agency is best able to resolve the complaints?
- Is there a "hidden" or "root" problem that is leading to the current concerns?
- What outcomes does the resident want?
- Is the resident willing to participate in the problem-solving process?
- Who else (besides the Ombudsman and the resident) needs to be involved?
- What are some possible solutions to the problem?
- Of the possible solutions, which one do you want to try first and why?
- What objections might the facility (or others) have to the proposed solution?
- How should an Ombudsman respond to those objections?

Interventions

- What actions (approaches) will you take to resolve the problem?

Resolution

- How will the Ombudsman know when the concerns are resolved?

TRAINER'S NOTE: *This is the end of Level I Ombudsman Training. Before ending the module, offer participants an opportunity to ask questions about the materials covered in this module. Before releasing participants for the day:*

- *Administer the Post-Test.*
- *Thank the individuals for participating in and completing the training. Reminding the individuals that Ombudsmen are available to provide assistance and direction.*

NOTES:

NOTES:

Appendices

Appendix A
Ombudsman Glossary

(PM Pg. 119)

An Ombudsman's Glossary

Abuse: Willful infliction of injury, unreasonable confinement, intimidation, cruel punishment with resulting physical harm, pain, or mental anguish; or willful deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness.

Area Agency on Aging or AAA: A public or private nonprofit agency designated by the Illinois Department on Aging (IDoA) in a planning and service area which is responsible for developing and administering an area plan for a comprehensive and coordinated system of services for caregivers and persons over the age of sixty.

Area Plan: A plan developed by an area agency on aging for its relevant planning and service area as set forth in the Older Americans Act.

Case: Each inquiry or allegation brought to, or initiated by, the Long-Term Care Ombudsman Program (LTCOP) on behalf of a resident or group of residents involving one or more complaints or problems which requires opening a case file and which includes Ombudsman investigation, fact gathering, development and implementation of a resolution strategy in keeping with Chapter 500 of the Illinois Long-Term Care Ombudsman Standards, Procedures and Practice Manual.

Community Education: Presentations to community groups or to groups of residents or families on long-term care issues.

Complaint: A concern or allegation that is brought to the attention of, or initiated by, the LTCOP for action, regarding action, inaction, or decisions that may have or have already adversely affected the health, safety, welfare, or rights of one or more residents of a long-term care facility.

Conflict of Interest: A competing interest, obligation, or duty which compromises, influences, interferes with (or gives the appearance of compromising, influencing or interfering with) the integrity, activities, or conduct of all designated Ombudsmen, the Department, State Long-Term Care Ombudsman (SLTCO), AAA or provider agency in faithfully and effectively fulfilling his or her official duties.

Date of First Action: The date indicated by a conversation with the resident, or the resident's representative, which results in a preliminary plan for either an investigation or steps to be taken toward resolution.

Department or IDoA: The Illinois Department on Aging (IDoA).

Designation: The certification and classification provided by the Office to:

- an individual who meets minimum qualifications, is free of conflicts of interest, has successfully completed training and other criteria and has been registered on the Ombudsman Registry. Designation authorizes such individual to act as a representative of the Office or in keeping with the standards of the Illinois Long-Term Care Ombudsman Standards, Procedures and Practices Manual;
- a provider agency which meets the minimum qualifications stipulated in Section 305 of the Illinois Long-Term Care Ombudsman Standards, Procedures and Practices Manual. Designation authorizes the agency to operate a Regional LTCOP in a planning and service area or a specified geographic area.

Director: The Director of the Illinois Department on Aging.

Exploitation: The illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit, or gain.

Family Council Activities: Provision of technical assistance, information, training or support to the family members of residents and/or facility staff about the development, education, work, or maintenance of a family council.

Good Faith: Evidence of performing duties in "good faith" includes, but is not limited to:

- Making reasonable efforts to follow procedures set forth in applicable laws and the Illinois Long-Term Care Ombudsman Standards, Procedures and Practices manual;
- Seeking and making reasonable efforts to follow direction from the relevant Regional Ombudsman; and,
- Seeking and making reasonable efforts to follow direction from the Office of the State Long-Term Care Ombudsman.

Guardian: Person or entity appointed by a court to exercise the legal rights and powers of another individual as specified in the court order.

Immediate Family: Those persons related to an individual such as a spouse, child, sibling, parent or domestic partner.

Initiate: Obtain the authorization for a record check from a student, applicant, employee, or volunteer.

Intake Date: The date of receipt of the information or message received by the LTCOP provider agency.

Interference: Includes, but is not limited to, the following: the infliction of physical harm; threats to inflict physical harm; intimidation; deception; tampering with physical evidence; destroying, hiding, or altering records; making false statements or encouraging others to do so; bribery or attempted bribery; retaliation; and restricting, without legal authority, the personal movements or travel of any individual, when such actions are done for the sole purpose of preventing the Ombudsman from discharging his or her official duties.

Information and Consultation to Individuals: The provision of information in response to a request made by telephone or in person, on a one-to-one basis on needs ranging from alternatives to institutional care, to how to select a nursing home, to residents' rights, to understanding Medicaid.

In-Service Education and Training: A presentation to LTCO or long-term care facility staff on long-term care issues.

Interagency Coordination: Activities that involve meeting or coordinating with other agencies to learn about and to improve conditions for one or more residents of long-term care facilities.

Issues Advocacy: Activities supporting and promoting issues that benefit or advance the health, safety, welfare or rights of residents of long-term care facilities.

Legal Representative: An agent under a valid power of attorney, provided that the agent or attorney-in-fact is acting within the scope of his or her agency; an agent under a power of attorney for health care; surrogate decision maker; or an executor, executrix, or administrator, or administratrix of the estate of a deceased resident; or guardians of the person and estate.

Long-Term Care Facility or Facility: Long-Term Care Facility means any facility as defined by Section 1-113 of the Nursing Home Care Act, as amended by Public Act 93-0241, of any skilled nursing facility or a nursing facility which meets the requirements of Section 1819 (a), (b), (c), and (d) or Section 1919 (a), (b), (c), and (d) of the Social Security Act, as amended (42 U.S.C. 1395i- 3(a), (b), (c), and (d) and 42 U.S.C. 1396r(a), (b), (c), and (d). Facilities or establishments with the following types of licensed beds or certified units are included in the definition:

- skilled nursing;
- skilled nursing unit of a hospital licensed facility;
- intermediate care;
- intermediate care for the developmentally disabled;
- sheltered care;
- assisted living;
- shared housing; and,
- supportive living - a facility established under Section 5-5.01a of the Illinois Public Aid Code.

Long-Term Care Ombudsman or LTCO: Unless otherwise specified, any designated representative of the Office of the State LTCOP. Specific categories include:

- State Long-Term Care Ombudsman (SLTCO);
- Regional Ombudsman (RO);
- Community Ombudsman (CO) [paid or unpaid];
- Volunteer Ombudsman (VO).

Neglect: The failure to provide the goods or services that are necessary to avoid physical harm, mental anguish, or mental illness or the failure of a caregiver to provide the goods and services.

Office or SLTCOP: The Office of the State Long-Term Care Ombudsman Program (SLTCOP) as established and operated by IDoA and headed by the State Long-Term Care Ombudsman (SLTCO).

Official Duties: Those duties of a LTCO as set forth in applicable federal and state law and the Illinois Long-Term Care Ombudsman Standards, Procedures and Practice Manual.

Ombudsman: A paid staff person who has completed Level I and Level II training and four (4) hours of probationary supervision. Community Ombudsmen work directly under the supervision of the RO.

Ombudsman Annual Services Plan: A written plan, prepared by the Regional LTCOP, for submission to the Office and the Area Agency on Aging, setting goals and objectives for the Regional LTCOP for the following federal fiscal year.

Volunteer Ombudsman: A person who is a volunteer and who has completed Level I and Level II training and four (4) hours of probationary supervision. Volunteer Ombudsmen provide information about the Long-Term Care Ombudsman Program to residents, investigate complaints, and report issues to the Regional Ombudsman or Community Ombudsman. She or he works under the supervision of the Regional Ombudsman or Community Ombudsman.

Planning and Service Area or PSA: A geographic area of the State, as defined in the Illinois Act on Aging, that is designated by the IDoA for the purposes of planning, development, delivery, and overall administration of services under an area plan.

Provider Agency: The entity designated by the Office to operate a Regional LTCOP in a planning and service area or a specified geographic area.

Record: Any medical, social, personal and financial information maintained by any long-term care facility, or by any State or local agency, pertaining to a resident of a long-term care facility or to the facility.

Regional Ombudsman: A person who works full-time (35-40 hours/week) to perform LTCOP functions. S/he has the overall responsibility for the activities of the Regional LTCOP.

Regional Long-Term Care Ombudsman Program or Regional LTCOP: An entity designated by the Office as a local Ombudsman entity.

Registry or Ombudsman Registry: The official listing of LTCO, maintained by the Office, who have been designated as representatives of the Office of SLTCO.

Resident: Any individual who is a current or former resident of any long-term care facility, including individuals seeking admission to a long-term care facility, if the complaint or request for information involves procedures or practices related to admission, discharge and/or the individual's entitlement to care and services under Federal and State laws and regulations.

Resident Council Activities: Provision of technical assistance, information, training or support to the residents, family members and/or facility staff about the development, education, work or maintenance of a resident council.

Resident's Representative: Any person who is knowledgeable about a resident's circumstances and has been designated by that resident in writing to represent him or her, including a resident's legal representative as defined in Section 1-123 of the Nursing Home Care Act, or the resident's legal guardian.

State Long-Term Care Ombudsman (SLTCO): A person authorized to head the SLTCOP, who meets the requirements set forth in the Illinois State Long-Term Care Ombudsman Standards, Procedures, and Practices manual.

State Long-Term Care Ombudsman Program (SLTCOP): The Program as established and operated by the IDoA and carried out through the Office of the SLTCOP and headed by the SLTCO.

Appendix B
Legal Authority for Ombudsman Work & Administrative Codes for LTC Facilities

(PM Pg. 125)

Legal Authority for Ombudsman Work

Federal Authority

Older Americans Act - Title 42, chapter 35, Subchapter XI, Part A, subpart ii, Section 3058g
Created the long-term care Ombudsman program.

OBRA '87 - Title 42, Chapter 7, Subchapter XIX, Section 139r
Known as the Federal Nursing Home Reform Act. This applies to facilities that are certified for the Medicaid and Medicare programs and sets a national minimum set of standards of care and rights for people living in certified nursing facilities. OBRA stands for Omnibus Reconciliation Act.

Medicaid Provisions - 42 U.S.C. 1396r(b)(4)
OBRA provisions regarding Medicaid certified facilities.

Code of Federal Regulations - 42 C.F.R. 483
Federal regulations promulgated pursuant to OBRA '87.
Found online at http://www.access.gpo.gov/nara/cfr

Long-Term Care State Operations Manual
CMS-generated regulatory guidance manual for long-term care facilities.
Found online at http://new.cms.hhs.gov/manuals

Illinois State Authority

Illinois Nursing Home Care Act - 210 ILCS 45/2 et. seq.
Illinois law pertaining to *long-term care*. Passed in 1979.
Found online at http://www.ilga.gov/legislation

Illinois Administrative Code - 89 Ill. Adm. Code 120 et. seq.
Illinois regulations pertaining to *Medicaid-certified facilities*.
Found online at http://www.ilga.gov/commission/jcar/admincode

Illinois Administrative Code - 89 Ill. Adm. Code 146 et. seq.
Illinois regulations pertaining to *supportive living establishments*.
Found online at http://www.ilga.gov/commission/jcar/admincode/809

Illinois Administrative Code - 89 Ill. Adm. Code 350 et. seq.
Illinois regulations pertaining to *long-term care facilities.*
Found at http://www.ilga.gov/commission/jcar/admincode

Assisted Living and Shared Housing Act - 210 ILCS 9/1 et. seq.
Illinois regulations pertaining to *assisted living facilities*.
Found online at http://www.ilga.gov/legislation/ilcs

Illinois Dept of Family and Health Care Services Cash, Food Stamp and Medical Manual
This is the document used by Department workers to determine eligibility for Medicaid in long-term care settings. The Policy Manual (PM) contains Departmental policy. The Worker's Action Guide (WAG) instructs the workers on how to evaluate applications.
Found online at http://www.dhs.state.il.us/ts/cfsmm

IDPH Rules for Administrative Hearings - 2 Ill. Adm. Code 1125 Section 430 et.seq.
Regulations for hearings before IDPH administrative law judges.
Found online at http://www.ilga.gov/commission/jcar/admincode

IDOA LTCOP Standards, Procedures & Practices Manual
Regulates the operation of the Ombudsman Project.
Found at http://www.state.il.us/aging/2rules/ombuds/index.htm

Other relevant Illinois Statutes

Power of Attorney Act – 755 ILCS 45 et. seq.

Living Will Act – 755 ILCS 35 et. seq.

Health Care Surrogate Act – 755 ILCS 40 et. seq.

Administrative Codes for Long-Term Care Facilities

Health and Human Services Part 483 - Requirements for States and Long-Term Care Facilities
http://www.access.gpo.gov/nara/cfr/waisidx_02/42cfr483_02.html

State Operations Manual Chapter 7 - Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities
http://www.cms.gov/manuals/downloads/som107c07.pdf

State Operations Manual Appendix PP - Guidance to Surveyors for Long-Term Care Facilities
https://www.cms.gov/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

Index to Title 77 of the Illinois Administrative Code Public Health Chapter 1, Department of Public Health http://www.idph.state.il.us/rulesregs/rules-index.htm#77-index

Assisted Living & Shared Housing Establishment Code
http://www.ilga.gov/commission/jcar/admincode/077/07700295sections.html

Skilled Nursing & Intermediate Care Facilities Code
http://www.ilga.gov/commission/jcar/admincode/077/07700300sections.html

Sheltered Care Facilities Code
http://www.ilga.gov/commission/jcar/admincode/077/07700330sections.html

Illinois Veterans' Homes Code
http://www.ilga.gov/commission/jcar/admincode/077/07700340sections.html

Intermediate Care for the Developmentally Disabled Facilities Code
http://www.ilga.gov/commission/jcar/admincode/077/07700350sections.html

Elder Abuse Statutes

Abused and Neglected Long Term Care Facility Residents Reporting Act (21o ILCS 30)
http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1222&ChapterID=21

Elder Abuse and Neglect Act (320 ILCS 20)
http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1452&ChapterID=31

Appendix C
Bibliography

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Equipping Long-Term Care Ombudsmen for Effective Advocacy: A Basic Curriculum. *Sara Hunt, Consultant, National Long-Term Care Ombudsman Resource Center and Linda Sadden, Louisiana State Long-Term Care Ombudsman. May, 2004.*

History and Role of the Long-Term Care Ombudsman Program Teaching Notes. *Sara S. Hunt, Consultant, National Long-Term Care Ombudsman Program. May, 2004.*

State Long-Term Care Ombudsman Programs: A Primer for State Aging Directors and Executive Staff. National Ombudsman Resource Center. *May, 2010.*

The Long-Term Care Ombudsman Compendium. N*ational Long-Term Care Ombudsman Resource Center. Undated.*

The Long-Term Care Ombudsman Program: History and Responsibilities Under the Older Americans Act. S*ara S. Hunt, Consultant, National Long-Term Care Ombudsman Resource Center. May, 2004.*

Tools for change: Vol. 1, No. 2, April, 2011. Positive outcomes of culture change–the case for adoption. *The Pioneer Network. Available online at* http://www.pioneernetwork.net/Providers/ToolsforChange/

State Operations Manual, Appendix PP – Guidance to Surveyors for Long-Term Care Facilities. Available online at

Appendix D
Pre-Test & Post-Test

TRAINER'S NOTE: *Do not distribute the Pre-Test until the beginning of Day 1 of Level 1 Training. Do not distribute the Post-Test until the end of Day 2 of Level 1 Training. The Trainer's Key follows the participant's version of the Pre-Test and PostTest.*

TRAINER'S NOTE: *Allow participants approximately ten (10) to complete the test.* ***Following the Post-Test on day two****, you may provide the answers to the test. To determine the change in knowledge, ask participants to compare their Pre-Test answers to Post-Test answers. This will give participants an opportunity to see how much they have learned and to identify specific areas that may need review. Allow yourself time to answer any questions that may arise or to clarify specific areas of the training that challenge a majority of participants. Participants may especially have trouble with statements 13 and 14 on the Pre-Test and Post-Test. Be sure to continue to remind them that* ***Ombudsmen are not disinterested, but always advocate for residents****.*

Level I Pre-Test

Adapted from the 1998 Georgia LTCOP Training Manual

From the list of 19 statements below, circle the nine (9) statements that you believe most accurately reflect the position of a Long-Term Care Ombudsman.

1. I always seek direction from the resident.
2. I do what I think is right for the resident.
3. I most enjoy talking to residents about their life, interests and feelings.
4. The residents are very lonely; my main job is to show them friendship, love and concern.
5. I try to provide education and information to facility residents, family members and staff.
6. My work with the care giving facility staff is so rewarding.
7. I use my knowledge and communication skills to empower and support residents.
8. I attempt to discover every resident's problems so they can be discussed and resolved.
9. There are so many unfounded complaints. More often than not, staff will help me sort out the real problems from the imagined ones.
10. Documented evidence for inappropriate facility actions must be presented firmly and clearly to assure action and resolution.
11. Many residents just need someone to care about them – to love them.
12. I act as a disinterested third party when resolving complaints in a facility.
13. When resolving a resident's complaint, I make sure that I not only present them with the available options, but also get their permission before I take action at each step of the resolution process.
14. I serve residents best by being a trusted and reliable source of information.
15. Despite occasional problems, things run fairly well at my facility.
16. I am exclusively committed to pursuing the residents' interests above all other competing considerations and viewpoints.
17. To be fair, I take into account constraints and challenges faced by facility staff in providing care – one has to be realistic.
18. I most enjoy the residents' company.
19. I consistently push for the resident's cause and believe in strong enforcement and corrective action for facilities that fail to provide good care.

Below are 11 statements. Decide whether or not you think the statements are true and mark your answer accordingly.

20. Residents of nursing homes have the right to go to bed and rise at any hour of their choosing. **T** **F**
21. Residents have the right to choose what they please to eat unless there is a doctor's order that specifies dietary restrictions. **T** **F**
22. Residents have the right to visit with anyone they wish unless their guardians or responsible parties say otherwise. **T** **F**
23. Facilities have the right to discharge residents whose behavior is described by staff as disruptive. **T** **F**
24. Facilities have the right to discharge residents for non-payment. **T** **F**
25. A resident can be tied to a wheelchair with a bed sheet to keep him or her safe if the Director of Nursing thinks it is appropriate. **T** **F**
26. Only the resident's responsible party, the family, or the attending physician can approve the release or disclosure of the resident's personal and medical records. **T** **F**
27. If the resident's payor source is Medicare or Medicaid, the resident may be discharged if a Medicare or Medicaid medical necessity review determines that the resident no longer requires the level of care provided by the facility. **T** **F**
28. A facility is not responsible for the dentures of an incompetent resident who cannot take his or her dentures out without help. **T** **F**
29. A resident's family member cannot visit if the doctor orders that the family member is a danger to the resident. **T** **F**
30. Residents have the freedom to leave the facility when they choose unless the resident's family or the responsible party has specified that it is not safe for the resident to do so. **T** **F**

Your Name_____

Level I Post-Test

Adapted from the 1998 Georgia LTCOP Training Manual

From the list of 19 statements below, circle the nine (9) statements that you believe most accurately reflect the position of a Long-Term Care Ombudsman.

1. I always seek direction from the resident.
2. I do what I think is right for the resident.
3. I most enjoy talking to residents about their life, interests and feelings.
4. The residents are very lonely; my main job is to show them friendship, love and concern.
5. I try to provide education and information to facility residents, family members and staff.
6. My work with the care giving facility staff is so rewarding.
7. I use my knowledge and communication skills to empower and support residents.
8. I attempt to discover every resident's problems so they can be discussed and resolved.
9. There are so many unfounded complaints. More often than not, staff will help me sort out the real problems from the imagined ones.
10. Documented evidence for inappropriate facility actions must be presented firmly and clearly to assure action and resolution.
11. Many residents just need someone to care about them – to love them.
12. I act as a disinterested third party when resolving complaints in a facility.
13. When resolving a resident's complaint, I make sure that I not only present them with the available options, but also get their permission before I take action at each step of the resolution process.
14. I serve residents best by being a trusted and reliable source of information.
15. Despite occasional problems, things run fairly well at my facility.
16. I am exclusively committed to pursuing the residents' interests above all other competing considerations and viewpoints.
17. To be fair, I take into account constraints and challenges faced by facility staff in providing care – one has to be realistic.
18. I most enjoy the residents' company.
19. I consistently push for the resident's cause and believe in strong enforcement and corrective action for facilities that fail to provide good care.

Below are 11 statements. Decide whether or not you think the statements are true and mark your answer accordingly.

20. Residents of nursing homes have the right to go to bed and rise at any hour of their choosing. **T** **F**
21. Residents have the right to choose what they please to eat unless there is a doctor's order that specifies dietary restrictions. **T** **F**
22. Residents have the right to visit with anyone they wish unless their guardians or responsible parties say otherwise. **T** **F**
23. Facilities have the right to discharge residents whose behavior is described by staff as disruptive. **T** **F**
24. Facilities have the right to discharge residents for non-payment. **T** **F**
25. A resident can be tied to a wheelchair with a bed sheet to keep him or her safe if the Director of Nursing thinks it is appropriate. **T** **F**
26. Only the resident's responsible party, the family, or the attending physician can approve the release or disclosure of the resident's personal and medical records. **T** **F**
27. If the resident's payor source is Medicare or Medicaid, the resident may be discharged if a Medicare or Medicaid medical necessity review determines that the resident no longer requires the level of care provided by the facility. **T** **F**
28. A facility is not responsible for the dentures of an incompetent resident who cannot take his or her dentures out without help. **T** **F**
29. A resident's family member cannot visit if the doctor orders that the family member is a danger to the resident. **T** **F**
30. Residents have the freedom to leave the facility when they choose unless the resident's family or the responsible party has specified that it is not safe for the resident to do so. **T** **F**

Your Name_____

Level I Pre/Post-Test – Trainer's Version

Adapted from the 1998 Georgia LTCOP Training Manual

Below is a list of 19 statements. Choose 9 statements that you believe most accurately reflect the position of a Long-Term Care Ombudsman.

1. ***I always seek direction from the resident.***
2. I do what I think is right for the resident.
3. I most enjoy talking to residents about their life, interests and feelings.
4. The residents are very lonely; my main job is to show them friendship, love and concern.
5. ***I try to provide education and information to facility residents, family members and staff.***
6. My work with the care giving facility staff is so rewarding.
7. ***I use my knowledge and communication skills to empower and support residents.***
8. ***I attempt to discover every resident's problems so they can be discussed and resolved.***
9. There are so many unfounded complaints. More often than not, staff will help me sort out the real problems from the imagined ones.
10. ***Documented evidence for inappropriate facility actions must be presented firmly and clearly to assure action and resolution.***
11. Many residents just need someone to care about them – to love them.
12. I act as a disinterested third party when resolving complaints in a facility.
13. ***When resolving a resident's complaint, I make sure that I not only present them with the available options, but also get their permission before I take action at each step of the resolution process.***
14. ***I serve residents best by being a trusted and reliable source of information.***
15. Despite occasional problems, things run fairly well at my facility.
16. ***I am exclusively committed to pursuing the residents' interests above all other competing considerations and viewpoints.***
17. To be fair, I take into account constraints and challenges faced by facility staff in providing care – one has to be realistic.
18. I most enjoy the residents' company.
19. ***I consistently push for the resident's cause and believe in strong enforcement and corrective action for facilities that fail to provide good care.***

Below are 11 statements. Decide whether or not you think the statements are true and mark your answer accordingly.

20. Residents of nursing homes have the right to go to bed and rise at any hour of their choosing. ***T*** **F**
21. Residents have the right to choose what they please to eat unless there is a doctor's order that specifies dietary restrictions. **T** ***F***
22. Residents have the right to visit with anyone they wish unless their guardians or responsible parties say otherwise. **T** ***F***
23. Facilities have the right to discharge residents whose behavior is described by staff as disruptive. **T** ***F***
24. Facilities have the right to discharge residents for non-payment. ***T*** **F**
25. A resident can be tied to a wheelchair with a bed sheet to keep him or her safe if the Director of Nursing thinks it is appropriate. **T** ***F***
26. Only the resident's responsible party, the family, or the attending physician can approve the release or disclosure of the resident's personal and medical records. **T** ***F***
27. If the resident's payor source is Medicare or Medicaid, the resident may be discharged if a Medicare or Medicaid medical necessity review determines that the resident no longer requires the level of care provided by the facility. ***T*** **F**
28. A facility is not responsible for the dentures of an incompetent resident who cannot take his or her dentures out without help. **T** ***F***
29. A resident's family member cannot visit if the doctor orders that the family member is a danger to the resident. **T** ***F***
30. Residents have the freedom to leave the facility when they choose unless the resident's family or the responsible party has specified that it is not safe for the resident to do so. **T** ***F***