



Human Services Committee  
Texas House of Representatives  
March 15, 2019

*Re: Testimony in Support of HB 2285, "Relating to administrative penalties assessed against certain nursing facilities for the improper discharge or transfer of a resident."*

My name is Greg Shelley. I am the managing local ombudsman for the Harris County Long-term Care Ombudsman Program. In this role, I oversee the provision of advocacy services to the 103 nursing homes in my area. The testimony I provide today is as a representative of the Office of the State Long-Term Care Ombudsman, and does not reflect the positions of my agency.

I have advocated for the residents of nursing homes in Fort Bend, Harris, and Waller counties over the course of the last 9 years. I have made over 1,000 visits to more than 100 different nursing homes during that time. The topic of involuntary discharges is by far the most prevalent of all my consultations and individual casework. These cases are also generally the most contentious and heated, and they contribute to some of the most stress and anxiety that the residents and family members experience through their journeys in long-term care.

Volunteer and Staff Ombudsmen encounter far too many problems with the lack of oversight and enforcement surrounding these issues to cover them thoroughly in this forum. We deal on a daily basis with complaints from nursing home residents about a wide variety of improper discharge practices. Here are just a few examples:

- A non-ambulatory, wheelchair dependent, young disabled man was issued a discharge notice due to non-payment even though the only issue was that the facility failed to do their due diligence to allow him to qualify for his Medicaid benefits. The facility removed him against his will and attempted to drop him at his elderly and frail grandparent's second floor apartment with no elevator. With ombudsman advocacy, he returned to the facility, and the facility did what was needed for him to qualify for his Medicaid benefits within two weeks.
- A 60+ year old man with disabilities had approved medical necessity for nursing home care was issued a discharge notice stating that the facility believed he would lose his Medicaid coverage, despite representatives at HHSC stating otherwise. After 30 days, the facility had a man who runs an unlicensed group home/motel come pack his things and moved him to that location, placing him back in the same circumstances that led to him needing hospital and nursing care in the first place. Despite the objections of the ombudsman, the administrator claimed she was in her rights to do so and didn't believe HHS Regulatory would do anything about it.
- Nursing facilities frequently issue discharge letters threatening to put the resident out at a homeless shelter. I have personally witnessed a regional vice president of a corporation say he could put the resident out on the sidewalk if he wanted.
- A facility sent a discharge notice to a previous address where the resident and his estranged spouse had lived. The facility knew that this address was not current, but wanted to discharge the resident anyway.



This was done over the objection of the facility social worker, who was especially concerned about the resident's mental health challenges.

- Facilities frequently issue discharge notices stating that they "cannot meet the needs" of residents whose behaviors they don't know how, or don't want, to manage. These are often residents who call out or are confused, and who the facility did not adequately assess at admission. The facilities with inadequate assessments also tend to be short-staffed or employ caregivers who are neither empathetic nor properly trained.
- Facilities also issue discharge notices stating that they "cannot meet the needs" of residents because a resident's friends or family exercise their right to complain about the care and conditions.

Facilities often fail to appreciate (or simply don't care) about the detrimental impact of their actions on residents and their caregivers. For example, the sudden change in environment for a resident with dementia who is being discharged can impact his sense of security and psychological wellbeing. In other cases, family members without the skills or abilities to care for their loved ones are suddenly faced with having to do so. And, in all of the scenarios above, the manner in which the discharge letters are delivered can be threatening and intimidating to residents and family. Regardless of the reason for discharge, the facilities should not be able to punish residents by placing them in harm's way. Current conditions often leave vulnerable residents at a dangerous and intimidating disadvantage. The elderly and disabled residents in these facilities need and deserve better.

Please support HB 2285 so that we can provide these vulnerable Texans the help they need. Thank you for all you do.

Sincerely,

A handwritten signature in blue ink, appearing to read "G. Shelley".

Greg Shelley  
Managing Local Ombudsman  
Harris County Long-term Care Ombudsman Program  
(713) 252-7861



Statement of Involuntary Discharges  
Lydia Nunez Landry  
Volunteer Long-term Care Ombudsman  
Harris County, Texas  
**For H.B. No. 2285**  
Protecting Nursing Facility Residents from Improper Discharge

I am a volunteer LTC Ombudsman, and I am writing today to share my observations of improper and involuntary discharges of nursing facility residents. The testimony I provide today is as a representative of the Office of the State Long-Term Care Ombudsman, and does not reflect the positions of my agency. My first encounter with this practice occurred in 2017 when a nursing facility social worker told me that if a significantly disabled resident didn't quickly find other living arrangements, she would have no other choice than to "refer [him] to Salvation Army." Being, at the time, a somewhat new LTC Ombudsman, I had never imagined a social worker would so flagrantly admit to what amounted to abandoning a resident at a homeless shelter. I asked questions to ensure that I didn't misinterpret her. Sadly, my initial understanding was indeed correct. When I explained that this was a violation of the resident's rights, she objected, saying that this was the standard procedure at every facility where she had worked. Of course, I immediately phoned my supervisor, who asked whether the resident had received the required 30-day advanced notice of involuntary discharge; he had not. Yet even after I managed to get the facility to follow the proper notification procedure, after 30 days no arrangements had been made the resident was still without a home and the means to afford one. The resident was discharged, and I can now only hope that he is ok.

The second case of improper and involuntary discharge involved a young, disabled resident. He had contacted me on numerous occasions for assistance. On each occasion, we spoke to the staff member relevant to his concerns. Eventually the facility became exasperated by the resident's grievances, and he began to experience myriad instances of retaliation and harassment. This culminated to such an intolerable level of neglect that regulatory was called. A month later, the resident contacted me again. In great distress, he told me that he had been rushed to the emergency room with a serious infection—he attributed the infection to the staff's intentional, retaliatory neglect. While he was in the hospital, the facility had notified him that he was not allowed back and that his personal belongings, including his personal wheelchair (his only means of mobility), had been packed and needed to be retrieved immediately. He had no place to go and wasn't sure what to do. The resident never received a discharge notification, and though a complaint was filed with Texas Health and Human Services, he was never allowed to return to the facility.

The third case concerned a blind resident with a significant mobility impairment. I was called to the facility that day by the social worker. When I arrived, the resident sat in an ambulance markedly distressed. He had entered voluntarily, having been told that he was going for dialysis, but became upset when he discovered their plans to discharge him. The social worker and other staff were also agitated and demanded that I tell the resident that he had to leave. When I inquired whether the resident had received a



discharge notification, the social worker admitted that he had not. As before, I informed them that this was a violation of the resident's rights. After hearing my explanation, the ambulance driver told the staff that he couldn't transport the resident against his will, that doing so would be considered "kidnapping." As I spoke to the resident from outside the ambulance, he stated that he didn't want to move to another place and requested that I help him out of the vehicle, which I promptly arranged with the ambulance driver. The resident then requested that I file a complaint, but as he was speaking to me, a nurse quickly whisked him away without his permission. When I finally located the resident, he was with the same nurse at a designated smoking area. He no longer wanted to speak with me. As I left the facility, the social worker angrily disclosed that the nurse had given the resident a cigarette, assured him they wouldn't discharge him, and promised to buy him an entire pack on the condition that he not talk to me or file a complaint. I suggested that perhaps a care plan might be arranged, as there seemed to be communication issues among the staff and with the resident. Shortly thereafter, the resident was summarily and involuntarily discharged and the ombudsman office never received notification. I do not know what happened to this gentleman. This case deeply upset and sickened me.

There have been other heartbreaking instances that I must leave out for brevity's sake. I hope you will support HB 2285 to better protect residents from these terrible situations.

Sincerely,

Lydia Nunez Landry



Human Services Committee  
Texas House of Representatives  
March 16, 2019

*Re: Testimony in Support of HB 2285, "Relating to administrative penalties assessed against certain nursing facilities for the improper discharge or transfer of a resident."*

My name is Shirley Cromartie and I am the Managing Local Ombudsman for the North Texas Area. My office is in Wichita Falls, TX. As Managing Local Ombudsman, I oversee advocacy services to the residents of the 27 nursing homes in my area in the districts of Chair Frank and Representative Springer, Jr. The testimony I provide today is as a representative of the Office of the State Long-Term Care Ombudsman, and does not reflect the positions of my agency.

As an ombudsman (resident advocate) I help nursing home residents and their families with questions and concerns they may have about their life in a nursing home. A lot of questions come from residents and family members when a resident is sent to acute care hospital or a psychiatric hospital for evaluation and assessment; then after two weeks or a month, has been evaluated and is ready to be readmitted back to their nursing home, then they are told that the nursing home will not accept them back even though there is a state requirement to do so. **When I call the facility to explain that the state requirement requires for them to accept back the resident or possibly be cited by HHS Regulatory Services, the facility says that they know this requirement to accept back the resident but they are not going to comply.** I am told that they would rather take the deficiency from HHS Regulatory than take back the resident. Some of these residents are now being cared for by our homeless shelter and walking the streets.

As an advocate for these vulnerable Texans, I urge you to support HB 2285.

Sincerely,

Shirley Cromartie, Managing Local Ombudsman  
Area Agency on Aging of North Texas  
4309 Jacksboro Hwy. Suite 200  
Wichita Falls, TX 76301  
1-800-460-2226 or local 940-322-5281





6800 Burleson Road, Building 310, Suite 165  
Austin, TX 78744-2306  
(P) 888-622-9111, ext. 6062 (F) 512-916-6042  
A program of the Capital Area Council of Governments  
[aacap.org](http://aacap.org)  
[capcog.org](http://capcog.org)

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BASTROP BLANCO BURNET CALDWELL FAYETTE HAYS LEE LLANO TRAVIS WILLIAMSON

To whom it may concern:

As Staff Ombudsman for the Capital Area, I serve as a resident advocate in the skilled nursing facilities located in Travis, Hays, Bastrop, Fayette, Caldwell, Lee, Williamson, Burnet, Llano and Blanco counties. The Ombudsman Program helps people who live in skilled nursing facilities address concerns that impact the quality of resident care and quality of resident lives. Our program strives to empower residents in long term care settings by educating them about their rights. The testimony I provide today is as a representative of the Office of the State Long-Term Care Ombudsman, and does not reflect the positions of my agency.

Frequently our program deals with inappropriate discharge cases where a skilled nursing facility discharges a resident without following required regulations. One case in particular stands out involving a resident at a skilled nursing facility with complex and on-going medical needs. This particular resident was discharged to an inappropriate community setting (a motel) which could not meet his needs and violates the regulation for a safe and appropriate discharge. The facility failed to follow proper discharge and notification requirements. According to the resident, the skilled nursing facility gave him \$100 in cash and placed him in a taxi. The facility did not notify the resident's family about the discharge until he was on the way to the motel. By the time the family arrived, the resident was in acute physical distress and needed EMS transport to a hospital. From the hospital, the resident was discharged to another skilled nursing facility in Austin and was later transferred to a third skilled nursing facility much farther away. The final outcome was another "unsafe discharge" to the Austin Resource Center for the Homeless (ARCH). The ARCH is not a safe and appropriate placement for a resident in need of skilled nursing care.

As a resident advocate, I believe skilled nursing facility administrators have a responsibility to uphold residents' rights and adhere to HHSC regulations regarding safe and appropriate discharges. The tiered penalty structure in HB 2285 could create strong financial disincentives to discourage nursing facilities from violating the law and ignoring residents' rights.

Thank you very much for all that you do to support and protect our most vulnerable Texans.

Sincerely,

A handwritten signature in cursive script that reads "Darla Bower".

Darla Bower  
Staff Ombudsman, Capital Area Ombudsman Program  
[Dbower@capcog.org](mailto:Dbower@capcog.org)  
512-916-6051







Human Services Committee  
Texas House of Representatives  
March 13, 2019

Re: Support of HB 2285

Dear House Human Services Committee Members:

My name is Suzanna Sulfstede and I am the Managing Local Ombudsman for The Senior Source in Dallas. As a long-term care ombudsman, I protect the health, safety, welfare and rights of long-term care residents. Each year, my program serves more than 11,000 residents living in the 76 nursing facilities in Dallas County. The comments I submit to you today are on behalf of the Ombudsman Program and do not represent the Senior Source, where I am employed.

One of the basic rights for nursing facility residents is the right to not be improperly discharged from the facility. While this right is protected by federal law and there are administrative penalties set by the State for violating these laws, my program has witnessed multiple instances where a nursing facility has chosen to ignore that right and been willing to pay the small fine for violating the resident's discharge rights. The penalty for violating this law needs to be strengthened so that it serves as a deterrent to facilities improperly discharging residents.

From my experience, improper discharges are frequently a form of retaliation against residents or family members who have made frequent complaints at the facility, which is also a resident's right. On more than one occasion, my program has received a concern from residents who have complained about poor care at a facility and then received a discharge notice shortly thereafter. In other situations, we have seen improper discharges where facilities discharge individuals to unsafe or inappropriate locations. For example, multiple Dallas facilities routinely make immediate discharges, sending medically-fragile residents to a local homeless shelter with no coordination for services. Residents are typically left by themselves at the entrance to the shelter with their personal belongings and no one to help them.

As an advocate for these vulnerable Texans, I urge you to support HB 2285. The impact of these improper discharges is often devastating for the residents. Individuals who reside in nursing facilities are elderly or severely disabled. Being forced out of a facility that is familiar to them, and has become home for them, often leaves the residents feeling overwhelmed, scared and anxious—all of which can



have a negative impact on their health. With some improper discharges, residents are relocated to other facilities that are far away from family and friends, leaving the residents isolated and with little social interaction.

I thank you for all that the Human Services Committee does to protect the Texans who need you the most.

Sincerely,

Suzanna Sulfstede, LMSW | Managing Local Ombudsman  
3910 Harry Hines Boulevard | Dallas, Texas 75219  
214.823.5700  
[ssulfstede@theseniorsource.org](mailto:ssulfstede@theseniorsource.org)

Attachment: Dallas County Examples of Improper Discharge Cases



## Dallas County Examples of Improper Discharge Cases

### Discharges to homeless shelters

Almost a dozen Dallas facilities routinely make immediate discharges, sending the resident to a local homeless shelter with no coordination for services. Residents are typically left by themselves at the entrance to the shelter with their personal belongings. The Ombudsman has repeatedly educated nursing facility staff that due to lack of medical services, homeless shelters cannot be considered a "safe discharge".

APS is notified with each discharge, but most of the time cannot locate the person, as they are now on the street. The majority of these residents are sent to the County hospital ER when discovered and re-enter long term care through placement from this entity. The time frame for getting back into a long term care facility, if they go through this process can take from three days to several weeks, depending on their physical condition, needs and experience with homelessness.

### Ms. Smith\*

Three years after Ms. Smith was admitted to the nursing facility, she received a 30-day discharge notice. The reason stated for discharge was that the facility was "unable to meet the resident's needs." Ms. Smith's grandson was very involved with her care, and was persistent and vocal about concerns. According to the nursing facility administrator and leadership team, they experienced frequent conflict with the resident's family and the resident was being discharged because of those challenges. This is an unlawful reason for discharge.

With the assistance of the ombudsman, the grandson filed an appeal to the discharge. Despite the pending discharge hearing that requires the facility to retain the resident until a decision is rendered by the hearing officer, the administrator proceeded with discharging the resident to another facility before the hearing was held. The discharge appeal hearing occurred several months later, and the hearing office ruled in favor of the resident. Due to the harsh treatment that the resident received by the administrator and her staff, the family decided to not pursue having the resident return to the nursing facility. Therefore, by violating the law, the facility achieved its goal of removing the resident from its care.

### Ms. Carter\*

Ms. Carter was a 93-year old resident who had lived at the nursing facility for approximately 8 years. Her daughter was very involved in her care and was very vocal with any concerns. Due to her assertiveness, the nursing facility staff described the daughter as "an overly aggressive family member". When Ms. Carter was admitted to the hospital with an illness, the nursing facility administrator notified the hospital social worker that he would not be readmitting the resident from the hospital. The ombudsman educated the administrator about residents' rights and the discharge regulations that require the nursing facility to allow a person transferred to a



hospital to return to their nursing facility, but the administrator stated that we would not issue a discharge notice because he “knew the daughter would appeal it”. The administrator stated that he did not want the resident to return to the nursing facility because he did not want to have any further interactions with the resident's daughter. The administrator said he was prepared to defend his decision with any HHSC Long-Term Care Regulatory Services’ investigations. Subsequently, the ombudsman reached out to the HHSC Facility-Surveyor liaison for assistance. The liaison notified the administrator and again talked with him about residents’ rights pertaining to discharges. The administrator continued to refuse to allow the resident to return to the nursing facility when she was discharged from the hospital. He also continued to refuse to issue a discharge notice. Ms. Carter eventually discharged from the hospital to a different nursing facility, away from her familiar surroundings and friends that she had made over the 8 years while living in the first nursing facility.

#### Ms. Davis\*

Ms. Davis received a discharge notice from the nursing facility stating that she no longer met medical necessity to qualify for Nursing Facility Medicaid. While her daughter was notified of the facility’s intent to discharge, there was no coordination with her regarding the date and time of discharge. Ms. Davis’ daughter notified the facility that the transfer had to be coordinated to assure she would be home when her mother arrived. On the date of discharge, the resident was transported with her wheelchair and personal belongings via taxi and left alone on the sidewalk in front of her daughter’s home. It was mid-day and in August. That afternoon, the daughter looked out a front window and saw her mother slumped in her wheelchair, sitting on the sidewalk. She was unable to determine from Ms. Davis how long she had been sitting out in the sun. The daughter notified the ombudsman and made a formal complaint to HHSC Long-Term Care Regulatory Services. The complaint was investigated and found to be unable to substantiate, even though the facility verified the resident had been transferred by a taxi service.

#### Ms. Rodriguez\*

Ms. Rodriguez was admitted to the nursing facility as a result of a traumatic brain injury. More than two years after she was admitted to the facility, the resident received a 30-day discharge notice that stated the facility was no longer able to meet the resident's needs. Although the resident’s mother, who was her guardian, filed an appeal to the discharge (state and federal law requires that the resident not be discharged while an appeal is pending), the facility discharged Ms. Rodriguez to a local behavioral health hospital. The behavioral health hospital refused to admit Ms. Rodriguez due to her inability to ambulate, and because the nursing facility administrator refused to allow her back into the facility, she was then transferred to the emergency room of a local hospital. The resident remained in the emergency room area for almost 6 weeks because she did not have a medical need to be admitted and no other nursing facility would accept her due to her diagnosis of a traumatic brain injury. The resident’s mother eventually decided to bring her home, but that transition was delayed significantly as a result of



Ms. Rodriguez losing her Medicaid coverage due to her being out of the nursing facility for an extended period of time.

Two months after the discharge notice was initially issued, a fair hearing was conducted. The HHSC Fair Hearing Officer found that the nursing facility's action was not correct. The nursing facility was instructed to rescind the discharge notice and they were directed to allow Ms. Rodriguez to return to the facility. By the time the decision letter was received, the guardian had moved her daughter home.

#### Multiple 30-day notices issued to the same residents

The Dallas County Long-Term Care Ombudsman Program is aware of at least six instances in three nursing facilities, where a resident received a 30-day discharge notice, the resident appealed the discharge and the HHSC Fair Hearing Officer found in favor of the resident. Shortly after the Fair Hearing Officer issued the decision, the nursing facility issued a second 30-day discharge notice to the resident for the same reported issue and using the same reason for discharge. In each case, residents reported feeling anxiety and being harassed by the facility. The ombudsman notified the facilities that they could not issue a 30-day notice for issues found already in favor of the resident. Three of the discharges were then rescinded, but three were submitted as new appeals. In those three cases, a second appeal hearing was held and the Fair Hearing Officer educated facility staff and again found in favor of the resident.

These same facilities also have a history of issuing new 30-day notices to residents while the original 30-day discharge appeal was still pending. Again, residents reported feeling harassed.

\*All resident names have been changed.

\*\* I am providing these examples as a representative of the Office of the State Long-Term Care Ombudsman, this testimony does not reflect the positions of my agency.

Sincerely,

Suzanna Sulfstede, LMSW| Managing Local Ombudsman  
3910 Harry Hines Boulevard | Dallas, Texas 75219  
214.823.5700  
ssulfstede@theseniorsource.org





Human Services Committee  
Texas House of Representatives  
March 13, 2019

*Re: Testimony in Support of HB 2285, "Relating to administrative penalties assessed against certain nursing facilities for the improper discharge or transfer of a resident."*

Dear Committee,

My name is Tonya Jackson and I am the Managing Local Ombudsman for the Deep East Texas Area. As a Deep East Texas Ombudsman, I oversee the provision of advocacy services to the residents of the 41 nursing homes in the districts of Representative Clardy, Representative Paddie, Representative Ashby, Representative White, and Representative Polk. The testimony I am submitting today is on behalf of the Long-Term Care Ombudsman Program and does not represent the Deep East Area Agency on Aging.

As resident advocates, ombudsmen help residents and families resolve issues they encounter within the facility. Ombudsmen help explain residents' rights and explore options to identify the proper course of action to take when presenting a concern on behalf of the residents. As an advocate for these vulnerable Texans, I urge you to support HB 2285.

The Deep East Ombudsman Program recently assisted a family with an improper discharge of their loved one. The facility originally accepted the resident knowing that he exhibited certain behaviors related to his dementia diagnosis and agreed that they could care for these behaviors. However, the facility did not keep their promise. When the resident then exhibited these same behaviors in their facility, they sent him to a behavior hospital. After he was released from the hospital, the facility did not want to accept him back. **The facility told me they would "rather take a 'slap on the wrist' than take him back".** Our ombudsman program strenuously advocated on behalf of the resident and the facility chose to readmit him.

**With HB 2285, we feel the residents in our facilities will be more protected and secure from improper discharge.**

We thank you for all that the Human Services Committee does to protect the Texans who need you the most.

Sincerely,

Tonya Jackson  
Managing Local Ombudsman, Deep East Ombudsman Program  
[tjackson@detcog.org](mailto:tjackson@detcog.org)  
409-384-5326







House Human Services Committee  
Testimony FOR HB 2285  
March 22, 2019

Dear Human Services Committee,

My name is Frank Conigliaro, and I am a Staff Ombudsman for the Houston-Galveston Region, which includes the 12 counties that surround Harris County. In this role, I provide advocacy services to nursing homes residents. I have worked in this position for over a year, trying to make sure that the rights of my residents are protected and their choices are respected in the nursing facilities they call home. The testimony I provide today is as a representative of the Office of the State Long-Term Care Ombudsman, and does not reflect the positions of my agency.

I frequently work on cases involving nursing home staff who do not know or do not follow state and federal regulations related to resident rights. One of the most egregious cases involved a nursing home resident whose daughter was contacted by facility staff on a Friday afternoon and told to pick up her mother on Saturday. The facility had not given the resident or her daughter a written discharge notice 30 days in advance, as required by law. In fact, when I contacted the facility administrator, he claimed that he had no idea he was required to provide such a notice, and even said that *he discharged people all the time without providing such a notice!* After my colleague at the State LTCOP office provided him a copy of the applicable regulations, and reiterated that the facility could not discharge this resident on the following day and could not require her daughter to pick her up, the facility administrator grudgingly agreed to allow her to remain.

Ultimately, the facility gave the resident a discharge notice claiming that the resident was being discharged because she failed to pay her bill. At her request, we filed an appeal of the discharge, and we pointed out to the hearing officer the many ways in which the discharge notice itself failed to meet state and federal regulatory requirements. The hearing officer agreed with our position, finding that the facility "offered no evidence" either in the discharge notice or at the appeal hearing itself to show that its proposed discharge



complied with applicable law. Consequently, the hearing officer reversed the facility's attempt to discharge the resident.

One of the most troublesome things that I learned from this case is how easy it is for residents and their families to be bullied by facility staff who don't want to follow the law. Had this resident's daughter not called us for help after receiving the facility's demand to pick up her mother the following day, this resident would have been discharged against her wishes without knowing that the facility was not allowed to do that.

It is for these reasons that I support HB 2285, which will deter facilities from behaving in this fashion. I hope that you will join me in supporting this bill, and I thank you for the work that you do to protect vulnerable Texans.

Sincerely,

Frank Conigliaro

Staff Ombudsman  
Houston-Galveston Area Ombudsman Program  
[Frank.Conigliaro@h-gac.com](mailto:Frank.Conigliaro@h-gac.com)  
832-681-6661



March 15, 2019  
Testimony For HB 2285

Dear Human Services Committee:

My name is Amanda Sedeno and I am the Managing Local Ombudsman of the Concho Valley, which includes nursing facilities in the districts of Rep. Darby, Rep. Sheffield, Rep. Murr, and Rep. Lang. I am writing to ask your support for HB 2285, related to protecting nursing facility residents from improper discharge. As a long-term care ombudsman, I know that discharge rights of residents are not always discussed with the family or the resident upon admission. Unfortunately, without the resident knowing these rights, facilities may do improper discharges, despite what the regulations say. This is something that is not only illegal but is putting these residents in harm.

For example, imagine you are a resident and you just had your leg amputated. Then imagine that you are now being told that you had to leave the facility and that you are being sent to The Salvation Army during non-working hours with boxes of your belongings. This is what happened to a resident I advocate for in a long-term care facility. The facility knew this person had applied for Medicaid, required wound care and needed assistance taking his own medications. This was in no way a safe discharge. However, to the facility, this resident is very vocal regarding his care and was labeled a "trouble maker" for complaining. This facility would rather get a small fine instead of allowing him to stay during the application process. We are asking that the fines for improper discharges be increased so that this does not happen again.

I am also seeing residents being dumped at the hospitals with promise of them being able to return, then once the resident leaves the facility, he or she is issued a notice of discharge. This goes against the rights of the resident to be notified of the facility's bed hold policy, request a bed hold, and a right to stay in the facility during an appeal. For example, one resident resided in his facility for over 30 days when one day he started yelling for staff to get him care. Instead of trying to understand the behavior or get the resident to ask for his needs in a different way, the facility sent the resident to a behavioral hospital and then issued him a discharge notice. The facility is now refusing to take this resident back and would rather take the small fine, leaving it up to the hospital to get his belongings and find him new placement.

As an ombudsman, I see improper discharges on a regular basis. Without proper regulations to hold these facilities accountable and without larger fines, we will continue to see the rights of these residents be violated. The testimony I provide today is as a representative of the Office of the State Long-Term Care Ombudsman, and does not reflect the positions of my agency.

Sincerely,

A handwritten signature in black ink that reads "A Sedeno". The signature is written in a cursive style.

Amanda Sedeno  
Concho Valley Ombudsman Program  
325 223 5704 ext 238  
[amanda.sedeno@cvcog.org](mailto:amanda.sedeno@cvcog.org)





Human Services Committee  
Texas House of Representatives  
March 21, 2019

*Re: Testimony in Support of HB 2285, "Relating to administrative penalties assessed against certain nursing facilities for the improper discharge or transfer of a resident."*

Dear Human Services Committee,

My name is Delicia Marshall and I am a staff ombudsman for Tarrant County. The testimony I provide you today is as a representative of the Ombudsman program and does not represent my agency.

I ask that you support HB 2285 to better protect nursing facility residents. I want to tell you about a time when a resident was improperly discharged to help you understand this issue.

One day, the elderly mother of a resident, who is also the resident's power of attorney agent, contacted me to find out if a nursing facility could refuse to take her son back once a psychiatric hospital assessed him and documented he was not a danger to himself and others. The mother told me that the facility had sent the resident out for evaluation to a hospital, her son agreed to go to the hospital, the hospital determined that he was not a threat and not appropriate for their care, and now the facility was refusing to take the resident back. The mother said "I know my son is not perfect, but this is not right". The facility had accepted this resident, who has a diagnosis of a traumatic brain injury, with the promise that they could care for him. The resident had a habit of yelling when he wanted a cigarette, and instead of trying other interventions with him, the facility said they needed to send him to a behavioral health hospital. The ombudsman informed the mother the facility could not refuse to take the resident back after the hospital completed the evaluation, in accordance with federal regulation.

The mother talked to the facility about his right to return and her conversation with the facility led her to believe that her son would be transported back to the facility on that Friday. The mother confirmed with the hospital that the resident would be returning to the facility on that Friday, and I planned to meet the mother at the facility on Monday to check on how the resident was doing after his return. Meanwhile, his mother and I didn't know that the facility issued a 30-day discharge notice to the resident while he was at the hospital. But we soon learned that the facility wouldn't give him the 30 days that it promised – instead, this served as four days notice.

The hospital did transport the resident back to the facility on Friday, but, unbeknownst to his mother, the facility had surreptitiously arranged to discharge him to another nursing facility - an hour away from his mother's home and the current facility. The discharging facility drove the resident on that same Friday to the other facility. The mother called me in distress because her son had been moved from his original facility a block away from her house to the new facility over an hour away.



The mother decided to appeal the discharge through the state fair hearings process. The resident and his mother won the appeal and the facility was ordered to take the resident back. The facility, however, refused to readmit the resident and continues to deny him return in violation of the fair hearing officer's order. Almost a year later, the resident remains an hour away from his elderly mother. **The resident and his mother were devastated that even though they followed the regulations and won their fair hearing, there is nothing they can do to get him back to his home.**

Please support HB 2285 so that we can provide these vulnerable Texans the help they need. Thank you for all you do.

Sincerely,

Delicia Marshall  
Tarrant County Ombudsman Program  
[delicia.marshall@unitedwaytarrant.org](mailto:delicia.marshall@unitedwaytarrant.org)  
(817) 258-8109



Human Services Committee  
Texas House of Representatives  
March 11, 2019

*Re: Testimony in Support of HB 2285, "Relating to administrative penalties assessed against certain nursing facilities for the improper discharge or transfer of a resident."*

Dear Chair Frank, Vice Chair Hinojosa, and Human Services Committee members,

My name is Heather Armstrong and I am the Managing Local Ombudsman for the Alamo Area, which is the 12 counties surrounding Bexar County. As Managing Local Ombudsman, I oversee the provision of advocacy services to the residents of the 50 nursing homes in my area. These homes are in the districts of Rep. Kuempel, Rep. King, Rep. Guillen, Rep. Biedermann, Rep. Murr, and Rep. Cyrier. The testimony I provide today is as a representative of the Office of the State Long-Term Care Ombudsman, and does not reflect the positions of my agency.

As a resident advocate, I help nursing home residents and their families help resolve concerns, offer ideas and options. As an advocate for nearly 11 years, I work to ensure the rights of my residents are protected and their choices are respected in the nursing facility they call home.

**As an advocate for these vulnerable Texans, I urge you to support HB 2285. To illustrate this issue, I want to share one example of the impact of improper discharge on residents. Three weeks ago, one of my residents was issued a 30-day discharge notice. He has been at this nursing home for over a year and calls it his home. The resident contacted me and asked for help with this discharge. I went to the nursing home and told him I will be working on his behalf to fight this discharge so he can stay in his home with his friends.**

**Even though I filed an appeal on his behalf, my resident was discharged before the 30-day notice, which is a violation of state and federal law. The response I received when I brought this to the attention of staff was, "We are willing to take the 'hit' with Regulatory for the discharge, if it comes to that". I was in disbelief. I told my resident that I will continue to work on his appeal so that he can return home. He told he loved me and God Bless.**

**I spoke to my resident yesterday and he said "I want to come home. I am ready to come home". I told him I am working on it and we have a hearing for his appeal of the discharge scheduled for later this month. I will be spending additional hours working to help ensure he can come home to his friends and family.**



I thank you for all that the Human Services Committee does to protect the Texans who need you the most. Again, I hope you will join me in supporting this important bill to better protect nursing facility residents.

Sincerely,

A handwritten signature in black ink that reads "Heather Armstrong". The signature is written in a cursive style.

Heather Armstrong, M.A., CDP  
Alamo Managing Local Ombudsman, Area Agencies on Aging  
8700 Tesoro Drive, Suite 160  
San Antonio, TX 78217-6221  
210.362.5283  
harmstrong@aacog.com





Human Services Committee  
Texas House of Representatives  
March 13, 2019

*Re: Testimony in Support of HB 2285, "Relating to administrative penalties assessed against certain nursing facilities for the improper discharge or transfer of a resident."*

My name is Iris Gutierrez, and I am the Managing Local Ombudsman for the South Texas Region which includes Webb, Zapata, Jim Hogg, and Starr counties and in the districts of Representative Tracy King, Representative Richard Raymond, and Representative Ryan Guillen. The testimony I provide today is as a representative of the Office of the State Long-Term Care Ombudsman, and does not reflect the positions of my agency.

I urge you to support HB 2285.

It is a common practice for nursing homes to issue out discharges once a resident starts displaying what the facility sees as "behavior problems". Instead of trying other interventions first, as required by state and federal law, the facility simply tries to discharge the resident by claiming they are "unable to meet the resident's needs". Most often, when a facility says it is "unable to meet the resident's needs" it is because facility staff do not have basic knowledge and education on how to work with residents with dementia or mental health needs. With many residents having some form of dementia-related illnesses and without sufficient training and resources for caring for those residents, it becomes appealing for a facility to discharge a resident the facility deems to be "difficult". Often, a facility will push for discharge regardless of whether the discharge meets state and federal law.

A traumatic example that I see all too often is when a facility will recommend that the resident be sent for a psychological evaluation and convinces the family that it is in the best interest of the resident. The facility sends the resident to a behavioral hospital and tells the family that it will only be temporary. However, once the resident is out of the facility, the facility will refuse to take the resident back. This practice violates state and federal law related to transfers and discharge planning requirements and leaves the family in the terrible position of having to find emergency placement for the resident with no discharge planning assistance from the facility. Sometimes, the family feels the only option is to care for the resident at their home. But at home, the family must balance work and caring for the rest of their family. A family in this situation could feel threatened to be charged with neglect. As you can imagine, this situation places a severe strain on the resident and the family and the possibility of losing a job while trying to care for someone with dementia starts to become a reality – all because the facility refused to comply with the law. Facilities tell residents and their families that they have expertise in working with residents with



dementia and residents and their families should not suffer when the facility later fails to live up to its promise.

I hope this letter will help you understand why HB 2285 is so important to protecting residents.

Sincerely,

Iris Gutierrez  
Managing Local Ombudsman  
South Texas Ombudsman Program  
956-722-3995 ext. 125  
[irisg@stdc.cog.tx.us](mailto:irisg@stdc.cog.tx.us)



## Testimony in Support of HB 2285

My name is Edna L. Ramirez. I am the Ombudsman for the Coastal Bend area. I manage eleven counties and ten Volunteer Ombudsmen for the Coastal Bend. The testimony I provide today is as a representative of the Office of the State Long-Term Care Ombudsman, and does not reflect the positions of my agency.

I began as an Ombudsman on June 2018. During my time as a Managing Local Ombudsman I have experienced several cases of Improper Discharges. One in particular that I experienced was at Nursing Home facility. The resident was considered one that was a “troublesome” resident. The resident was a younger male, verbal and ambulatory. The staff feared the resident and did not want him at the facility because he had a temper. The resident was not violent towards staff or residents, but when he was upset he would throw things in his room and made it verbally known when he was unhappy.

It was brought to my attention by the hospital that this resident was sent to the hospital for a psychological evaluation and the facility no longer wanted to accept him back. The hospital social worker was in contact with me several times during the days that the resident was at the hospital but no longer needed treatment. The nursing facility social worker yelled at me and was unprofessional towards me when I explained to her how unacceptable it was to not allow the resident to return to the nursing facility. I went to the facility to advocate for the resident and inform the facility management about its responsibilities and the resident’s rights related to discharge, but the Administrator and social worker refused to see me. Later, when I finally was able to speak with the Administrator she told me that she determined that this resident was at risk of hurting the other residents, and she was willing to take whatever fines they would get for not accepting the resident back. The Administrator was basing her decision on the resident throwing his personal items in his own room and with no evidence of violence or threats to other residents or staff. I asked the facility why they had originally accepted him if they knew his history, but the Administrator just stated they weren’t going to accept him back.

A day later, the facility administrator reached out to the hospital social worker to tell her she would consider taking the resident back. But later that day, the administrator changed her mind and would not discuss the situation further with me or hospital staff.

My greatest concern here is what happened to the resident. He was not allowed to return to the facility – though it was his legal right to return. He was not given proper notice of discharge and he had to move 17 miles away from where he had lived. This facility didn’t care about its responsibilities to the resident. I urge you to support HB 2285 to deter a facility from ignoring discharge laws that protect residents’ rights.

Sincerely,

Edna Ramirez

March 18, 2019





Testimony FOR HB 2285

March 18, 2019

Dear Human Services Committee members,

My name is Melissa Whitaker and I am the Managing Local Ombudsman for the Panhandle Area, which has the 26 counties in Texas' panhandle. As Managing Local Ombudsman, I oversee the advocacy for residents of the 39 nursing homes in my area. These homes are in the districts of Representative Price, Representative Smithee, Representative King, and Representative Springer, Jr. The testimony I provide today is as a representative of the Office of the State Long-Term Care Ombudsman, and does not reflect the positions of my agency.

As a resident advocate, I help nursing facility residents and their families navigate the various issues and circumstances that may arise while the resident is in a facility. These include guidance on how their nursing home care is paid, complaints or issues with staff, the cleanliness of the facility, food concerns, and transfers or discharges from one facility to another or back into the community.

As an advocate for these vulnerable Texans, I urge you to support HB 2285.

I have had multiple instances when a facility would rather make an improper discharge of a resident and "take the hit" than to care for a resident who they labeled a "squeaky wheel." The majority of these residents just need a little extra care or time from the staff.

I had a resident whom the facility said was someone "whose needs could not be met." The director of nursing oversaw staff members who physically abused the resident and who neglected his needs so much to the point that they left him bleeding for 11 hours after an injury they caused. His wife called an ambulance and he was transferred to the local hospital in severe condition. The facility told me in a meeting that they would rather "take the hit than to have to deal with this man ever again." They in fact received an "Immediate Jeopardy" or "IJ", which is the highest level of federal deficiency, for how the staff treated this man. After he was transferred to another facility we appealed the discharge and won his appeal. It doesn't change the fact that the facility had no remorse or worry that they would be in jeopardy of closing because of how they treated this man. It was one of the most heinous ways I have witnessed a resident treated especially due to the kind of injury that they inflicted on him.

The resident has multiple sclerosis and has no movement below his waist. He has very limited movement with his arms and hands. He is one of the kindest and most reasonable residents that I have ever worked with as an Ombudsman. In his new facility he finally started to gain weight, he finally looks healthy, he is very happy, and he is a social butterfly with the other residents and staff. The staff has no



issues with him and is very close to the resident. He will always be someone that I feel was severely mistreated due to the idea that the facility had no accountability for how they treat people.

I thank you for all that the Human Services Committee does to protect the Texans who need you the most.

Sincerely,

A handwritten signature in black ink that reads "Melissa T. Whitaker". The signature is written in a cursive style.

Melissa Whitaker

Managing Local Ombudsman  
Panhandle Long-Term Care Ombudsman Program



Human Services Committee  
Texas House of Representatives  
March 13, 2019

*Re: Testimony in Support of HB 2285, "Relating to administrative penalties assessed against certain nursing facilities for the improper discharge or transfer of a resident."*

My name is Shazia Sultan, and I am the managing local ombudsman for the Brazos Valley Ombudsman Program, which includes Brazos, Burleson, Grimes, Leon, Madison, Robertson, and Washington counties. In this role, I oversee the provision of advocacy services to the 21 nursing homes in my area. These homes are in the districts of Rep. Kacal, Rep. Raney, Rep. Ashby, and Rep. Leman. The testimony I provide today is as a representative of the Office of the State Long-Term Care Ombudsman, and does not reflect the positions of my agency.

This January, a nursing facility in my area issued a 30-day discharge notice to a resident. I helped the resident file an appeal, informed the administrator of the appeal, and explained the resident's right to stay at the facility while his appeal was pending. Nineteen days later, while the appeal was still pending, the facility issued another discharge letter to the resident that said he would be "immediately discharged." The facility claimed that the resident posed a danger to the health and safety of other residents and staff due to prior verbal threats and harassment and failure to follow the facility's policies.

I called the Administrator and explained that even if an "immediate discharge" was warranted, the resident had the right to be discharged to a safe and appropriate place. I offered my help to the facility and resident about finding a new facility. The next morning, however, when the resident returned to the facility from a doctor's appointment offsite, the facility locked him out of the building. The resident called me from a staff member's phone from the facility parking lot to tell me about the situation. I called the Administrator and reminded him that what he was doing was not lawful or safe, but he still refused to allow the resident back into the building.

I reached out for help from my state office, the Office of the State Long-Term Care Ombudsman, for help. We called the Administrator again, asked for details about the circumstances that supposedly justified an "immediate discharge," and explained that the facts did not meet the legal criteria for such a discharge. The Administrator said his "hands were tied by corporate," so we called the corporate owner, and had the same conversation. That individual agreed that the resident could come back into the building, but minutes later the resident called me again saying that he was only allowed to go into the lobby, not permitted to return to his room as the facility was legally obligated to do.



We called the Administrator again. This time, he said that facility staff had already packed up the resident's belongings and he was considered "discharged." We learned that the facility's discharge plan involved sending the resident either to a hospital or a hotel room. The Administrator also claimed that he had consulted with regional Long-Term Care (LTC) Regulatory Services personnel, who had not raised any objections to the pending discharge.

Once again, we called the corporate owner to raise our concerns and outline the appropriate process. He initially insisted that the immediate discharge was proper. We told him that the resident had given us permission to file a regulatory complaint, and he eventually allowed the resident to return to his room. LTC Regulatory Services determined this complaint was a high priority and investigated the next day. Finding the resident was in his room, the facility was not cited. We managed to persuade the facility to allow the resident to remain until another suitable facility - in a location acceptable to the resident - was located, and within five more days the resident willingly moved.

What this experience taught me is that some nursing facilities will "test" the system and see whether there are consequences to the facility's business. Because I'd forged a relationship with this resident facing discharge, he knew his rights and that he could call on me for help. But the rigidity of the facility to not see that its actions were unjust - if gone unchecked - could have meant that the facility and its corporate owner could have improperly discharged other residents in the future. In this case, I'm hopeful that the facility learned that it can take action that protects its interests without threatening or harming a resident.

**Please support HB 2285. Your support will deter nursing facilities from violating the law that protects residents from improper discharge.**

Sincerely,

Shazia Sultan  
Managing Local Ombudsman  
Brazos Valley Ombudsman Program  
[Shazia.Sultan@bvcog.org](mailto:Shazia.Sultan@bvcog.org)  
979-595-2801





Human Services Committee  
Texas House of Representatives  
March 13, 2019

*Re: Testimony in Support of HB 2285, "Relating to administrative penalties assessed against certain nursing facilities for the improper discharge or transfer of a resident."*

My name is Stephanie Willms, and I am a Staff Ombudsman for the North Central Area, which includes the 14 counties surrounding Dallas and Tarrant Counties. In this role, I provide advocacy services to the residents of the 34 nursing homes to which I am assigned, which are in the districts of Representatives John Wray, Cody Harris, Keith Bell, Dan Flynn, Justin Holland and Rhetta Andrews Bowers. I have worked in this position for 6 years, trying to make sure that the rights of my residents are protected and their choices are respected in the nursing facilities they call home. The testimony I provide today is as a representative of the Office of the State Long-Term Care Ombudsman, and does not reflect the positions of my agency.

I urge you to support HB 2285. This bill is especially important now, because increasingly I find myself trying to help residents who are being threatened with discharge (and, in some cases, have already been discharged) from facilities where they have lived for years. Here is a particularly egregious example.

For approximately three years, Mr. Jones (not his real name) had lived in a nursing home in North Central Texas. One day, after raising concerns about an increase in the price of sodas in the nursing facility machines, and then asking a physician assistant who came to see him to leave his room, he discovered that his exercise of his rights to complain about conditions at the nursing home and to refuse a PA's visit had been interpreted by the nursing home administrator as evidence of mental illness, and subsequently mischaracterized by the facility in order to justify his forced removal from the premises. To his great dismay, on that day the nursing home persuaded a county justice of the peace to issue an Emergency Detention Order and called the police to take him away. The police handcuffed him, rolled him in a blanket and gave him several injections to sedate him and get him out of the building over his strenuous objections. Then they took him to a behavioral health facility for a psychiatric evaluation. Mr. Jones was not told at any time, either before or during this transfer, that he was actually being discharged; rather, two days after his transfer the nursing home hand-delivered a letter to him at the hospital, telling him he had been discharged two days earlier. Even though Mr. Jones was cleared by the behavioral hospital to return to the nursing home a few days later, the nursing home refused to allow him to go home. Consequently, he was taken instead to a different facility, over an hour away, where he knows no one.

As soon as he got there, he began making efforts to return to his home at the original facility. As part of that effort, he asked me to help him appeal his discharge, which we did. After a hearing on his appeal, an HHSC Hearing Officer determined that that the nursing home's actions were "not in accordance with applicable law and policy;" reversed the facility's discharge decision; instructed the facility to rescind the



discharge notice it had issued to Mr. Jones; and ordered the facility to readmit him as soon as they received her Order. Mr. Jones was initially overjoyed; but his joy quickly turned into despair and frustration when he realized that although he had a piece of paper requiring the nursing home to readmit him, there was no way to make that happen: despite the Order, the nursing home repeatedly refused to readmit Mr. Jones, even though he continued to insist – correctly – that he had a right to return there and made it clear many times that he wanted to return. What was particularly upsetting to Mr. Jones, and to me, was that although both local nursing home administration and their regional corporate leadership admitted they were aware of the HHSC Hearing Officer’s Order requiring Mr. Jones’ readmission, they said they had no intention of following that Order, and flatly refused to readmit him. In fact, one of the corporate representatives told HHSC Regulatory surveyors, who were investigating a complaint filed by Mr. Jones, that she would not allow Mr. Jones to be readmitted to the facility because “the judge [Hearing Officer] got it wrong.” Representatives of the nursing home made it clear that they would rather face any consequences by HHSC Long-Term Care Regulatory Services than readmit Mr. Jones.

Due to this blatant disregard by the nursing home of a legally binding Order, Mr. Jones was forced to spend the next *eight months* trying to get back to the nursing facility he called home. Rather than being able to enjoy time with his friends, engaged in activities that would enhance his quality of life and help him deal with the medical problems that life has dealt him, he instead spent hours each day on the telephone. He repeatedly called the nursing home to plead his case, and was told that the facility had instructed its employees not to speak with him. He made several calls to the Hearing Officer who had issued the Order requiring his readmission, as well as her supervisors, asking them to enforce the Order and compel the nursing home to readmit him. He called the regional offices of the HHSC Long-Term Care Regulatory Division, asking them to enforce nursing facility licensure regulations and require the facility to readmit him. He called around the state trying to find a lawyer who would help him get back to the nursing home. He contacted his state elected officials, and representatives of the Office of the State Long-Term Care Ombudsman. He told anyone who would listen that his doctor and the therapy team at that facility put him back together after his hip surgery, and the staff had taken him into their hearts. He further stated that he had no family and considered the staff and the residents at that facility to be his family, and that he wanted to return to the facility because it was his home. He said that he had resigned himself, when he was admitted to that facility in 2015, that it was where he would stay until he died. He noted that he had friends there, and he was involved with the Resident Council. He pointed out that he spent his own money on other residents and advocated for his roommate. He said he felt it was his duty to speak for those who could not stand up or speak for themselves. And, most poignantly, he stated he felt like the nursing home took away his rights and “threw him out like a bag of trash.” Everyone to whom he spoke agreed that the Hearing Officer’s Order required the facility to take him back; and yet everyone also agreed that it was unclear how to make that happen given the nursing home’s refusal to allow him to come back.

At his new facility, Mr. Jones ate in his room, only played Bingo occasionally and did not participate in other activities. He missed his friends at the first nursing home, with whom he was very close, and he found himself unable to build relationships at the new facility because he was so focused on returning to



his previous home. He couldn't stop thinking about his former life, and the injustice he was suffering. Every day he woke up thinking about it, spent all day thinking about it, and went to bed thinking about it. He became increasingly distressed, depressed, anguished, and anxious. He worried daily that he would never be able to return home.

Finally, after nine months, two separate complaint investigations by the HHSC Long-Term Care Regulatory Services division, the termination by the nursing home's parent corporation of both the facility administrator who issued the discharge notice and the corporate representative who refused to obey the Hearing Officer's Order, and hundreds of person-hours invested by the numerous individuals inside and outside HHSC who tried to make the nursing home to follow the rules, Mr. Jones was finally transferred back to the nursing facility from which he had been forcibly removed nearly a year earlier. Despite this "happy ending," the harm that this process caused to Mr. Jones is real, and it is permanent.

Sincerely,

A handwritten signature in black ink that reads "Stephanie Willms". The signature is written in a cursive, flowing style.

Stephanie Willms  
Certified Ombudsman  
North Central Texas Area Agency on Aging  
[SWillms@nctcog.org](mailto:SWillms@nctcog.org)  
817-695-9198





Human Services Committee  
Texas House of Representatives  
March 11, 2019

*Re: Testimony in Support of HB 2285, "Relating to administrative penalties assessed against certain nursing facilities for the improper discharge or transfer of a resident."*

Dear Human Services Committee Members,

My name is Cindy Boyum, and I am the Managing Local Ombudsman for Bexar County. As the Managing Local Ombudsman for this area, I oversee the advocacy for residents in 69 nursing homes in the region. The representatives that oversee my area are Rep. Minjarez, Rep. Larson, Rep. Allison, Rep. Bernal, Rep. Martinez-Fischer, Rep. Gervin-Hawkins, Rep. Gutierrez, Rep. Cortez and Rep. Pacheco. The testimony I provide today is as a representative of the Office of the State Long-Term Care Ombudsman, and does not reflect the positions of my agency.

As an Ombudsman, I am an advocate who works to resolve concerns regarding the quality of life and care of residents. I strive to empower the residents by educating them on their rights. In order to better serve the residents, I ask you to support HB 2285.

**Recently, one of my staff had to appeal the wrongful discharge of a resident. The facility issued a 30-day notice to the resident who is in a vegetative state. The notice stated that the facility could not meet his needs due to "family harassment", which is not a valid reason to discharge. The family strongly advocated for quality care, which caused tension with facility staff. Although the resident requires around the clock care, the discharge location was to his family's home without the support to care for him.**

**HHS Regulatory Services recently cited the facility for health care deficiencies, including care that relates to this resident. While we await the result of the appeal of his discharge, staff stated, "Regardless of the outcome, the resident will be discharged". If the facility follows through with this claim, the resident's discharge would be in violation of state and federal law and place the resident in danger or not having a safe place to live and receive care. As a veteran, he worked to protect us, and now it's time for us to protect him.**

I appreciate all that the Human Services Committee does to safeguard the rights of our citizens.

Sincerely,

Cindy L. Boyum

Managing Local Ombudsman, Area Agencies on Aging  
8700 Tesoro Dr. Suite 160  
San Antonio, TX. 78217  
210-362-5226  
cboyum@aacog.com

