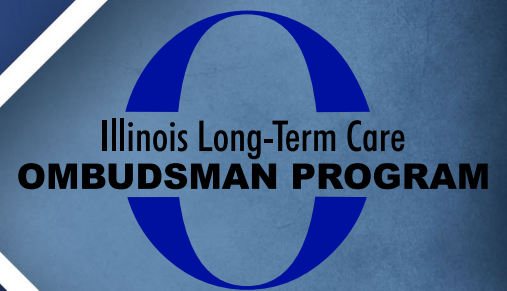


LEVEL II  
TRAINER'S  
MANUAL

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# 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.

NASOP Mission Statement,  
Adopted May 2004

*Updated January 2019*



## ACKNOWLEDGMENTS

The materials in this manual were compiled under the direction of the Illinois Office of the State Long-Term Care Ombudsman. The original training/writing committee included: Jessica Belsly, Ombudsman Specialist; Cathy Weightman-Moore, Regional Ombudsman at Catholic Charities Long-Term Care Ombudsman Program (PSA 01), Rockford, Illinois; Jamie Freschi, Regional Ombudsman at the I-CARE Long-Term Care Ombudsman Program (PSA 07), Springfield, Illinois; Audrey Thompson, Regional Ombudsman at the City of Evanston Senior Services Long-Term Care Ombudsman Program (PSA13), Evanston, IL; and Terri Simpson, Regional Ombudsman at Senior Protective Services (PSA09), Effingham, IL.

The primary sources for this training are the Illinois State Long-Term Care Ombudsman Policies and Procedures Manual (2018); the State Operations Manual Appendix PP – Guidance to Surveyors for Long-Term Care Facilities (Rev. 173, 11/22/2017); the Illinois Act on the Aging; and the many useful resources available through the National Ombudsman Resource Center (NORC) website ([www.ltcOmbudsman.org](http://www.ltcOmbudsman.org)).

Special thanks to the Illinois Pioneer Coalition and the National Pioneer Network for use of the material in Module 1.

The 2019 revision was written by Jamie Freschi, State Ombudsman and Jessica Belsly, Ombudsman Specialist.

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## About the Trainer's Manual

**TRAINER'S NOTES** are emphasized in dark blue capital letters 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 2018, The Illinois Act on the Aging, and the Older Americans Act.

Please note that at various points throughout the text, the corresponding page number in the Participant's Manual can be found next to the abbreviation PM. Corresponding PowerPoint slide references can be found next to the abbreviation PPS. These page numbers will always be displayed in the format **(PPS #) (PM #)** and are most frequently found underneath headings.

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.

## Training Requirements

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, videos, etc. the night before training. Go ahead and play a couple of minutes of the training videos to assure that the device plays correctly and that the volume control is set correctly.

## Training Materials

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

- Computer with internet access to videos or a DVD compatible computer
- Projector
- PowerPoint presentation (provided)
- One trainer's manual for each trainer
- Participant's materials as listed below
- Snacks and meals as local convention dictates

## Managing the Training Environment

As a trainer, you must cover a lot of material in a limited period. 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 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 later in the training may answer some of their questions.
- 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 be an effective Long-Term Care Ombudsman.

## Introduction: Level II Training (PM 6)

As your ability to resolve residents' problems develops, you will find yourself faced with increasingly difficult cases. The objective of Level II training is not to teach a student how to be a good Ombudsman, but to give a good Ombudsman tools. Level II is written assuming the Ombudsman can resolve basic complaints. It is strongly recommended that Ombudsmen have a minimum of three months experience prior to attending Level II training. Throughout this Level II training you will find resources that will help you in your advocacy.

As always, when you face a difficult case, approach your Regional Ombudsman for assistance. The Illinois State Long-term Care Ombudsman Program offers support to any Ombudsman who needs assistance while advocating with or on behalf of residents.

### **TRAINER'S NOTE:**

**Activity - Have participants give their name, location, how long they have been in the Ombudsman Program, and name two aspects of their daily routine that they would not give up if they had to move into a long-term care facility tomorrow.**

**If available, place responses on a white board or flip chart as this information will be referenced in the Culture Change module and throughout the training. Trainer should give their information first as an example.**

## **TRAINING AGENDA (PM 7)**

### **DAY 1**

<b>9:00 – 9:30</b>	<b>Welcome/Introductions with Activity</b>
<b>9:30 – 10:00</b>	<b>Module 1 Culture Change and Person-Centered Care</b>
<b>10:00 – 10:15</b>	<b>Break</b>
<b>10:15 – 11:00</b>	<b>Module 2 Federal and State Agencies</b>
<b>11:00 – 12:00</b>	<b>Module 3 Federal and State Regulations</b>
<b>12:00 – 12:45</b>	<b>Lunch</b>
<b>12:45 – 2:00</b>	<b>Module 4 Working with IDPH</b>
<b>2:00 – 2:10</b>	<b>Break</b>
<b>2:10 – 2:40</b>	<b>Module 5 When Residents Threaten to Harm Themselves</b>
<b>2:40 – 3:45</b>	<b>Module 6 Resident Assessment and Care Planning</b>
<b>3:45 – 4:00</b>	<b>Day 1 Wrap Up</b>

### **DAY 2**

<b>9:00 – 10:30</b>	<b>Module 7 Medicaid and Medicare</b>
<b>10:30 – 10:45</b>	<b>Break</b>
<b>10:45 – 11:15</b>	<b>Module 8 Advance Planning</b>
<b>11:15 – 12:00</b>	<b>Module 9 Financial Exploitation</b>
<b>12:00 – 12:45</b>	<b>Lunch</b>
<b>12:45 – 2:15</b>	<b>Module 10 Transfer and Discharge</b>
<b>2:15 – 2:30</b>	<b>Break</b>
<b>2:30 – 3:30</b>	<b>Module 11 Documentation</b>
<b>3:30 – 4:00</b>	<b>Evaluation/Wrap Up</b>



# CULTURE CHANGE AND PERSON-CENTERED CARE

(PM 5)

MODULE 1

**TRAINER’S NOTE:** Refer to the activity from the introduction.

## **What is Culture Change? (PPS 3) (PM 6)**

Culture Change refers to transforming long-term care facilities through person-directed values and practices where the voices of the individual residents, and those closest to them, are honored and respected.

## **What is Person-Centered Care? (PPS 4) (PM 6)**

Person-centered care focuses on the needs, desires, routines and preferences of the resident rather than the needs of the service provider.

## **The Changing Culture in Nursing Homes (PM 6)**

The need for nursing homes arose about 50 years ago out of the requirements for hospitals to discharge chronically ill people to focus on acute care needs instead. Because of this, today’s nursing homes were typically created as “homes for the aged” to care for chronically ill older adults. Many nursing homes were built like hospitals and organized to run in a similar manner. As a result, nursing homes became regimented. Tasks and schedules became their main focus. Today, daily life in many nursing homes is still organized around predetermined schedules where the tasks become the focus, not the person that is being cared for. Because the emphasis is primarily on quality of care and not on quality of life, the resident’s life often lacks choice, meaning, and purpose. There is little sense that the nursing home is “home” for the person living there.

## **Culture Change (PM 6-7)**

There is a movement in the nursing home industry to transform this institutional approach of care delivery into one that is person-centered and directed. The culture envisioned is one of a community where each person’s capabilities and individuality are affirmed and celebrated. This movement, referred to as Culture Change, promotes quality of care and quality of life simultaneously, making each inseparable and equally important. The results are better functional and behavioral outcomes for individuals and greater satisfaction with care by the residents, their families and caregivers (Rader & Tomquist, 1995). These positive results were shown even when older adults had complex chronic conditions.

Each person is an individual and has different needs and wants. A Culture Change Home will respect this and adapt their care and services so that you can have the same quality of life that you had before needing nursing home care.

With Culture Change the voices of individuals needing care and those working closest with them always come first. It involves a continuing process of listening and changing routines and organizational approaches to individualize and de-institutionalize the care. This is also referred to as person-directed or person-centered care where care values include dignity, respect, purposeful living and having the freedom to make informed choices about daily life and health care. Care is directed by and centered on the person receiving care.

Culture Change in nursing homes occurs through meaningful relationships where caregivers and staff really know the people whom they care for so that individuals can continue to live a meaningful life and feel “at home” wherever they are.

### **Key Components of Culture Change**

A nursing home that practices a Culture Change philosophy treats the person as an individual and respects his/her personal wishes, needs, and choices. The care provided honors personal habits, cultural preferences, and values. The caregivers see the person as a complete being who has thoughts, feelings, physical and spiritual needs. This occurs through consistent and trusting caregiving relationships which promote physical and emotional comfort while keeping the person involved with family, friends and his/her social network.

### **What Does Culture Change Look Like? (PPS 7)**

The chart below illustrates some of the differences between traditional nursing home care and care at a Culture Change Home.

**Figure 1 - Traditional vs. Person-Centered Care**

<b>Traditional Care</b>	<b>Person-Centered Care</b>
Residents are told when to wake up, go to bed, eat, and bathe based upon institutional schedules and set routines.	Residents wake up, go to bed, eat and bathe when they choose to. Staff alters their work routines to honor residents’ preferences.
Residents frequently have different care staff. The staff does not know the residents well so they are not familiar with their preferences. Residents often feel unknown, insecure and scared.	The same staff takes care of the same residents; they know each other and caring relationships develop. Staff ultimately provide better care and residents feel more secure, content and happy.

**TRAINER’S NOTE:** Discuss a situation in which a solution that works in one facility might not work in another. For example, expectations for care or willingness to complain may vary based on culture (i.e. Greek vs Asian), geographic region (urban vs rural) or age (those 85 and older [The Greatest Generation] vs those 73 and younger [Baby Boomers])

### **(PPS 9)**

There is no formula for Culture Change. What works in one environment may not work in another. One resource for Culture Change practices can be found on The Consumer Voice website: [http://theconsumervoice.org/uploads/files/issues/culture-change-in-nursing-homes-fact-sheet-final\\_\(1\).pdf](http://theconsumervoice.org/uploads/files/issues/culture-change-in-nursing-homes-fact-sheet-final_(1).pdf)

## **Culture Change Basis in Law (PPS 10)**

Culture Change practices have roots in the Nursing Home Reform Law (OBRA '87).

This federal law requires nursing homes to:

- Promote the “physical, mental and psychosocial well-being of each resident”.
- Promote the quality of life, choice, self-determination and rights of each resident.

OBRA '87 also requires state and federal governments to:

- Evaluate whether each resident is receiving care which promotes the highest practicable well-being.
- Ensure facility compliance with residents’ rights and quality of life.

## **Ombudsman Support of Culture Change Practices (PPS 11)**

The Ombudsman Program provisions in the Older Americans Act are aligned with the federal regulations for nursing homes. This federal law requires Ombudsmen to:

- Act on residents’ behalf in response to actions or inactions on the part of facilities or state agencies that adversely affect residents’ health, safety, welfare or rights.
- Address residents’ problems on an individual and systemic level.
- Support community efforts to improve nursing home care.
- Resolve problems in a way that promotes residents’ interests.

## **What Do These Have in Common? (PPS 12)**

<b>Nursing Home Reform Law</b>	<b>Older Americans Act</b>
<b>Calls upon providers to develop individual approaches to resident care that help residents maintain and attain their highest possible level of functioning.</b>	<b>Gives ombudsmen the tools to help providers see a situation from a resident’s point of view and make reasonable accommodations to promote their well-being.</b>

## **Nursing Home Federal Regulations (PPS 13)**

**TRAINER’S NOTE: Don’t get bogged down on a discussion of this topic. Module 6 covers care planning in much more detail. The point here is to bring their attention to the fact that person-centered care is written in federal regulations and not just a theory presented by Ombudsmen.**

Person-centered care is a requirement of certified long-term care facilities.

The revised regulations contain language specific to person-centered care such as the following from the nursing home federal regulations:

“§483.21 Comprehensive Person-Centered Care Planning”

§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care

plan for each resident, consistent with the resident rights.

Surveyors are trained to look for and investigate concerns about person-centered care. “The LTCSP (Long-Term Care Survey Process) is a resident-centered, outcome-oriented inspection...”

### **The Original Vision (PPS 14)**

The “Culture Change” movement emerged from the ground-breaking work of nursing home practitioners in their effort to reduce the use of chemical and physical restraints.

Practitioners found that, in order to remove restraints, they had to:

- Understand residents’ underlying problems.
- Develop individualized responses to those problems.

Sarah Burger at the National Citizens Coalition for Nursing Home Reform (NCCNHR, now known as The Consumer Voice) and a social worker named Carter Williams joined efforts by practitioners around the country who were working to reduce the use of physical and chemical restraints.

In 1996, four practitioners who were already doing transformational work in their own individual nursing homes and had worked with NCCNHR on federal nursing home policy, came together to present on a panel at NCCNHR’s Annual Meeting.

In 1997, through the efforts of Rose Marie Fagan, Director of the Monroe County Long-Term Care Ombudsman Program, supported by Carter Williams, M.S.W., LIFESPAN of Greater Rochester, New York received funding to bring together the leaders of four pioneering approaches to Culture Change in nursing homes. The Pioneers met in Rochester, NY with 28 other invited participants from across the United States. A published report of that historic meeting documents the common elements of their varied approaches.

Additional information about the history of the “Culture Change” movement can be found in the document “Ombudsman Best Practices: Supporting Culture Change to Promote Individualized Care in nursing homes” by Barbara Frank. <http://ltcombudsman.org/uploads/files/support/Best-Practices-Paper-Ombudsman-Culture-Change.pdf>

### **National Pioneer Network (PPS 15)**

The Pioneer Network advocates and facilitates deep system change and transformation in our culture of aging. Key actions are to:

- Create communication, networking and learning opportunities.
- Build support relationships and community.
- Identify and promote transformations in practice, services, public policy and research.
- Develop and provide access to resources and leadership.

## **Values and Principles (PPS 16-17)**

- Know each person
- Understand that each person can and does make a difference
- Recognize that relationships are the fundamental building block of a transformed culture
- Respond to spirit, as well as mind and body
- Understand that risk taking is a normal part of life
- Put the person before the task
- Assure all residents are entitled to self-determination wherever they live
- Recognize that community is the antidote to institutionalization
- Do unto others as you would have them do unto you
- Promote the growth and development of all
- Shape and use the potential of the environment in all its aspects: physical, organizational, psycho/social/spiritual
- Practice self-examination, searching for new creativity and opportunities for doing better
- Recognize that culture change and transformation are not destinations but a journey, always a work in progress

## **Ombudsman Role in Culture Change (PPS 18)**

- Integrate culture change in every aspect of your work (community education, systems change)
- Make it the foundation of problem solving
- Advocate for resident-directed care
- Learn about culture change
- Ask about culture change practices in the homes in your area
- Become involved in your regional pioneer/culture change coalition
- Promote resident-directed care

## **ADDITIONAL RESOURCES:**

National Pioneer Network: <http://www.pioneernetwork.net>

Illinois Pioneer Coalition: <http://www.illinoispioneercoalition.org>

Acknowledgement to Illinois Pioneer Coalition and the Your Way: How to Find Dignity and Choice in a Nursing Home

This image shows a full page of blank, lined paper. It features approximately 20 evenly spaced horizontal black lines across the entire width of the page, typical of notebook or legal stationery. The background is a solid off-white color. There are no margins, text, or other markings present.





# FEDERAL AND STATE AGENCIES

(PM 13)

MODULE 2

## Introduction

**TRAINER'S NOTE:** The section gives you an opportunity to introduce participants to the idea that many agencies have an interest in Ombudsman activities. Furthermore, participants may benefit most from examples of how you or other Ombudsmen have consulted with these agencies to help residents. Case scenarios are included in the **TRAINER'S NOTES**.

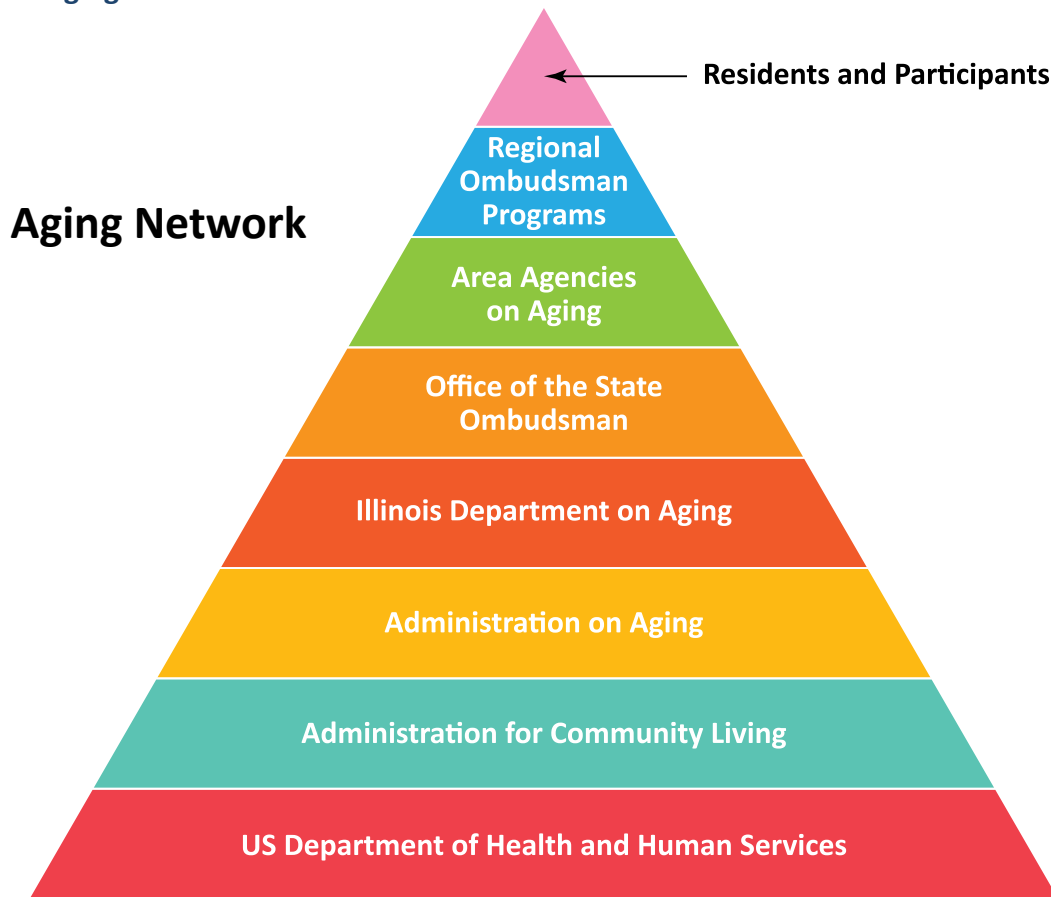
### (PM 14)

The purpose of this module is to familiarize you with federal and state agencies offering services designed to assist and protect residents. It is also helpful for you to understand where the Long-Term Care Ombudsman Program fits into this larger network.

The availability of services can vary widely from region to region. You may find that you work more with some agencies than others, or that you collaborate with agencies not listed in this module. As always, work with your Regional Ombudsman to seek out those agencies and services that are most likely to result in a satisfactory resolution for the residents.

**TRAINER'S NOTE: (PPS 2)** This slide displays a flow chart of the Aging Network. The Ombudsmen trainees may recall a similar chart from their Level I training.

**Figure 2 - Aging Network**



## Federal Agencies & Programs

**TRAINER'S NOTE:** The information below serves only as an introduction to these agencies.

### (PM 15)

The *Administration for Community Living*, The *Administration on Aging*, and the *Centers for Medicare and Medicaid Services* have the most direct impact on the lives of seniors requiring long-term care services of any kind. Therefore, this module will focus on those divisions and on state agencies that hold responsibility for program and service delivery.

The *United States Department of Health and Human Services (HHS)*, also known as the Health Department, is a cabinet-level department of the U.S. federal government with the goal of protecting the health of all Americans and providing essential human services. Its motto is "Improving the health, safety, and well-being of America." Programs the agency oversees are Medicare, Medicaid, and services for older Americans, including home-delivered meals.

The *Administration for Community Living (ACL)* was formed in April 2012 as an umbrella agency for the Administration on Aging, the Office on Disability, and the Administration on Developmental Disabilities.

The ACL also works with the Administration on Aging (AoA) on the Managed Long-Term Care Services and Supports (MLTSS) initiative. Grants provided by ACL help aging and disability networks develop MLTSS systems and increase their capacity to contract with managed care organizations.

### (PPS 4-5)

The *Administration on Aging (AoA)* is responsible for the administration of home- and community-based services to older adults through programs funded by the Older Americans Act and provided through the Aging Network.

Since 2006, the Aging Network has been involved in efforts to modernize the long-term health care system by integrating best practices from a number of HHS initiatives that encourage the use of home- and community-based services as an alternative to institutions providing long-term care. Community-based services provided by the Aging Network include home-delivered meals, congregate meal programs, personal care services, transportation assistance, adult day care services, and elder rights protection programs.

Because every State Ombudsman Program receives a portion of its funding through Title III and Title VII of the Older Americans Act, AoA is also the federal agency responsible for the Long-Term Care Ombudsman program.

If you are a paid Ombudsman, you are undoubtedly learning about the National Ombudsman Reporting System (NORS), a topic that requires a separate training. Information that is reported in PeerPlace, our state- approved documentation system, eventually reaches AoA in the form of statistics exploring what types of cases Ombudsmen opened, how many of those cases were successfully resolved, etc.

In its efforts to support the Long-Term Care Ombudsman Program, AoA provides funding for the *National Long-Term Care Ombudsman Center (NORC)*. According to its website, NORC provides “support, technical assistance and training to 53 State Long-Term Care Ombudsman Programs and their statewide networks of almost 600 regional (local) programs.” NORC services help “enhance the skills, knowledge, and management of the State programs to enable them to handle residents’ complaints and represent resident interests (individual and systemic advocacy).”

NORC operates in cooperation with *National Association of States United for Aging and Disabilities (NASUAD)*. NASUAD represents 56 state and territorial agencies on aging and disability to improve state systems and develop national policy that advances the goal of providing home- and community-based services for seniors, people with disabilities, and their caregivers.

### **(PPS 6)**

The *Centers for Medicare and Medicaid Services (CMS)* provide oversight for the Medicare program and the federal portion of the Medicaid Program. The Affordable Care Act made CMS responsible for developing the Health Insurance Marketplace, expanding Medicaid, and regulating private health insurance plans. You can learn more about Medicaid and the Affordable Care Act from the Federal Medicaid website or from the Illinois HFS Affordable Care Act website.

### **(PPS 7)**

More importantly to you as an Ombudsman, CMS is responsible for oversight of programs that fund long-term care. Therefore, CMS develops and enforces standards that facilities must meet in order to continue to receive Medicare and/or Medicaid funding and reimbursements. CMS publishes the Code of Federal Regulations and State Operations Manual used by State Survey Agencies to assure that nursing homes provide the quality of care and quality of life assured to recipients of long-term care services by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). These documents are discussed in more depth later in this training.

In all likelihood, your first contact with CMS will be the result of reading letters in which CMS is imposing or rescinding sanctions (usually fines) on long-term care facilities as the result of poor performance on annual surveys or negative findings on a complaint investigation. From time to time, the State and Deputy State Long-Term Care Ombudsmen and Regional Ombudsmen may consult with CMS representatives for clarification of CMS policies and procedures.

## **The Social Security Administration (PPS 8)**

The *Social Security Administration* is responsible for the management of social insurance programs benefiting retired workers and their dependents, disabled workers and their dependents, and survivors of deceased workers.

In 2018, 63 million Americans received approximately \$1 trillion in Social Security benefits. Most Social Security benefits were distributed to retired workers and their dependents. Nearly 21% of older married couples and 44% of unmarried beneficiaries depend on Social Security for 90% or more of their income (Social Security Administration, <https://www.ssa.gov/news/press/fact-sheets/basicfact-alt.pdf>).

The Social Security Administration becomes important to Ombudsmen when Social Security benefits are used to pay for long-term care. As you will remember from the Level I module on Residents' Rights, residents are not required to make a facility the representative payee for their social security benefits. However, when a resident cannot manage his or her own financial affairs and/or there is evidence of financial exploitation, changing the representative payee to the facility is an option.

**TRAINER'S NOTE: Case Scenario.** Mrs. Jones has been in the nursing home for 6 months. Her daughter, Linda, who lives in Mrs. Jones' house paid the nursing home for the first two months but has not made a payment in the last four months. Mrs. Jones' Social Security payment is directly deposited into a bank account that Linda has access to. After numerous attempts by the facility to persuade Linda to pay the outstanding bill, Linda told the staff member that she had spent her mother's money to take a much-deserved vacation. After all, she had been taking care of her mother at home for the past 2 years. Mrs. Jones shared with the Ombudsman that she is terribly embarrassed that her bill has not been paid. She has always paid her bills on time. The Ombudsman explained to Mrs. Jones that she could set up a new bank account or contact the Social Security office and have the facility become Rep Payee. Mrs. Jones worked with facility staff to ensure payment came directly to the facility.

## **The Department of Veterans Affairs (VA) (PPS 9)**

*The Department of Veterans Affairs (VA)* is responsible for assuring that military veterans, surviving spouses, and parents of deceased Veterans receive benefits earned through active duty services in the military. Some of these benefits include disability benefits, medical treatment and vocational rehabilitation.

Of interest to Ombudsmen are benefits for eligible seniors and burial benefits. The *Office of Geriatrics and Extended Care* provides information on long-term care benefits including those provided in the community and in nursing homes and other residential settings.

As an Ombudsman, you are most likely to have contact with VA through the Illinois Department of Veteran's Affairs, discussed later in this module.

## **State Agencies (PPS 10) (PM 17)**

### **Illinois Department on Aging (PPS 11)**

**TRAINER'S NOTE: This is the State Unit on Aging.**

*The Illinois Department on Aging (IDOA)* is responsible for oversight of federal and state funded programs designed to help older adults and persons age 18-59 with a disability. IDOA programs fall into four categories: Community Care Programs, Older Americans Act Services, Elder Rights Services (Adult Protective Services, the Long-Term Care Ombudsman Program, and legal assistance programs), and Community Services, Communications and Training.

The State Long-Term Care Ombudsman is responsible for administration of the Long-Term Care Ombudsman Program and Home Care Ombudsman Program at the Departmental level.

Most IDoA programs, including Regional Ombudsman Programs, are delivered through regional *Area Agencies on Aging (AAAs)*. Many AAAs award grants to local providers who agree to provide services such as routine health screenings, transportation, home-delivered and congregate meals, information and assistance, in-home respite care, caregiver counseling, legal assistance, medication management, and the Long-Term Care Ombudsman Program. Ombudsman Programs may refer residents to the free legal services available through the legal assistance foundations associated with the Aging Network.

In keeping with the intent of the Older Americans Act, most services are designed to help seniors remain in community living situations for as long as possible and to protect the rights and safety of seniors. The Long-Term Care Ombudsman Program is an exception to this general rule.

### **Senior Health Insurance Program (SHIP) (PPS 12)**

*Senior Health Insurance Program (SHIP)* is a free counseling service provided by the Illinois Department on Aging. SHIP counselors can answer questions about: Medicare, Medicare Supplement Insurance, Medicare Advantage Plans such as HMOs, PPOs, PFFs, Prescription Drug Coverage through Medicare and other sources, Long-term Care Insurance, Medicare Claims and Appeals and Medicare Beneficiary Rights and Guarantees. The SHIP hotline can be contacted at 1-800-548-9034.

**TRAINER'S NOTE: Case Scenario. An Agent under Power of Attorney received a bill from a pharmacy for a resident's prescriptions that were to be paid by Medicare. After the Agent tried to work with the facility and pharmacy to rectify the situation, he contacted an Ombudsman. The Ombudsman contacted a SHIP Counselor. The SHIP Counselor sent emails and made phone calls to Medicare on behalf of the resident and the Agent. The bill was adjusted properly.**

### **Benefit Eligibility Assistance & Monitoring (BEAM) (PPS 13)**

*Benefit Eligibility Assistance & Monitoring (BEAM)* provides services only to professionals. BEAM serves to verify benefits, eligibility and assistance, and monitors various senior services. These services include the following: 1) free rides on mass transit for seniors and persons with disabilities, and reduced-fee license plate registration through the Secretary of State's office, 2) client data for the Community Care Program and Managed Care Organizations, and 3) billing rejection and federal match information for Medicaid reimbursement.

### **Community Care Program (CCP) (PPS 14)**

*The Community Care Program* is designed to meet the needs of Illinois residents age 60 and older who are at risk of nursing facility placement. Services include comprehensive care coordination, adult day/in-home care, emergency home-response services and, in limited areas,



senior companions. A care coordination unit (a local senior center, social service agency or health department) determines an individual's eligibility, designs a care plan and makes arrangements for services with contractual provider agencies. Care coordinators pre-screen individuals who plan to enter a long-term care facility and may recommend that the individual continue to live at home and receive Community Care Program services.

**TRAINER'S NOTE: Why contact CCP? Residents who have been living in the community with assistance from the Community Care Program and are preparing to return to their home after a stay in a long-term care facility may request that the Ombudsman contact their Case Manager to make arrangements to have the services reinstated.**

### **Adult Protective Services (APS) (PPS 15)**

*Adult Protective Services (APS)* investigates reports of alleged cases of abuse, neglect, (including self-neglect) and exploitation by third parties, and self-neglect of vulnerable adults 18 years of age or older. APS provides protective services to reduce or eliminate the risk of abuse, neglect, self-neglect and exploitation.

APS is not a custodial agency. APS does not have the authority to take custody of any adult for any reason.

**TRAINER'S NOTE: Assure that Ombudsman are clear that APS deals with those individuals who are victims of abuse, neglect, and exploitation that occurred in the community. APS will be discussed in greater detail in Module 9.**

**TRAINER'S NOTE: Why contact APS? Resident in a nursing facility is going to be returning to their home in the community. APS has had contact with this resident prior to their entering the facility due to financial exploitation by family member. As an Ombudsman, you may, with resident permission, contact APS and inform the case worker that this individual is returning to the community.**

### **Illinois Department of Healthcare and Family Services (HFS) (PPS 16) (PM 18)**

The *Illinois Department of Healthcare and Family Services (HFS)* is responsible for administration of the Medicaid Long-Term Care program. HFS fulfills this responsibility by developing long-term care policies in accordance with federal and state regulations.

HFS also makes financial decisions that affect long-term care facilities. For example, HFS establishes the daily per diem rate that long-term care facilities receive for the care of Medicaid residents and assures that sanctions set by the Department of Public Health are implemented. HFS also works with the Department of Human Services to assure that payments to providers are made properly.

HFS oversees the Illinois Supportive Living Program. Supportive Living Facilities provide services to individuals between the ages of 22 and 64 with a physical disability (as defined by the Social Security Administration) and to individuals 65 and over. Individuals with primary or secondary diagnoses of developmental disabilities or serious mental illnesses do not meet the eligibility criteria for Supportive Living facilities.

## **Illinois Department of Public Health (IDPH) (PPS 17) (PM 19)**

**TRAINER'S NOTE: This should be a very brief overview of IDPH as another Module covers the complaint process with IDPH.**

The primary function of the *Illinois Department of Public Health (IDPH)* is to prevent and control injury and disease. Public health services include food, water and drug testing, licensing health care facilities, investigations to control the outbreak of infectious diseases, and collection and evaluation of health statistics to develop prevention and regulatory programs.

Most relevant to Ombudsmen, the IDPH Office of Health Care Regulation is responsible for assuring that nursing homes comply with the Illinois Nursing Home Care Act and other Federal Regulations and State Administrative Codes for facilities receiving Medicare and/or Medicaid funding. Two Divisions of IDPH, LTC Quality Assurance and LTC Field Operations, focus specifically on long-term care.

### **(PPS 18)**

IDPH also maintains the Health Care Worker Registry, a database that lists information on anyone who has had a background check conducted in accordance with the Health Care Worker Background Check Act. The Registry contains training information as well as administrative findings in cases of abuse, neglect or misappropriation of property.

<http://www.idph.state.il.us/nar/home.htm>

As an Ombudsman, you will frequently interact with IDPH surveyors or with intake specialists at the Central Complaint Registry. Much more detailed information about surveys and the complaint process appear later in this training.

## **The Illinois Department of Human Services (DHS) (PPS 19)**

The *Illinois Department of Human Services (DHS)* is responsible for the administration of many programs that help families meet their basic needs. DHS assistance programs provide access to cash, food, childcare, housing, health and medical care for low-income families, people with disabilities, and the elderly. Some of the DHS administered programs that may be familiar to you include the Supplemental Nutrition Assistance Program (SNAP/food stamps) and Temporary Assistance for Needy Families (TANF).

Although medical programs are administered by HFS, applications for medical assistance programs (i.e. Medicaid) are completed at *DHS Family Community Resource Centers (FCRC)* (the local Medicaid office) as part of the larger Public Aid application process. To locate an office near you go to: <http://www.dhs.state.il.us/page.aspx?module=12&officetype=5&county>

**TRAINER'S NOTE: Allow time for discussion regarding why an Ombudsman would initiate assistance from DHS.**

From time to time, you may need to encourage facility staff to contact an FCRC to follow-up on a Medicaid application. With the permission of your Regional Ombudsman, you may also call DHS staff to learn more about how the Medicaid program works for individuals living in a long-term



care facility. For example, one Ombudsman working on a facility-initiated discharge called DHS to get more information on allowances for maintaining a home in the community.

### **(PPS 20)**

In addition to referring facility staff or family members to FCRCs, you may come in contact with other divisions within DHS. The *Division of Rehabilitative Services (DRS)* is available to help individuals with disabilities maximize their potential for independent community living, education and employment. Some services provided by DRS include: vocational rehabilitation, home services (i.e. personal assistants, homemaker services, etc.).

As an Ombudsman working in long-term care settings, you are most likely to consult DRS staff for clarification regarding services available to individuals with disabilities aged 18-59 wishing to transition from a long-term care setting to a community living arrangement. Your first contact is most likely to be with the staff of one of the 23 Centers for Independent Living (CILs) in Illinois. These professionals help locate housing and develop service plans for community reintegration.

The *Division of Developmental Disabilities* is responsible for administrative oversight of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD). The Division also manages oversight of State Operated Developmental Centers (SODCs). This is an oversight role much like the role of CMS in long-term care facilities. IDPH is the surveying agency for ICF/DD, and SODC facilities.

There is a high likelihood that you will, at some point, visit a facility serving individuals with developmental disabilities or that you will come across an older adult with developmental disabilities and chronic medical needs that cannot be met in community or intermediate care settings. This population needs specialized services that meet their biopsychosocial needs. You may also find, after discussion with the facility social worker, that the individual has a caseworker from a regional Developmental Disabilities Services office. Individuals from these offices can help you understand the needs of people with developmental disabilities as well as the unique legal precedents and guardianship issues that come into play when working with individuals with developmental disabilities.

The Office of the Inspector General (OIG) is also housed in the Department of Human Services. The OIG investigates abuse allegations of adults with severe mental illnesses or developmental disabilities who are receiving services from state-operated psychiatric hospitals, developmental centers, and/or community programs licensed or funded by DHS. The OIG can arrange services to help alleviate abusive situations. To report abuse against adults with mental illnesses or developmental disabilities in state-operated facilities, call the OIG hotline at 1-800-368-1463.

### **Office of the Attorney General (AG) (PPS 21)**

The *Office of the Attorney General* is responsible for protecting the interests of the citizens of Illinois. In its efforts to fulfill its responsibilities, AG staff is involved in advocacy, legislative efforts and litigation covering issues ranging from building better charities to consumer protection and advocacy for women and older citizens.

The AG's office participates in four major programs designed to help protect Illinois seniors. A brief description of these programs is provided below. More information can be found on the AG's "Advocating for Older Citizens" page.

The Illinois TRIAD Program is an association of local TRIAD programs from across the state. TRIAD programs form in local communities to help fight crimes against seniors. TRIAD programs are made of up law enforcement officials, county sheriffs, municipal chiefs of police, legal representatives, elder rights advocates, and other community activists.

The Elderly Services Officer Training Program is an outgrowth of the TRIAD program. Elderly Services Officers receive an intensive, week-long training designed to educate and sensitize them to issues affecting older adults and to offer methods for helping to prevent crimes against seniors. An Advanced Elderly Services Officer Training is also available. Ombudsmen have been able to develop strong positive relationships with ESOs. In some cases, ESOs have been available to assist in investigation of abuse or exploitation of a nursing home resident by someone living in the community.

The Silver Beat Program was created by the Illinois Attorney General's Office in cooperation with AgeOptions to help assure that seniors have access to information about deceptive practices. Topics covered in Silver Beat training include: financial exploitation, fake check cashing scams, debt settlement traps, reverse mortgages, health care fraud, and more. Copies of Silver Beat tip sheets are available in your supplemental materials.

The B\*Safe Program is a cooperative effort between the Attorney General's Office, Illinois TRIAD and the banking community. The B\*Safe Program attempts to address financial exploitation of older adults by helping banks train their employees to identify, report, and stop exploitation.

### **Illinois State Police (ISP) (PPS 22)**

In its efforts to protect the public, the *Illinois State Police* is involved in programs intended to reduce fraud. The ISP Medicaid Fraud Control Unit investigates situations in which Medicaid is billed for services that were not provided or were under provided.

When Medicaid money is involved, the ISP Medicaid Fraud Control Unit may also investigate cases of physical abuse or neglect including battery, sexual assault, and failing to deliver services or medications in addition to drug diversion. You can report any of these concerns to Medicaid Fraud, by calling (888) 557-9503.

The Illinois State Police is also responsible for updating the Illinois Sex Offender Database. The Sex Offender Database identifies individuals who are required to register as the result being convicted of certain sex offenses and/or crimes against children.

### **Illinois Department of Financial and Professional Regulation (IDFPR) (PPS 23)**

The Illinois Department of Financial and Professional Regulation (IDFPR) is responsible for professional licensing and for monitoring most of the state's financial institutions. The Division

of Professional Regulation licenses nearly 1 million professionals in over 100 industries in the State of Illinois. The IDFPR online license look up allows individuals to search for any disciplinary actions that may have been taken against a physician, nursing home administrator, licensed nurse, licensed social worker, dietician, or other licensed health care professional.

## **The Illinois Department of Veterans' Affairs (PPS 24)**

*The Illinois Department of Veterans' Affairs* helps veterans and their caregivers access benefits, provides long-term health care in four veteran's homes, and helps connect veterans to other agencies providing assistance with concerns related to education, employment, housing, mental health, etc.

Veteran Services Officers help veterans and caregivers navigate the complex web of services and benefits available through the VA and IDVA. VSO's are trained and accredited through the U.S. Department of Veterans Affairs.

Facility social services directors may be unaware of benefits available to veterans or unsure how to contact a VSO. You can guide them to this helpful information. Contact information for all Veteran's Services Offices is available online.

<https://www2.illinois.gov/veterans/benefits/Pages/benefits-assistance.aspx>

One of the most useful benefits you can be aware of is the Burial Benefit. This benefit will contribute up to \$900 toward funeral expenses for indigent veterans. To help family members or facility staff access the benefit, guide them to a VSO.

Additionally, VSOs can help veterans obtain copies of their discharge papers (DD214), service records, military medical records, medals, ribbons, and awards. One Ombudsman successfully contacted a VSO who replaced a number of medals that had been stolen from a veteran during a home invasion that occurred before the veteran moved into a long-term care facility.

**TRAINER'S NOTE: Ombudsmen may inform facility staff, as they may not be aware, VSO services are available.**

**An Ombudsman contacted the VA because a resident (who was a veteran) needed a wheelchair. With resident permission the local VA office was contacted and a wheelchair was eventually provided.**

**Some Veterans are eligible for an increased personal needs allowance of \$90 per month, instead of \$30 that others receive. Facility staff are not always aware of this benefit and may need to be educated about how to inquire with the Local Service Officer with the VA.**

## Local Agencies (PPS 28) (PM 22)

### Area Agencies on Aging (AAA) (PPS 26)

Area Agencies on Aging have the primary task of planning and coordinating services and programs for older people in their respective areas. The Area Agencies receive funding from the Department based on a formula which takes into consideration the number of older citizens and minorities in that area, as well as the number living in poverty, in rural areas, and alone. Funding is allocated to the Area Agencies on Aging through the Department on Aging. The AAAs are responsible for the administration of the Long-Term Care Ombudsman Programs.

Like the Department on Aging, Area Agencies are not, as a rule, direct service providers. Area Agencies contract with local agencies which provide services to the older people who live in the same community.

Because State Long-Term Care Ombudsman Programs are funded, in part, through Titles III and VII of the Older Americans Act, they often work closely with the Area Agencies on Aging.

**TRAINER'S NOTE:** Examples of other grants are: Routine health screenings, transportation, congregate and home-delivered meals, information and assistance services, in-home respite care, caregiver counseling, legal assistance, medication management, senior employment programs, and caregiver training and education programs.

### Legal Services (PPS 27)

Ombudsmen consult with and refer clients to legal services available through legal assistance organizations. These organizations receive federal funding to provide free legal services to seniors. The three legal service organizations are Prairie State Legal Services, Land of Lincoln Legal Assistance Foundation and LAF.

Figure 3 - Legal Assistance Organizations



## Resources (PM 24)

The following links provide additional information and resources regarding the agencies and programs referenced in this module.

### **Federal Agency Websites**

Administration for Community Living (ACL)

<http://www.acl.gov/>

The Administration on Aging (AoA)

<http://acl.gov/about-acl/administration-aging>

National Long-Term Care Ombudsman Center (NORC)

<http://ltombudsman.org/>

National Association of States United for Aging and Disabilities (NASUAD)

<http://www.nasuad.org/>

Centers for Medicare and Medicaid Services (CMS)

<http://www.cms.gov/>

Medicaid

<https://www.medicaid.gov/>

Social Security Administration

<http://www.ssa.gov/>

The Department of Veterans Affairs (VA)

<https://www.va.gov>

### **State Agency Websites**

Illinois Department on Aging (IDOA)

<https://www2.illinois.gov/aging>

Senior Health Insurance Program (SHIP)

<https://www2.illinois.gov/aging/ship/Pages/default.aspx>

Illinois Department of Healthcare and Family Services (HFS)

<https://www.illinois.gov/HFS/Pages/default.aspx>

Illinois Department of Public Health (IDPH)

<http://www.dph.illinois.gov/>

Illinois Department of Human Services (DHS)

<http://www.dhs.state.il.us/page.aspx>

DHS Family Community Resource Centers (FCRC)  
<http://www.dhs.state.il.us/page.aspx?module=12&officetype=5&county>

DHS Division of Rehabilitative Services  
<http://www.dhs.state.il.us/page.aspx?item=29764>

DHS Developmental Disabilities Services office  
<http://www.dhs.state.il.us/page.aspx?item=29761>

DHS Office of the Inspector General (OIG)  
<http://www.dhs.state.il.us/page.aspx?item=29959>

Office of the Attorney General  
<http://www.illinoisattorneygeneral.gov/>

IAG Advocating for Older Citizens:  
<http://illinoisattorneygeneral.gov/seniors/index.html>

Illinois TRIAD Program:  
<http://www.illinoistriad.com/>

Elderly Services Officer Training Program  
<http://illinoisattorneygeneral.gov/seniors/eso.html>

Illinois State Police  
<http://www.isp.state.il.us/>

ISP Medicaid Fraud Unit  
<http://www.isp.state.il.us/crime/medicaidfraud.cfm>

Illinois Sex Offender Database  
<http://www.isp.state.il.us/sor/>

Illinois Department of Financial and Professional Regulation (IDFPR)  
<https://www.idfpr.com/>

Illinois Department of Veteran's Affairs  
<http://www2.illinois.gov/veterans/Pages/default.aspx>

All Veterans' Services Office Locations (Map and Contact Information)  
<https://maps.google.com/maps/ms?ie=UTF8&hl=en&msa=0&msid=103591904087477906918.00046209f7e7827b062e2&ll=40.245992,-89.362793&spn=5.382338,16.962891&z=6>

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# FEDERAL & STATE REGULATIONS

(PM 27)

MODULE 3

## **Introduction**

### **(PPS 2) (PM 28)**

Health care is one of the most heavily regulated industries in the United States. As you have learned, any health care organization that receives funding through Medicare or Medicaid Programs falls under the regulatory eye of both Federal and State agencies.

This module will introduce you to some of the most important regulations affecting the Ombudsman Program and long-term care facilities. We will not discuss the regulations or codes in great depth. However, links to many applicable regulations are provided at the end of this module. Hyperlinks appear in bold, underlined, italic text.

All long-term care facilities operating in Illinois are licensed and must meet the appropriate state regulations. Facilities that are certified for Medicare and/or Medicaid funding are subject to both federal and state regulations.

## **Federal Law**

### **(PM 28)**

### **Social Security Act (PPS 4)**

The Social Security Administration established laws that spell out requirements for long-term care facilities specific to Medicare and Medicaid.

#### **Standards for skilled nursing facilities receiving Medicare:**

Title XVIII of the Social Security Act; found in 42 USC 1395i-3, is the portion of Social Security Law that sets standards for skilled nursing facilities. You can find the text of 42 USC 1395i-3 on the Social Security Administration's Compilation of Security Laws website.

#### **Standards for nursing facilities receiving Medicaid:**

Title XIX of the Social Security Act, found in 42 USC 1396r, is the portion of Social Security Law that establishes requirements for nursing facilities receiving Medicaid funding. You can find the text of 42 U.S.C. 1396r on the Social Security website.

### **The Federal Nursing Home Reform Act (OBRA 87) (PPS 5)**

The Federal Nursing Home Reform Act was part of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87). OBRA 87 amended the Social Security Law and created a set of minimum standards that certified nursing facilities must meet in order to receive Federal funding through the Medicare and Medicaid programs.

Positive changes came about as a result of OBRA 87:

- Surveyors are now required to meet with residents during the survey.
- The use of anti-psychotic drugs and restraints has decreased.
- Residents' rights are clearly defined.
- Uniform certification standards are in place for both Medicare and Medicaid facilities.
- Training requirements for paraprofessional staff were established.

OBRA 87 also recognized the important role the Long-Term Care Ombudsman Program plays assuring that residents receive quality care by writing distinct advocacy roles and mechanisms for assuring Ombudsman participation in surveys into law.

## **Federal Regulations** (PM 29)

### **Code of Federal Regulations** (PPS 6)

The Social Security Act requires that providers and suppliers participating in the Medicare and Medicaid programs meet minimum health and safety standards. The minimum standards are set forth in the Code of Federal Regulations, specifically for long-term care facilities, in 42 CFR 483. The Centers for Medicare and Medicaid Services (CMS) is the agency responsible for assuring that surveys are conducted to assure that facilities are in “substantial compliance” with Federal regulations.

As an Ombudsman, you should be aware of the significant federal regulations that grew out of OBRA 87. Most significantly, 42 CFR 483 is the Federal Regulation that spells out minimum requirements for long-term care facilities. An electronic version of the complete regulation can be found online at the Government Printing Office.

42 CFR 483 serves as the foundation for the State Operations Manual (SOM) written by CMS and used by State Survey Agencies to assure that long-term care facilities receiving federal funding through Medicare and/or Medicaid meet minimum standards. The SOM can be an important tool in Ombudsman problem-solving and is discussed in more depth in the next module.

### **State Operations Manual & Appendices** (PPS 7)

CMS delegates responsibility for conducting certification surveys and complaint investigations to state survey agencies like the Illinois Department of Public Health. To assure that states are conducting surveys in an appropriate manner, CMS not only provides written guidance to surveyors, but also participates in a certain number of surveys each year. The State Operations Manual is the guide to states on how to certify and monitor long-term care facilities that receive Medicare and Medicaid funding.

### **(PPS 8)**

The State Operations Manual is comprised of ten chapters.

- Ch. 1 – Medicare/Medicaid Program Background and Responsibilities
- Ch. 2 – The Certification Process
- Ch. 3 – Additional Program Activities
- Ch. 4 – Program Administration & Fiscal Management
- Ch. 5 – Complaint Procedures
- Ch. 6 – Special Procedures for Laboratories
- Ch. 7 – Survey & Enforcement Process for Skilled Nursing Facilities and Nursing Facilities
- Ch. 8 – Standards & Certification
- Ch. 9 – Exhibits Table of Contents
- Ch. 10 – Survey and Enforcement Process for Home Health Agencies

**TRAINER'S NOTE: Ombudsmen may use the Appendices more often than the actual chapters of the SOM.**

## **Appendices (PPS 9)**

There are eight (8) out of 24 appendices that are of particular interest to Long-Term Care Ombudsmen. These are:

- Appendix I - Life Safety Code
- Appendix J - Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Appendix M - Hospice
- Appendix P - Survey Protocol for Long-Term Care Facilities
- Appendix PP - Guidance to Surveyors for Long-Term Care Facilities
- Appendix Q - Core Guidelines for Determining Immediate Jeopardy
- Appendix R - Resident Assessment Instrument for Long-Term Care Facilities
- Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs.

### **Appendix PP (PPS 10)**

Of all CMS documents discussed in this module, Appendix PP - Guidance to Surveyors for Long-Term Care Facilities is the most useful to Long-Term Care Ombudsmen.

### **(PPS 11)**

Sample Appendix PP Entry taken from Appendix PP- Guidance to Surveyors. Note that the F Tag is listed, the specific federal regulation, the intent of the regulation and finally the guidance provided to a surveyor when conducting an investigation about residents' rights or when conducting an annual survey.

### **F550 Tag**

#### **§483.10(a) Resident Rights**

*The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.*

**§483.10(a)(1)** *A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.*

**§483.10(a)(2)** *The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.*

#### **§483.10(b) Exercise of Rights**

*The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.*

**§483.10(b)(1)** *The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.*

**§483.10(b)(2)** *The resident has the right to be free of interference, coercion, discrimination, and*

*reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.*

***INTENT §483.10(a)-(b)(1)&(2)***

*All residents have rights guaranteed to them under Federal and State laws and regulations. This regulation is intended to lay the foundation for the resident rights requirements in long-term care facilities. Each resident has the right to be treated with dignity and respect. All activities and interactions with residents by any staff, temporary agency staff or volunteers must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's, goals, preferences, and choices. When providing care and services, staff must respect each resident's individuality, as well as honor and value their input.*

***GUIDANCE §483.10(a)-(b)(1)&(2)***

*Examples of treating residents with dignity and respect include, but are not limited to:*

- Encouraging and assisting residents to dress in their own clothes, rather than hospital-type gowns, and appropriate footwear for the time of day and individual preferences;*
- Placing labels on each resident's clothing in a way that is inconspicuous and respects his or her dignity (for example, placing labeling on the inside of shoes and clothing or using a color coding system);*
- Promoting resident independence and dignity while dining, such as avoiding:*
  - Daily use of disposable cutlery and dishware;*
  - Bibs or clothing protectors instead of napkins (except by resident choice);*
  - Staff standing over residents while assisting them to eat;*
  - Staff interacting/conversing only with each other rather than with residents while assisting with meals;*
- Protecting and valuing residents' private space (for example, knocking on doors and requesting permission before entering, closing doors as requested by the resident);*
- Staff should address residents with the name or pronoun of the resident's choice, avoiding the use of labels for residents such as "feeders" or "walkers." Residents should not be excluded from conversations during activities or when care is being provided, nor should staff discuss residents in settings where others can overhear private or protected information or document in charts/electronic health records where others can see a resident's information;*
- Refraining from practices demeaning to residents such as leaving urinary catheter bags uncovered, refusing to comply with a resident's request for bathroom assistance during meal times, and restricting residents from use of common areas open to the general public such as lobbies and restrooms, unless they are on transmission-based isolation precautions or are restricted according to their care planned needs.*

*Consider the resident's life style and personal choices identified through their assessment processes to obtain a picture of his or her individual needs and preferences.*

*Staff and volunteers must interact with residents in a manner that takes into account the physical limitations of the resident, assures communication, and maintains respect. For example, getting down to eye level with a resident who is sitting, maintaining eye contact when speaking with a resident with limited hearing, or utilizing a hearing amplification device when needed by a resident.*

*Pay close attention to resident or staff interactions that may represent deliberate actions to limit a resident's autonomy or choice. These actions may indicate abuse. See F600, Free from Abuse, for guidance.*

*The facility must not establish policies or practices that hamper, compel, treat differently, or retaliate against a resident for exercising his or her rights.*

### **The Older Americans Act (PPS 12)**

Congress passed The Older Americans Act of 1965 (OAA) in response to concerns about a lack of community-based social services for older persons.

The Older Americans Act is one of the most important sources of legislative authority for services to elders. The Older Americans Act not only established the Administration on Aging, it laid the groundwork for federal grants that are used to support the Aging Network. As you will remember from the module on Federal and State Agencies, the Aging Network is responsible for providing many home- and community-based services that enhance the ability of seniors to remain in the community.

Authorization for the Long-Term Care Ombudsman Program appears in Title VII, Chapter 2, Sections 711/712 of the Older Americans Act. Statewide Ombudsman programs receive Federal funding through Titles III and VII of the Act along with other federal, state, and local sources.

### **Ombudsman Federal Rule 45 CFR 1324 (PPS 13)**

The Ombudsman Federal Rule became effective on July 1, 2016. Never before had the Program operated with a federal rule. The Ombudsman Federal Rule clarifies definitions, provides for consistency throughout the states and focuses on the following:

- Office is a “distinct entity, separately identifiable”
- State Ombudsman functions and responsibilities including but not limited to, designation, and refusal, suspension, or removal of designation, of local Ombudsman entities and representatives of the Office; includes requirements for:
  - Monitoring of local Ombudsman entities;
  - Establishing certification training requirements;
  - Investigation of allegations of misconduct by representatives of the Office.
- Duties of representatives of the Office
- Responsibilities of State Units on Aging, Area Agencies on Aging and Provider Agencies
- Conflict of interest requirements
- Ombudsman responsibility to perform systems advocacy functions
- State policies and procedures
- The establishment of the Office
- Confidentiality of records



## State Law and Regulations (PPS 14) (PM 32)

### **Illinois Nursing Home Care Act (PPS 15)**

Similar to the Federal Nursing Home Reform Act, The Illinois Nursing Home Care Act spells out the requirements long-term care facilities must meet. Topics covered in the Act include residents' rights, facility responsibilities, licensing, enforcement, violations, penalties and remedies, requirements for appropriate discharge and transfer, circumstances under which the State may request that monitors or receivers be placed in troubled facilities, duties of the facility, and complaint processes.

### **Illinois Administrative Code (PPS 16)**

Like Federal Regulation, the Nursing Home Care Act also resulted in the development of much more detailed instructions to nursing facilities. These appear in Illinois Administrative Codes. Below is a list of Administrative Codes that may be of particular interest to you as an Ombudsman. Links to each code are provided at the end of the module.

*Title 77* contains the Administrative Rules for Illinois Department of Public Health programs. Administrative Rules for long-term care facilities are located in Chapter 1, Subchapter C. Links to Administrative Codes contained in Subchapter C appear in the "Important Links" section of this module.

Long-term care facility rules appear in Chapter 1, Subchapter C.

- Part 295 Assisted Living and Shared Housing Establishments
- Part 300 Skilled Nursing Facilities
- Part 330 Sheltered Care Facilities
- Part 340 Veteran's Home Code
- Part 350 Intermediate Care for the Developmentally Disabled Facilities
- Part 380 Specialized Mental Health Rehabilitation Facilities Code
- Part 396 Life Care Facilities
- Part 390 Long-Term Care for Under Age 22 Facilities Code (MC/DD)

**TRAINER'S NOTE: Life Care Facilities are facilities that agree to provide a resident with nursing services, medical services or personal care services, in addition to maintenance services for a term in excess of one year or for life pursuant to a life care contract. These facilities are often referred to as Continuing-Care Retirement Communities (CCRCs).**

*Title 89* contains the Administrative Rules for Social Services programs in the State of Illinois. As you can imagine, Title 89 is huge. The index alone for this title is 116 pages long. There are a few sections of Title 89 that are important to Ombudsmen. Links to these sections are available in the "Important Links" section of this module.

- PART 146 – Supportive Living Facilities Code

### **Illinois Act on the Aging (PPS 17)**

The Illinois Act on the Aging (20 ILCS 105) regulates the Aging Network in Illinois. Section 4.04 discusses the purpose of the Ombudsman Program and provides many of the rules upon which Ombudsman Program standards are based. The Illinois Act on the Aging can be found on the General Assembly website.

The Ombudsman Program is addressed in Part 270 of Title 89 Chapter 2 – Administrative Rules for Aging Programs.

### **TRAINER’S NOTE: Walk through example in PowerPoint slides. (PPS 18)**

To give you an idea what an Administrative Code looks like, we will examine the following link:  
<http://www.ilga.gov/commission/jcar/admincode/077/077003000C06100R.html>

- If we click on any one of the lines of blue underlined type, it will take us to that section of the Code.
- For instance, if I click on Section 300.610 Resident Care Policies, that page opens.

## **Resources (PM 34)**

The following links are provided to help you access rules and regulations discussed in this module. If any of the hyperlinks provided in the module do not work, simply copy and paste the web address below into your web browser.

### **Federal Regulations**

42 CFR 483 Requirements for States and Long-Term Care Facilities

[http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr483\\_main\\_02.tpl](http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr483_main_02.tpl)

42 USC 1395i-3 Social Security Requirements for, and Assuring Quality of Care in, Skilled Nursing Facilities

[http://www.ssa.gov/OP\\_Home/ssact/title18/1819.htm](http://www.ssa.gov/OP_Home/ssact/title18/1819.htm)

42 USC 1396r Social Security Requirements for Nursing Facilities

[http://www.ssa.gov/OP\\_Home/ssact/title19/1919.htm](http://www.ssa.gov/OP_Home/ssact/title19/1919.htm)

Ombudsman References in Federal Nursing Home Requirements

<http://ltombudsman.org/uploads/files/library/ltcop-references-new-regs-old-regs-side-by-side.pdf>

### **State Laws and Administrative Codes**

210 ILCS 105 Illinois Act on the Aging

<http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=224&ChapterID=5>



Illinois Nursing Home Care Act

<http://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1225&ChapterID=21>

20 ILCS 110 Department on Aging Law

<http://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=225&ChapterID=5>

225 ILCS 7 Illinois Board and Care Home Act

<http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1292&ChapterID=24>

Illinois Administrative Code Index:

<http://www.idph.state.il.us/rulesregs/rules-index.htm#77-I-c>

Title 77, Part 100 Practice and Procedures in Administrative Hearings

<http://www.ilga.gov/commission/jcar/admincode/077/07700100sections.html>

Title 77, Part 295 Assisted Living and Shared Housing Establishment Code:

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

Title 77, Part 300 Skilled Nursing and Intermediate Care Facilities Code

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

Title 77, Part 330 Sheltered Care Facilities Code

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

Title 77, Part 340 Illinois Veteran's Home Code

<http://www.ilga.gov/commission/jcar/admincode/077/07700340sections.html>

Title 77, Part 350 Intermediate Care for the Developmentally Disabled Facilities Code

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

Title 77, Part 380 Specialized Rehabilitation Facilities Code

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

Title 77, Part 390 LTC for Under Age-22 Facilities Code

<http://www.ilga.gov/commission/jcar/admincode/077/07700390sections.html>

Title 77, Part 395 Long-Term Care Assistants and Aides Training Programs Code

<http://www.ilga.gov/commission/jcar/admincode/077/07700395sections.html>

Title 77, Part 396 Life Care Facilities Contract Code

<http://www.ilga.gov/commission/jcar/admincode/077/07700396sections.html>

Title 77, Part 400 Central Complaint Registry

<http://www.ilga.gov/commission/jcar/admincode/077/07700400sections.html>

Title 77, Part 420 Implementation of Titles XVIII and XIX of Social Security Act Relating to Skilled Nursing and Intermediate Care Facilities

<http://www.ilga.gov/commission/jcar/admincode/077/07700420sections.html>

Title 89 Part 146 Illinois Supportive Living Facilities Code (Subpart B) and Supportive Living Facilities with Dementia Units (Subpart D)

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

Title 89 Part 270 Adult Protection and Advocacy Services

<http://www.ilga.gov/commission/jcar/admincode/089/08900270sections.html>

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# WORKING WITH ILLINOIS DEPARTMENT OF PUBLIC HEALTH

(PM 37)

MODULE 4

## Introduction (PPS 2) (PM 38)

As a Long-Term Care Ombudsman, it is important to know how to access resources to help resolve the resident's concerns. A number of federal and state agencies are involved in assuring that residents of long-term care facilities receive good care and are free from abuse and/or neglect. Many of these agencies are discussed in Module 2 Federal and State Agencies. Because IDPH has such an important role in assuring that nursing homes meet standards set forth in state and federal regulations, this module will focus on the annual survey process and filing complaints through the Illinois Department of Public Health.

The Illinois Department of Public Health (IDPH) is the agency designated by the U.S. Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), and the State of Illinois to assure that nursing homes, intermediate care facilities for developmental disabilities, and assisted living establishments meet federal and/or state standards for health care quality.

This Module will provide information about how an Ombudsman works with IDPH and also about the role an Ombudsman may have in annual surveys and complaint investigations.

**TRAINER'S NOTE: Assisted living facilities must follow the Illinois Assisted Living and Shared Housing Act and the Assisted Living and Shared Housing Establishment Code. Board and Care facilities must follow the Board and Care Home Act. Links to each of these Acts and Codes is provided in the "Important Links" listing at the end of this module.**

### **Responsibilities of the Illinois Department of Public Health (IDPH): (PPS 3-4)**

IDPH is responsible for surveying, investigating complaints, licensing, certifying, and regulating the following:

- Skilled nursing facilities
- Intermediate care facilities
- Intermediate care facilities for the developmentally disabled (ID/DD) or ICF/DD)
- Assisted living and shared housing establishments
- Sheltered care facilities
- Specialized mental health rehabilitation facilities (SMHRFs)
- Medically complex for the developmentally disabled (MC/DD)

Healthcare and Family Services (HFS) is the regulatory agency for Supportive Living Facilities.

**TRAINER'S NOTE: explain that from here on out, for the sake of convenience, you will be stating "IDPH" even though the same information may also apply to HFS.**

## Certified Facilities and Licensed Facilities (PPS 5-6) (PM 38)

All long-term care facilities are licensed by the State of Illinois. There are different types of licensures. Most nursing homes are also certified by Centers for Medicare and Medicaid Services (CMS) to provide specific care for individuals receiving Medicare and Medicaid. The certification allows facilities to receive payment for services when the facility is in substantial compliance with the federal regulations.

### CMS (Certified)

- Federal Agency
- *Certifies* nursing homes
- Deficiencies
- OBRA '87
- Code of Federal Regulations
- Writes State Operations Manual

### IDPH (Licensed)

- State Agency
- *Licenses* nursing homes
- Violations
- Nursing Home Care Act
- Illinois Administrative Code
- Uses State Operations Manual

Facilities that are licensed by the State but not certified by CMS must still go through a survey process to assure they meet state standards. With the exception of Supportive Living Facilities, facilities that are licensed but not certified do not receive reimbursement through Medicaid or Medicare.

### (PPS 7)

If skilled nursing or therapy services are provided, the facility can seek reimbursement through Medicare. If the facility has Medicaid beds, it can seek reimbursement through Medicaid. "Certified" facilities are also "licensed" by the state.

## Types of Facilities (PM 39)

**TRAINER'S NOTE: no need to go over types of facilities. This should be used as a reference for the trainees if they are not familiar with the types of facilities Ombudsmen visit. There is no Power Point slide for this section.**

**Skilled nursing facilities** (Licensed and most often certified) are able to provide services that require licensed nursing staff for administration (i.e. IV's or wound care), or provide skilled rehabilitation services to residents who are expected to return to the community.

**Intermediate care facilities** (Licensed and most often certified) provide basic nursing care and other restorative services. Such facilities are for residents who have long-term illnesses or disabilities that may have reached a plateau. Some intermediate care facilities specialize in providing services to individuals with serious mental illnesses.

**Intermediate care facilities for the developmentally disabled (ICF/DD)** (Licensed and certified) provide custodial care for individuals with developmental disabilities. 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.

The ID/DD Community Care Act provides the following definitions:

- a) An intermediate care facility for persons with developmental disabilities, whether operated for profit or not, which provides, through its ownership or management, personal care or nursing for three (3) or more persons not related to the applicant or owner by blood or marriage. It includes intermediate care facilities for the intellectually disabled as the term is defined in Title XVIII and Title XIX of the federal Social Security Act. (Section 1-113), and
- b) An intellectual disability is a disability characterized by significant limitations in both intellectual functioning (intelligence) and in adaptive behavior which covers many everyday social and practical skills. This disability originates before the age of 18.
- c) Habilitation – an effort directed toward increasing a person’s level of physical, mental, social, or economic functioning.
- d) Personal Care – assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision and oversight of the physical and mental well-being of an individual who is incapable of maintaining a private, independent residence, or who is incapable of managing his or her person.

**Assisted living (ALF) and shared housing establishments** (Licensed only) provide care for residents who do not need the services of a nurse but who do need help with activities of daily living (i.e. meal preparation, getting dressed). An ALF can be any size beyond three or more unrelated adults, but a shared housing establishment can be no larger than 16 residents. Both types of facilities are required to have at least 80% of occupants over the age of 55.

Both ALFs and shared housing establishments are required to recognize the resident’s living unit as his or her home. Each unit has room for small kitchen appliances and private washing and toileting areas. Some ALF and shared housing establishments have shared bathing/shower areas. Residents are usually higher functioning and have more autonomy than residents of intermediate or skilled nursing facilities. When services are necessary, they can be provided by the facility or an outside entity as arranged by the facility with the consent of the resident or resident’s representative. Because these facilities do not provide nursing care, residents cannot use Medicare or Medicaid to pay for their stay. Therefore, residents must cover all of their own expenses.

Assisted living and shared housing establishments are regulated by Illinois Administrative Code. They are licensed through IDPH but not certified by CMS. Facility surveys are conducted by IDPH. A directory of currently licensed establishments is also available on the IDPH website.

**Supportive living facilities (SLF)** are similar to assisted living facilities. SLFs integrate housing with health, personal care, and supportive services and are designated settings that offer residents their own separate, private, and distinct living units. As a Medicaid waiver program established by Illinois Public Aid Code [305 ILCS 5/5-5.01a], supportive living facilities accept residents who qualify for assistance through Public Aid and Medicaid. The Illinois Department of Healthcare and Family Services (HFS), the agency responsible for administration of Public Aid Programs, administers the supportive living program and surveys supportive living facilities. A directory of licensed supportive living facilities is available online.



Supportive living programs serve two distinct groups of people: people with disabilities between the ages of 22 and 64; or persons over the age of 65 who meet other program requirements set forth in 89 Illinois Administrative Code 146.

**Sheltered care facilities (SHL)** (Licensed only) are similar to supportive living facilities. However, they are regulated by the Nursing Home Care Act and are surveyed by IDPH staff. Sheltered care facilities are licensed to provide maintenance and personal care such as mental health treatment, psychiatric rehabilitation, physical rehabilitation, or assistance with activities of daily living.

**Specialized Mental Health Rehabilitation Facilities (SMHRF)** (Licensed only) 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. SMHRFs provide a 24-hour program that includes intensive support and recovery services designed to assist persons, 18 years or older, with mental disorders, to develop skills to become self-sufficient and capable of increasing levels of independent functioning. This includes the following:

- (1) 100% of the consumer population has a diagnosis of serious mental illness;
- (2) no more than 15% of the consumer population is 65 years of age or older;
- (3) none of the consumers are non-ambulatory;
- (4) none of the consumers have a primary diagnosis of moderate, severe, or profound intellectual disability; and
- (5) the facility must have been licensed under the Specialized Mental Health Rehabilitation Act or the Nursing Home Care Act immediately preceding the effective date of the Act and qualifies as an institute for mental disease under the federal definition of the term.

**Medically Complex for the Developmentally Disabled (MC/DD)** (Licensed and certified) 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.

### **Medicaid Distinct Part Facilities**

**Trainer' Note: Prior to the training, the trainer may wish to look up the distinct part facilities in the region being trained. The Department on Aging sends updates to the Regional Ombudsmen on facilities that have a distinct part on a regular basis.**

#### **(PPS 8)**

Some facilities are “distinct part”, meaning beds or units are certified specifically to Medicaid residents. Not all beds in the facility are certified for Medicaid. According to Title 77: Public Health Part 300 Skilled Nursing and Intermediate Care Facilities Code Section 300.330, a distinct part is “an entire, physically identifiable unit consisting of all of the beds within that unit and having facilities meeting the standards applicable to the levels of service to be provided. Staff and services for a distinct part are established as set forth in the respective regulations governing the levels of services approved for the distinct part.”

## **Ombudsman Role**

### **(PPS 9) (PM 41)**

**TRAINER’S NOTE:** State that it is helpful to talk to residents and family members throughout the year and ask them for permission to give their names to surveyors during an annual survey. Be careful never to disclose the dates of the survey.

### **Off-Site Survey**

Once the Regional Ombudsman receives the notification of surveys from the Office for the following month, Ombudsmen are asked to fill out an “Off-Site Survey” form as soon as possible. The form not only addresses residents’ rights, but it also organizes the questions in same order in which they are asked to residents during the group meeting by the surveyor. Ombudsmen are asked to state specific concerns related to federal regulations and state standards then state how the concern negatively affects the residents involved.

Any area that is not of concern can just be skipped and left blank. If there is a facility with no concerns, there is no need to fill out an Off-Site Survey form. Simply explain to the surveyor when he/she calls to inform the Ombudsman that IDPH has entered the building for the annual survey.

The final section has space to add residents’ or family members’ names who have given prior approval and who wish to talk to an IDPH surveyor.

The form is to be e-mailed to the Regional IDPH Supervisor in the appropriate region as early as possible because surveyors prepare for annual surveys weeks in advance. Once the form is e-mailed to the Regional IDPH Supervisor, enter the activity in PeerPlace as “participation in facility survey”. Only one entry may be made per facility survey. Any subsequent involvement with the survey by anyone must be documented in the same original activity.

Note that an Ombudsman cannot disclose to anyone, including volunteer Ombudsmen, the dates of the planned Annual Survey. Disclosure of the survey dates can result in a \$2,000 fine.

Never call the facility and ask for a Surveyor unless they have made the initial call to the Ombudsman.

### **Surveyor Call (PPS 10)**

A Surveyor should call the local Ombudsman program shortly after entering the building for the annual survey.

When the Surveyor calls, the Ombudsman should ask the Surveyor for the date and time of the resident meeting and the exit meeting. The Ombudsman should also ask the Surveyor if he or she has received the off-site survey that was submitted to the Regional IDPH office. If not, arrange for a way to get the off-site survey to the Surveyor. Also, discuss the concerns over the phone. Do not disclose names of residents or complainants without their permission.

Document the conversation in PeerPlace in the same entry used when the off-site survey was documented.

### **At the Facility**

While the survey is taking place at a facility, the Ombudsman has opportunities to be involved in the survey process. The following sections explain the survey process and indicate where Ombudsman involvement occurs.

### **The IDPH Survey Team** **(PPS 11-12) (PM 42)**

IDPH is responsible for assuring that all state standards and federal regulations that address quality of care and quality of life are met. Surveyors conduct unannounced, annual licensing surveys to assure that regulations are being met.

IDPH has field supervisors in regional offices who:

- Monitor facilities in their region
- Schedule surveys
- Review past survey results
- Recommend enforcement actions and remedies
- Keep track of general information about each facility in their area
- Provide direction to survey teams

The on-site survey team is made up of:

- Registered nurses
- Nutritionists
- Sanitarians
- Environmental specialists
- Other professionals

### **Survey Goals** **(PPS 13) (PM 43)**

- Assess compliance with residents' rights and quality of life requirements
- Determine the accuracy of residents' comprehensive assessments and care plans
- Assess quality of care and services based on:
  - Medical
  - Nursing
  - Rehabilitation
  - Medication
  - Dietary and nutrition
  - Activities and social participation
  - Sanitation
  - Infection control

## **The Annual Survey Process** **(PPS 14-15) (PM 43)**

**The Illinois Department of Public Health has a comprehensive process for surveying long-term care facilities. Effective November 28, 2017, the survey process was significantly changed. See the Long Term Care Survey Process (LTCSP) Procedure Guide for further details: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTCSP-Procedure-Guide.pdf>**

The survey team conducts offsite preparation in advance of the actual onsite survey. Offsite activities include but are not limited to:

- Ensuring enough residents are in their sample based on bed count
- Reviewing past or repeat deficiencies
- Reviewing complaints investigated since the last survey
- Reviewing any facility reported incidents since the last survey
- Determining if complaints will also need to be investigated during the survey
- Noting if the facility has a history of abuse allegations or citations
- Assigning surveyors particular tasks during the survey
- Reviewing offsite selected residents (about 70%) and their MDS indicators or
- Reviewing discharged residents who were selected for a closed record review

The survey team enters the facility at an unannounced time and date. In most cases, the team will enter the building during normal business hours. However, they do have the authority to enter a building at any time of the day or night and on any day of the week.

Upon entering a facility: **(PPS 16)**

- The Team Coordinator of the survey team will hold a brief entrance conference with the facility administrator. The purpose of this meeting is to inform the administrator about the survey and to request specific items for the survey.
- Team members begin the survey by going to their assigned areas and will ask for a resident roster with an indicator of new admissions in the last 30 days. The Surveyor assigned to the kitchen will conduct an initial brief visit to the kitchen.
- The Team Coordinator is required to call the Regional Ombudsman Program.

During the Survey: **(PPS 17-19)**

- Surveyors are required to observe and screen all residents in their assigned area and observe, interview, and complete a limited record review for initial pool residents (about eight residents per surveyor). This entire process should take about eight to ten hours.
- Surveyors are to conduct resident representative interviews (RRI) /family interviews for non-interviewable residents with the goal of at least three RRIs the first day.
- Conduct record reviews
- Complete all resident observations and interviews from the initial pool.
- Observe the first scheduled full meal.
- Based on concerns that were observed or disclosed on day one, the surveyors will select a sample of residents (30%) and will conduct an in-depth investigation for any area of concern. **TRAINER'S NOTE: The selection is based on a great deal of criteria such as**

**vulnerable residents, new admissions, complaints, facility-initiated incidents and identified concerns– refer to the Long Term Care Survey Process (LTCSP) Procedure Guide.**

- The surveyors will investigate all concerns identified for the remainder of the survey.
- All surveyors are to observe for breaks in infection control throughout the survey.
- Observe medication passes and storage
- Consider sufficient and competent nursing staffing

### **Resident Meeting (PPS 20)**

The Surveyor works with the Resident Council President to arrange the meeting. Surveyors can invite any resident to the meeting. With permission of the Resident Council President, the Surveyor reviews three months of council minutes prior to the meeting to identify any unresolved concerns.

With residents' permission, Ombudsmen may attend the resident meeting. It is a good idea to go to the facility prior to the resident meeting to talk to residents whom the Ombudsman thinks may be interested in talking to a surveyor either during the resident meeting or in private. Arriving early will give the Ombudsman a chance to talk to residents to encourage and empower them to speak up and share concerns with a surveyor. The Ombudsman attends the resident meeting to primarily observe. The goal of the meeting is for residents to express concerns and to give the Surveyor some insight into the care residents receive.

### **Exit Conference (PPS 21)**

- Conducted with the facility administrator to inform the facility of the survey team's observations and preliminary findings
- Ombudsman and one or two residents are invited to attend
- Identification of residents related to the survey is not discussed
- The facility can discuss and supply additional information they believe is pertinent to the findings.

Life Safety Code:

**TRAINER'S NOTE: There is no slide for this section.**

In addition to the Health Survey, an annual Life Safety Code Survey is conducted to assure that the physical environment is safe and meets the standards of the Life Safety Code. This survey may be conducted independent of or in concurrence with the Health Survey. The Life Safety team will check items such as structural integrity, electrical systems and compliance with fire codes.

## **Survey Results**

### **(PM 45)**

#### **Tags**

The State Operations Manual, Appendix PP has its own Tag designation (e.g. F-Tags for nursing homes). When a survey identifies a deficient practice and non-compliance with the regulations and guidelines, the surveyor must name the specific Tag under which the deficient practice falls. This is how the citation is officially classified and documented.

## **Complaint Investigations**

### **(PPS 22) (PM 45)**

Annual surveys are not the only time IDPH surveyors enter a facility. Public Health Surveyors also investigate complaints made through the IDPH Central Complaint Registry. Any person may file a complaint with IDPH. As an Ombudsman, it is important to know how and when to refer individuals to the IDPH Central Complaint Registry and the Supportive Living Hotline at HFS. This section will explain how to refer a complainant to the Hotline and how Ombudsmen file complaints with IDPH and HFS.

#### **IDPH Investigation vs. Ombudsman Investigations (PPS 23)**

IDPH investigations differ from Ombudsman investigations. First, unlike the Ombudsman program, IDPH does not need the consent of the complainant, resident or resident's representative to investigate a complaint. Second, the goal of an IDPH investigation is to determine if the facility is in compliance with minimum state and/or federal regulations and requirements for nursing home care. However, an Ombudsman's goal is intended to resolve a complaint to the satisfaction of the resident or, in the case of a resident who is unable to provide direction, the resident's representative.

## **Filing a Complaint with IDPH Central Complaint Registry (The Hotline)**

### **(PM 45)**

#### **Referring a Complainant to the "Hotline" (PPS 24)**

**TRAINER'S NOTE:** The "Central Complaint Registry" and "IDPH Nursing Home Hotline" terms are used interchangeably and are referring to the same entity. Sometimes it is simply referred to as "the hotline".

**TRAINER'S NOTE:** Whenever possible, it is better to work with the resident or family member and facility staff to resolve the complaint before calling public health. Once you have exhausted your problem-solving options then the Ombudsman may file a complaint with resident's permission.

Ombudsmen often receive complaints about long-term care facilities. When talking to the complainant, explain the role of the Ombudsman and the role of IDPH in protecting the safety of residents and assuring that nursing homes meet state and federal requirements for long-term care facilities. Also explain the right of any individual who has a concern about a resident in a facility to file a complaint with IDPH. If the complainant is not seeking Ombudsman assistance, but wants to file a complaint with IDPH, then empower the complainant by explaining the process for submitting an effective complaint as described below.

### **In an emergency**

Ombudsmen are not emergency responders. If the complainant indicates that residents are in imminent danger, explain that the appropriate action is to call 9-1-1 and refer the complainant to the Central Complaint Registry. Follow up with the facility and the residents involved if appropriate.

### **Anonymous Complaints**

A complainant may remain anonymous and report a concern to the hotline. However, it is best to give a name, address, and call back number for a surveyor to contact the complainant for additional information and for the complainant to receive a written report after the investigation is complete.

## **Ombudsmen Filing Complaints: Individual and Systemic Complaints (PM 46)**

### **Individual Complaints (PPS 25)**

If an Ombudsman speaks to a complainant who is not the resident, the Ombudsman shall request consent to share the complainant's concerns with the resident. If the resident has a concern, the Ombudsman shall explore all possible options for resolving the complaint. The resident may or may not want to handle the concerns at the facility level. If the resident wishes to file a complaint, the Ombudsman may assist the resident. Or, the resident may ask the Ombudsman to file the complaint on his/her behalf. The Ombudsman must have permission to file the complaint and to name the resident in the complaint.

### **Systemic Complaints (PPS 26)**

**TRAINER'S NOTE: Explain that all complainants must give permission for their name to be used in the complaint – this includes staff, residents and family members. The exceptions are when using the name of the alleged perpetrator(s) or when using the names of staff involved in the complaint.**

Systemic complaints involve some or all residents in the facility. There are circumstances when Ombudsmen work on complaints without resolution even after addressing them with facility staff. An Ombudsman can choose to file a complaint with IDPH for investigation. In order to reveal identities in the complaint, the Ombudsman will need permission from the individuals, unless the individual is named as a perpetrator or is a staff member involved in the complaint, but not if the staff member is the complainant.

### **Filing the Complaint (PPS 27)**

The complainant may file a complaint via phone at 1-800-252-4343 or e-mail at [dph.ccr@illinois.gov](mailto:dph.ccr@illinois.gov). IDPH also has an electronic form that may be filled out on their website and directly submitted to the central complaint registry. It is called "Health Care Facilities Complaint Form" and can be found under the Nursing Homes tab at: <http://dph.illinois.gov/forms-publications>. You can also use this form as a reference to ensure all necessary information has been gathered to file a complaint. If the complainant would like

more information about regulations, quarterly reports, violations, or a listing of nursing homes, refer to the IDPH website <http://www.dph.illinois.gov/>.

When writing the complaint, it is important to give as many specifics as possible. Add the written complaint and the results of the IDPH investigation into the case (see below). Check with the Regional Ombudsman prior to filing a complaint against a facility.

If the complaint is about a supportive living facility, refer the complainant to the supportive living hotline number: 1-800-226-0768.

**TRAINER’S NOTE:** Either use the hyperlink on the PowerPoint presentation on slide 26 or refer trainees to the resource section to look at the on-line complaint form. The Ombudsman must print out the completed form prior to submitting the complaint because it cannot be saved and once submitted, the form is blank. Also included after the Complaint Form is another form called “Complaint Investigations Frequently Asked Questions”.

#### **(PPS 28-29)**

Whenever possible, gather and include the following information in your complaint:

- Resident(s) name (with permission)
- Ombudsman name, address and phone number
- Name and phone number of any other witnesses (with permission)
- Name and address and phone number of the facility
- Names of employees involved
- Important dates
- State the specific allegations (abuse/neglect/ acquired infections, medication error, etc.)
- When did the incident occur?
- Where in the facility did the incident occur?
- How was the resident(s) harmed?
- How could the resident(s) have been potentially harmed?
- How was the complaint addressed by the facility?

If known, provide information about why the incident occurred. For example, report that a resident was injured during a transfer without the use of adequate staff or assistive equipment. Establish a timeline for an incident if possible. Below is an example of a complaint that was not written using the on-line form, but equally acceptable to use.

**TRAINER’S NOTE:** Refer trainees to the complaint example in their manual and explain when describing the problem, to consider beginning the statement with “The facility failed to...” then describe what service the facility failed to provide. Then state, “As a result of this failure...” and describe the consequences of the facility’s failure. Provide a concise, narrative description of the situation that includes as much useful information as possible.



### **(PPS 30)**

Date: 1/1/18

To: Illinois Department of Public Health Nursing Home Hotline Central Complaint Registry

Nursing Home: Be Well

1234 Main St

Anywhere, IL 54321

(000) 555-1212

Residents Affected: All

Referring Agency Contact: Susie Caseworker

I Think I Can Ombudsman Program

5678 Little Engine Dr.

Any Town, IL 55555

(000) 111-2222

Allegation:

The facility fails to provide licensed nursing staff to administer medications to residents during the evenings and weekends. This has resulted in some residents not receiving their medications and some residents receiving the wrong medications.

Two anonymous residents complained that unlicensed staff members have dispensed medications to residents when the registered nurse is off duty. The residents report that CNAs Annie and Betty, and Candy, the laundry worker (all unlicensed staff) are administering medications on evenings and weekends.

Keep in mind that the person filing the complaint becomes the contact person or “Complainant” for IDPH surveyors investigating the complaint. With permission, include contact information for the resident and/or original complainant. If filing a complaint on behalf of a resident or family member, it is best to know as much as possible about the complaint without having to refer the surveyor to a third party.

## **The Complaint Investigation**

### **(PPS 31)**

When a complaint is filed with the central complaint registry at IDPH, it is triaged and notification is sent to an IDPH regional office. The complaint is assigned to a surveyor or survey team qualified to conduct the investigation.

### **IDPH Investigation Time Frames (PPS 32)**

If the complaint involves a resident who is at risk of serious harm or death as a result of abuse, neglect, or other life-threatening situations, then the investigation will begin within 24 hours. Complaints involving abuse, neglect or situations that have the potential for causing harm but that do not put the resident in a life-threatening situation (i.e. falls with harm) are investigated within 7 days.

Most other issues (i.e. not turning resident with no negative results, resident did not receive bath for one week) are investigated within 30 days.

There are a few situations that can result in delayed complaint investigations. First, if the complaint does not involve the health or safety of a resident, or a violation of the regulations, then IDPH is not required to conduct an on-site investigation. Second, if the facility is nearing its survey window, IDPH has the option to hold complaint investigations until they enter the facility for the annual survey. Occasionally, if several complaints against a facility are pending at the same time the survey window is approaching, the surveyors may enter the facility a little bit sooner for the annual survey. If this happens, complaints are investigated as part of the annual survey.

### **Contacting the Complainant (PPS 33)**

As a first step in the investigation, the surveyor will read the complaint then attempt to reach the complainant by phone. Surveyors are required to make three attempts at different times of the day to reach the complainant.

If the surveyor reaches the complainant, he or she will ask for any further information. At this time, the complainant may name other witnesses to the incident who can be interviewed by the surveyor. If the Ombudsman filed a complaint on behalf of a resident or another complainant, with proper permission, the Ombudsman should refer the surveyor to the original complainant. Information received during the interview with the complainant becomes part of the investigation documentation.

The Complaint will also receive written notice to acknowledge IDPH is in receipt of the complaint.

### **IDPH Abbreviated Standard Survey (PPS 34-36)**

When the surveyor or survey team enters the building, they open what is called an abbreviated standard survey. The abbreviated survey looks only at specific areas of concern for the purpose of substantiating a complaint. If another concern comes up that is unrelated to the original complaint, then the complainant will have to file a new complaint with the hotline. The surveyor on-site cannot receive and investigate a new complaint.

During the investigation, the surveyor will:

- Discuss the nature of the complaint with the facility administrator.
- Tour the facility.
- Identify the resident.
- Choose a resident sample for investigation.
- Review records.
- Interview individuals who may have knowledge of the events in question.
- Observe conditions in the facility that are related to the complaint.

After the investigation, the surveyor will:

- discuss the findings of the investigation with the facility administrator
- complete a report explaining the investigation
- substantiate (or not substantiate) each allegation in the complaint
- Send the report and all other documentation to the surveyor's supervisor.

## **Standard Survey**

**TRAINER’S NOTE: The Standard Survey is mentioned in slide 34 “Abbreviated Survey” in the TRAINER’S NOTES. It does not have its own slide.**

If the surveyor or survey team finds evidence that suggests more investigation is necessary, they may extend the survey. When this happens, the investigation becomes a Standard Survey. This broadens the investigation and may trigger IDPH supervisors to send a complete survey team into the facility.

## **Complaint Determination (PPS 37)**

A written report of the findings of the investigation will be sent to the complainant within 10 days of the final determination. This report does not include the details of the investigation. Often, it is only a cover letter and a sheet indicating whether or not the complaint was “valid”, “invalid”, or “undetermined”. If the complaint is investigated as part of an annual survey, the complaint findings become part of the annual survey report.

## **Determination (PPS 38)**

- **Valid** – the facility was cited with a State violation or Federal deficiency related to the complaint allegation
- **Invalid** – IDPH had determined that there is no credible evidence of non-compliance with State or Federal requirements related to the complaint allegation
- **Undetermined** – if IDPH finds that there is insufficient information reported to initiate or complete an investigation

**TRAINER’S NOTE: Allegation of resident injury will ALWAYS be VALID if there is evidence that the resident who is the subject of the allegation was injured regardless of whether a violation or deficiency was cited.**

## **(PPS 36)**

Keep in mind that the purpose of an IDPH complaint investigation is to determine if the facility is in compliance with federal and state regulations. An IDPH investigation may not always achieve the result desired by the resident or complainant. In most situations, Ombudsmen work with the resident and facility staff or owners to try to resolve the complaint before contacting Public Health. Once all options have been exhausted for complaint resolution you may, with the resident’s permission, file a complaint with IDPH.

Ombudsmen may have several complaints pending at any given time. Work with your Regional Ombudsman to develop a system for tracking complaint investigations. If results have not been received on a complaint after a period of 30 days or more, with the permission of the Regional Ombudsman, contact the IDPH Regional Office Supervisor.

LTC07202

## COMPLAINT DETERMINATION FORM

FAC. NAME: [REDACTED]  
 LIC. ID #: [REDACTED]  
 DATE COMPLAINT RECEIVED: 04/04/14 04:12:00

COMPLAINT #: 0069115

IDPH Code	Allegation Summary	Determination
-----	-----	-----
104	NEGLECT	2
105	IMPROPER NURSING CARE	2
406	ADMINISTRATION	2
409	POLICY AND PROCEDURES	2

   The facility has committed violations as indicated in the attached\*  
   No Violation

\*Facilities participating in the Medicare and/or Medicaid programs  
 will not receive a copy of the certification deficiencies as they  
 have already received a copy through the certification program  
 process.

## Determination Codes

- 
- 1 = VALID - A complaint allegation is considered "valid" if the Department determines that there is some credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.
  - 2 = INVALID - A complaint allegation is considered "invalid" if the Department determines that there is no credible evidence that there has been a deficiency (non-compliance with the Act or rules & regulations) relating to the complaint allegation.
  - 3 = UNDETERMINED - A complaint allegation is considered "undetermined" if the Department finds there is insufficient information reported to initiate or complete an investigation.

RESIDENT INJURY - Per the P&A v. Lumpkin consent decree, allegations of resident injury will always be "valid" if the resident who is the subject of the allegation was injured.

## **Re-investigations**

**TRAINER’S NOTE:** There is not a slide on re-investigations.

Although it is not common, IDPH may re-investigate a complaint. If the Ombudsman believes that an investigation was not conducted properly, or that the findings were inadequate or incorrect, consult with the Regional Ombudsman regarding steps to request a re-investigation.

## **Statement of Deficiencies: Surveys and Complaints (PPS 38)**

When the team has completed a survey, they return to the regional office with the survey results. These results are reviewed by Regional Supervisors and a “Statement of Deficiencies” is generated. Statements of deficiency must contain:

- Data prefix tag
- Regulatory citation
- Description of the evidence used to justify the deficiency
- Scope and severity of the problem

Additionally, the survey team must categorize deficiencies based on how widespread the problem is and the impact of the problem on residents’ quality of care or quality of life.

When a facility is not in “Substantial Compliance” with Title 42, Code of Federal Regulations, the facility receives a packet that includes a cover letter from IDPH, a “Statement of Deficiencies” and an explanation of the scope and severity assigned to each deficiency.

## **Statement of Deficiencies Cover Letter**

**TRAINER’S NOTE:** Refer to example in resource guide

### **(PPS 40-41)**

The first few pages of the survey report packet includes the cover letter from IDPH. This letter explains that, for all but the most minor deficiencies (A-level) the facility must submit a Plan of Correction (POC) within 10 days of receiving the Statement of Deficiencies. The POC must show that the facility has put systemic changes in place to solve the problem and that the facility has “initiated a program to monitor the continued effectiveness of its Plan of Correction.”

The POC must explain:

- How the facility will identify other residents who might experience the same problem
- How the facility will assure that the problem does not recur
- What method will be used to monitor facility performance to assure that improvements are achieved and made permanent
- When the corrective action will be completed

Depending on the scope and severity of deficiencies, IDPH may choose to do what is called a “desk review.” When IDPH does a desk review and the plan of corrections are found to be adequate, the team does not conduct a follow-up visit to the facility.

## **Potential Remedies (PPS 42)**

Facilities with deficiencies at the level of “D” or higher are subject to remedies such as:

- Denial of payment for new and/or current Medicare/Medicaid admissions
- Civil Money Penalties up to \$10,000 per day per instance
- Transfer of residents
- Transfer of residents with facility closure
- Termination of the provider agreement
- Temporary management of the facility (by IDPH)
- State monitoring of the facility
- Directed Plan of Corrections
- Directed In-Service Trainings

If the facility remains non-compliant for 90 days, Denial of Payment for New Medicare/Medicaid admissions becomes mandatory. If the facility is not in compliance within 6 months they are subject to mandatory termination from the Medicare and Medicaid programs.

## **Statement of Deficiencies (2567) (PPS 43-44)**

A mockup of a “Statement of Deficiency” form is provided below. The form contains quite a bit of information that is useful to Ombudsmen.

Figure 5 - Statement of Deficiency Mockup

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE AND MEDICAID SERVICES		FORM APPROVED OMB NO 0938-0391	
Statement of Deficiencies and Plan of Correction	(X1) Provider/Supplier/ CLIA Identification Number	(X2) Multiple Construction A. BUILDING _____ B. WING _____	(X3) Date Survey Completed <b><u>04/01/2018</u></b>
NAME OF PROVIDER OR SUPPLIER <b><u>Home on the Range</u></b>			Street address, City, State, Zip Code <b><u>123 Main Street,</u></b> <b><u>Anytown, IL 62000</u></b>

Each page includes facility particulars, such as the name and address of the facility, the date the survey was completed, and the facility’s provider number.

The summary of deficiencies begins below the facility identification information. On the first page, second line, indicates that this was a “Licensure and Certification Annual” survey. If the survey team had been conducting a concurrent investigation of certain complaints you would see a line here that reads “Complaint Investigation” followed by the Federal and State complaint ID numbers.

Figure 6 - Statement of Deficiency Sample

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  4/01/2014
NAME OF PROVIDER OR SUPPLIER  Home on the Range		STREET ADDRESS, CITY, STATE, ZIP CODE  123 Main Street, Funkytown, IL 62000	
(X4) ID PREFIX TAG  F000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(X4) ID PREFIX TAG  F000  F314
F314 SS=D	<p>INITIAL COMMENTS</p> <p>Licensure and Certification Annual</p> <p>SubPartS</p> <p>483.25(C) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, record review, and staff interview, the facility failed to prevent the formation of pressure ulcers and provide pressure relief for 1 of 3 residents (R3) reviewed for pressure ulcers in the sample of 24.</p> <p>Findings include:</p> <p>1. On 03/27/14 at 9:15 a.m., R3 was observed sitting in a reclining wheelchair with legs in the up position. R3 was observed to have non-skid socks on and no pressure relieving pad under the heels and nothing to float heels off the chair. A mechanical lift sling was under R3's back. R3 stated that he had been up in the chair at least an hour before breakfast.</p> <p>On 03/27/14 at 10:30 a.m., R3 had to be readjusted in the reclining chair to position the mechanical lift sling properly to transfer R3 to bed. R3 complained of pain at his bottom and right foot. When transferred, the mechanical lift sling and R3's pants were saturated with urine and a foul odor was noted. E10 Certified Nursing Assistant (CNA) stated that R3 is part of the "Get Up" list that the night shift does and that R3 had been up in the reclining chair since early this morning. When the sock was removed from the right foot, the dressing was up around the ankle, exposing the pressure ulcer on the lateral side of the heel. The ulcer had about 75% yellow slough with outside edges a flaky dark brown/black.</p> <p>At 10:50 a.m., E11, Licensed Practical Nurse (LPN) stated that R3 developed the right heel ulcer by crossing his feet. E11 was not sure when the heel protectors were added to R3's orders.</p> <p>The Minimum Data Set (MDS), dated 02/15/14, identified R3 as having moderate cognitive impairment and requiring total assist of at least two staff for all transfers, locomotion and bathing, and requires extensive assist of at least two staff for bed mobility, toilet use and dressing. The determination for pressure ulcer risk development was coded yes and having unhealed stage III pressure ulcers. The MDS also identified R3 as having Range of Motion limitations to both upper and lower extremities. It also identified R3 as being incontinent of both bowel and bladder.</p> <p>December, 2013, Physician Order Sheet documented "Keep Prevalon Boots on to prevent ankle pressure."</p> <p>The Care Plan (CP) dated 02/15/14, identified R3 as requiring "nearly total assist" with Activities of Daily Living (ADL's) due to Cerebrovascular Accident with left Hemiplegia. The CP identified R3 as being at high risk for pressure ulcers secondary to Diabetes Mellitus, limited mobility with contracture formation, desensitization pain/pressure and gross incontinence. The interventions listed, in part, are "pressure relieving mattress on bed/chair and "bilateral gel boots on at all times."</p>		

Below the survey identification line is the letter “F” followed by the number “684.” Next are the letters “SS=D”. This set of numbers and letters identifies the specific area of Federal Regulation where the facility is not compliant and the scope and severity of that non-compliance. The next column, lists the number F684. This code indicates that the facility is in violation of 42 CFR 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES.

Below the deficiency code is text that comes directly from the regulation. This helps people who are reading the report to understand the nature of the problem without having to refer back to another document.

The statement that begins “This REQUIREMENT is not met as evidenced by:” indicates the methods surveyors used to gather evidence to prove that the problem exists. For a deficiency to “stick” surveyors must be able to provide two types of supporting evidence. Often, they will provide three types of supporting evidence. In this case, observation, record review, and staff interviews provided evidence for this deficiency.

Next is a description of the actual situation leading to the deficiency. This section will explain what the surveyors saw, what they learned from a record review, and what they learned from interviews. Although surveyors and facility staff will know which residents are part of the sample, the findings statement must be written in such a way that the resident’s identity is not revealed in the report. The goal of the report is to describe and justify the findings of a deficiency. Therefore, this document is public record.

Every Annual Health or Complaint Investigation Survey with findings will follow this format. **(PM 54)**

### **Scope and Severity Codes (PPS 45)**

The Scope and Severity level is assigned by surveyors based on how widespread a problem is within the facility and the impact of the problem on the residents in terms of safety.

Figure 7 - Scope and Severity Codes

<b>SEVERITY</b>			
Immediate jeopardy to resident health or safety	J	K	L
Actual harm that is not an immediate jeopardy	G	H	I
No actual harm with potential for more than minimal harm that is not an immediate jeopardy	D	E	F
Immediate jeopardy to resident health or safety	A	B	C
<b>SCOPE</b>	Isolated	Pattern	Widespread



*Appendix PP* provides the following guidance to surveyors with regard to scope and severity codes:

“There are four severity levels. Level 1, no actual harm with potential for minimal harm; Level 2, no actual harm with potential for more than minimal harm that is not immediate jeopardy; Level 3, actual harm that is not immediate jeopardy; Level 4, immediate jeopardy to resident health or safety. These four levels are defined accordingly:

- Level 1 is a deficiency that has the potential for causing no more than a minor negative impact on the resident(s).
- Level 2 is noncompliance that results in no more than minimal physical, mental and/or psychosocial discomfort to the resident and/or has the potential (not yet realized) to compromise the resident’s ability to maintain and/or reach his/her highest practicable physical, mental and/or psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- Level 3 is noncompliance that results in a negative outcome that has compromised the resident’s ability to maintain and/or reach his/her highest practicable physical, mental and psychosocial well-being as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. This does not include a deficient practice that only could or has caused limited consequence to the resident.
- Level 4 is immediate jeopardy, a situation in which immediate corrective action is necessary because the facility’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. (See Appendix Q.)

Scope has three levels: isolated; pattern; and widespread. The scope levels are defined accordingly:

- Scope is **isolated** when 3 residents or less are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations.
- Scope is a **pattern** when greater than 3 residents are affected, and/or more than a very limited number of staff is involved, and/or the situation has occurred in several locations, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive throughout the facility.
- Scope is **widespread** when the problems causing the deficiencies are pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility’s residents. Widespread scope refers to the entire facility population, not a subset of residents or one unit of a facility. In addition, widespread scope may be identified if a systemic failure in the facility (e.g., failure to maintain food at safe temperatures) would be likely to affect a large number of residents and is, therefore, pervasive in the facility.”

## **Ombudsman Actions Following the Survey** (PPS 46) (PM 55)

- Review survey results
- Discuss plan of correction with administrator or other appropriate facility staff
- Look for visible signs the plan of correction is being followed
- Ask residents and/or family members if they are seeing improvement
- If no improvement, contact your RO to discuss the need to file a complaint

## **Appealing the Results of an Investigation**

**TRAINER’S NOTE: This is not a common action taken by Ombudsman. Few complainants decide to appeal the results of an investigation. If you are running short on time, just refer trainees to this section.**  
(PPS 47) (PM 60)

Only a complainant can appeal the results of an investigation. If the Ombudsman is the referring agent, then the Ombudsman cannot appeal. If a complainant is dissatisfied with the results of an investigation or determination, they may request an appeal hearing within 30 days of receipt of the Department’s notice of determination of the complaint. The request must be made in writing and sent to:

Illinois Department of Public Health  
OHCR-Division Long-Term Care Quality Assurance  
525 W. Jefferson, 5th Floor  
Springfield, IL 62761-0001

After receiving a request for hearing, the Department’s Chief Administrative Law Judge will assign an Administrative Law Judge to conduct the hearing.

When a request for appeal hearing is honored, the primary goal of the hearing is to determine whether or not the IDPH investigation was conducted appropriately and adequately. IDPH should schedule the hearing within 30 days of the receipt of the hearing request. The Administrative Law Judge has the power to subpoena both persons and records and to take depositions. The complainant may choose to have an attorney present. The facility will be notified of the pre-hearing and hearing and will be allowed to participate as a third party. The facility has the right to have an attorney present. If the facility chooses to participate as a third party, it must file an appearance with the ALJ. The hearing is not bound by common law or statutory rules of evidence.

At the hearing, the complainant will have the opportunity to contest three things:

1. The adequacy of IDPH’s investigation
2. The determination with regards to the complaint being valid, invalid, or undetermined
3. The decision to issue a violation as a result of the determination

The complainant has the burden of proof to prove “by a preponderance of the evidence” (more likely than not) that the Department’s investigation was inadequate or that its determination was incorrect.

The Director of the Department of Public Health has the responsibility and authority for issuing a final decision in the matter after reviewing the ALJ's recommendation. The Director's decision is final and binding, but subject to judicial review.

During the appeal process, the ALJ will try to determine whether:

- The facility had advanced notice of the investigation
- The investigation was conducted weeks or months after the problem was reported and evidence of the problem had disappeared
- The problem was investigated at an appropriate time. For instance, a complaint about weekend staffing is not likely to be verified if the investigation is conducted on a weekday
- The investigation relied exclusively on the facility's documentation and statements while minimizing or ignoring the documentation or statements of residents, families and others
- All witnesses, especially residents and families, were fully interviewed
- The conclusions reached in the investigation are supported by the reported and "accepted facts"

Figure 8 - Request for Appeal Hearing

REQUEST FOR APPEAL HEARING (Example only)
Date:
Illinois Department of Public Health Division of Long-Term Care 525 W. Jefferson St., 5 <sup>th</sup> Floor Springfield, IL 62671
Re: Complaint # 123456 Facility Name & Address
To Whom It May Concern:
As a representative of ( <i>Resident's name</i> ), the subject of the above mentioned complaint, and as co-complainant, I am requesting an appeal hearing on the above captioned complaint, pursuant to Section 3-702(g) and Section 3-703 of the Nursing Home Care Act.
Also, per 77 Ill. Admin. Code 100.12(a). I am requesting all of the Department's inspection or investigative reports relating to the allegations of non-compliance.
Please mail the information to: ( <i>Your program name and office address</i> )
Please contact me at ( <i>Your office phone number</i> ) with any questions or concerns.
Sincerely, ( <i>Your signature</i> )

## Resources (PM 62)

Administrative Code Title 77, Chapter 1, Sub-Chapter C (Skilled Nursing and Intermediate Care Facilities Code)

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

Appendix PP Guidance to Surveyors:

[https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_pp\\_guidelines\\_ltcf.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf)

Assisted Living and Shared Housing Establishment Code:

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

Centers for Medicare and Medicaid Services Provider Enrollment and Certification Guidelines for Laws and Regulations:

<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAnd-Regulations/index.html?redirect=/GuidanceforLawsAndRegulations/>

IDPH Long-Term Care homepage:

<http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes>

Illinois Administrative Codes Regulating Long Term Care Facilities

Assisted and Shared Living Establishments

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

Illinois Administrative Rules Index:

<http://www.idph.state.il.us/rulesregs/rules-index.htm#77-I-c>

Illinois Assisted Living and Shared Housing Act

<http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1217&ChapAct=210%C2%A0ILCS%C2%A09/&ChapterID=21&ChapterName=HEALTH+FACILITIES&ActName=Assisted+Living+and+Shared+Housing+Act%2E>

Illinois Board and Care Home Act

<http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1292&ChapAct=225%C2%A0ILCS%C2%A07/&ChapterID=24&ChapterName=PROFESSIONS%20AND%20OCCUPATIONS&ActName=Board%20and%20Care%20Home%20Act>

Illinois Health Care Worker Registry

<http://www.idph.state.il.us/nar/home.htm>

Illinois Nursing Home Care Act:

<http://www.ilga.gov/legislation/ilcs/ilcs5.asp?ActID=1225&ChapterID=21>

Illinois Public Aid Code [305 ILCS 5/5-5.01a]

<http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=030500050K5-5.01a>

Illinois Supportive Living Facilities Code

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

Illinois Supportive Living Facilities Listing of Operational Sites

<https://www.illinois.gov/hfs/MedicalPrograms/slf/Pages/OperationalSites.aspx>

NOTES:

This image shows a full page of blank white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page, providing a guide for writing. There are no margins, text, or other markings on the paper.

# WHEN RESIDENTS THREATEN TO HARM THEMSELVES

(PM 61)

MODULE 5

## Introduction

This Module is based on Dr. Susan Wehry's Risk Assessment written for the National Ombudsman Resource Center as a resource for Ombudsmen when addressing residents who threaten self-harm. (PPS 2)

### **Purpose (PPS 3-4)**

In the event a resident verbalizes suicidal thoughts or a plan, Ombudsmen will know what steps to take for the safety of the resident and others. It is not unusual for individuals to express frustration or disappointment by sometimes making statements such as "I wish I were dead" or, "I'd rather die than stay here" and yet have no intention of taking their own lives. Others, making the same or similar statements, such as "I'd be better off dead", may very well be communicating suicidal ideation. Suicidal ideation is wanting to take your own life or thinking about suicide. How is an Ombudsman supposed to know when to take it seriously? The answer is simple: ALWAYS.

### **(PPS 5)**

In other words, while not every statement means the person is going to take his or her life, every statement is worthy of some follow-up questions to determine:

1. Is the person thinking of taking his or her life?
2. How likely is he or she to act on those thoughts?
3. Does the individual have a plan and have the means to carry out their plan?

### **Expectation of the Ombudsman (PPS 6)**

In these situations, the role of the Ombudsman is to systematically inquire about thoughts of self-harm. The Ombudsman is NOT RESPONSIBLE for making the final determination of suicide risk OR for single-handedly protecting a person from his or her suicidal thoughts. The Ombudsman IS RESPONSIBLE for asking the appropriate questions and making an appropriate referral.

### **Basic Steps (PPS 7)**

The Ombudsman may also play a role in educating the resident and helping him or her access necessary supports and interventions. For all residents who express thoughts of suicide or wishing to be dead Ombudsmen will:

1. perform a preliminary risk assessment using a standard set of questions provided by the Office
2. communicate risk according to protocol
3. determine which supports or crisis assistance to involve
4. assist resident in accessing supports
5. discuss with an Ombudsman supervisor



**Ombudsman Protocol when the resident has spontaneously verbalized thoughts of suicide.  
(PPS 8)**

**(PPS 9)**

1. The Ombudsman asks: *Have you told your doctor or anyone about these thoughts?*  
The resident may answer yes or no. Regardless of the answer, the Ombudsman asks the next question.

**(PPS 10)**

2. The Ombudsman asks: *Do you feel these feelings and thoughts are a problem for you, or something you might act on?*
  - a) If the resident answers **NO**, the Ombudsman says: *You know I am not a clinician and I am not qualified to fully evaluate these thoughts and feelings. I'm glad this is something you feel you would not act on, but these thoughts and feelings could be a sign of depression. Is there anyone that you would like to talk to about these feelings?*
  - b) If the resident answers **YES** or answers equivocally, (such as "I don't know or I'm not sure" to the question: Do you feel these feelings and thoughts are a problem for you, or something you might act on? The Ombudsman says: *You know I am not a clinician and I am not qualified to fully evaluate these thoughts and feelings. I am concerned about you. I would like to ask you a few more questions and then help put you in touch with the professionals who can help you.*

**(PPS 11)**

3. The Ombudsman then asks: *Have you thought about how you would hurt yourself? In other words, is there a plan?*
  - a) If the resident answers **yes**, the Ombudsman asks: *If there is a plan, do you have a way to carry it out?* In other words, is there access to the means to carry out the plan? For example, a resident who plans to overdose may easily hoard medicines.
  - b) If **yes** to #3, the Ombudsman asks: *What has helped you not act on these feelings? In other words, are there any deterrents?*
  - c) If **yes** to #3, the Ombudsman asks: *How likely do you think you are to act on these thoughts?*

**(PPS 12)**

Based on the resident's responses, the Ombudsman will form a preliminary impression of whether or not the resident is at low, medium or high risk of acting on their feelings and will proceed according to protocol.

The Ombudsman also informs the resident that the Ombudsman will be discussing the situation with his or her supervisor saying, *"I want to make sure I'm offering you the best help."*

**TRAINER'S NOTE: Go over the Preliminary Assessment below.**

**Preliminary Suicide Risk Assessment  
for Ombudsman Use**  
(PPS 13-16)

Check all that apply

**Low**

- ☐ No plan
- ☐ Has vague plan but has no access or idea on how to carry it out OR has very strong deterrents for not pursuing suicide
- ☐ States NO INTENTION of acting on suicidal thoughts or feelings

**Medium**

- ☐ Has plan but it is vague
- ☐ Has specific plan but no access to the means for carrying it out
- ☐ Has some deterrents
- ☐ States LITTLE INTENTION of acting on suicidal thoughts or feelings but cannot say for sure

**High**

- ☐ Has clear plan (how, when, where)
- ☐ Plan involves use of a firearm
- ☐ Has no or few strong deterrents
- ☐ States intention of acting on suicidal feelings regardless of when or where

## NEXT STEPS

### A. If the resident scores in the LOW RISK category

- 1) Say something to the resident such as:

*I am concerned about you. I understand from what you've told me, that it is unlikely that you would act on the thoughts about suicide you've had. Nonetheless, I think it would be helpful for you to talk to someone. May I help you arrange it? May I let someone on the staff know what you're dealing with?*

- 2) Document your contact and determination of risk.
- 3) Seek permission to talk to facility staff, medical personnel, and/or a family member.  
With resident consent, the Ombudsman then proceeds to schedule a time to talk with someone on the care team or proceeds with making a referral to the nurse or the resident's physician.
- 4) Advise the resident to tell someone (doctor, nurse, family or friend) if suicidal thoughts become more of a prevalent.
- 5) Ask the resident what additional supports they have or could use in his or her life. Provide them with the Friendship Line (Center for Elderly Suicide Prevention's warm line) 1-800-971-0016.
- 6) Give the resident your contact information.
- 7) If the resident does not give you permission to disclose the nature of the conversation, you may not do so to anyone other than an Ombudsman.
- 8) Discuss with your Ombudsman supervisor as soon as possible or at least within the work week.

### B. If the resident scores in the MEDIUM RISK category

- 1) Say something to the resident such as:

*I am concerned about you. I understand from what you've told me, that these thoughts of suicide are a problem. I think it would be helpful for you to see your doctor or a mental health professional. Let's ask the staff to schedule an appointment with your doctor now.*

- 2) Document your assessment and determination of risk.
- 3) Seek permission to talk to facility staff, medical personnel, and/or a family member.  
With resident consent, the Ombudsman then proceeds to schedule a time to talk with someone on the care team immediately.
- 4) Ask the resident if he or she is willing to ask the facility staff to schedule a doctor's appointment.
- 5) Facilitate a referral. Before leaving the facility, the Ombudsman should try to have the resident talk with staff and offer to accompany the resident to this meeting. If the resident is unwilling, ask them for an alternate plan. Provide them with the Friendship Line (Center for Elderly Suicide Prevention's warm line) 1-800-971-0016.
- 6) Give the resident your contact information.
- 7) If the resident does not give you permission to disclose the nature of the conversation with anyone, you may not do so unless you are speaking with an Ombudsman.
- 8) Discuss with the Regional Ombudsman or the Office as soon as possible (within 24 hours but no longer than 48 hours)

### **C. If the resident scores in the HIGH RISK category**

- 1) Say something to the resident such as:

*I am concerned about you. I believe you are at risk for hurting yourself and it is important that we get proper medical attention for you. Do you have a mental health counselor? I can call or should we ask the nurse to call your doctor or the crisis clinic?*

- 2) Document your assessment and determination of risk.
- 3) Tell the resident the concern for being at risk of harm and state additional assistance is needed.
- 4) Seek permission to talk to facility staff, medical personnel, counselor and/or a family member. Provide them with the Friendship Line (Center for Elderly Suicide Prevention's warm line) 1-800-971-0016 and assist with making the call.
- 5) Advise the resident of the need to talk with nursing staff and if the resident refuses, call the local crisis service or the Center for Elderly Suicide Prevention's warm line 1-800-971-0016 to discuss the situation and to help determine next steps.
- 6) Discuss with the Regional Ombudsman or the State Ombudsman before leaving the facility.

#### **(PPS 23)**

If the resident scores at a high-risk level and his or her plan involves harming others, the Ombudsman should immediately report to the person in charge at the facility, the Ombudsman's immediate supervisor, and the State Ombudsman.

#### **(PPS 24)**

Disclaimer: The guidelines described above are intended to provide direction but should never be used as the sole determinant.

NOTES:

This image shows a full page of blank white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page, providing a guide for writing. There are no margins, text, or other markings on the paper.



# RESIDENT ASSESSMENT & CARE PLANNING

(PM 67)

MODULE 6

## Introduction

**TRAINER’S NOTE:** Inform trainees that there is no way that all aspects of resident assessment and care planning can be obtained during this module. The supplemental information provided to each trainee with this training can be used to gain additional insight into the subject matter. However, this module provides the nuts and bolts of what each Ombudsman should know about care planning and its importance. During the module, where possible, include information about culture change and its importance in the care planning process.

### **(PPS 2) (PM 68)**

Nursing homes are required by OBRA 87, Medicare, Medicaid, and Social Security regulation to provide the care and services necessary to help residents reach or maintain their “highest practicable” level of well-being. One of the most important tools for assuring that residents receive adequate care is through resident assessment. To give good care, staff must assess each resident and plan care to support each person’s life-long patterns, current interests, strengths and needs. Resident and family involvement in care planning gives staff information they need to make sure residents get good care. Their participation is the cornerstone of good care planning.

### **(PPS 3)**

Every person in a nursing home has a right to good care. To accomplish this, staff must conduct the three steps of the care planning process. These steps include: 1) Resident Assessment; 2) Care Plan Development; and 3) Care Plan Conference.

### **Baseline Care Plan (PPS 4)**

Effective November 28, 2017, facilities are required to conduct a baseline care plan within 48 hours of admission. The baseline care plan promotes continuity of care and communication among nursing home staff, increases resident safety, and safeguards against adverse events that are most likely to occur right after admission. The baseline care plan must include instructions that are needed to provide effective and person-centered care and minimum healthcare information such as:

- (A) Initial goals based on admission orders.
- (B) Physician orders.
- (C) Dietary orders.
- (D) Therapy services.
- (E) Social services.
- (F) PASARR recommendation, if applicable.

PASARR stands for preadmission screening and resident review. According to Medicaid.gov, “The screening is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI) and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.”



The facility is required to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the baseline care plan.

## **FIRST STEP: The Resident Assessment (The Minimum Data Set)** **(PPS 5) (PM 69)**

Appropriate resident assessment helps skilled nursing facilities gather information on resident health care needs and psychosocial well-being. Data collected during the assessment helps facilities integrate sound clinical and social interventions. This assures residents achieve or maintain their highest practical level of functioning.

The Long-Term Care Minimum Data Set (MDS) is a standardized, primary screening and assessment tool of health status. It forms the foundation of the comprehensive assessment for all residents in a Medicare and/or Medicaid-certified long-term care facility. The MDS contains items that measure physical, psychological and psychosocial functioning. The items in the MDS give a multidimensional view of the patient's functional capacities and helps staff to identify health problems.

### **(PPS 6-7)**

Nursing homes are required to complete an MDS assessment on each resident at the following intervals: time of admission, quarterly, annually, if the resident experiences a significant change in status, when a significant correction to a prior assessment needs to be made, and at the time of the resident's discharge from the facility. When Medicare Part A is paying for the resident's stay, the facility must complete Assessments at the following intervals: 5-day, 14-day, 30-day, 60-day, and 90-day mark, if there is a readmission/return, if there is a significant change in resident status, if a significant correction needs to be made to an assessment, and when therapy begins, ends or changes.

### **(PPS 8)**

The MDS collects more than 500 pieces of resident data. It is the instrument that uses language standardized across health care settings. Because it collects so much data, the MDS provides a comprehensive review of resident physical, functional, and psychosocial well-being. Because it uses language common to both long-term and acute-care settings, the MDS makes it possible for care providers both inside and outside the facility to communicate clearly and effectively about the needs of residents.

### **(PPS 9)**

The Resident assessment gathers information about the following:

- How well residents can take care of themselves (i.e., walk, talk, eat, dress, bathe, understand, etc.)
- Residents' habits, activities and relationships
- What problems are occurring and causes
  - Poor balance = medications, sitting too long, weak muscles, shoes, urinary tract infections, ear ache, etc.

### **(PPS 10)**

Minimum Data Set (MDS) 3.0 represents a remarkable shift toward resident involvement in the assessment process. Unlike earlier MDS assessments, which relied heavily on record review, MDS 3.0 requires facility staff to interview residents when completing the following sections:

- 1) Section C - Cognitive Patterns
- 2) Section D - Mood
- 3) Section F - Preferences for Customary Routines and Activities
- 4) Section J - Health Conditions (i.e. pain management, shortness of breath, and history of falls)
- 5) Section Q - Participation in Assessment and Goal Setting

### **Importance of “Section Q” of the Minimum Data Set**

**TRAINER’S NOTE: Ensure that trainees understand the importance of facility staff referring residents to the Local Contact Agency if they express an interest in returning to the community. More information is included in the module regarding specific LCAs and what agency the resident would be referred based on age, mental health status, etc.**

### **(PPS 11)**

Section Q of MDS 3.0, created a significant change in discharge planning by requiring facility staff to interview residents about their expectations for discharge and goals for returning to the community. If the resident says they want to return to the community, the facility must contact a Local Contact Agency (LCA) within 10 business days. In Illinois, the following steps shall be followed regarding referral to the LCA:

- 1) Residents age 60 and over shall be referred to the local Case Coordination Unit
- 2) Residents younger than 60 without serious mental illness (SMI) shall be referred to the local Center for Independent Living
- 3) Residents of any age with an SMI diagnosis shall be referred to the appropriate mental health community agency
- 4) Residents of any age with a development disability shall be referred to the appropriate developmental disability authority

The LCA is then required to contact the resident in a timely manner. LCA staff provides the resident with information about appropriate community services and supports that can be used to help the resident successfully transition back to the community and works with nursing facility staff to organize the transition to community living. Approaches to helping residents return to the community vary from region to region. If you are contacted or a resident asks you for help returning to the community, contact your Regional Ombudsman for direction.

If the resident is unable to participate in MDS interviews, staff must complete the interview with a family member or significant other. Staff may only complete the MDS without interview if the resident, a family member, or significant other is unable to complete the section.

## **Helping Residents Participate in the Assessment Process (PPS 12) (PM 76)**

Ombudsmen help assure that residents participate in the assessment process to the greatest extent possible by:

- Suggesting that residents and family members prepare for the assessment by thinking about daily routines, activity preferences, and goals before staff begin interviews
- Reminding residents that they can suggest/request activities or daily routines that are not included in the list provided on the MDS assessment form
- Helping residents and family members work with facility staff to resolve any issues related to assessment interview procedures

## **SECOND STEP: Care Plan Development (PPS 13-15) (PM 71)**

Federal regulations require nursing homes to develop and implement a baseline care plan for each resident within 48 hours of admission. The baseline care plan must include minimum healthcare information necessary to care for the resident such as: initial goals, physician, dietary orders, therapy and social series as well as the PASARR recommendation (if applicable).

Federal regulations also require the facility to develop and implement a comprehensive person-centered care plan within 7 days after completion of the comprehensive assessment. The care plan is prepared by an interdisciplinary team that must include the physician and a registered nurse with responsibility for the resident, along with a nurse aide with responsibility for the resident, and dietary staff. Additional staff members participate as requested by the resident (or resident's representative), or if appropriate based on the resident's needs. The resident and the representative are key members of the care plan team.

When an area is triggered on the assessment, the team must decide what, if any, interventions are necessary to address the concern. Interventions should be individualized and based on effective problem solving and decision-making approaches that take all of the information available into consideration. Interventions should be designed to help residents achieve goals and should be designed to improve resident functioning or minimize decline.

### **(PPS 12)**

According to 42 CFR 483.21, the comprehensive person-centered Care Plan must include "measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment." Furthermore, the care plan must describe services that will be used to help the resident attain or maintain the "highest practicable physical, mental, and psychosocial well-being." Care Plans must include the resident's preferences and potential for discharge.

### **(PPS 16)**

#### **A good care plan should:**

- Be individualized
- Be specific
- Be written in language everyone can understand
- Reflect the resident's concerns
- Support the resident's well-being, functioning and rights
- Avoid labeling resident choices or needs as "behaviors"
- Use a multi-disciplinary approach, including outside referrals as needed.
- Document resident's desire to move back into the community and must note any referrals made to appropriate agencies for such referrals.

Residents have the right to make choices about their care, services, and daily routines. Therefore, they should be informed of the contents of the care plan and be consulted on personal preferences. If the resident refuses services that would have ordinarily been provided this must be noted in the care plan.

**TRAINER'S NOTE: Refer back to specific examples given during activity in the Introduction of Level II. This activity focused on trainee's desire to keep certain areas of their daily routine in the event they are moving into a nursing home. The care plan can be a very important tool used to obtain those rights. Trainer can give an example of how that particular right can be written in the care plan.**

### **Medical Model Care Plan vs. Resident Directed Model (PM 77)**

**TRAINER'S NOTE: The Medical Care Plan Model is known as the traditional model. Individual Care Plan Models are also referred to as "I Care" Plans and Person (Resident) Directed Care Plans. While the names of the care plans may change based on trends, ensure that trainees know that the key is that care plans must allow the resident to "direct" their own care.**

In the past, facilities used a medical model care plan. The care plans were written from the perspective of the staff and were not conducive to individualized approaches to care. A medical model care plan might look like this:

**(PPS 17)**

Figure 8 - Medical Model Care Plan

Problem	Goal	Approaches
Incontinence	Will become independent in toileting	Assist to bedpan at 6am, 9am, 12 noon, 4pm, 9pm (or when requests) (CNA) Assess ability to stand and pivot on left leg in one week to transfer to commode or toilet, 2/14/05 (N/PT*)

Facilities have begun to use resident directed care plans, written from a resident's perspective. These are sometimes called "I Care" Plans. An "I Care" Plan may look like:

**(PPS 18)**

Figure 9 - Resident Perspective Plan

Need	Goals	Approaches
I need assistance with using the bathroom	I want to regain my independence in using the toilet so that I may go home	I know when I have to go to the bathroom and will tell you. Please assist me to the bedpan on my usual schedule from home at 6am, 9am, 12 noon, 4pm, 9pm (and when I request) (CNA). Assess my ability to stand and pivot on left leg in one week. Then help me to the commode or toilet, 2/14/05 (N/PT*)

**THIRD STEP: Care Plan Conference**

**TRAINER'S NOTE:** Inform trainees that care plans are a great tool for an Ombudsman to use when resolving a complaint. If an Ombudsman participates in a care plan meeting, he or she should request a copy of the most recent care plan as well as the new one. In order to facilitate discussion, ask the trainees if they have used care plans in the past and what their experience is with them.

**(PPS 19) (PM 72)**

Once the assessment (Minimum Data Set) is completed and a care plan has been written, a care plan conference is held. The Care Plan Conference is a meeting where staff and residents/families talk about life in the facility. These may include discussions about meals, activities, therapies, personal schedule, medical and nursing care as well as emotional needs. Residents and their responsible parties may attend the care plan meeting. While an effective assessment requires an interdisciplinary approach, all members of the team may not actually attend the conference.

**(PPS 20)**

The Care Plan Conference must be held no later than 21 days after admission, every three months or whenever there is a significant change in a resident's physical or mental health that might require a change in care. The Interdisciplinary Team gathers at this meeting to review the contents of the care plan and to sign off on their portion of the assessment and care plan. By

this time, the Interdisciplinary Team has already reached many decisions about ongoing care needs, goals and interventions. Meetings are often fast-paced with discussion of individual care plans lasting only 5-15 minutes. Residents and representatives have the right to ask for a longer meeting. The request should be made in advance so as not to interfere with another resident's care plan conference.

### **(PPS 20)**

The Care Plan Conference is a meeting where staff and residents/families talk about life in the facility. These may include discussions about meals, activities, therapies, personal schedule, medical and nursing care as well as emotional needs. Residents and their responsible parties may attend the care plan meeting. While an effective assessment requires an interdisciplinary approach, all members of the team may not actually attend the meeting.

### **Who May Attend? (PPS 21)**

A registered nurse must contact or coordinate the assessments. An effective assessment requires an interdisciplinary approach (all may not be in attendance at the meeting). The members of the team may include:

### **(PPS 22)**

- Resident
- Resident's legal representative
- Physician(s)
- Nursing staff
- Dietary staff
- Therapy staff
- Social services staff
- Activities staff
- Anyone else invited by the resident (e.g., Ombudsman)

### **Participating in Care Planning**

The Consumer Voice offers the following advice for residents and resident representatives who want to participate in the care planning process.

### **Before the meeting (PPS 24)**

Talk with facility staff about your concerns, what help you need and what questions you have. Prepare your questions regarding needs, problems and goals to be discussed during the meeting. Know or ask your doctor or the staff about your condition, care and treatment. Ask staff to hold the meeting when your family can come, if you want them there.

### **During the meeting (PPS 25)**

- Discuss options for treatment and for meeting your needs and preferences. Ask questions if you need terms or procedures explained to you
- Be sure you understand and agree with the care plan and feel it meets your needs.
- Ask for a copy of your care plan
- Ask with whom you should talk if you need changes

### **After the meeting (PPS 26)**

- See how your care plan is followed
- Talk with nursing staff, other staff or the doctor about it

Family members (and Ombudsmen) can help the resident by supporting the resident's choices and desire to participate in the care planning process and by following up with the resident to assure that the care plan is working and talking with staff if questions arise. Once the care plan meeting is over, staff should begin to use the goals and approaches set forth in the care plan.

### **(PPS 27-28)**

Care plan conference barriers may include:

- The care plan meeting notification process is inadequate
- The resident or representative does not understand the care plan process and therefore does not respond to care plan meeting notices
- The care plan meeting format is not conducive to open conversation and problem-solving

### **(PPS 29)**

Ombudsmen can help make the care plan meeting process more accessible to residents and their representatives by: educating them about the care plan process and helping them attend care plan meetings. Often, if a resident or family member asks in advance to attend a care plan meeting, facility staff can schedule the meeting in such a way that there is adequate time for a more in-depth discussion of the care plan.

Keep in mind that a resident or representative can request a care plan meeting at any time. This is especially useful when there seems to be a significant change in resident condition. With the help and guidance of an Ombudsman, residents and their representatives can use the care plan meeting to meet with appropriate members of the Interdisciplinary Team. This gives facility staff, the resident, and the representative an opportunity to take a more holistic look at the needs of the resident, concerns that may have come up for the resident or the representative since the last care plan meeting, and various approaches the facility could use to meet resident needs and preferences.

## **Evaluating the Care Plan**

During the day-to-day operations of the facility, staff will evaluate the resident's response to care plan interventions. This will require facility staff to observe resident progress in the terms set forth by the measurable objectives and timetables in the care plan. Some evaluation may be accomplished using departmental assessments such as weigh-ins, cognitive status assessments, progress in therapy, etc.

In the "I Care" Plan, the resident's goal is to become independent with toileting so that he/she can return home. The approach includes measureable goals (being able to pivot, being able to toilet independently, and being able to return home) and timetables (one week to improve the ability to stand and pivot) that can be assessed by direct care staff and physical therapy staff. Should the resident exceed expectations or fail to meet benchmarks, changes to the care plan will need to be made. Minor changes to the care plan can be made without a new assessment or care plan meeting. Significant changes in resident functioning will trigger the need for a new assessment and care plan.

## **Future care plan conferences**

The nursing home is required to complete a short version of the Minimum Data Set and have a care plan conference every 90 days. The purpose is to see if any basic information about the resident has changed. Every future care plan conference should be a complete discussion of whether any goals set at the last meeting need to be changed based on the following:

- Goals have been met or are now impossible, or resident no longer wants to meet them – and if new goals should be set
- If resident has a "significant change in condition" in between care plan conferences, the nursing home is required to redo resident's Minimum Data Set within 14 days after the change occurs, and hold a new care plan conference within the next 7 days. A "significant change in condition" includes:
  - Resident has lost some ability to do two or more activities of daily living, communication and cognitive abilities. For example, resident loses the ability to walk without assistance; use his/her hands to hold small objects, and thus feed and groom self.
  - Resident's behavior or mood has changed so as to create daily problems or damage relationships and the staff believes the situation will not change without staff intervention.
  - Resident's health becomes so much worse that the resident's life is in danger, for example from a stroke, heart disease, or cancer that has spread.
  - Resident's health becomes worse, and this change is associated with a serious health problem. Examples of a serious health problem are a new stage 3 pressure sore, prolonged delirium or a repeated decline in level of consciousness.
  - Resident's health becomes worse, and this change is associated with a new disease that is likely to affect physical, mental or psychosocial well-being for a long time. For example, resident has developed diabetes or dementia.
  - Resident has lost a significant amount of weight.



- Resident's mood, behavior or functional status improve to the extent that the care plan no longer meets needs and the resident has stopped improving.

Not all changes require a new care plan. A new assessment and care plan are not required if the change in the resident's condition is temporary. If the resident cannot get out of bed and has no appetite because of a cold and fever, for example, the staff needs to monitor the resident's status and attempt various interventions to rectify the issue. A new care plan may not be necessary.

A new care plan is required if the change is an improvement in health, but resident has now stopped improving. If resident is readmitted to the facility after a hospital stay, a new assessment is necessary and a new care plan if there has been a significant change in condition.

### **Empowering the Resident (PPS 30)**

- Support the resident's agenda, choices, and desire to participate in the care planning process
- Follow up with the resident to make sure the care plan is working
- Talk with staff if questions arise

### **Remember... (PPS 31)**

Care plans can be used in the complaint resolution process in multiple ways. Examples include:

- 1) To request and hold the facility accountable for services that are not traditionally a part of the care plan (e.g., requesting that staff and resident sign for medication administration when a resident claims he is not receiving medications and staff claim resident is requesting medications more often than prescribed by the doctor).
- 2) To hold the facility accountable for not providing services written in the care plan (e.g., not providing the amount of therapy specified in the care plan).

This image shows a full page of blank, lined paper. It features approximately 20 evenly spaced horizontal black lines running across the width of the page, typical of notebook or legal stationery. The background is a solid off-white color. There are no margins, text, or other markings present.

# MEDICARE AND MEDICAID

(PM 79)

MODULE 7

## Introduction (PPS 2) (PM 80)

Medicare and Medicaid are both social insurance programs that help cover the cost of medical care. Many people in long-term care settings rely on these programs to help cover at least a portion of the cost of their stay in the facility. However, residents and family members often confuse the two programs. Furthermore, they may not understand what benefits are available through each program. Paying particular attention to the concerns of residents of long-term care facilities, the table below helps highlight some of the differences between Medicare and Medicaid.

Figure 10 - Medicare vs. Medicaid

MEDICARE	PUBLIC AID/MEDICAID
Federally funded	Combination of state and federal funding
Administered by Centers for Medicare and Medicaid Services (CMS)	Administered by Centers for Medicare and Medicaid Services AND the Illinois Department of Healthcare and Family Services
Available to individuals over the age of 65 who have sufficient work history and have paid into social security or a railroad retirement system. Also covers individuals with documented disabilities who have been receiving disability benefits through Social Security or certain Railroad Retirement Board disability benefits for 24 months. Parts A & B also cover individuals with Amyotrophic Lateral Sclerosis (also known as ALS or Lou Gehrig's disease) and individuals with end-stage renal disease.	Available to aged, blind or disabled individuals who qualify for Supplemental Security Income (SSI) or who meet other means tested criteria. (Other groups also qualify for assistance. However, they will not be covered in this training.)
Provides limited coverage for rehabilitative or skilled nursing services provided in long-term care settings.	Provides "Financial aid and all rehabilitative and other services provided under this Code for basic maintenance support; medical, surgical, dental, pharmaceutical, optometric, or nursing services, or other remedial care recognized under State law; rehabilitative services; education, training or retraining for employment or self-support work; funeral and burial expenses; and such other care and services as are determined to be necessary in each case." (Source: Laws 1967, p. 122.)
Benefit periods are limited to 100 days and CANNOT be used to pay for intermediate or custodial care in long-term care settings.	Benefits are long-term and CAN be used to cover the cost of intermediate or custodial care in long-term care settings.

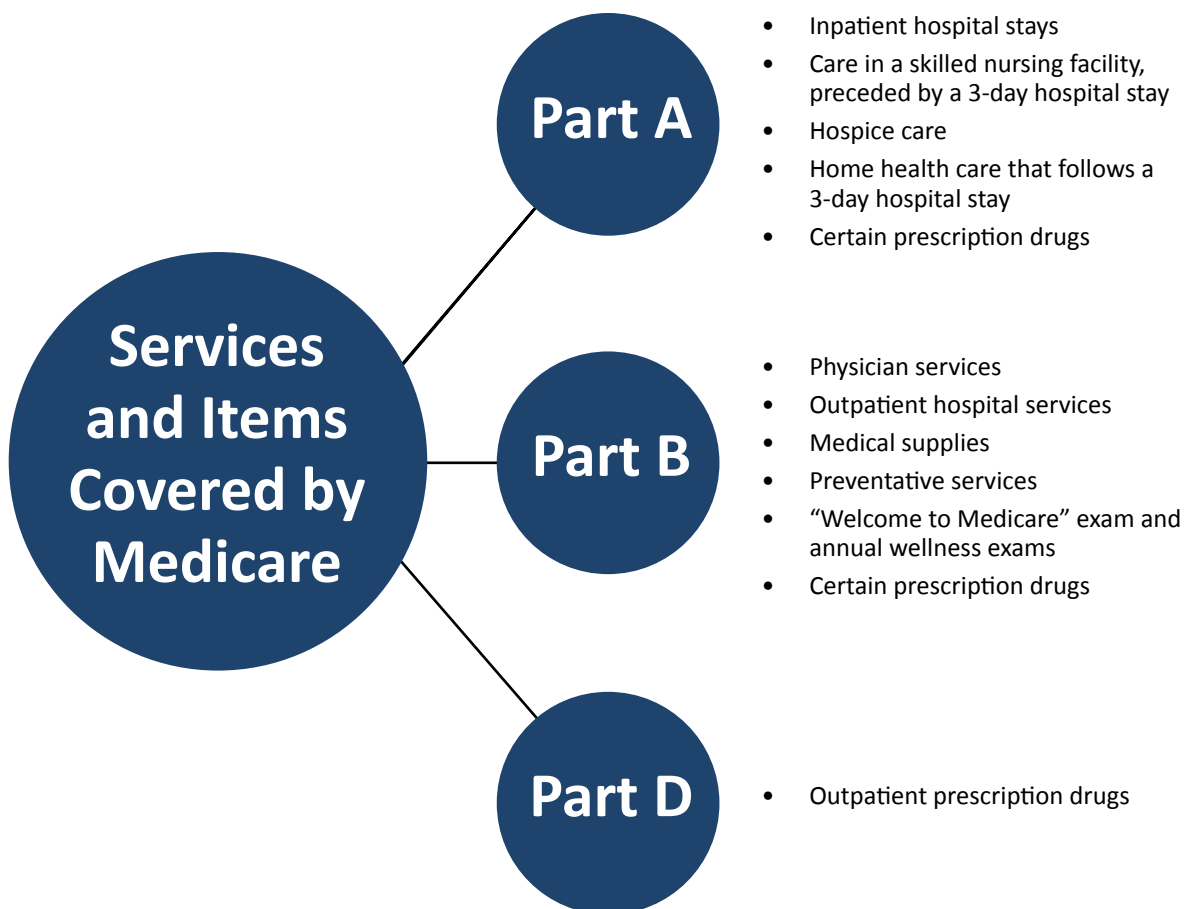
**TRAINER'S NOTE:** Intermediate refers to the type of facility license (e.g., intermediate care facility) whereas custodial refers to the type of care provided (e.g., long-term services and supports-bathing dressing, etc.).

## Medicare (PM 81)

As mentioned in the table above, Medicare is a medical insurance program available to individuals based primarily on age, working history or disability status. Individuals who receive assistance through Medicare have an opportunity to participate in an annual open enrollment period. During this time, individuals may choose to participate in either an Original Medicare Plan or a Medicare Advantage Plan. Almost all Medicare services require the patient to pay a deductible, a coinsurance, or co-pay.

(PPS 4)

Figure 11 - Medicare Coverage



## **Original Medicare Plans (PPS 3)**

- Part A (Hospital Insurance):
  - ◊ Coverage includes:
    - Inpatient hospital care
    - Inpatient care in a skilled nursing facility (does not cover intermediate or custodial care)
    - Hospice care services
    - Home health care services
    - Room and board and long-term services and supports – bathing, dressing, etc.
    - Patient may incur some deductible and co-pay costs for some services (i.e. inpatient hospital stays)
- Part B (Medical Coverage):
  - ◊ Covers medically necessary -
    - Doctor's services
    - Outpatient care
    - Home health services
    - Durable medical equipment (i.e. walkers)
    - Preventive services (i.e. mammograms, cardiac rehabilitation, diabetes screenings, etc.)
  - ◊ Patient may be required to pay deductibles and coinsurance or co-pays.
- Part D (Prescription Drug Coverage)
  - ◊ Individual usually pays a monthly premium
  - ◊ Private companies approved by Medicare provide services
- Medicare Supplemental Insurance (Medigap)
  - ◊ Covers some health care costs not already covered by Medicare
  - ◊ Sold through private insurance companies or may be provided by employers or unions
  - ◊ Regulated by federal and state laws
  - ◊ Must be clearly labeled as "Medicare Supplement Insurance"
  - ◊ Cost varies depending on plan, company, etc.

## **Medicare Advantage Plans (PPS 5)**

- Part C
  - ◊ Combines Part A & B and usually Part D.
  - ◊ Medicare Advantage Plans may operate like a:
    - Health Maintenance Organization (HMO) plan
    - Preferred Provider Organization (PPO) plan
    - Private Fee-For-Service (PFFS) plan
    - Special Need Plan (SNP)
    - HMO Point of Service (HMOPOS) plan
    - Medical Savings Account (MSA) plan
  - ◊ Part D may be added if it is not already included in the selected plan.

## **Skilled Nursing Care Benefits (PPS 6-7)**

It is not at all unusual for an individual to arrive at a skilled nursing facility with a very limited understanding of the Medicare Skilled Nursing Care benefit. As a Long-Term Care Ombudsman, you will need to be able to explain this benefit to others.

Individuals need to know that Medicare will only pay for their stay in a long-term care facility when the patient requires skilled nursing care or skilled rehabilitation services.

Additionally, the patient must complete a “qualifying” three-day inpatient hospital stay. Hospital days are counted at midnight, therefore the day a patient is admitted to the hospital counts as one day, but the day a patient leaves the hospital does not count toward the length of the stay. The patient must be admitted to the hospital for an illness or injury related to the reason the long-term care stay is necessary AND the patient’s physician must certify that the patient needs daily skilled medical care that can only be provided by a registered nurse or doctor (i.e. certain types of intravenous injections) or physical therapy to recover function.

Problems can arise when doctors keep a patient in the hospital for a 72-hour “observation” period without actually admitting the patient to the hospital or when the patient’s discharge plan does not include a doctor’s order for daily skilled nursing services or physical therapy.

## **Covered Long-Term Care Services (PPS 8)**

When a patient has a qualifying hospital stay and has been discharged to a facility for skilled nursing or rehabilitation services, Medicare will pay for a semi-private room, meals, skilled nursing care, skilled rehabilitation services (i.e. physical therapy) and other medically necessary supplies and services.

Benefit periods for individuals using the Original Medicare Plan are 100 days long. Although some deductibles, such as an inpatient hospital stay deductible, may apply, Medicare covers most of the cost of these services for the first 20 days. On the 21st day, the patient’s coinsurance must begin pick up a part of the cost of the stay (usually about 80%). Again, deductibles may apply. If the patient does not have co-insurance, they must pay out-of-pocket for the portion of costs not covered by Medicare. Medicaid is the coinsurance for some patients.

## **Benefit Periods (PPS 9)**

Resident cost in Original Medicare includes the following:

- Days 1-20: \$0 for each benefit period
- Days 21-100: 20%. (Medicare pays approximately 80% of the cost of care).
- Coinsurance may pick up the rest of the cost for the benefit period.
- Medicaid can be the coinsurance.
- If there is no coinsurance, the resident must pay out of pocket.

## **(PPS 10)**

Medicare benefit periods begin on the day an individual begins an inpatient hospital or skilled nursing facility stay. In order to receive the full 100 days of the benefit period, the individual must continue to require skilled nursing care or rehabilitation services.

Residents and family members are most likely to have questions about benefit periods when a patient reaches the point that they no longer need skilled nursing or rehabilitation services but have not reached the end of their benefit period and are also not able to return to the community.

Problems can also arise when a resident who is receiving physical therapy begins to refuse to participate in therapy or reaches a point beyond which therapists determine the resident will not experience significant improvement. At this point, therapists are required to drop the resident from physical therapy and Medicare will stop paying for the stay.

## **(PPS 11)**

If the individual is dropped from Medicare and is then readmitted to the hospital or needs skilled nursing care before 60 days has passed, they are readmitted to Medicare using the remaining days of the original 100-day benefit period.

When an individual has not received inpatient or skilled nursing care for a period of 60 days, they qualify for a new 100-day benefit period. Patients can qualify for an unlimited number of benefit periods. They are responsible for the inpatient hospital stay deductible for each new benefit period.

## **Some Things are Not Covered (PPS 12)**

Medicare does not cover custodial long-term care, routine dental and eye exams, dentures, cosmetic surgery, acupuncture, hearing tests or hearing aids. If a resident of a long-term care facility needs these services, the cost must be paid out of pocket or covered by another insurance or Medicaid.

## **Medicare and the Affordable Care Act (PPS 13)**

According to the Medicare website, there are five important things individuals need to know about the Affordable Care Act and Medicare.



- Medicare is not a part of the Health Insurance Marketplace. Individuals who already have coverage through Original Medicare or a Medicare Advantage Plan will keep the coverage they already have. This means that current Medicare recipients did not need to participate in the Open Enrollment that occurred between October 1, 2013 and January 1, 2014.
- Medicare now covers preventative services such as mammograms and colonoscopies and a yearly “Wellness” visit. This means that the individual will not have to cover the deductibles and that their Part B co-insurance will not be charged for these services.
- Individuals who are in the pharmaceutical “donut hole” now get a 50% discount when buying Part D covered brand name prescription drugs. Individuals don’t have to do anything to qualify for this discount. It is automatically applied at the pharmacy when prescriptions are purchased.
- Care coordination initiatives will improve treatment consistency between providers.
- The Medicare Trust fund is now protected until 2029, creating savings on the cost of premiums and coinsurance recipients must cover.

## **Medicare Savings Programs**

**TRAINER’S NOTE: Please let trainees know that this is the program that helps qualified individuals pay their premiums. This becomes important when...**

There are four programs called Medicare Savings Programs. These programs help individuals who also qualify for both Medicare and Medicaid (called “dual eligibles”) for paying Medicare premiums. The programs are called the Qualified Medicare Beneficiary (QMB) Program, the Specified Low-Income Medicare Beneficiary (SLMB) Program, the Qualified Individual (QI) Program, and the Qualified Disabled and Working Individuals (QDWI) Program. Each of these programs is a means tested program. Individuals must apply for these programs through the Illinois Medicaid Program.

## **Learn More (PPS 14)**

To learn more about the Medicare program, visit [www.medicare.gov](http://www.medicare.gov). There you can search a wide range of topics related to health care or download a copy of the most recent version of *Medicare & You*, the annual consumer guide to the Medicare program.

## **Medicaid** **(PPS 15) (PM 85)**

The purpose of the Medical Assistance Program under Public Aid is to provide essential medical care and rehabilitative services to individuals who qualify for Public Aid or who otherwise have inadequate resources to meet their essential medical needs.

Medicaid is the payer of last resort for medical services. This means that the State will only pay for medical services after all other options (i.e. private insurance, Medicare, etc.) have been exhausted.

The Illinois Public Aid Code (305 ILCS/5) is over 400 pages long. For the sake of brevity, we will discuss those parts of the code that are most likely to raise questions in long-term care settings. Should you need, or want, more in-depth understanding of the Public Aid Code, you may access the Code through the Illinois General Assembly website.

### **Program Administration (PPS 16)**

The Illinois Department of Healthcare and Family Services (HFS) and the Illinois Department of Human Services are both responsible for administration of public aid programs. Each department has responsibility for certain portions of the code. However, there are some portions of the code over which the departments have shared, but clearly defined, responsibility. Please refer to Module Two: Agencies for more information about public aid programs and which department holds primary responsibility for the functions defined in those articles.

### **Qualifying for Public Aid**

**TRAINER’S NOTE: Please inform trainees that Public Aid and Medicaid are NOT one in the same. A person can have Public Aid without the Medicaid benefit. Medicaid is a part of Public Aid.**

#### **(PPS 17)**

Public Aid is available for low-income families, seniors, the blind and the disabled. Individuals qualify for Public Aid (and Medicaid) based on financial need. In order to qualify for Public Aid, individuals (and low-income families) must provide substantial proof of need. Because you are most likely to encounter seniors or people with disabilities receiving Public Aid, this portion of the training focuses primarily on Article III - Aide to the Aged Blind, or Disabled.

#### **(PPS 18)**

**Eligibility Requirements** - In order to be eligible for Public Aid, the individual must qualify for Supplemental Security Income (SSI), a federal program that provides benefits to low-income, disabled adults and children. Low-income adults over the age of 65 may also qualify for SSI. Although the service is not available in all areas, the DHS may provide advocacy services to help individuals who have been denied SSI work through the appeals process.

#### **(PPS 19-20)**

Individuals who are eligible for Public Aid are also eligible for medical assistance (Medicaid). Individuals who would otherwise be eligible for Public Aid, but who do not meet income restrictions, may qualify for Medicaid if their income is equal to or less than 100% of the federal poverty level or their income, after deduction of costs for medical care, is equal to or less than 100% of the federal poverty level. These individuals may be required to pay for a portion of their medical care before Medicaid will begin to pay for care. This is called a “spend-down.” Spend-downs are paid to HFS on a monthly-basis. When it does not cause an extensive financial burden, Medicaid recipients may also be required to provide co-pays for some medications and services.

The expenses of individuals who become ill are injured or die without money, property, or other resources to pay the cost of necessary medical care or burial may also qualify for Medicaid.

### (PPS 21)

**Asset Limitations** - Because Public Aid and Medicaid are mean tested programs, DHS requires applicants to release all of their financial information at the time of application. This process may seem intrusive to some family members; however, failure to release information will result in the denial of coverage.

DHS considers the value of both real and personal property including:

- homes and furnishings
- cars
- earned income from work, Social Security, pensions, veterans' benefits
- contributions in money, substance or services from other sources such as financially responsible family members
- expenses and equity related to income producing businesses and farmland also become part of the means-testing process

Assets that are not counted during the application process may include pre-paid funeral or burial contracts or funeral insurance; irrevocable trust funds that contain the resources of a person with a disability; a homestead that is occupied by the individual receiving Public Aid; and occasional gifts in cash or goods and services from individuals who are not financially responsible for the individual. There are limitations on the allowable value of these assets. Asset limitations are included in the Public Aid Code. However, DHS caseworkers ultimately determine whether or not an asset is allowable. Individuals with specific questions should be referred to their local Family Community Resource Center.

Asset limitations change from year to year. It is important that you direct individuals with questions about homesteads, trust accounts, or any other financial or real estate to qualified DHS caseworkers.

### (PPS 23)

**Prevention of Spousal Impoverishment** - Both the federal government and state legislature recognize that when a spouse is admitted to a long-term care facility, the spouse remaining in the community needs income and assets to survive. The government developed rules called the "prevention of spousal impoverishment" to provide sufficient income and assets to the spouse living in the community. State and Federal regulations allow individuals who need to move into a nursing home to transfer assets to a community dwelling spouse. Spousal impoverishment is discussed in Section 5-4 of the Illinois Public Aid Code. However, information provided by the publication HFS 3191 Long Term Services and Information for Couples is more accessible for the average reader.

When a person moves into a nursing home, the community dwelling spouse may keep the couple's home, car, and household furnishings. DHS caseworkers will then determine the value of bank accounts, certificates of deposit, etc. The spouse moving into the nursing home may transfer up to \$109,560 in assets (not including the home, furnishings and car) to the community dwelling spouse or to someone else for the sole benefit of the spouse. If the spouse moving into the nursing home has income from Social Security, pensions, disability payments, or

veterans' benefits, up to \$2,739 per month may be transferred to a community dwelling spouse. Up to \$655 per month may be transferred to dependent children under the age of 21, dependent adult children with severe disabilities, dependent parents, or dependent brothers or sisters of either spouse.

The dollar amounts provided here are not guaranteed to the community dwelling spouse or dependents. First, these dollar amounts are based on regulations and may be changed through legislation. Second, the amount of income that may be transferred depends on any income dependents may already receive through employment, Social Security, pensions, etc. Allowable income transfers are determined by DHS caseworkers at the time of application. If you have a resident or family member with specific questions about the prevention of spousal impoverishment direct them to DHS caseworkers at the nearest Family Community Resource Center.

#### **(PPS 24)**

**Other Asset Transfers** - It is important that individuals applying for Medicaid understand that neither they nor their spouses may transfer assets to another person for less than fair market value. Assets include money, savings, retirement accounts, stocks and investments, homes, cars, and other possessions.

Federal regulation requires a 5-year look-back from the date a person applies for medical assistance and is living in a nursing home or SLF or has applied for in-home care through Department on Aging home- and community-based programs.

#### **(PPS 25)**

Discovery of asset transfers during the look-back period can result in a penalty period equal to the amount of time the transferred assets would have paid for care in a nursing home or SLF, or for care through a home and community-based program. During this period, the state will not pay for long-term care in a nursing home or SLF or for care through Department on Aging home- and community-based programs. The penalty period can only be eliminated if the applicant is able to get his property back or if it can be proven that the penalty would cause the applicant to be without food, shelter, clothing, or necessary medical care.

#### **(PPS 26)**

DHS workers make decisions about which asset transfers are allowable. Individuals with specific questions should be directed to local Family Community Resource Centers.

#### **The Personal Needs Allowance (PPS 27)**

Individuals living in nursing homes are allowed to keep \$30 per month of their income. This is called a personal needs allowance and can be used in anyway the resident sees fit. Resident's must give permission for nursing homes to manage their personal needs allowance. If the facility has more than \$50 of the resident's money, it must put the money in an interest-bearing bank account.

There is an asset disregard associated with Medicaid. This asset disregard makes it possible for long-term care residents to have up to \$2,000 in personal assets. Residents who "bank" their personal needs allowance for long periods of time, or who have family members contributing to

their personal fund can get into a situation where they exceed the \$2,000 asset disregard. If this happens, a spend-down goes into effect until the resident's assets are once again below \$2,000.

### **Medical Services Provided (PPS 28)**

HFS establishes policies, in accordance with state and federal regulations, regarding the types of services available to Medicaid recipients. Currently, Medicaid covers all or a portion of the cost of the following medical services:

- Inpatient hospital services
- Outpatient hospital services
- Laboratory and X-ray
- Family planning
- Nursing facility services
- Physicians' services
- Medical and surgical services furnished by a dentist
- Podiatrists' services
- Optometrists' services
- Chiropractors' services (under 21)
- Home health
- Nursing facility services
- Physical therapy
- Occupational therapy
- Prescribed drugs
- Preventative Services
- Prosthetic devices
- Eyeglasses
- Early screening, diagnostic, and treatment services
- Services for individuals 65 or older in mental institutions
- Transportation
- Personal care services
- Emergency hospital services
- Rural and federally qualified health centers
- Durable medical equipment and supplies
- Community behavioral health services (provided under the Medicaid Rehabilitation Option, known as Rule 132 Services)

There are limitations on the services and equipment provided by Medicaid. For example, Medicaid may limit the number of sets of dentures or glasses it will purchase for seniors. This can be a problem when dentures or glasses are lost in long-term care facilities. Medicaid also limits the use of name brand drugs. In some cases, there are small co-pays for prescriptions and other services received through Medicaid. Medicaid also limits the quantity of supplies, such as incontinence briefs it purchases for individual residents. Lists of durable medical equipment and supplies that qualify for Medicaid reimbursement are available on the HFS website. The "Instructions for Reading the Attachments" will show you how to tell if a long-term care facility is responsible for the cost of items on the lists.

### **Facility Bed Rates (PPS 29)**

The daily per diem a long-term care facility receives for each Medicaid resident varies from facility to facility and is determined by HFS. The Department uses a formula that combines costs associated with nursing and direct care based on the results of quarterly MDS assessments for each Medicaid-eligible resident, general administrative costs associated with residential care (i.e. food, laundry, housekeeping, utilities, etc.), and capital cost based on a blending of the

inflated historical cost per bed of the building and the uniform cost per bed for all facilities in the same age and region. These rates can be found at:

<https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/LTC.aspx>

### **Medical Assistance Waivers (PPS 30-31) (PM 89)**

Home and Community Based Services (HCBS) Waivers, also referred to as Medical Assistance Waivers or Medicaid Waivers, provide services to allow individuals to remain in their own home or to live in a community-based setting. There are nine Medicaid waivers in Illinois which all fall under the provisions of Section 1915(c) of Social Security Act. The Ombudsman Program works with individuals receiving services through five of these waivers:

#### **(PPS 32)**

- Persons with Disabilities
- Persons with Brain Injuries
- Persons who are Elderly
- Persons with HIV or AIDS
- Supportive Living Facilities

In order to be eligible for any of the Illinois Medicaid Waivers, individuals must:

- Be U.S. Citizens or legal aliens and residents of the state of Illinois;
- Meet Medicaid financial eligibility criteria;
- Require an institutional level of care as specified by each waiver and
- Must have service needs that can be provided cost-effectively.

States are not allowed to spend more on waivers services than it would cost to provide care in an institutional setting, such as a hospital, nursing facility, or an intermediate care facility for the developmentally disabled.

### **Waiver Service Descriptions:**

- **Personal Assistant (PA):** Services provided by individuals who are selected, employed and supervised by the customer. These individuals may assist with or perform household tasks, personal care and, with the permission of a physician, certain health care procedures.
- **In Home Service (Homemaker):** Services consisting of general household activities (meal preparation and routine household care) and personal care provided by a trained homemaker aide, when the individual regularly responsible for these activities is unable to manage the home and care for himself or herself. Homemaker aides shall meet such standards of education and training as are established by the State for the provision of these activities. This service will only be provided if personal care services are not available or are insufficient to meet the care plan or the consumer cannot manage a personal assistant.

- **Adult Day Service/Adult Day Care (ADC):** Provides direct care and supervision in community-based setting for the purposes of providing personal attention, and promoting social, physical and emotional well-being in a structured setting.
- **Emergency Home Response Service:** A 24-hour emergency communication link to assistance outside the participant's home for participants based on health and safety needs and mobility limitations.
- **Environmental Accessibility Adaptations:** Services to physically modify the participant's home to accommodate the participant's loss of function in the completion of his/her Activities of Daily Living.
- **Specialized Medical Equipment:** Includes devices, controls, or appliances, specified in the plan of care, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items and durable and non-durable medical equipment not available under the State Plan.
- **Home Delivered Meals:** One or more ready-to-eat meals per day which are delivered to the home. This service is provided to individuals who can feed themselves but are unable to prepare a meal.
- **Personal Emergency Response System:** A 24-hour emergency communication link to assistance outside the participant's home for participants based on health and safety needs and mobility limitations.
- **Respite:** Services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the customer. Services may include personal assistant, homemaker, nurse, or adult day care. Services are available for a maximum of 240 hours per year.
- **Nursing:** Nursing is provided within the scope of the State's Nurse Practice Act by a registered nurse, licensed practical nurse, or vocational nurse.
- **Intermittent Nursing:** Used for purposes of evaluating customer needs (including assessments and wellness checks) and monitoring.
- **Home Health Aide:** Provided within the State's standards for a Certified Nursing Assistant.
- **Therapies:** Provided by a licensed therapist. May be approved under the waiver if the individual is no longer eligible for therapies under the State Plan, but continues to need long-term habilitative services.
- **Day Habilitation:** Assist the individual with the acquisition, retention or improvement in self-help, socialization and adaptive skills. These services are provided in a setting separate from the individual's home. These services focus on enabling the individual to attain or maintain a maximum functional level and may be coordinated with therapies listed in plan of care.
- **Prevocational Services:** Services provided that prepare an individual for paid or unpaid employment by teaching concepts such as compliance, attendance, task completion, problem solving and safety. Activities in this service are not primarily directed at teaching specific job skills, but at underlying habilitation goals, such as span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitation, rather than explicit employment objectives.

- **Supported Employment:** Intensive ongoing supports that enable participants for whom competitive employment at or above the minimum wage is unlikely in a paid employment work setting. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services because of their disabilities.
- **Cognitive Behavioral Therapies:** Remedial therapies to decrease maladaptive behaviors and/or to enhance cognitive functioning of the individual. These services are intended to enable the participant to better manage his or her behavior and therefore be more capable of living independently.

### **Persons Who Are Elderly (PPS 33)**

The Persons who are Elderly waiver covers individuals 60 years of age or older who are at risk of placement in a nursing facility. Target groups are those who are aged, ages 65 and older, and those who are physically disabled, ages 60 through 64. The Local Point of Entry to access services is the CCP Care Coordination Units (CCU).

<https://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/Elderly.aspx>

Additional eligibility criteria for this waiver include:

- Age 60 or older
- Medicaid eligible
- At risk of nursing facility placement as measured by the Determination of Need (DON) assessment
- Estimated cost to the State for home care is less than estimated cost for institutional care
- Can be safely maintained in the home or community-based setting with the services provided in the plan of care

Services:

- In-home Service (Homemaker)
- Adult Day Service
- Emergency Home Response Service

### **Persons with Disabilities Waiver (PPS 34)**

The Persons with Disabilities waiver covers individuals with disabilities who are under age 60 at the time of application and are at risk of placement in a nursing facility. The Local Point of Entry to access services is the Local DHS-DRS Office.

<https://www.illinois.gov/hfs/medicalclients/hcbs/pages/disabilities.aspx>



Additional eligibility criteria for this waiver includes:

- Medicaid eligible or enrolled in the Health Benefits for Workers with Disabilities (HBWD) <https://www.illinois.gov/hfs/MedicalPrograms/hbwd/Pages/default.aspx>
- Medical determination of a diagnosed, severe disability which is expected to last for 12 months or for the duration of life
- At risk of nursing facility placement as measured by the Determination of Need (DON) assessment
- Estimated cost to the State for home care is less than estimated cost for institutional care
- Can be safely maintained in the home or community-based setting with the services provided in the plan of care
- Services:
  - ◊ Personal Assistant
  - ◊ Home Health Aide
  - ◊ Homemaker
  - ◊ Adult Day Care
  - ◊ Environmental Accessibility Adaptations
  - ◊ Specialized Medical Equipment
  - ◊ Home Delivered Meals
  - ◊ Personal Emergency Response System
  - ◊ Respite
  - ◊ Intermittent Nursing
  - ◊ Nursing
  - ◊ Extended State Plan Therapy Services (Physical, Occupational, Speech)

### **Persons with Brain Injury (PPS 35)**

The Persons with Brain Injury waiver covers individuals of any age with a brain injury who are at risk of placement in a nursing facility due to functional limitations resulting from the brain injury. The Local Point of Entry to access services is the Local DHS-DRS Office.

<https://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/bi.aspx>

Additional eligibility criteria for this waiver includes:

- Medicaid eligible or enrolled in the Health Benefits for Workers with Disabilities (HBWD) program
- Have functional limitations directly resulting from an acquired brain injury as documented by a physician or neurologist

- Includes traumatic brain injury, infection (encephalitis, meningitis), anoxia, stroke, aneurysm, electrical injury, malignant or benign, neoplasm of the brain and toxic encephalopathy. This does not include degenerative, congenital or neurological disorders related to aging
- At risk of nursing facility placement as measured by the Determination of Need (DON) assessment
- Estimated cost to the State for home care is less than estimated cost for institutional care
- Can be safely maintained in the home or community-based setting with the services provided in the plan of care
- Services:
  - ◊ Personal Assistant
  - ◊ Homemaker
  - ◊ Adult Day Care
  - ◊ Environmental Accessibility Adaptations
  - ◊ Specialized Medical Equipment
  - ◊ Home Delivered Meals
  - ◊ Personal Emergency Response Systems
  - ◊ Respite
  - ◊ Intermittent Nursing
  - ◊ Extended State Plan Therapy Services (Physical, Occupational, Speech)
  - ◊ Day Habilitation
  - ◊ Prevocational Services
  - ◊ Supported Employment
  - ◊ Cognitive Behavioral Therapies

### **Persons with HIV or AIDS (PPS 36)**

The Persons with HIV or AIDS waiver covers individuals of any age who are diagnosed with Human Immune Deficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) and are at risk of placement in a nursing facility. The Local Point of Entry to access services is the DRS Statewide HIV/AIDS Unit or the Local DHS-DRS Office.

<https://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/hiv.aspx> Additional eligibility criteria for this waiver includes:

- Medicaid eligible or enrolled in the Health Benefits for Workers with Disabilities (HBWD) program
- Medical determination of HIV or AIDS with severe functional limitations, which is expected to last for at least 12 months or for the duration of life
- At risk of nursing facility placement as measured by the Determination of Need (DON) assessment
- Estimated cost to the State for home care is less than estimated cost for institutional care

- Can be safely maintained in the home or community-based setting with the services provided in the plan of care
- Services:
  - ◊ Personal Assistant
  - ◊ Home Health Aide
  - ◊ Homemaker
  - ◊ Adult Day Care
  - ◊ Environmental Accessibility Adaptations
  - ◊ Specialized Medical Equipment
  - ◊ Home Delivered Meals
  - ◊ Personal Emergency Response System
  - ◊ Respite
  - ◊ Intermittent Nursing
  - ◊ Nursing
  - ◊ Extended State Plan Therapy Services (Physical, Occupational, Speech)

### **Supportive Living Facilities Waiver (PPS 37)**

The Supportive Living waiver is for persons age 22-64 with a physical disability or persons age 65 or over. A Supportive Living Facility must designate which of these two populations it will serve. Even though Supportive Living Facilities fall under the Home and Community Based Services Waiver, the Ombudsman program treats Supportive Living Facilities as long-term care facilities. Individuals can access services to contact a supportive living facility directly to assist with arranging for required assessments.

<https://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/slf.aspx>

Additional eligibility criteria for this waiver includes:

- Persons age 22-64 who have a physical disability (as determined by the Social Security Administration), or persons age 65 or over
- Screened by Health Care and Family Services or a designated screening agency, found to be in need of nursing facility level of care and Supportive Living Program is appropriate to meet the person's needs
- No primary or secondary diagnosis of developmental disability or serious and persistent mental illness
- Be checked against required sex offender websites
- Documentation of tuberculosis (TB) testing in accordance with the Control of TB Code showing absence of active TB
- Not a participant in other HCBS waiver programs
- Income equal to or greater than current maximum allowable amount of Supplemental Security Income (SSI), and must contribute all but \$90 each month toward lodging, meals, and services

- Apartment-style housing with the following menu of services:
  - ◊ Intermittent nursing services
  - ◊ Meals and snacks
  - ◊ Medication oversight
  - ◊ Personal care
  - ◊ Social/recreational programming
  - ◊ Health promotion & exercise programming
  - ◊ 24-hour response/security staff
  - ◊ Emergency call system
  - ◊ Laundry
  - ◊ Housekeeping
  - ◊ Maintenance
  - ◊ Well-being check
  - ◊ Ancillary services

### **Medicaid Managed Care (PPS 39) (PM 96)**

According to HFS, seniors (over age 65) and persons with disabilities make up only about 16% of the total number of people receiving Medicaid benefits in Illinois. However, because these groups often have complex medical and/or behavioral health needs, they account for approximately 55% of Medicaid spending. Under the current a “fee-for-service” program structure, the State is responsible not only for administration of the program, but also for paying medical bills for Medicaid recipients.

Currently, DHS case managers determine whether or not individuals qualify for Medicaid. Once a person is on Medicaid, they see providers who have a contract with the state to provide care using a “fee-for-service” reimbursement plan.

#### **(PPS 40-41)**

In an effort to reform Illinois Medicaid, the State has launched a transition to Medicaid Managed Care. The Medicaid reform law [PA 96-1501], required that by January 1, 2015, at least 50 percent of the individuals covered under Medicaid enroll in a care coordination program that organizes care around their medical needs. As of the fall of 2016, over 60% of the 3 million participants were enrolled in a health plan that coordinates their health care. Care coordination is the centerpiece of Illinois’ Medicaid reform. Managed care programs operate much like insurance programs. Instead of paying providers directly, the State contracts with an insurance company. Each month, the State pays the insurance company a fixed amount of money for the delivery of health care services. This amount is an agreed upon figure for each person included in the plan times the number of people enrolled. This is sometimes called “capitation.” The insurance company then manages all aspects of Medicaid recipient care, from determining eligibility to assuring that services are provided in a manner that meets State and Federal regulations.

Managed care improves health care by improving relationships between clients and their providers and by encouraging coordination among care providers. Managed care also allows the State to pay a lump sum to insurance companies for the care of Medicaid recipients, reducing fluctuations in cost. Under a managed care structure, the state is responsible for oversight but not the day-to-day management of health care services.

### **HealthChoice Illinois (PPS 43-44)**

Illinois is transitioning to a mandatory managed care program called HealthChoice Illinois. The Statewide roll-out will be implemented in three phases, eventually covering every county in Illinois by the end of 2019.

All counties will offer the same 5 health plans, except for Cook County which will offer 7 health plans. The goal of the Statewide Medicaid Managed Care Program is to offer a streamlined, accountable and integrated managed care program that delivers member-centric care, enhanced quality, improved outcomes, and sustainable costs.

All HealthChoice Illinois Plans have the same basic Medicaid services with the added benefit of care coordination services within a network of providers including primary care providers, specialists, hospitals and long-term care facilities.

### **Medicare & Medicaid Alignment Initiative (PPS 45)**

Of the 420,000 Seniors and Persons with Disabilities (SPD) whose medical and behavioral health care are provided by Medicaid, about 261,000 are eligible for both Medicaid and Medicare. These individuals are called “Dual Eligibles” or “Duals.” Medicare covers most health care costs for these individuals while Medicaid covers the cost of long-term care in nursing homes, or home and community-based programs. Because of their complex needs, and Illinois’ historic reliance on institutional care, these individuals account for a substantial portion of Medicaid spending.

### **(PPS 46-49)**

The State of Illinois has entered into a Memorandum of Understanding with the Centers for Medicare and Medicaid Services (CMS) to test a “Capitated Financial Model for Medicare-Medicaid Enrollees.” This demonstration project, called the Illinois Medicare-Medicaid Alignment Initiative or MMAI, supports the State’s efforts to move Medicaid beneficiaries to managed care systems by moving individuals who are eligible for Medicare Part A, enrolled in Medicare Parts B and D, and eligible for full Medicaid benefits from the current fee-for-service program to the Managed Care Program.

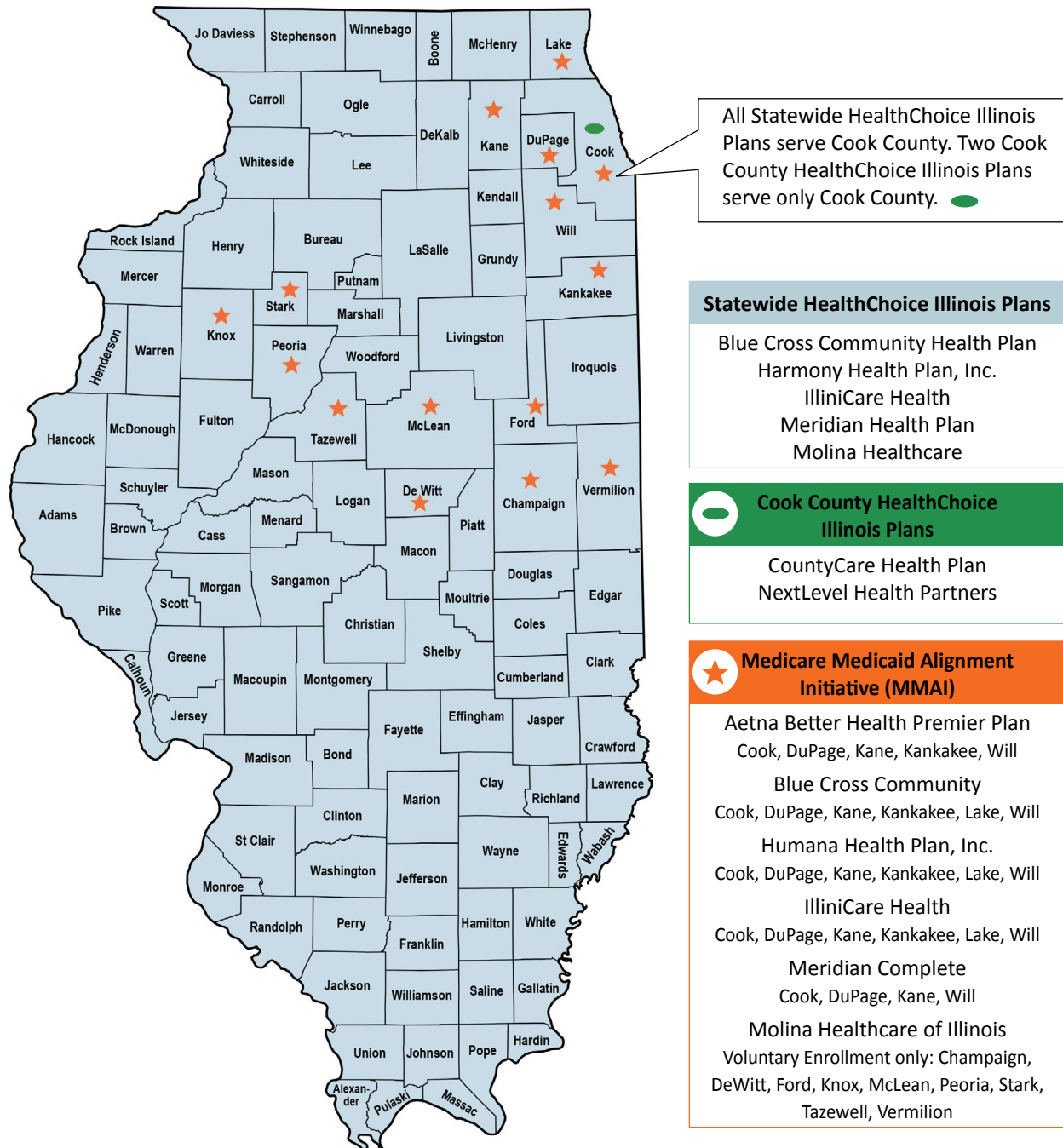
The State will pay a capitated rate for each person on the plan. Managed Care Organizations (MCOs) will then accept full responsibility for assuring that the mental and physical health care needs of beneficiaries are met. The State and CMS are responsible for oversight of the Demonstration Plans.

MMAI Demonstration Projects are currently underway in the Greater Chicago and Central Illinois regions.

## Illinois Medicaid Managed Care Program Map (PPS 47)

The following map displays the areas affected by the rollout of Managed Care in Illinois. The following website should contain the most recent version of the map: <https://www.illinois.gov/hfs/SiteCollectionDocuments/StatewideHealthChoiceIllinoisPlans5418.pdf>

Figure 13 - Illinois Medicaid Managed Care Program Map (PPS 49)



## **Resources**

### **(PM 99)**

HFS 3191 Long Term Services & Information for Couples. Illinois Department of Healthcare and Family Services. Available online at:

<https://www.illinois.gov/hfs/info/Brochures%20and%20Forms/Brochures/Pages/HFS3191.aspx>

Medicaid 101. Illinois Department of Healthcare and Family Services. Available online at:

<https://www.illinois.gov/hfs/SiteCollectionDocuments/medicaid101.pdf>

Medicaid Reimbursement, Durable Medical Equipment Downloadable Information.

Illinois Department of Healthcare and Family Services. Available online at

<https://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/DME.aspx>

Medicare & You 2018. Centers for Medicare and Medicaid Services. Available online at:

<https://www.medicare.gov/medicare-and-you>

Memorandum of Understanding (MOU) Between The Centers for Medicare & Medicaid Services (CMS) and The State of Illinois Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees Illinois Medicare-Medicaid Alignment Initiative. Available online at

<https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/ILMOU.pdf>

Public Aid (305 ILCS5/) Illinois Public Aid Code. Illinois General Assembly. Available online at

<http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ChapterID=28&ActID=1413>

This image shows a full page of blank, lined paper. It features approximately 20 evenly spaced horizontal black lines across the entire width of the page, typical of notebook or legal stationery. There are no margins, text, or other markings present.



# ADVANCE PLANNING

(PM 101)

MODULE 8

**TRAINER’S NOTE: Most Ombudsmen are not attorneys. However, Ombudsmen run across advance directives in our case work, most often when working with a client who is not capable of making his or her own decisions. This module is intended to provide a basic overview of the advance planning options used in Illinois.**

## **Introduction**

### **(PM 102)**

Many residents are facing death or at least faltering capabilities. In order to maintain continuity in their lives, even after they are no longer able to make decisions, many people plan for the future by documenting their wishes using legal tools.

At times, Ombudsmen can help residents plan for the future by providing access to these documents or by introducing the resident to someone who can help him or her with preparing those documents. Other times, Ombudsmen should be familiar with the documents related to advance planning when conducting an investigation or resolving a complaint.

## **Documents Prepared and Approved While Person is Competent**

### **(PM 102)**

### **Living Will (PPS 4)**

A living will is a document in which a person can declare his or her desires for death-delaying procedures. The person decides to what extent he or she wants treatment in cases of terminal illness or persistent vegetative state. If the principal uses the Illinois statutory form, example following, “only medication, sustenance, or the performance of any medical procedure deemed necessary by [my] attending physician to provide [me] comfort will be administered.” The law that governs this document is a state law, the Living Will Act, (755 ILCS 35/). Once the principal’s doctor records a terminal condition the Living Will is in effect. <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2110&ChapterID=60>

<h1>Living Will</h1> <h2>DECLARATION</h2>	
This declaration is made this _____ day of _____ (month, year).	
I, _____, born on _____, being of sound mind, willfully and voluntarily make known my desires that my moment of death shall not be artificially postponed.	
If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.	
In the absence of my ability to give directions regarding the use of such death delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.	
Signed _____	
City, County and State of Residence _____	
The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.	
Witness _____	
Witness _____	
<small>History (Source: P.A. 85-1209.) Annotations Note. This section was Ill.Rev.Stat., Ch. 110 1/2, Para. 703.</small>	
Rev 5/2012	



**What is a Living Will?** A Living Will is a document in which a person can declare his or her desire to have death-delaying procedures withheld or withdrawn in the event he or she has been diagnosed with a terminal condition by a physician. (Specific definitions are provided for these legal terms in the Illinois Living Will Act).

**What are the advantages of a Living Will?** A Living Will assures that your rights will be respected if you are not able to actively participate in death-delaying decisions relating to your own health care due to a physical or mental condition. Additionally, a Living Will saves your family from the burden of having to make health care decisions about consenting to or refusing death-delaying procedures without knowing your wishes.

**Who may execute a Living Will?** Any person age 18 or older who is a resident of Illinois may execute a Living Will at any time. The Living Will document (see reverse side) must be signed by you and two (2) independent witnesses.

**Must an attorney prepare the Living Will document for you?** Although Illinois law does not require that an attorney prepare a Living Will document, you may want to consult with an attorney for additional guidance in protecting your interests using advance directives.

**When should you execute a Living Will?** The best time for you to execute a Living Will is right now, long before you anticipate anything happening to you. This will ensure that the attending physician and your family know your wishes if you are ever in a situation where death-delaying procedures become necessary.

**When does a Living Will take effect?** Under Illinois law, a properly signed and witnessed Living Will takes effect once a person has been diagnosed with a terminal condition and his or her attending physician verifies such information in writing as a part of the medical record.

If the attending physician is unwilling to comply with the instructions stated in a Living Will document, then the physician must notify his or her patient of that fact. If the patient is unable to initiate a transfer of his or her care to another physician, then the physician is required by law to notify: (1) any person authorized by the patient to make such arrangements, (2) the patient's guardian, or (3) any member of the patient's family.

HOWEVER, a Living Will shall not be given effect so long as an agent is available who is authorized to deal with death-delaying decisions on your behalf under a Durable Power of Attorney for Health Care.

**How can a Living Will be revoked?** You may revoke your Living Will by (1) burning, tearing, or otherwise destroying or defacing the document, (2) signing a written revocation, or (3) making an oral revocation in the presence of a witness 18 years of age or older who then puts the revocation in writing for you.

**Will your Living Will be recognized in another state?** The answer depends on the laws of each state. Although most states will recognize a Living Will, some require a document to be both witnessed and notarized to be valid. After you execute a Living Will, you may want to sign this document in the presence of your witnesses and a notary public to avoid any possible problems.

HOWEVER, a Living Will document which has been executed in compliance with the law of another state will be recognized in Illinois.

**Other things to consider:**

- (1) You should talk to your physician about your Living Will to be sure that he or she will comply with your instructions about withholding or withdrawing death-delaying procedures.
- (2) You should give the original Living Will document upon its completion (signed, witnessed, and notarized) to your physician, and provide copies to your health care facility, hospital, lawyer, agent under a Durable Power of Attorney for Health Care, family, or other individuals whom you can rely on to act according to your interests and values.
- (3) You may want to make a note about your Living Will on the reverse side of your driver's license or add a notification card to your wallet.

## **IDPH Uniform Order for Life-Sustaining Treatment (POLST) (PPS 5)**

The “DNR” or “do-not-resuscitate order” has been consolidated with the former POLST form and is now called IDPH Uniform Practitioner Order for Life-Sustaining Treatment. This document is a doctor’s order based on the patient’s medical condition and preferences. It states specifically what measures a patient would like taken if he or she goes into full cardiac arrest or is found with a pulse and/or is breathing.

A POLST form is intended for a person who is seriously ill or with a life-limiting illness. It is a signed medical order reflecting a person’s wishes that travels with the person across settings of care. A POLST form must be honored by all healthcare providers.

A POLST may be updated and changed to reflect the patient wishes at any time. This is important because a person’s health situation and wishes may change over time.

A POLST is not always an advance directive because an Agent under a Power of Attorney for Healthcare or a Health Care Surrogate can approve a POLST according to what would have been the patient’s wishes.





State of Illinois  
Illinois Department of Public Health

**IDPH UNIFORM PRACTITIONER ORDER FOR  
LIFE-SUSTAINING TREATMENT (POLST) FORM**

**For patients, use of this form is completely voluntary.**  
Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition, new orders may need to be written.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Address (street/city/state/ZIP code)		

**A**

Check One

**CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.**

- ☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR**  
(Selecting CPR means Full Treatment in Section B is selected)

*When not in cardiopulmonary arrest, follow orders B and C.*

**B**

Check One (optional)

**MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.**

- ☐ **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*
- ☐ **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*
- ☐ **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. **Request transfer to hospital only if comfort needs cannot be met in current location.**

Optional Additional Orders \_\_\_\_\_

**C**

Check One (optional)

**MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.**

- ☐ Long-term medically administered nutrition, including feeding tubes. **Additional Instructions (e.g., length of trial period)** \_\_\_\_\_
- ☐ Trial period of medically administered nutrition, including feeding tubes. \_\_\_\_\_
- ☐ No medically administered means of nutrition, including feeding tubes. \_\_\_\_\_

**D**

**DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)**

- ☐ Patient ☐ Agent under health care power of attorney  
☐ Parent of minor ☐ Health care surrogate decision maker (See Page 2 for priority list)

**Signature of Patient or Legal Representative**

Signature (required)	Name (print)	Date
----------------------	--------------	------

**Signature of Witness to Consent (Witness required for a valid form)**

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature (required)	Name (print)	Date
----------------------	--------------	------

**E**

**Signature of Authorized Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)**

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Authorized Practitioner Name (required)	Phone
_____	( ) _____ - _____
Authorized Practitioner Signature (required)	Date (required)
_____	_____

Page 1

Form Revision Date - May 2017

(Prior form versions are also valid.)



**HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT**

**\*\*THIS SIDE FOR INFORMATIONAL PURPOSES ONLY\*\***

Patient Last Name	Patient First Name	MI
-------------------	--------------------	----

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

**Advance Directive Information**

**I also have the following advance directives (OPTIONAL)**

<input type="checkbox"/> Health Care Power of Attorney	<input type="checkbox"/> Living Will Declaration	<input type="checkbox"/> Mental Health Treatment Preference Declaration
--	--	---

Contact Person Name	Contact Phone Number
---------------------	----------------------

**Health Care Professional Information**

Preparer Name	Phone Number
Preparer Title	Date Prepared

**Completing the IDPH POLST Form**

- The completion of a POLST form is always voluntary, cannot be mandated and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

**Reviewing a POLST Form**

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g. ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

**Voiding or revoking a POLST Form**

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

**Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order**

- |  |   |
|--|---|
| 1. Patient's guardian of person                            | 5. Adult sibling                        |
| 2. Patient's spouse or partner of a registered civil union | 6. Adult grandchild                     |
| 3. Adult child   | 7. A close friend of the patient        |
| 4. Parent  | 8. The patient's guardian of the estate |

For more information, visit the IDPH Statement of Illinois law at  
<http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives>

**HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT**

IOCI 17-564

 Page 2

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2017

## **Power of Attorney (POA)**

Advance directives include the documents Power of Attorney for Healthcare and Power of Attorney for Property.

The Illinois Power of Attorney Act (755 ILCS 45/) is the related law. Refer to it for answers to any questions about this section. Though the term power of attorney may be used as a title for the decision maker, the power of attorney is the document and the agent is the decision maker. Both a Healthcare Power of Attorney and Power of Attorney for Property can be limited in scope and duration. The principal can notify in the document the boundaries of the agency.

A durable POA is a term used for a POA that does not have an expiration date and is in place should the principal lose the ability to make decisions. This is the most common type of POA.

## **Power of Attorney for Healthcare (PPS 7)**

Definitions:

1. Principal - the individual who is giving the authority to make health care decisions on his or her behalf
2. Agent - the person authorized to make health care decisions on behalf of the principal
3. Power of Attorney for Healthcare – a legal document in which a principle designates an agent to communicate or make decisions about the principal's health care in accordance to the principal's wishes and as indicated in the POA document

This document allows a principal, the person who grants the agency, to name an agent to act on behalf of the principal at a time when the principal becomes unable to make decisions for him or herself. Powers of attorney for healthcare must be witnessed, but do not have to be notarized. The agent of a POA can only make authorized health care decisions if the principal is not able or if the principal gives the agent permission to do so.

Often, Ombudsmen face situations when an agent under a POA is preventing the person, (the principal) from doing something or making decisions that are not aligned with the principal's wishes. In these cases, the Ombudsman must always follow the wishes of the principal. Healthcare POAs are always revocable, no matter the competency of the principal. It is imperative that any principal who revokes a POA, and an Ombudsman who helps a principal revoke a POA, understands that a new agent cannot be named if the principal is not capable of making an informed decision. Therefore, a principal can revoke a power of attorney, and not be able to assign another agent leaving the principle with no legal decision maker.

According to 77 Ill. Admin Code 300.1035(c), the administrative code for skilled nursing facilities, every skilled nursing facility must provide residents the opportunity to execute a living will or a power of attorney. Because the facility has this responsibility, the Ombudsman should never have to assist a resident with preparing a Healthcare Power of Attorney.



## **Power of Attorney for Property (PPS 8)**

Definitions:

1. Principal - the individual who is giving the authority to make financial on his or her behalf
2. Agent - the person authorized to make financial decisions on behalf of the principal
3. Power of Attorney for Property – a legal document in which a principal designates an agent to make decisions about the principal's property and finances in accordance to the principal's wishes and as indicated in the POA document

This document is set up in the same manner as a Healthcare Power of Attorney, except the POA for Property must be notarized. The POA for Property may be revoked in the same manner as a Healthcare Power of Attorney, except the principal must be competent in order to revoke the POA for Property. A facility does not have to give a person the opportunity to complete a Power of Attorney for Property.

### **REVOKING A POWER OF ATTORNEY**

Revocation can occur in the following manner: orally, in writing, or by physically destroying the document. When an agent is removed, all relevant parties, including but not limited to, the agent, physicians, bankers, and facility staff must be notified. If you encounter a person who wants to revoke a power of attorney, use the form following the Healthcare Power of Attorney. Mail a copy of the signed document to any person or organization who works with the person. Legally, the former agent must also be notified that he or she is no longer the agent in order for him or her to stop using the POA.

**Figure 15 - Power of Attorney for Health Care Notice Form**

**Notice to the Individual Signing the Illinois  
Statutory Short Form Power of Attorney for Health Care.  
Please Read This Notice Carefully.**

The form that you will be signing is a legal document. It is governed by the Illinois Power of Attorney Act. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

The purpose of this power of attorney is to give your designated “agent” broad powers to make health care decisions for you, including the power to require, consent to, or withdraw treatment for any physical or mental condition, and to admit you or discharge you from any hospital, home, or other institution. You may name successor agents under this form, but you may not name co-agents.

This form does not impose a duty upon your agent to make such health care decisions, so it is important that you select an agent who will agree to do this for you and who will make those decisions as you would wish. It is also important to select an agent whom you trust, since you are giving that agent control over your medical decision-making, including end-of-life decisions. Any agent who does act for you has a duty to act in good faith for your benefit and to use due care, competence, and diligence. He or she also must act in accordance with the law and with the statements in this form. Your agent must keep a record of all significant actions taken as your agent.

Unless you specifically limit the period of time that this power of attorney will be in effect, your agent may exercise the powers given to him or her throughout your lifetime, even after you become disabled. A court, however, can take away the powers of your agent if it finds that the agent is not acting properly. You also may revoke this power of attorney if you wish.

The powers you give your agent, your right to revoke those powers, and the penalties for violating the law are explained more fully in Sections 4-5, 4-6, and 4-10(c) of the Illinois Power of Attorney Act. This form is a part of that law. The “NOTE” paragraphs throughout this form are instructions.

You are not required to sign this power of attorney, but it will not take effect without your signature. You should not sign it if you do not understand everything in it, and what your agent will be able to do if you do sign it.

Please put your initials on the following line indicating that you have read this notice.

\_\_\_\_\_  
(principal’s initials)

Figure 16 - Power of Attorney for Health Care Form PAGE 1

<div><div>Illinois Statutory Short Form</div><div>Power of Attorney for Health Care</div></div> <div><p>I, _____ (insert name, date of birth and address of principal) hereby revoke all prior powers of attorney for health care executed by me and appoint: _____ (insert name and address of agent)</p><p>(NOTE: You may not name co-agents using this form.) as my attorney-in-fact (my “agent”) to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue.</p><p>A. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others.</p><p>B. Effective upon my death, my agent has the full power to make an anatomical gift of the following (initial one): (NOTE: Initial one. In the event none of the options are initialed, then it shall be concluded that you do not wish to grant your agent any such authority.)</p><p>_____ Any organs, tissues or eyes suitable for transplantation or used for research or education.</p><p>_____ Specific organs: _____</p><p>_____ I do not grant my agent authority to make any anatomical gifts.</p><p>C. My agent also shall have full power to authorize an autopsy and direct the disposition of my remains. I intend for this power of attorney to be in substantial compliance with Section 10 of the Disposition of Remains Act. All decisions made by my agent with respect to the disposition of my remains, including cremation, shall be binding. I hereby direct any cemetery organization, business operating a crematory or columbarium or both, funeral director or embalmer, or funeral establishment who receives a copy of this document to act under it.</p><p>D. I intend for the person named as my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records, including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations thereunder. I intend for the person named as my agent to serve as my “personal representative” as that term is defined under HIPAA and regulations thereunder.</p><p>(i) The person named as my agent shall have the power to authorize the release of information governed by HIPAA to third parties.</p><p>(ii) I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Informational Bureau Inc., or any other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment for me for such services to give, disclose and release to the person named as my agent, without restriction, all of my individually identifiable health information and medical records, regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug or alcohol abuse, and mental illness (including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act).</p></div>
--

**Figure 17 - Power of Attorney for Health Care Form PAGE 2**

Illinois Statutory Short Form Power of Attorney for Health Care

Page 2

(iii) The authority given to the person named as my agent shall supersede any prior agreement that I may have with my health care providers to restrict access to, or disclosure of, my individually identifiable health information. The authority given to the person named as my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

(NOTE: The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care, including withdrawal of food and water and other life-sustaining measures, if your agent believes such action would be consistent with your intent and desires. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to make an anatomical gift, authorize autopsy or dispose of remains, you may do so in the following paragraphs.)

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations:

(NOTE: Here you may include any specific limitations you deem appropriate, such as: your own definition of when life-sustaining measures should be withheld; a direction to continue food and fluids or life-sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electro-convulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc.)

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(NOTE: The subject of life-sustaining treatment is of particular importance. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. If you agree with one of these statements, you may initial that statement; but do not initial more than one. These statements serve as guidance for your agent, who shall give careful consideration to the statement you initial when engaging in health care decision-making on your behalf.)

I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

Initialed \_\_\_\_\_

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued, unless I am, in the opinion of my attending physician, in accordance with reasonable medical standards at the time of reference, in a state of "permanent unconsciousness" or suffer from an "incurable or irreversible condition" or "terminal condition," as those terms are defined in Section 4-4 of the Illinois Power of Attorney Act. If and when I am in any one of these states or conditions, I want life-sustaining treatment to be withheld or discontinued.

Initialed \_\_\_\_\_

Figure 18 - Revocation of Power of Attorney Form

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**REVOCATION OF POWER OF ATTORNEY**

I, \_\_\_\_\_,

(Name and address of principal)

hereby revoke the power of attorney for health care / property (circle one) which was executed by me  
on \_\_\_\_\_, which appointed \_\_\_\_\_ as my agent.

(Date)

(Name of agent)

Said agent no longer has authority to act on my behalf in any matter. This revocation is effective  
immediately.

\_\_\_\_\_  
Signature of Principal

\_\_\_\_\_  
Date

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**TRAINER'S NOTE: The Mental Health Treatment Preference Declaration is not included in the PowerPoint.**

**Mental Health Treatment Preference Declaration**

Another Illinois advance directive is the Mental Health Treatment Preference Declaration. This form is typically used by individuals with mental illness; however, anyone can complete the form. If you are facing a case that involves the advance directives of someone with mental illness, contact your Regional Ombudsman.

Mental Health Treatment Preference Declaration Act:

<http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2112&ChapterID=60>

Declaration for Mental Health Treatment Form:

<https://www2.illinois.gov/sites/gac/forms/documents/dmhtform.pdf>



## **Other Points of Interest:**

Living Wills, DNRs, and Powers of Attorney can be revoked by the principal. Agents under a Power of Attorney cannot be one of the principal's health care providers.

Often times, advocates look for a ranking order between a Living Will, a DNR, a Health Care Surrogate and a Power of Attorney so the advocate can easily decide from whom to take direction. Unfortunately, all of these documents fill different roles and may include different clauses. Also, principals do not have to use the complete statutory forms. A defined ranking is impossible. It is important that Ombudsmen take all of the facts of a case when working with these documents and contact an attorney for advice if necessary.

Health care providers, including nursing homes, can object to certain types of advance directives. If they do, the facility must continue providing care while it assists the resident with finding proper placement.

## **Prepared and Approved When Person Is Not Capable of Assigning a Decision Maker (PPS 9-10) (PM 114)**

### **Health Care Surrogate**

**TRAINER'S NOTE:** "Health care provider" means a person that is licensed, certified, or otherwise authorized or permitted by the law of this State to administer health care in the ordinary course of business or practice of a profession, including, but not limited to, physicians, nurses, health care facilities, and any employee, officer, director, agent, or person under contract with such a person.

**If there is more than one surrogate decision maker at the same level of priority, those surrogates must make reasonable efforts to reach a consensus decision regarding treatment on behalf of the patient. If two or more such surrogates tell the attending physician that they disagree about a decision, the decisions will then be made by a majority of the available surrogates in the same category, unless the minority initiates guardianship proceedings.**

### **(PPS 11)**

In Illinois, if a person does not have a Healthcare Power of Attorney and someone has to make decisions for him or her, a health care provider can designate someone to be a health care surrogate decision maker under the Health Care Surrogate Act 755 ILCS 40/1. This person can only make health care decisions.

According to the law, the health care provider should seek a surrogate who is the highest priority person according to the following list:

1. The patient's guardian (of the person)
2. The patient's spouse

3. Any adult son or daughter of the patient
4. Either parent of the patient
5. Any adult brother or sister of the patient
6. Any adult grandchild of the patient
7. A close friend of the patient
8. The patient's guardian of the estate

This person must be identified by the attending physician and the physician's letter stating so should be in the person's chart. Also, a health care surrogate decision maker cannot withhold life-sustaining measures without the approval from two physicians and can't consent to psychotropic medication or electroconvulsive therapy. The surrogacy ends when the person is discharged from the facility in which the surrogacy was initiated.

## **Guardianship**

### **TRAINER'S NOTE:**

- **Plenary has all rights except placement issues unless specified in the court order**
- **Individual can write the judge if he wants to remove or change a guardian**
- **Public Guardian – held in each county & serves if the person has more than \$25,000**
- **OSG for person who has assets below \$25K**

### **(PPS 12) (PM 115)**

Guardianship is a last resort. If a person is unable to make a medical or financial decision that must be made and advance planning is not in effect, someone must petition for guardianship. In order for a court to appoint a guardian, a doctor must find that the person is not able to make decisions concerning his or her healthcare or financial matters. In court, the petitioner and the person or group who wants to make the decisions for the person must make a convincing argument that the person needs a decision maker. Then the guardian ad litem, someone appointed by the judge to be the eyes and ears of the court, will observe the person to see if he or she does need a guardian. All this must happen before the person is adjudicated incompetent. This is a complex legal process. If an Ombudsman has any questions about guardianship, he or she should turn to an attorney.

If you have a case in which the person has a guardianship of which he or she questions validity, empower the person to write a letter to the judge who appointed the guardian. This should start a review of the person's case. You can find out the judge's information by calling the probate court. If appropriate, the Ombudsman can also write this letter.

The Public Guardian is a position held in each county. The Public Guardian may petition for guardianship and act as guardian if the person has at least \$25,000.00 in assets.

The Office of the State Guardian will provide guardians for people who need them and their assets are below \$25,000.00. Someone besides the Office of the State Guardian must petition for guardianship. Illinois Ombudsmen do not do this. The facility may have to do this if the person has no family or friends willing to file the petition. The facility cannot be the guardian. The judge will appoint a guardian from the Office of the State Guardian. Information about the Office of the State Guardian can be found at <https://www2.illinois.gov/sites/gac/OSG/Pages/default.aspx>.

The Illinois Guardianship and Advocacy Commission, of which the Office of the State Guardian is a division, has other resources for Ombudsmen, such as, the Legal Advocacy Service and the Human Rights Authority. More information about these divisions can be found at the above listed website. The Human Rights Authority will investigate complaints in nursing homes if the complaint states that the rights of a disabled person have been violated.

All guardianship information is public information. The local probate court has information about guardianships. Law regarding guardianships can be found at <http://gac.state.il.us/hcsa.html>.

Use caution when a person who says that he or she is a person's guardian or of a person who states that he or she has a guardian. People often use the term guardian as a replacement for caregiver or an agent under a power of attorney. To clarify any confusion, ask the person, or supposed guardian, if the person was adjudicated, in a court, to be incompetent and if the guardian was appointed by a judge. Ask for the guardianship papers to be sure and review to find out what authority was granted to the guardian by a judge. Just because someone has a guardian does not mean that they cannot make any decisions on their own behalf. Ombudsmen can confirm the findings with the probate court. If the person does not have a guardian, return to the resident for direction.



This image shows a full page of blank, lined paper. It features approximately 28 horizontal black lines spaced evenly across the page, typical of standard notebook paper. The lines are thin and extend from the left edge to the right edge. There is no handwriting or other markings on the page.



# FINANCIAL EXPLOITATION AND MEDICAID FRAUD

(PM 119)

MODULE 9

## **Introduction**

### **(PPS 2) (PM 120)**

Placement in a long-term care facility does not always assure that individuals are safe from abuse. One form of abuse that may follow individuals into the nursing home is financial exploitation. Financial exploitation of individuals living in long-term care facilities can have a number of negative consequences.

Medicaid fraud is form of financial abuse and is common among long-term care residents. This module is intended to help you understand how Ombudsmen and other professionals can assist residents who are experiencing financial exploitation and/or Medicaid Fraud.

## **Financial Exploitation**

### **(PPS 3) (PM 120)**

According to the Administration on Aging, financial exploitation is defined as, “the illegal taking, misuse, or concealment of funds, property, or assets of a senior for someone else’s benefit.”

### **Warning Signs of Financial Exploitation (PPS 4-5)**

The *Illinois Attorney General's Office* website highlights warning signs of financial exploitation in the community. These warning signs may also be relevant to residents living in long-term care settings. These include:

**TRAINER’S NOTE: No need to go over all bullet points. Select points that are common or points that the trainer can give examples of. However, don’t spend too much time on this.**

- Someone seems overly interested in the resident’s financial situation; sometimes the interested individual has no visible means of self-support.
- Someone has access to a resident’s money and appears to be using the money solely for himself or herself.
- Someone charges a “fee” for assisting the individual.
- A resident makes a large loan to someone with no arrangement for repayment.
- Valuable personal items are taken from the resident’s room.
- Suspicious activity with the checking or savings accounts, certificates of deposit, trust funds, credit cards or other financial instruments.
- Suspicious signatures begin to appear on checks and bank documents.
- The resident no longer has access to information about his or her personal bank accounts.
- The resident is unaware of transactions made using his or her accounts.
- Someone, other than the resident’s disabled child or spouse, lives in the resident’s home while the resident is in a long-term care facility.

**TRAINER'S NOTE: Medicaid makes allowances for spouses, siblings with equal equity in the home, and disabled adult children.**

### **Financial Exploitation Complaints (PPS 6)**

Ombudsmen are most likely to become aware of alleged financial exploitation in a long-term care facility against residents when:

- A resident, a resident's family member, or acquaintance, voices a concern about how the resident's assets are being handled.
- A facility issues a notice of transfer or discharge for non-payment.
- A bank calls with concerns about transactions against the accounts of a long-term care resident.
- Facility staff share concerns about family members' behaviors such as selling property without the resident's knowledge or permission, isolating the resident from friends and family members, or other suspicious behaviors.

## **Adult Protective Services**

On January 1, 2019 Public Act 100-0641 was enacted. This Act amends the Adult Protective Services Act by redefining the definition of an "eligible adult". The new definition includes residents of long-term care facilities when the abuse occurs outside of the facility and is perpetrated by a family member, caregiver, or another person who has a continuing relationship with the resident, but who is not an employee of the facility. Therefore, with consent, the Ombudsman may refer complainants and residents to APS via the Senior HelpLine 1-800-252-8966.

## **Ombudsman's Role (PM 121)**

### **Capable Resident (PPS 7&8)**

In accordance with federal law, Ombudsmen are not mandated reporters with regard to work on behalf of residents. An Ombudsman shall not report exploitation of a resident when a resident or representative has not communicated informed consent. According to the LTCOP Policies and Procedures Manual, the Ombudsman shall:

1. encourage caller to make a police report, contact legal services, or hire a private attorney;
2. provide the number to the Senior HelpLine or to the local Adult Protective Services Program;
3. open a case if there is a threat of a facility-initiated transfer or discharge or if a resident requests Ombudsman assistance.
4. request the permission of the resident to report suspected exploitation if the resident is unwilling to report themselves;
5. inform the complainant, if the complainant is a mandated reporter, 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]), Section 1150(B) of the Social Security Act and/or
6. 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.

The Ombudsman's ability to advocate will depend on the consent given by the resident and the direction that the resident gives the Ombudsman. Encourage the resident to contact legal services or a private attorney.

When an Ombudsman receives a complaint about financial exploitation, the first order of action is to visit the resident. During the visit, the Ombudsman should educate the resident about their rights and their options which include but are not limited to:

- Visitation rights
- Right to legal representation
- Right to file a complaint or police report
- Right to file a report with APS
- Revoking a POA
- Assigning a new agent
- Removing individuals from their bank account

Ombudsman advocacy is limited to the permission granted by the resident. Ombudsman investigate by:

- gathering information,
- requesting records, including an accounting of records from the agent under a POA for property, and
- interviewing all parties with whom we've received permission to talk with

Ombudsman gather all information and share it with the resident to assist with making an informed decision and then follow the direction of the resident.

### **Incapable resident (PPS 9)**

According to the Policy and Procedures Manual, when a resident is unable to provide consent for an Ombudsman to work on a complaint directly involving the resident, the Ombudsman shall seek evidence to indicate what the resident would have desired and, where such evidence is available, work to bring about that desire. In situations of an incapable resident with a complaint of financial exploitation, the Ombudsman shall:

- Encourage the complainant to file a police report.
- Provide the number to the Senior HelpLine or to the local Adult Protective Services Program.
- Remind mandated reporters of their duty to report to the proper entities and include an explanation that reporting to the Ombudsman program does not fulfill their reporting requirements.
- Open a case if there is a threat of a facility-initiated transfer or discharge.
- Check to see if the resident has a guardian or representative.
- 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.

**TRAINER'S NOTE: These are the minimum requirements; the Regional Ombudsman has discretion to do further investigation as time allows.**

### **Ombudsman Investigation (PPS 10)**

Part of the investigation includes gathering as much information as possible to obtain an accurate understanding of the situation and to present the information to the resident to allow for the resident to make an informed decision about next steps. Ombudsman must follow the direction of the resident in order to proceed with any investigation. However, sometimes the resident has not been presented with all of the facts in order to make an informed decision. The following are questions and actions that may assist an Ombudsman when working on cases that involve financial exploitation:

- Is the resident aware of a potential problem?
- Does the resident agree that the situation is a problem?
- Is the resident capable of making decisions?
- If yes, does the resident want help from the Ombudsman?
- Is there an agent under POA (property or health care?), a guardian, a trustee/trust administrator, a joint bank account owner, a representative payee for Social Security?
- Does anyone other than the above listed have access to the resident's accounts?
- How is the resident's bill being paid? (Private pay, Medicaid, Medicare?)
- If the resident is not Medicaid approved, has anyone started the Medicaid application process? If not, why not?
- If the resident is on Medicare, how many days have been used and what is the payment plan for the future?
- Is the account in arrears? If yes, what is the outstanding balance?
- Has the facility starting the process of transfer or discharge process?
- What are all sources of resident's income?
- Where does the resident's monthly income go?
- Has the resident recently made "gifts" of money or property? If yes, what and to whom?
- Does Resident have long term care insurance? If yes, has this insurance coverage been investigated (by the facility) as a source of payment?
- Is the pharmacy bill in arrears?

### **Steps to Resolution**

Once the necessary information has been gathered, and with the resident's consent, you can begin steps to resolve the problem.

### **Required Facility Action (PPS 11)**

Talk to the facility about their responsibility to report suspected crime to law enforcement. Ask the facility to explain their policy for reporting crimes against residents and encourage the facility to report financial exploitation to law enforcement, APS and IDPH.

- Section 1150(B) of the Social Security Act requires nursing homes to “report any reasonable suspicion of crimes committed against a resident of that facility” to at least one law enforcement agency and IDPH not later than 24 hours after suspicion.
- The Abused and Neglected Long-Term Care Facility Residents Reporting Act requires facilities to report to report “suspected resident abuse and neglect” to the Department of Public Health. <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1222&ChapterID=21?>
- The Adult Protective Services Act includes nursing home staff as mandated reporters of eligible adults. Mandated reporters under this Act are required to report to APS when the resident is unable to do so. <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1452>
- Facilities must also have a policy explaining how they address crimes against residents.

### **Ombudsman can assure the following actions are considered/taken**

**TRAINER’S NOTE: If the police are also investigating the financial exploitation, the Ombudsman must not interfere with their investigation. Therefore, some of these actions should only be taken with the knowledge of the police. Refer to the next module for steps to take regarding a facility-initiated transfer or discharge due to non-payment as a result of financial exploitation.**

#### **(PPS 12-14)**

The following steps assume that proper permission has been obtained.

- A capable resident can request that the nursing home become representative payee of the resident’s Social Security.
- The facility can request to become the representative payee of an incapable resident.
- A capable resident can change the address or account to which the pension is mailed or deposited.
- The facility may need to assist the resident with changing the resident’s mailing address to the facility’s address.
- The resident may revoke his or her Agent under a Power of Attorney and assign a new Agent, if capable.
- The resident has the option of hiring the bank Trust Department to manage funds and pay bills.
- The resident has the right to have an attorney and may contact a legal services provider.
- If the family of an incapable resident is accessing the resident’s facility trust account, speak with the facility trust account manager about requesting receipts for reimbursement prior to releasing resident’s funds. The facility may also request to see the items purchased with the resident’s funds.
- The resident may review bank statements. If any cancelled checks appear to have forged signatures, alert the bank and law enforcement.
- The resident has a right to file a report with law enforcement and or APS.



**TRAINER'S NOTE: The willingness of police to pursue suspected financial exploitation cases varies greatly from jurisdiction to jurisdiction. Each Regional Program may have different experiences regarding police participation.**

**(PPS 15)**

If police are not involved or with the knowledge of the police:

- Contact all banks used by the resident regarding potential financial exploitation.  
**TRAINER'S NOTE: Will need a written consent for release of information.**
- Write a letter to the Agent under the POA for bank statements and an accounting of the resident's money (A sample letter appears at the end of this module). The Regional Ombudsman should consult with the Office prior to sending the demand letter.

**TRAINER' NOTE: The IL Power of Attorney Act gives the Ombudsman authority to request financial statements from the Agent under the POA for property.**

- According to (755 ILCS 45/2-7.5) Illinois Power of Attorney Act:
  - (c) An agent shall keep a record of all receipts, disbursements, and significant actions taken under the authority of the agency and shall provide a copy of this record when requested to do so by:*
    - (3) a representative of the Office of the State Long-Term Care Ombudsman, acting in the course of an investigation of a complaint of financial exploitation of a nursing home resident under Section 4.04 of the Illinois Act on the Aging;*
    - (d) If the agent fails to provide his or her record of all receipts, disbursements, and significant actions within 21 days after a request under subsection (c), the adult abuse provider agency, the State Guardian, the public guardian, or a representative of the Office of the State Long Term Care Ombudsman may petition the court for an order requiring the agent to produce his or her record of receipts, disbursements, and significant actions. If the court finds that the agent's failure to provide his or her record in a timely manner to the adult abuse provider agency, the State Guardian, the public guardian, or the State Long Term Care Ombudsman was without good cause, the court may assess reasonable costs and attorney's fees against the agent, and order such other relief as is appropriate.*

**(PPS 16)**

- Incapable residents as a last resort:
  - ◊ Educate facilities on guardianship process and the nursing home's responsibilities (See Nursing Home Care Act, 210 ILCS 45, Sec. 2-201 (11) regarding Resident's funds; 2-202(a)(3) regarding execution of nursing home contract).
  - ◊ Remind facility staff they are mandated reporters and should report to APS.
  - ◊ Contact Public Guardian if the resident's assets are over \$25,000 or the Office of State Guardian if the resident's assets are under \$25,000.
  - ◊ Contact the Office to discuss making a referral to Adult Protective Services

In either case, someone must serve as the Petitioner and there will be attorney's fees and court costs. The nursing home can be the Petitioner. Ombudsmen CANNOT Petition.

## **Encouraging Facility Action (PPS 17)**

As mentioned earlier, nursing homes are required to report any reasonable suspicion of crimes committed against a resident of that facility to local law enforcement. Facilities are also obligated to assure residents' needs are being met and doctors' orders are being followed. Often, the Ombudsman must inform facility staff of their responsibilities to assist the residents. For example:

- Sometimes it is not only the nursing home bill that doesn't get paid, but the resident's pharmacy bill also does not get paid. In these instances, pharmacies sometimes refuse to send the resident's medication to the facility. If the pharmacy threatens to stop delivering meds due to non-payment, encourage the facility to alert the pharmacy about the financial exploitation and inform them that interventions are being implemented. The facility should ask the pharmacy to continue delivering the medication while problem is being resolved.
- Facility staff may also assist with the Medicaid application if warranted.
- Regarding banking concerns, talk to the facility about taking the resident to the bank if a bank employee is not able to visit the resident in the facility:
  - ◊ If the joint owner/authorized signer is the alleged abuser, the resident can choose to close the account and open a new account.

**TRAINER'S NOTE: There could be some situations where relationships between the bank staff and alleged abusers may impact bank staff members' belief that financial exploitation has taken place. This dilemma may be solved by opening a new account at a different bank.**

- ◊ If resident cannot close account, the resident may open his/her own account and have future monies deposited in the new account?

**TRAINER'S NOTE: This can result in need to change automatic deposits, including Social Security. There could be a lapse during change over, making it difficult to pay bills on time.**

- ◊ Check if there have been electronic transfers from the resident's account to someone else's account. Will the bank flag all activity on the account? Will the bank stop all electronic transfers out of the resident's account?
- ◊ If the resident's bank account has a debit or cash card, find out who has possession of the card and pin number. The card can be cancelled if necessary.

**TRAINER'S NOTE: If resident wants a card, a new one may be issued and held in a safe place for the resident (for example, in the facility's business office). Changing the pin number may not be enough. The card can be used without a pin number by asking the merchant to run it as credit rather than as debit.**

For additional information regarding financial exploitation, refer facility staff to the Consumer Financial Protection Bureau at <http://www.consumerfinance.gov/older-americans/>. This website gives facilities and others working with seniors' information on warning signs of financial exploitation and tips on how to assist the individual.

## Working with Adult Protective Services (APS)

**(PPS 18) (PM 126)** On January 1, 2019 Public Act 100-0641 became effective. This Act amends the Adult Protective Services Act by modifying the definition of “Eligible Adult”. Prior to January 1st, APS could not investigate any concern about a person who lives in a long-term care facility. Now, an *“‘Eligible adult’ also includes an adult who resides in any of the facilities that are excluded from the definition of ‘domestic living situation’ under paragraphs (1) through (9) of subsection (d), if either: (i) the alleged abuse or neglect occurs outside of the facility and not under facility supervision and the alleged abuser is a family member, caregiver, or another person who has a continuing relationship with the adult; or (ii) the alleged financial exploitation is perpetrated by a family member, caregiver, or another person who has a continuing relationship with the adult, but who is not an employee of the facility where the adult resides.”*

Because Ombudsmen can also advocate for residents who have been abused, neglected or exploited, there may be times where both the Ombudsman and the APS Programs are involved in the same case. The Act does not change Ombudsman jurisdiction, actions, protocol, policies or procedures. Ombudsman always investigate to gain information to provide to the resident that allows the resident to make an informed decision. However, APS investigates to verify or substantiate the allegation(s). Regardless of APS’ involvement, Ombudsmen will continue to follow the direction of the resident and may not share information with APS without permission from the resident, the complainant or the resident’s representative.

**TRAINER’S NOTE: The ability to refer to APS is a new process and will likely evolve over the next couple of years.**

### **(PPS 18-19) (PM 126)**

As previously mentioned, beginning January 1, 2019, Adult Protective Services has the ability to assist residents in long-term care facilities under the newly revised definition of “eligible adult” in the Adult Protective Services Act.

APS has jurisdiction to take a resident’s case if:

- The alleged abuse or neglect occurs outside of the facility **and**
  - Not under facility supervision **and**
  - The alleged abuser is a family member, caregiver, or another person who has a continuing relationship with the adult;
- OR**
- The alleged financial exploitation is perpetrated by a family member, caregiver, or another person who has a continuing relationship with the adult, but who is not an employee of the facility where the adult resides.

When a report is made to APS, a caseworker is assigned to investigate the validity of the allegations. The goal of the APS investigation is to alleviate the abuse. APS uses a variety of methods including:

- financial or legal assistance and protections, such as representative payee, direct deposit, trusts, order of protection, civil suit or criminal charges;

- counseling referral for the victim and the abuser; and
- when needed, guardianship proceedings or long-term care placement.

The resident has the right to accept or decline services from APS. As an adult, a competent person may refuse an assessment and may refuse all services and interventions. This is called the client's right to self-determination, upon which the Adult Protective Services program is based. No decisions are made about a competent adult without that adult's involvement and consent. Every effort is made to keep the person in his or her home.

Where a resident has dementia or another form of cognitive impairment, the Adult Protective Services Program works to assess the situation and to provide services, as needed. In some cases, the Adult Protective Services Provider Agency petitions the court for guardianship in order to ensure that the resident's needs are met. Guardianship is always the last resort.

According to the Adult Protective Services Act:

*"Substantiated case" means a reported case of alleged or suspected abuse, neglect, financial exploitation, or self-neglect in which a provider agency, after assessment, determines that there is reason to believe abuse, neglect, or financial exploitation has occurred.*

*"Verified" means a determination that there is "clear and convincing evidence" that the specific injury or harm alleged was the result of abuse, neglect, or financial exploitation.*

### **Individuals who live outside of a Long-Term Care Facility**

If an Ombudsman becomes aware of potential financial exploitation of an individual who lives in the community, the Ombudsman should have a discussion with the individual about making a referral to Adult Protective Services. The Ombudsman may only refer the individual to APS with their express consent - If financial exploitation is either suspected or is occurring with a senior or a person with a disability while living in the community, the local APS program is the entity designated to investigate the complaint. The local police may also be involved. If the individual enters a long-term care facility while the case is still open, the APS worker may follow the case into the facility for a limit period of time. Once APS closes the case, a referral may be made to the Ombudsman Program if follow up is needed or recommended.

## **Working with Law Enforcement** (PPS 20) (PM 128)

### **Elderly Service Officers (ESO)**

The Attorney General's (AG) Office has a program call the Elderly Services Officers (ESO). The AG's office provides training to local and state police officers with issues surrounding crimes against elders. These officers often have more experience, knowledge, and training with regards to elderly issues, including abuse and financial exploitation.

## **Local Law Enforcement**

When working with local police, find out if any officers are ESOs. Develop a working relationship with them and offer to either meet with them or to do an in-service training at their office about the Ombudsman program. Having a professional working relationship with the local police will improve the chances of the local police investigating a potential crime.

## **The B\*SAFE Program**

**TRAINER’S NOTE: This is not included in the PowerPoint. It is in the manual for the trainees’ reference. B\*SAFE was introduced in the first module. There is no need to go into further detail here.**

### **(PM 128)**

In 2001, the Illinois Department on Aging, the Illinois Bankers’ Association, the Illinois Community Bankers’ Association, the Office of the Attorney General and TRIAD (an organization comprised of law enforcement, public agencies and community organizations committed to preventing elder abuse) developed the Bankers and Seniors Against Financial Exploitation (B\*SAFE) Program to teach bank tellers how to detect financial exploitation and encourages networking between the bank, local law enforcement, and elder abuse prevention agencies.

In 2010, the Illinois Elder Abuse and Neglect Act (Public Act 96-1103) was amended to require the Department on Aging to collaborate with the Illinois Department of Professional and Financial Regulation to develop minimum training standards for any bank employee who has face-to-face or phone contact with individuals over the age of 60. Under the amendment, bank employees must receive at least 30 minutes of training addressing signs of financial exploitation and methods for reporting financial exploitation.

When bankers are aware of their responsibilities and familiar with the Ombudsman Program, the B\*SAFE Program can be an effective tool for coordinating investigations of financial exploitation of long-term care residents. In one such case, a banker called her local Ombudsman Program concerned about transactions on the account of an elder living in a private-pay intermediate care facility. The Ombudsman assigned to the facility visited the resident and determined that the resident was no longer able to direct her own affairs. After discussing the case with her Regional Ombudsman, the Long-Term Care Ombudsman contacted the local Elderly Services Officer (ESO). The local ESO worked with the local State’s Attorney to win a conviction against the perpetrator.

## **Medicaid Fraud** **(PPS 21) (PM 129)**

Medicaid fraud is defined by the Illinois State Police Medicaid Fraud Control Unit Website as “any effort to defraud the Medicaid system by billing for services not delivered, or under delivered. It can also manifest itself in cases where physical abuse or neglect has occurred. This includes, but is not limited to, battery, sexual assault and failure to deliver services or medications. In either case, in order for there to be Medicaid Fraud, Medicaid money must be involved.”

## **The Illinois State Police Medicaid Fraud Control Unit (PPS 22)**

The Illinois State Police Medicaid Fraud Control Unit investigates cases in long-term care facilities in which providers either under-provide or do not provide services for which Medicaid is billed. In some cases, the investigations involve physical abuse or neglect, battery or sexual assault, or situations in which medications or medical services are not properly delivered, including drug diversion.

The ISP Medicaid Fraud Control Unit has the authority to investigate Medicaid Fraud in long-term care facilities.

### **(PPS 23)**

#### **Examples of Medicaid Fraud:**

- Billing for services not provided
- Providing for unnecessary services
- Billing twice for the same medical service, but using two different dates
- Giving or accepting kickbacks for medical services

Regional contact information for the ISP Medicaid Fraud Control Units (MFCU) is:

Illinois State Police  
Medicaid Fraud Control Unit  
8151 W. 183rd Street  
Suite F  
Tinley Park, Illinois 60477  
Phone: (708) 633-5500

Illinois State Police  
Medicaid Fraud Control Unit  
801 South Seventh Street  
Suite 500 – A  
Springfield, Illinois 62703  
Phone: (217) 785-3322

Illinois State Police  
Medicaid Fraud Control Unit  
1100 Eastport Plaza Drive  
Collinsville, Illinois 62234  
Phone: (618) 346-3434

Reports of Medicaid Fraud, Abuse or Neglect may also be called in to the central line at (888) 557-9503. For additional information, visit the ISP web-site at:

<http://www.isp.state.il.us/crime/medicaidfraud.cfm>

## **The Illinois Department of Healthcare and Family Services (PPS 24)**

The Illinois Department of Healthcare and Family Services (HFS) is responsible for administration of the Medicaid Program in Illinois. Through the Illinois Department of Healthcare and Family Services is the Office of Inspector General (OIG). HFS is authorized to conduct research, audits, eligibility reviews and investigations in an attempt to reduce Medicaid fraud and abuse.

The OIG investigates fraud by both providers who receive funding through the Medicaid program and individual Medicaid clients. The OIG is authorized to:

- Conduct research
- Conduct audits
- Perform Medicaid eligibility reviews
- Investigate Medicaid fraud and abuse
- Sanction Medicaid providers
- Pursue criminal actions against providers and public aid clients
- Restrict access to Medicaid by clients who abuse the program

In some cases, the OIG refers to the ISP Medicaid Fraud Unit to investigate Medicaid fraud. The money recovered goes back to the state. HFS OIG hotline to report Medicaid fraud is 1-844-IL- Fraud.

## **Important Resources**

### **(PPS 25)**

- Illinois State Long-Term Care Ombudsman Program Policies and Procedures Manual
- The Illinois Adult Protective Services Act
- Section 1150B of the Social Security Act
- Adult Protective Services Act

Figure 19 - Financial Request Letter Sample

### **Sample “Request Letter”**

#### **Use when asking for copies of financial records**

Dear \_\_\_\_\_:

As you may know, the Illinois Long-Term Care Ombudsman Program is charged with advocating for and protecting older residents in nursing homes in the State of Illinois. In and for [insert County name] County, the designated agency which serves as the Regional Long-Term Care Ombudsman Program is [insert official agency name].

It is our understanding that you are serving as the financial agent for [insert Resident’s name] under a power of attorney for property, and thus manage her financial assets. The Long-Term Care Ombudsman Regional Program has received a report that raises concerns about the status of [insert Resident’s name]’s assets.

We ask for your cooperation in resolving this matter. Although the Long-Term Care Ombudsman Program is authorized under Illinois statute to make a “demand letter” on a financial agent for the records, we have instead chosen to ask for your voluntary cooperation.

We request that you share with our office complete and accurate copies of all of the records of financial transactions you have made as the financial agent for [insert Resident’s name] for the period from \_\_\_\_\_ to \_\_\_\_\_.

If you fail to cooperate, the Long-Term Care Ombudsman Program, pursuant to state law (755 ILCS 45/27.5), would be required to take further steps. Thus, it is our hope you will cooperate with us, to quickly resolve this matter.

(Signatures)

cc. State Ombudsman



Figure 20 - Sample Pension Letter 1

<p style="text-align: center;"><b>Sample “Pension Letter 1”</b></p> <p style="text-align: center;"><b>Use when Resident contacts pension company</b></p> <p>May 10, 2010</p> <p>[Name of Pension Company] [Pension Company Address] Wheaton, IL 60187</p> <p>To Whom It May Concern:</p> <p>I, John Doe (DOB [insert resident’s date of birth]) would like to find out if I have a pension with your company. If so, I would like to request that my pension check address be changed effective immediately. I would also like to request that any and all uncashed checks be re-issued and sent as soon as possible to my new address. I would like my checks to be mailed to:</p> <p>[insert facility address]</p> <p>I am authorizing that information regarding my pension be released to my agent for Power of Attorney, [insert agent’s name] and Regional Ombudsman [insert RO name] with [insert name of ombudsman agency].</p> <p>Sincerely,</p> <p>_____</p> <p>Signature of resident</p> <p>Witness:_____</p> <p style="padding-left: 100px;">Name of Witness</p> <p>Ombudsman:_____</p> <p style="padding-left: 100px;">Name of Ombudsman</p>
---

Figure 21 - Sample Pension Letter 2

### Sample "Pension Letter 2"

**Use when Ombudsman contacts pension company on behalf of resident**

**\*\*\* NOTE: Names should not be sent in BOLD; they are typed that way as a reminder for you to change them to the correct name.**

(Date)

To Whom It May Concern:

I am writing this letter on behalf of my client **John Doe**. **Mr. Doe** is currently a resident at [insert facility name], a skilled nursing facility [specify correct facility type] in [insert city], IL. I have been assisting **Mr. Doe** through the Illinois Long-Term Care Ombudsman Program due to concerns of financial exploitation by his daughter, **Jane Doe** [be sure to insert agent's real name]. **Mr. Doe** is unable to write or phone your company due to dementia and a stroke. In June of 2003 [enter correct date], **Mr. Doe's** daughter put him in a nursing home without informing any other family members. She [use correct pronoun] never visited him nor did she pay his nursing home bill. Instead, she kept his Social Security check and his pension for her personal use. [Insert facility name] took action against the daughter [correct as needed] for this. Administrative Law Judge [insert ALJ name] was involved in this case.

As part of the hearing agreement, **Ms. Doe** who at the time was agent under Power of Attorney who would be able to request the address change. I am requesting that this matter be looked into so **Mr. Doe's** pension check is mailed to [insert facility's address]. I have also enclosed all of the legal documents pertaining to **Mr. Doe's** case and the agreement made on that day. Administrative Law Judge [insert ALJ's name] can verify that all of this information is correct if necessary. I can also be contacted with any questions regarding **Mr. Doe's** case at [insert ombudsman's phone number]. I would greatly appreciate your assistance in this matter.

Sincerely,

Regional Ombudsman  
[insert Regional LTCOP Agency Name]  
Enclosure (1)  
cc: State Ombudsman

This image shows a full page of blank, lined paper. It features approximately 20 evenly spaced horizontal black lines across the entire width of the page, typical of notebook or legal stationery. The background is a solid off-white color. There are no margins, text, or other markings present.



# TRANSFERS AND DISCHARGES

(PM 135)

MODULE 10

## Introduction (PM 136)

**TRAINER’S NOTE:** This Toolkit was originally written by Jamie Freschi, State Ombudsman as a separate 4-hour training. There is no way to cover all material in this section in the time allowed by the Level 2 curriculum. The intent in this curriculum is to provide an overview and to give the trainees concrete examples of how to work a facility-initiated discharge case. Please refer trainees to the supplemental materials as well as the Appendices for further information.

### **About the Toolkit**

The purpose of the Facility-Initiated Transfer or Discharge Toolkit is to offer Ombudsmen information and guidance for assisting residents when a facility is threatening to issue a 30-day notice of involuntary transfer or discharge or after a 30-day notice of involuntary transfer/discharge has been issued. The toolkit contains information on state and federal regulations and federal laws and offers Ombudsmen suggestions about what to do when presented with a facility-initiated transfer or discharge. Skilled and Intermediate Care nursing homes are the focus of this module. However, also included in the Appendices are: Title 77 IL State Regulations Administrative Codes for transfer and discharge for Assisted Living facilities, Intermediate Care Facilities for the Developmentally Disabled, and IL Veteran’s Homes. As in all cases, when in doubt, please consult with your Regional Ombudsman for guidance and direction.

### **Learning Objectives (PPS 2)**

- Gain insight into the prevention of improper transfers or discharges;
- Improve communication with facility staff;
- Enhance knowledge of federal and state regulations;
- Understand the transfer and discharge process;
- Gain effective advocacy tools for working with challenging cases.

## Transfer and Discharge Prevention (PM 136)

### **Definitions (PPS 3-4)**

The following definitions are from the State Operations Manual (SOM) Appendix PP Guidance to Surveyors for Long Term Care Facilities:

**Transfer:** the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility.

**Discharge:** the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.

**Facility-initiated transfer or discharge:** A transfer or discharge which the resident objects to, did not originate through a resident's verbal or written request, and/or is not in alignment with the resident's stated goals for care and preferences.

**Resident-initiated transfer or discharge:** the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility (leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment).

**What's the Difference between facility-initiated and resident-initiated?**

<b><u>Facility-Initiated</u></b>	<b><u>Resident-Initiated</u></b>
Required to be sent to the Ombudsman	Not required to be sent to the Ombudsman
Was not the idea or intent of the resident	Resident's idea or intent to leave
All hospitalizations	Does not include elopement or an expressed desire to return home if the resident has cognitive impairment
Staff suggesting the family move the resident to another setting	Does not include a facility suggesting a resident move

Discharges after a completion of skilled rehabilitation may not always be resident-initiated. If a resident is objecting to the discharge and the facility wants to move forwards with a discharge, then the facility must issue a 30-day notice with the right to appeal.

**Federal Regulations for Facility-Initiated Transfers and Discharges (PPS 6)**

**§ 483.15 Admission, transfer, and discharge rights.**

(7)(c) Transfer and discharge— (1) Facility requirements—

(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless—

- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
- (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
- (D) The health of individuals in the facility would otherwise be endangered;
- (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have

paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(F) The facility ceases to operate.

**TRAINER'S NOTE: You won't have time to cover the information on required facility documentation. There are no slides. Be sure to tell participants to review the information on their own.**

When a resident is transferred to the hospital or an acute care setting for circumstances A, C, and D above, and then the facility decides to discharge the resident, the facility is required to fully evaluate the resident prior to, and may not base the discharge on the resident's status at the time of transfer to the acute care facility. (see "Hospitalization" below)

### **Required Facility Documentation**

The facility must prove that the reasons for transfer or discharge as specified in A-F above have occurred by documenting the basis for transfer or discharge in the resident's medical record. This documentation must be made before or as close as possible to the actual time of transfer or discharge.

In circumstances of A and B above for permissible facility-initiated transfer or discharge, the resident's physician must document information about the basis for the transfer or discharge.

Additionally, for circumstance A above, the documentation made by the resident's physician must include:

- The specific needs of the resident that the facility could not meet;
- The facility efforts to meet those needs; and
- The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.

In circumstances C and D above, documentation regarding the reason for the transfer or discharge must be provided by a physician, not necessarily the attending physician.

### **Facility-initiated transfer or discharge – Prior Notice (PPS 7)**

**TRAINER'S NOTE: Use the chart on PPS 7 to explain prior notice. You will not have time to go over the process for notification for other types of facilities listed below. Make sure you refer participants to their manual to read the information on their own.**

Facilities are required to submit all notices of facility-initiated transfers and discharges to the resident, the resident's representative and the Ombudsman 30-days in advance of the transfer or discharge. If the transfer or discharge is an emergency, the facility is required to send the notice to the Ombudsman as soon as practicable, such as in a monthly listing. If the resident is



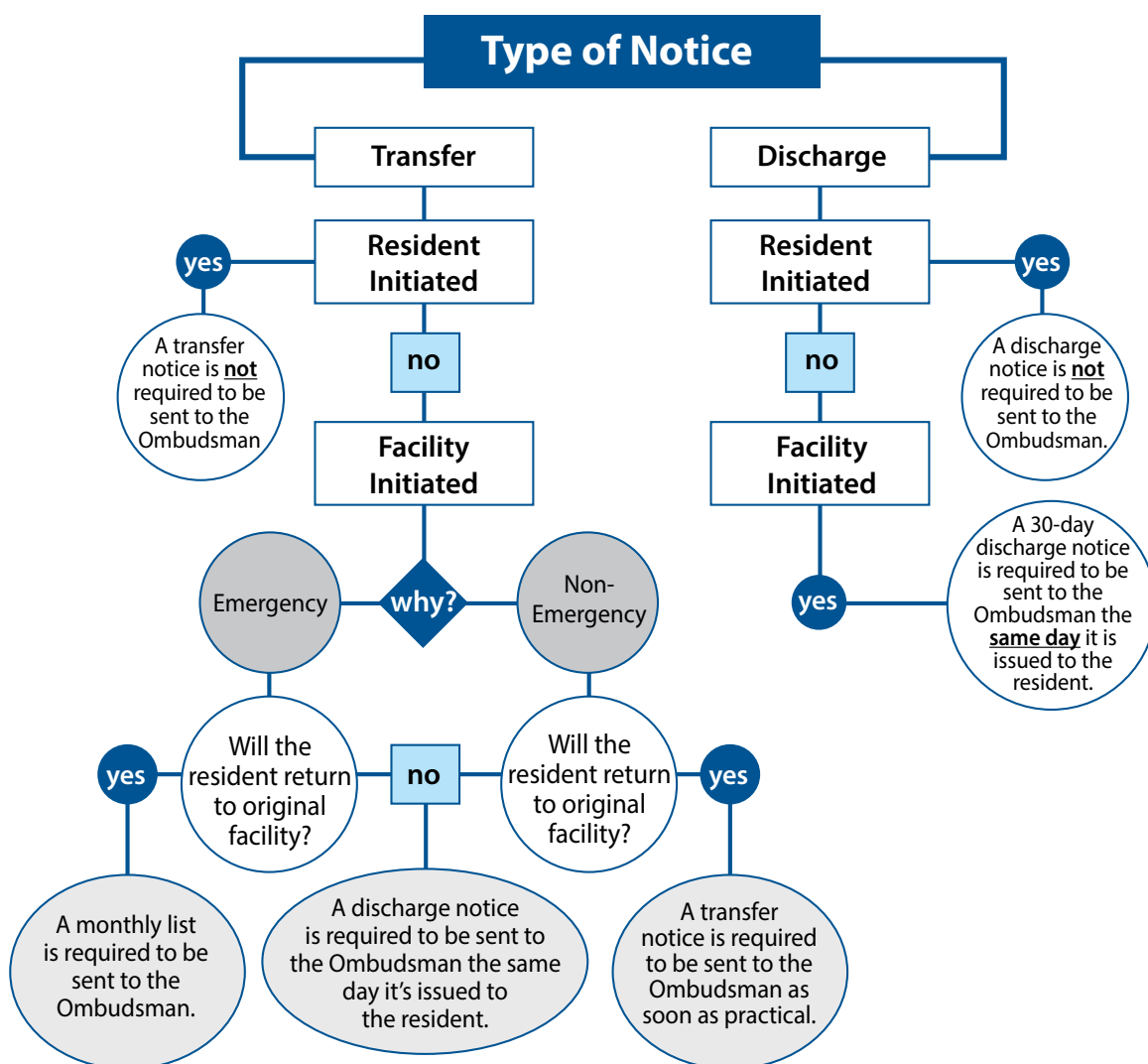
being transferred for a planned procedure at the hospital, those transfer notices must also be sent to the Ombudsman as soon as practicable, but prior to the hospitalization. All hospitalizations are considered facility-initiated. The notices should be on the Illinois Department of Public Health's (IDPH) approved form.

Resident-initiated transfers or discharges are not required to be sent to the Ombudsman Program. Resident-initiated transfers and discharges are just that, the resident has expressed a desire to be transferred or discharged either verbally or in writing. It is the resident's intent to leave the facility. This does not include residents with cognitive impairment who elope or express a desire to return home nor does it include a facility talking a family into moving a resident out.

Time frames of the notice to the Ombudsman varies depending on the type of notice. See Flowchart.



## FACILITY-INITIATED TRANSFER & DISCHARGE NOTICE



**Certified Facilities** (follows federal regulations)

Medicare/Medicaid certified homes are required to give a 30-day notice of transfer or discharge to a resident, resident's representative and the Ombudsman. If the resident is "private pay," but resides in a certified home, the facility must follow the 30-day notice rule.

**Licensed Only Facilities** (follows state regulations)

Facilities that are licensed under the Nursing Home Care Act but not certified are required to issue a 21-day notice of transfer or discharge to the resident and the resident's representative. There is no requirement for licensed only facilities to notify the Ombudsman.

**Assisted Living Establishments** (follows the Assisted Living and Shared Housing Act)

While Assisted Living Establishments are licensed only, they are required to provide a 30-day written notice to the resident, representative and the Ombudsman.

**Supportive Living Facilities** (follows Administrative Code Title 89 Chapter I (d)146 (B))

Supportive Living Facilities are required to provide a resident and the resident's representative a 30-day notice of discharge. There is no requirement for Supportive Living Facilities to notify the Ombudsman.

**(PPS 8)**

Applicable to certified facilities, according to the State Operations Manual (SOM) Appendix PP Guidance to Surveyors for Long Term Care Facilities, the facility's notice must include the following:

- The specific reason for the transfer or discharge,
- The effective date of the transfer or discharge;
- The location to which the resident is to be transferred or discharged;
- An explanation of the right to appeal to the State;
- The name, address (mail and email), and telephone number of IDPH;
- Information on obtaining assistance in completing and submitting the appeal hearing request; and
- The name, address, and phone number of the representative of the Office of the State Long-Term Care Ombudsman.

Other facility types have their own set of circumstances for transfer or discharge.

**Exceptions to the 30-Day requirement:** (PPS 9)

**TRAINER'S NOTE: Exceptions to the 30-day federal requirement apply when the transfer or discharge is affected because of: (PPS 11)**

- **Non-Payment.** If the facility determines to proceed with the discharge process for non-payment, then prior to issuing a 30-day notice, the facility should allow at least 45 days for the individual to pay the bill. If the bill has not been paid, then a written notice should be sent to the resident and the representative asking the individual to pay the bill within 30 days. If the bill still has not been paid, then the facility can issue the 30-day notice of discharge.

- **Criminal Record.** When the transfer/discharge involves a resident with a criminal history, refer to section 77 IL 300.626 Administrative Code Discharge Planning for Identified Offenders and section 77 IL Administrative Code 300.627 Transfer of Identified Offenders in the Appendices.

**TRAINER’S NOTE: while a 30-day notice is required for a facility-initiated discharge for non-payment, the facility has extra steps to take prior to issuing the Notice. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because: (PPS 11)**

- **The health or safety of others in the facility is endangered.** When residents are either a danger to themselves or others, a facility may immediately transfer them to the hospital or a psychiatric unit. Hospitalization in a psychiatric unit requires the procedures of the Illinois Mental Health Code to be followed. See “Emergency Hospitalization”
- **The resident’s welfare is at risk, and his or her needs cannot be met in the facility (i.e., emergency transfer to an acute care facility).** Emergency transfers are also considered facility-initiated transfers and a notice of transfer must be provided to the resident and resident’s representative as soon as practicable. Emergency transfer notices must be sent to the Ombudsman when practicable, such as in a monthly list of residents.

### **Significant changes to the notice:**

Significant changes to the notice, such as a change in the destination, requires a new notice to be issued that clearly describes the change(s) and resets the transfer or discharge date, to provide 30-day advance notification. (If minor information in the notice changes, the facility must update the recipients of the notice as soon as practicable with the new information to ensure that residents and their representatives are aware of and can respond appropriately, but a new notice is not required for minor changes.)

### **Hospitalization (PPS 10)**

If the facility decides to discharge the resident while the resident is still in the hospital after a transfer, a 30-day notice for discharge on the IDPH approved form must be given to the resident, resident’s representative and must be sent to the Ombudsman at the same time notice is given to the resident and resident’s representative. The resident retains the right to file an appeal and the facility is required to allow the resident back as long as the resident’s level of need has not surpassed the facility’s ability to care for the resident. The nursing home federal regulation for this is §483.15(e)(1).

If a resident has been sent to the hospital for treatment, make sure you get clarification from the facility if the movement of the resident is a transfer or a discharge. Ask the question, “do you plan to take the resident back?”.

## **Bed Hold (PPS 11)**

Upon admission and when a resident is sent to a hospital, the facility must provide the resident and/or representative written notification of its bed hold policy. Even if the facility has issued a 30-day notice of transfer or discharge to a resident who has been hospitalized, the facility should take the resident back. For Medicaid recipients, the bed hold is 10 days. If a Medicaid resident is gone longer than 10 days, and the resident's bed is filled, then the facility must offer the resident the next available bed to the resident. For private pay residents, the facility must give the resident and/or representative the option of paying for the bed while away from the facility.

If the facility refuses to take the resident back from the hospital and the resident wants to go back to the facility, with permission, contact the administrator to explain the bed hold regulation and resident's rights regarding the bed hold policy. This is now considered a facility-initiated discharge and the facility is required to send the resident a 30-day notice of discharge with the right to appeal. If the facility still refuses, the Ombudsman should refer the complainant to the IDPH Central Complaint Registry for improper discharge notice.

### **- Bed Hold Federal Regulations(d) *Notice of bed-hold policy and return***

1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies—

- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
- (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
- (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(3) of this section, permitting a resident to return; and

(iv) The information specified in paragraph (c)(3) of this section.

(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (c)(1) of this section.

**(e)(1) *Permitting residents to return to facility.*** A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.

(i) A resident, whose hospitalization or therapeutic leave exceeds the bed hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semiprivate room if the resident (A)

#### **§483.15(c)(7) ORIENTATION FOR TRANSFER OR DISCHARGE**

This federal regulation is intended to orient a resident in preparation of a transfer or discharge where discharge planning is not required due to an emergency or therapeutic leave. The facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Steps taken by the facility should include actions to minimize the resident's anxiety.

#### **Three actions to prevent transfer or discharge (PPS 13)**

There are three significant actions that Ombudsmen can take in order to prevent facility-initiated transfers or discharges. Everyone involved benefits when the problem can be resolved before the resident receives a notice.

1. **Maintain a regular presence in facilities.** As all Ombudsmen are aware, maintaining a regular presence in the facility is crucial in many aspects. With regular visits, residents are more likely to develop trust with an Ombudsman and staff members are more likely to understand the Ombudsman's role as an advocate. Regular visits can offer an opportunity for the Ombudsman to be proactive in resolving concerns before the concerns lead to a discharge.
2. **Maintain open communication with the administrator and other key staff members.** Maintaining open communication with the administrator or another significant staff member can be important in preventing a facility-initiated transfer or discharge notice from being issued. When entering a facility an Ombudsman should periodically ask the following questions:
  - Are there any residents who may need to speak to an Ombudsman?
  - Is the facility having trouble with any particular resident?
  - Are there any residents whose bills are not getting paid?
  - Are there any residents at risk of a facility-initiated transfer or discharge? Encourage the facility staff to inform you of problems before a transfer or discharge notice is issued.

In some cases, the resident may decide to take the necessary actions to prevent a discharge. For example, if the resident's bill is not being paid, the resident may choose to make the nursing home their representative payee, change their agent under a Power of Attorney, and/or apply for Medicaid. While Ombudsmen are not bill collectors for the facility, it is in the best interest of the resident to resolve the issue sooner rather than later. In cases where a resident's actions or "behaviors" are in question, it may help to call a care plan conference before a transfer or discharge notice is issued to address specific concerns. This option will be discussed later in the training.

3. **Discuss residents' rights with residents, family members, resident representatives, guardians, and staff on a regular basis. This may also include talking to resident and family councils.**

Take the opportunity to talk about residents' rights as often as possible. Knowledge is power. Empowerment is what happens when Ombudsmen explain residents' rights to residents and family members. Empowerment can occur during phone consultations, visits to nursing homes, and through speaking to resident and family councils. It is also important to educate facility staff about residents' rights and the transfer and discharge process.

## **Improper Discharges** **(PPS 14-15) (PM 143)**

An improper discharge occurs when a facility discharges a resident without following the federal and state guidelines. Actions leading to improper discharges could include the following:

- **Not issuing the Notice**  
One problem that Ombudsmen face with improper discharges is finding out after the resident has already been moved without notice. When this occurs, encourage the family or resident to file a complaint with the IDPH Central Complaint Registry and try to educate the administrator and facility staff about the transfer or discharge process. A resident still has the right to request a hearing even after a move.
- **Issuing the notice without making all attempts to meet the needs of the resident**  
The facility must make every attempt possible to meet the needs of the resident and this must be documented by the physician in the resident's record. The Ombudsman can determine exactly what the facility has done to resolve the problem and make suggestions on how to improve the situation.
- **Implying or telling the resident or family that the facility can no longer meet the resident's needs and that they need to find another facility without issuing the notice**  
This implication can be construed as retaliation or the facility's unwillingness to work with the resident and/or family. The facility must prove that they cannot meet the needs of the resident and document what has been attempted. The question to ask is "what can another facility provide that you can't?" Unless the resident has a medical condition that the facility does not have the proper equipment or certification to accommodate, or the resident's level of care has surpassed the facility's licensure, this excuse is not valid.

Sometimes facilities will tell families that they can no longer meet the resident's needs and will even offer to "help" them find a new facility without issuing the notice. The gesture may come across as helpful, but in fact, this is a facility-initiated discharge and the facility must issue a 30-day notice.

Any time a facility initiates a transfer or a discharge, the facility must issue a transfer or discharge notice.

- **Improperly filling out the notice**  
If the notice is not filled out correctly, it may not be a valid notice. The administrator may have to issue a new notice and this will affect the time-frame to request a hearing.

- **Transferring the resident to the hospital and refusing to take them back**  
As previously mentioned, the resident has a right to return to the facility after a transfer. If the facility then chooses to discharge the resident after hospitalization, the facility is required to send a 30-day notice of discharge to the resident along with the “Request for Hearing” form and should still take the resident back from the hospital pending the hearing. (See “Hospitalization”)
- **Not explaining the notice and the right to request a hearing to the resident and the resident’s representative**  
Facilities are required to explain the notice and the reason for the discharge to the resident. It is not the job of the Ombudsman to tell the resident that they have been issued a transfer or discharge notice. Before visiting the resident, make sure someone has talked to the resident about the reason for transfer or discharge and the resident’s right to request a hearing.
- **Not discharging to a safe, appropriate environment**  
The resident’s home or a relative’s home may not be a safe and appropriate placement. Often this is what is listed on the notice as the new address. Facilities have also discharged to homeless shelters, motels and even to the street. It is the facility’s responsibility to assure a safe and appropriate transfer or discharge.

**Steps Ombudsmen can take when the resident is still in the facility and faced with an improper transfer or discharge: (PPS 7)**

- Inform the resident, the family and/or representative and facility staff about the proper transfer and discharge procedures.
- Inform the resident, the family and/or representative and facility staff about the resident’s right to stay at the facility and their right to request a hearing within 10 days of receipt of the notice.
- Inform resident, the family and/or representative about the resident’s right to secure legal representation and of any legal services in your area. With permission of the resident, assist with making a referral.
- With permission of the resident, schedule a care plan meeting and attend either in person or via conference call.
- With permission of the resident, file a complaint with Public Health.

**Request for Hearing (PPS 17)**

The resident and/or representative have only 10 calendar days from receipt of the notice to request a hearing to appeal. It is important to speak with the resident and/or representative as soon as possible in order to explain their right to appeal. If the resident and/or representative asks the facility for assistance with completing the request for hearing or sending it in, the facility must assist them. If the request for a hearing form is not filed within 10 calendar days, the resident will have lost the right to appeal and cannot challenge the planned move. However, under some circumstances, the Administrative Law Judge (ALJ) may accept a late request for a hearing. An Ombudsman may not complete the Request for Hearing without consent from the resident nor may an Ombudsman complete the form for an incapable resident.

**TRAINER'S NOTE:** the trainer may give an example of a situation where the ALJ allowed a late Request for Hearing.

## **Ombudsman Protocol**

**TRAINER'S NOTE:** Explain that this checklist can be used when the Ombudsman receives a 30-Day Notice of Discharge. The checklist is divided into sections. The first section is to be filled out for all facility-initiated discharges, regardless of the reason for discharge. The Ombudsman is then instructed to find the next section that is directly related to the reason for discharge. You will find that the same questions are asked to all parties involved. The purpose is to help the Ombudsman get a better understanding of the situation.

**(PPS 18) (PM 146)**

### **Facility-Initiated Discharge Checklist**

According to the Illinois Long-Term Care Ombudsman Program Policies and Procedures Manual, an Ombudsman must act within three days when a resident has been issued a notice. Once the notice is received in the Ombudsman's office, make sure the following steps are taken as soon as possible. This checklist is a suggestion for most notices; please consult with your Regional Ombudsman for further direction.

**Is the notice filled out correctly?** ☐Yes ☐No

**On what date was the notice given to the resident?** \_\_\_\_\_

**Check the address of the person or persons responsible after discharge. Is it a safe, appropriate placement?** ☐Yes ☐No ☐Not Sure

**Call the administrator or designated person at facility immediately and ask the following questions:**

- Is the resident currently at the facility? ☐Yes ☐No  
If no, then where is the resident? \_\_\_\_\_
- Has the resident been made aware of and given a copy of the notice?  
☐Yes ☐No  
If yes, when? \_\_\_\_\_  
If no, why? \_\_\_\_\_
- Is the resident able to understand the notice? ☐Yes ☐No
- Is the representative who is listed on the notice a POA or guardian or does the resident make their own decisions? \_\_\_\_\_
- Has the representative been made aware of the notice? ☐Yes ☐No  
If yes, when? \_\_\_\_\_  
If no, why? \_\_\_\_\_
- Was the representative notified by certified mail? ☐Yes ☐No
- When was the notice sent? \_\_\_\_\_
- Were the Rights to Appeal explained to resident and/or representative?  
☐Yes ☐No



- Was the Request for Hearing form given to resident and/or representative? ☐Yes ☐No
- How long has the resident been at the facility? \_\_\_\_\_
- What is the age of the resident? \_\_\_\_\_
- Is there better time of day or certain days that are best to visit the resident?  
☐Yes ☐No ☐N/A If yes, when? \_\_\_\_\_

**Visit the resident as soon as practicable, but within the 10-day time-frame.** Enter the resident's room with their permission and introduce yourself.

- Make sure the resident is comfortable with discussing private information in his/her room. If not, ask where you can go to talk in private.
- Explain the Ombudsman program and why you are visiting.
- Let the resident know you are their advocate and the discussion is confidential.
- (Based on your observation) Is the resident capable of understanding the notice? ☐Yes ☐No
- Has the resident received the notice? ☐Yes ☐No
- Was the Request for Hearing form included? ☐Yes ☐No
- Did a staff member explain the resident's right to appeal the discharge to the resident?  
☐Yes ☐No If no, explain the right to appeal and include the 10-day time frame.
- Explain the discharge process.
- Does the resident wish Ombudsman assistance? ☐Yes ☐No
- Do you have permission to talk to the representative? ☐Yes ☐No
- Do you have permission to talk to staff at the facility? ☐Yes ☐No
- Is there anyone the resident does not wish for you to discuss the concern?  
☐Yes ☐No If yes, then who? \_\_\_\_\_
- Is the resident in agreement with the discharge plan? ☐Yes ☐No
  - ◊ Explain the resident's right to legal representation. Does the resident want legal representation? ☐Yes ☐No
  - ◊ Does the resident want a referral made to legal services? ☐Yes ☐No

**Proceed with the advocacy as directed by the resident and under direction of the RO.**

- **With proper permission, call the representative, provide the information below, and ask the following questions:**
  - ◊ Introduce yourself, briefly explain the program and explain why you are calling.
  - ◊ Has the representative received the notice? ☐Yes ☐No
  - ◊ Let the representative know you are the resident's advocate and you would like to explain residents' rights.
  - ◊ What is the relationship of the representative to the resident? Are they the POA or guardian or do they assist the resident informally? \_\_\_\_\_
  - ◊ In the representative's opinion, is the resident capable of understanding the notice?  
☐Yes ☐No
  - ◊ Was the Request for Hearing form included with the notice?  
☐Yes ☐No

- ◇ Did the administrator explain the right to appeal the discharge to the representative and/or the resident? ☐Yes ☐No (If no, explain the right to appeal and include the 10-day time frame.)
- ◇ Explain the discharge process, including the right to appeal.
- ◇ Explain the resident's right to legal representation.

**Go to the section that applies to the reason for discharge.**

### **Section 1: Late or Non-Payment**

- During the initial phone call, ask the administrator or designated facility staff these additional questions:
  - ◇ Is the resident private pay, or on Medicare or Medicaid? \_\_\_\_\_
  - ◇ Does the resident have private insurance? \_\_\_\_\_
  - ◇ How much does the resident owe the facility? \_\_\_\_\_
  - ◇ Was reasonable and appropriate notice given to resident and/or representative prior to issuing the discharge notice? ☐Yes ☐No Explanation: \_\_\_\_\_  
\_\_\_\_\_
  - ◇ What months are owed? \_\_\_\_\_
  - ◇ Who has the resident designated to pay the bill? \_\_\_\_\_
  - ◇ Has an application been made to Public Aid?  
☐Yes ☐No ☐N/A
  - ◇ If yes, when was the application filed? \_\_\_\_\_
  - ◇ Does the administrator believe the resident may be financially exploited by the representative? ☐Yes ☐No  
If yes, has or will the administrator call law enforcement or APS? ☐Yes ☐No
  - ◇ Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**During your initial visit or phone call, ask the resident these additional questions** (If you are certain that the resident will understand the concern over the phone, you may call the resident. Otherwise, a visit must be made with the resident to determine if further advocacy is needed):

- Is the resident private pay, or on Medicare or Medicaid? \_\_\_\_\_
- Does the resident receive Social Security? ☐Yes ☐No  
If yes, where are the checks sent? \_\_\_\_\_
- Does the resident receive a pension? ☐Yes ☐No  
If yes, where are the checks sent? \_\_\_\_\_
- Does the resident receive Veteran's Assistance? ☐Yes ☐No  
If yes, where are the checks sent? \_\_\_\_\_
- Does someone help the resident with their bills? ☐Yes ☐No  
If yes, then who? \_\_\_\_\_

- Is the resident satisfied with the individual(s) who are assisting him/her with their finances? ☐Yes ☐No ☐N/A
- Explain to the resident what “representative payee” means. Does the resident want the facility or someone else to be his or her Representative Payee? ☐Yes ☐No ☐N/A
- Does the resident need assistance in applying for Medicaid? ☐Yes ☐No ☐N/A

If your Ombudsman program assists residents with Medicaid applications, work with your Regional Ombudsman or Ombudsman supervisor to learn how you can help. If your program does not assist with Medicaid applications the facility should assist the resident with getting an application if they do not have someone (POA, guardian, family member) to assist with finances.

**Proceed with advocacy as directed by the resident and under direction of the RO.**

- **During the initial call with the Representative (with proper permission), ask the following questions:**

- ◊ Is the resident private pay, on Medicaid or on Medicare? \_\_\_\_\_
- ◊ Does the resident receive Social Security? ☐Yes ☐No
- ◊ If yes, where are the checks sent? \_\_\_\_\_
- ◊ Does the resident receive a pension? ☐Yes ☐No
- ◊ If yes, where are the checks sent? \_\_\_\_\_
- ◊ Does the resident receive Veteran’s Assistance? ☐Yes ☐No
- ◊ If yes, where are the checks sent? \_\_\_\_\_

**Section 2: Safety of Individuals**

- **During the initial phone call, ask the administrator or designated facility staff member these additional questions:**

- ◊ What harm does the resident pose? \_\_\_\_\_
- ◊ Were you aware of the behaviors prior to admission to the facility? ☐Yes ☐No
- ◊ Are the behaviors related to the resident’s diagnosis? ☐Yes ☐No
- ◊ What are the resident’s diagnoses? \_\_\_\_\_
- ◊ If applicable, does the resident have a Criminal History Report? ☐Yes ☐No
- ◊ What has the facility done to resolve the issues? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- ◊ What is the facility currently doing to assure all residents’ safety? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- ◊ What is the date of the last care plan? \_\_\_\_\_
- ◊ Did the resident participate in the last care plan meeting? ☐Yes ☐No
- ◊ Did the representative participate in the last care plan meeting? ☐Yes ☐No

- **During your initial visit ask the resident these additional questions:**
  - ◇ Did the resident attend the last care plan meeting? ☐Yes ☐No  
If no, why not? \_\_\_\_\_
  - ◇ Is the resident in agreement with the care plan? ☐Yes ☐No
  - ◇ Is the resident interested in having a new care plan to address the concerns?  
☐Yes ☐No
  - ◇ If yes, does the resident wish to have an Ombudsman present at the care plan meeting? ☐Yes ☐No
  - ◇ What are the resident's concerns? \_\_\_\_\_  
\_\_\_\_\_
- **Proceed with advocacy as directed by the resident and under direction of the RO.**  
Depending on the nature of the behaviors, the Ombudsman may not be able to advocate for the resident's stay in the facility. The Ombudsman must always advocate for the safety of all residents in the facility.
- During the initial call with the Representative (with proper permission), ask the following questions:
  - ◇ What has the facility done to assure the safety of individuals? \_\_\_\_\_  
\_\_\_\_\_
  - ◇ Was the facility aware of the behaviors prior to admission? ☐Yes ☐No
  - ◇ What is the date of the last care plan? \_\_\_\_\_
  - ◇ Have the "behaviors" been addressed in the care plan? ☐Yes ☐No
  - ◇ Does the facility follow the care plan? ☐Yes ☐No
  - ◇ Did the representative participate in the last care plan meeting? ☐Yes ☐No
  - ◇ If no, then why not? \_\_\_\_\_

### **Section 3: Welfare and Needs Cannot Be Met**

- **During the initial phone call, ask the administrator or designated facility staff these additional questions:**
  - ◇ What welfare and needs aren't being met? \_\_\_\_\_
  - ◇ Were you aware of the resident's needs prior to admission to the facility?  
☐Yes ☐No
  - ◇ What are the resident's diagnoses? \_\_\_\_\_
  - ◇ What has the facility done to resolve the issues? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - ◇ What is the facility currently doing to assure the resident's needs are being met? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - ◇ Is it documented in the resident's clinical record by his/her physician that the resident's needs cannot be met at the facility? ☐Yes ☐No

- ◇ What is the date of the last care plan? \_\_\_\_\_
- ◇ Did the resident participate in the last care plan meeting? ☐Yes ☐No  
If no, then why not? \_\_\_\_\_
- ◇ Did the representative participate in the last care plan meeting? ☐Yes ☐No  
If no, then why not? \_\_\_\_\_

- **During your initial visit ask the resident these additional questions:**

- ◇ Did the resident attend the last care plan meeting? ☐Yes ☐No  
If no, then why not? \_\_\_\_\_
- ◇ Is the resident in agreement with the care plan? ☐Yes ☐No
- ◇ Is the resident interested in having a new care plan to address the concerns?  
☐Yes ☐No
- ◇ If yes, does the resident wish to have an Ombudsman present at the care plan meeting? ☐Yes ☐No
- ◇ What are the resident's concerns? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- ◇ What has the facility done to alleviate the resident's concerns? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- **Proceed with advocacy as directed by the resident and under direction of the RO.**

- **During the initial call with the Representative (with proper permission), ask the following questions.**

- ◇ What welfare and needs aren't being met? \_\_\_\_\_  
\_\_\_\_\_
- ◇ Is anything addressed in the care plan related to these issues? ☐Yes ☐No  
If Yes, then what/how? \_\_\_\_\_
- ◇ Was the facility aware of the resident's needs prior to admission to the facility?  
☐Yes ☐No
- ◇ What are the resident's diagnoses? \_\_\_\_\_
- ◇ What has the facility done to resolve the issues? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- ◇ What is the facility currently doing to assure the resident's needs are being met? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- ◇ Is it documented in the resident's clinical record by his/her physician that the resident's needs cannot be met at the facility? ☐Yes ☐No

#### Section 4: Health of individuals in facility would otherwise be endangered

- During the initial phone call, ask the administrator or designated facility staff these additional questions:
  - ◊ What health dangers does the resident pose to others in the facility? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - ◊ Is the “endangerment” documented in the resident’s clinical file by his/her physician? ☐Yes ☐No
  - ◊ Did the resident have these health concerns prior to being admitted to the facility? ☐Yes ☐No
  - ◊ What has the facility done to protect the health of all residents in the facility? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - ◊ Was IDPH notified of the health risk? ☐Yes ☐No ☐N/A
  - ◊ Was the local Health Department notified ☐Yes ☐No ☐N/A
  - ◊ What was the local Health Department’s recommendation? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- **During your initial visit ask the resident these additional questions:** Consult with your RO to determine the safety of a face-to-face visit. This could be an instance where the Ombudsman may not be able to advocate for the resident to stay in the facility. The Ombudsman must always advocate for the safety of all residents in the facility.
  - ◊ What are the resident’s concerns? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  - ◊ Did the resident have this condition prior to being admitted to the facility? ☐Yes ☐No
  - ◊ If no, then does the resident know where he/she acquired the health concern? \_\_\_\_\_
  - ◊ Is this concern addressed in the care plan? ☐Yes ☐No ☐Don’t know
- Proceed with advocacy as directed by the resident and under direction of the RO.

#### During the initial call with the Representative (with proper permission), ask the following questions:

What health danger does the resident pose to others in the facility? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did the resident have these health concerns prior to being admitted? ☐Yes ☐No

What has the facility done to protect the health of all residents in the facility? \_\_\_\_\_

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**Section 5: Your Health Has Improved and You No Longer Need the Services Provided**

- **During the initial phone call, ask the administrator or designated facility staff these additional questions:**

- ◇ Does the resident have services set up at home if needed? ☐Yes ☐No
- ◇ Does the resident have family support at home? ☐Yes ☐No
- ◇ Has the resident's payer source stopped or threatened to stop payments?  
☐Yes ☐No
- ◇ Has the resident's doctor documented that the resident no longer needs the services provided? ☐Yes ☐No
- ◇ Is the administrator or designated staff member aware of any safety concerns at home? ☐Yes ☐No
- ◇ If yes, what are the concerns and how are they being addressed? \_\_\_\_\_

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- **During your initial visit ask the resident these additional questions?**

- ◇ Does the resident have services set up at home if needed? ☐Yes ☐No
- ◇ Does the resident have family support at home? ☐Yes ☐No
- ◇ Has the resident's payer source stopped or threatened to stop payments?  
☐Yes ☐No
- ◇ Has the resident spoken to their doctor about their wishes/concerns? ☐Yes ☐No
- ◇ Why does the resident want to stay in the facility? Or, why does the resident not want to go home? \_\_\_\_\_

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- ◇ Is the resident concerned about their safety at home? ☐Yes ☐No  
If yes, what are the concerns? \_\_\_\_\_

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- ◇ If applicable, does the resident wish you to make a referral to a community social service agency? ☐Yes ☐No

- ◇ If yes, which one? \_\_\_\_\_

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- Note: It is probably not necessary to call or speak to the representative since the resident is most likely capable of making decisions in these circumstances.

## **Challenging Situations** (PM 154)

### **Incapable Residents**

**TRAINER'S NOTE: Only cover the information that has not already been discussed. (PPS 19)**

According to the Policies and Procedures Manual Section 502 Investigative Services, when a resident is unable to provide consent, the Ombudsman will advocate for the resident's wishes to the extent he or she can express them. The Ombudsman may follow the direction of the resident's representative provided the representative is acting appropriately under his or her fiduciary duties.

According to the Policies and Procedures Manual Section 505 Investigative Services, for financial exploitation of an incapable resident an Ombudsman shall:

1. encourage the caller to make a police report; (and to contact APS)  
**TRAINER'S NOTE: Encouraging a caller to contact APS is not currently in the policies and procedures because the Act came into effect after the Policies and Procedures were finalized.**
2. open a case if there is a threat of a facility-initiated discharge; and
3. consider if the Ombudsman should work to find a representative to petition for guardianship.

### **Incapable Residents with no Representative**

At this time, Ombudsmen do not have authority to advocate on behalf of an incapable resident by requesting or participating in any legal forum, including a pre-hearing or hearing with IDPH when the resident doesn't have a representative or the representative is not providing consent for the Ombudsman to act. If the resident is incapable and has no representative, the facility may need to petition for State or Public Guardianship.

The Ombudsman should assume that the resident wishes to have his or her rights protected. Therefore, the Ombudsman may open a case and seek resolution, but cannot represent the resident in any legal forum.

### **Incapable Residents with Problematic Agent under a Power of Attorney or a Problematic Guardian**

If the resident has a representative, and he or she is not fulfilling his/her fiduciary duties, the facility could take the following steps:

- In cases of Agents under a Power of Attorney, the facility may petition the court for a guardian to be appointed.
- In cases of guardianship, the facility should send a letter to the court in the county where guardianship was established.



- In cases of suspected financial exploitation, the facility should contact the appropriate authorities (APS, local law enforcement). Contact information for all authorities is included in the section on financial exploitation.

## **Residents with Mental Illnesses (PPS 20)**

Residents with mental illnesses do not only reside in Specialized Mental Health Facilities (SMHRFs). Other facilities accept residents with serious mental illness and must follow rules under “Sub-Part S” of the Administrative Code. Most facilities are not equipped to accept or care for residents who are mentally ill. Facilities will typically use the categories “safety of others” and/ or “welfare and needs cannot be met” when issuing the transfer or discharge notice to individuals with mental illness.

Additional factors to consider in these cases include:

- Is this a qualified discharge?
- Did the facility make every attempt to prevent the discharge?
- Are any residents in danger?
- Is the resident getting all of his/her needs met?
- Are the procedures of the Illinois Mental Health Code being followed?

## **Residents with “Behaviors” (PPS 21)**

There are times when a facility will issue a discharge due to “behaviors” under the categories “safety of others” or “welfare and needs of the resident cannot be met”. The key question to ask in these cases is “what can another facility provide the resident that the current facility can’t provide?” This is especially true for skilled care facilities, facilities with specialized Alzheimer’s units and facilities with Subpart S certification. Unless the behaviors are dangerous to others or to the resident, there are few reasons to justify a discharge due to behaviors. Other questions to consider are:

- What are the potential causes of the behaviors?
- How long have the behaviors been occurring?
- Could a change in a medical condition be causing the behaviors?
- Are the behaviors a part of the resident’s disease?
- Did an event happen to cause the behaviors? (i.e. a loved one died)
- Is the resident able to communicate?
- Could the resident be in pain?
- When do the behaviors occur?
- Who is present when the behaviors occur?
- Does the resident respond differently to different people?
- What has been done to attempt to change the behaviors?
- Is the resident’s medication being administered at the correct times and is the resident taking their medication?
- Does the resident need to see a physician?

Encourage the family to request a care plan meeting to address the behaviors and attend with permission of the resident. If the Ombudsman cannot attend in person, ask to attend via phone conference. This will allow all key players to come together and work out a plan. If the resident can understand, make sure they are encouraged to attend the meeting. Let the family know they can request specific staff members to attend. If a resident does not show behaviors with certain staff members, make sure they are present at the meeting so they can share how they successfully interact with the resident. Some facilities will try to issue an emergency discharge to the hospital for a psychiatric evaluation due to behaviors. See the next section for details on how to handle that situation.

### **Emergency Transfers or Discharges (PPS 22)**

There are times when a resident needs immediate care that the facility cannot provide. This may be especially true during a medical emergency or when a resident has become a danger to self or others. Such transfers may be justified. The facility is required to submit a notice of emergency transfer to the resident and the resident's representative. Notice to the Ombudsman may be sent when practicable.

Sometimes facilities use "emergency" transfers as a means to discharge a resident without following the regulations. "Hospital dump" is a term used referencing a facility transferring a resident to the hospital and refusing to take him or her back. The federal regulations state that at the time the decision is made to permanently discharge the resident, the facility is required to submit a 30-day notice. When the facility refuses to allow the resident to return without going through the proper transfer and discharge process, the resident's right to request a hearing has been violated. One major problem with "hospital dumping" is that it is nearly impossible to "force" the facility to take the resident back.

Sometimes families and residents do not want to return to the facility when they do not feel "welcomed" back. Other times, the family and resident want to go back to the facility. Even with the threat of an IDPH tag for failure to give notice of discharge, some facilities will still not re-admit certain residents. In these cases, if the facility still refuses, then it is recommended that the Ombudsman either refer the complainant to, or with permission, file a complaint with IDPH.

### **Financial Exploitation (PPS 23-24)**

Financial exploitation has been discussed throughout this training. However, there are additional challenges to working with residents who are being discharged from a facility due to financial exploitation. Some of the challenges are:

- The resident does not want Ombudsman assistance. It is the responsibility of the Ombudsman to make sure the resident understands the assistance that an Ombudsman can provide and the available choices the resident has to change the situation. If the resident does not want Ombudsman assistance even after the explanation, respect the decision and close the case. Give the resident an Ombudsman brochure with Ombudsman contact information.

- The resident won't change his/her Agent under a POA when the agent is the alleged perpetrator. There are times when the resident refuses to believe their Agent under a POA or representative would financially exploit him or her and there are times when the resident is fully aware of the situation but refuses to change their Agent. In either case, a resident may change their mind at any time. It is important to keep checking in with the resident to see how they are doing and give them the opportunity to express a desire to change their Agent under a POA. However, if the resident does not change his or her mind, the Ombudsman must accept the resident's wishes and close the case. Give the resident an Ombudsman brochure with the name and local phone number on it and let them know they can reach an Ombudsman at the number on the brochure if they change their mind.
- The resident will not allow the Ombudsman to refer to the police or APS and/or the resident will not press charges. It is the resident's choice to report the exploitation. An Ombudsman cannot refer to the police or APS without the permission of the resident, even if there is reason to believe there is potential exploitation. It is not uncommon for residents to refuse to press charges against their loved ones. Not pressing charges does not mean there cannot be a successful resolution to the discharge.
- The police will not accept the referral as a case. While an Ombudsman has no control whether or not the police accept a referral, there are other options to consider. However, it is important to develop a rapport with the officers in your area who may be called to investigate. Questions to consider:
  - ◊ Is there an Elderly Services Officer (ESO) in the city or county of the resident?
  - ◊ Do you have a good working relationship with the ESO?
  - ◊ Can you call or e-mail the ESO or another officer for advice or direction with a case?
  - ◊ Are the local police aware of the Ombudsman program and aware of residents' rights?
  - ◊ Do you know State Police Officers that you can call directly and ask them to follow up on a case?
  - ◊ Have all police options been attempted? Sometimes the local police won't investigate, but State or County police will. Don't take no for an answer until there is no one left to ask.

#### (PPS 25)

- Possible Financial Exploitation Resources:  
If you are having trouble with a case that involves illegal activity, such as financial exploitation or Medicaid Fraud, and neither the police nor APS will not take the referral, with permission of the resident, approval from your Regional Ombudsman and the Office of the State Ombudsman, you may refer the case to the Attorney General's Office, to the Office of the Inspector General or to the local State's Attorney's Office.
  - ◊ **Attorney General's Office** - The Attorney General's Senior Citizens Consumer Fraud Hotline number is 1-800-243-5377 or 1-800-964-3013 (TTY). The Attorney General's Website is [www.IllinoisAttorneyGeneral.gov](http://www.IllinoisAttorneyGeneral.gov)
  - ◊ **Office of the Inspector General for Social Security Fraud** - The Office of the Inspector General (OIG) investigates instances of Social Security-related fraud. To report Social Security Fraud, call 1-800-269-0271, fax 410-597-0118 or report online at: <https://oig.ssa.gov/report>.

- ◇ When filing a report, keep in mind that the OIG must have as much identifying information as possible in order to act on your allegation. The Social Security Administration website ([www.socialsecurity.gov](http://www.socialsecurity.gov)) suggests that you provide as much of the following information as possible:
  - “Name, address, telephone number and Social Security number (SSN) of the person suspected of fraud. If the SSN is unknown, include as much identifying information as possible; e.g. the individual’s date and place of birth, father’s name and mother’s birth name
  - A complete description of the potential fraud incident; and
  - Your name, address and telephone number.”
- ◇ **Health Care and Family Services Office of the Inspector General (OIG) for Medicaid Fraud. OIG also investigates Medicaid Fraud.** To report Medicaid Fraud call 1-844-IL-FRAUD.
- ◇ **Illinois State Police for Medicaid Fraud.** To report Medicaid fraud, call the hotline at 888-557-9503 or contact your nearest Medicaid Fraud Control Unit at one of the locations listed in the Financial Exploitation Module.
- ◇ **Adult Protective Services.** To report financial exploitation to APS, contact the Senior HelpLine at 1-800-252-8966.

## Pre-Hearings and Hearings (PPS 26) (PM 158)

**TRAINER’S NOTE:** Either a Regional Health Officer or an Administrative Law Judge may preside over the hearings. Essentially, they are one in the same. All Regional Health Officers are Administrative Law Judges. RHOs have additional responsibility overseeing the management of the Regional Public Health buildings. Sometimes these terms are used interchangeably, and it is confusing. For the purposes of this training, “ALJ” will be the term used.

### Prior to the Hearings

When discussing the Request for Hearing form with the resident or the resident’s representative, make sure they understand that if they choose not to request a hearing or to “appeal” the discharge, they are essentially agreeing to the discharge. An Ombudsman cannot fill out a Request for Hearing form without the permission of the resident.

The Request for Hearing must be submitted to IDPH within 10 calendar days of receiving the Notice of Transfer or Discharge. Once the request for hearing has been submitted, the facility generally cannot discharge the resident until IDPH has made a decision. The exception to this rule is if there is a condition that develops that would require the resident to be sent out for additional care.

If there is a request for hearing but the facility and the respondent come to an agreement, or if the bill is paid in a non-payment situation, then the facility should rescind the notice. It is important to get this in writing from the facility.

An Administrative Law Judge (ALJ) will preside over the hearings and will set a date for the pre-hearing conference and notify all parties involved. With the express written consent from a resident capable of making decisions, an Ombudsman may represent a resident in the pre-hearing and hearing. A copy of the required form is in the supplemental materials.

### **Resident has a Right to Legal Representation (PPS 27)**

Unless the resident already has an attorney, often there is not a lot of time to secure legal representation prior to the pre-hearing. However, it is important to have a discussion with the resident about his/her right to have an attorney to assist with the hearings. Most residents cannot afford a private attorney. In these instances, educate the resident about the local legal services available to them that provide free legal services to residents 60 and over and free of charge.

- Talk to the resident about his/her right to an attorney.
- Make referral to legal services provider if necessary.

### **Ombudsman as Representative (PPS 28)**

If acting as the resident's representative, prior to the pre-hearing, it is important to gather information in order to strengthen the resident's case and prove the facility does not have a basis to discharge the resident. Depending on the concern, the following are steps to consider:

- Submit the "Appointment for Representatives for Purposes of Involuntary Discharge Hearing and Entry of Appearance".
- Review the resident's records for evidence and make copies as necessary.

### **Pre-Hearing**

**TRAINER'S NOTE: Explain the Ombudsman's ability to speak on behalf of a resident in the pre-hearing conference may depend on the ALJ.**

### **(PPS 29)**

Within 10 calendar days of receipt of the request for hearing, IDPH should hold a pre-hearing. This timeframe may be adjusted due to individual ALJ's schedule. Depending on the circumstances, the pre-hearing may be heard over the phone. Ombudsmen may attend the pre-hearing with permission of the resident or the representative when the resident is not able to make decisions. If the Ombudsman is not the resident's representative, then the Ombudsman's role in the pre-hearing is mainly to support the resident. However, if needed, the Ombudsman may ask questions for clarification or speak to advocate on behalf of the resident's rights. Those present at the pre-hearing generally include:

- Administrative Law Judge
- Facility administrator
- Facility attorney (the facility must be represented by an attorney)
- Resident
- Resident's representative

### **(PPS 30)**

Those present at the pre-hearing may also include:

- Ombudsman
- An attorney representing the resident
- Any other individual invited by the representative or resident for support

### **(PPS 31)**

During the pre-hearing, the ALJ will gather information from both sides, starting with the respondent (facility representative). After each side is addressed by the ALJ, there is open dialog to determine if the problem can be mutually resolved. The facility must prove the discharge is valid thus the burden of proof is on the facility.

If the ALJ finds that both parties have come to a mutual agreement or if the facility withdraws the discharge notice or if the resident withdraws their request for hearing, then the pre-hearing is over and the situation is resolved.

When Medicaid approval is pending, the process is continued until a decision is received from the DHS office.

### **Hearing (PPS 32)**

The ALJ will determine the need for the hearing under the following circumstances:

- Further information needs to be obtained for the ALJ to make a recommendation
- There is not a mutual agreement

Depending on the ALJ and the circumstances of the parties involved, a hearing may be held over the phone.

The hearing may occur immediately after the pre-hearing, or it may be continued to another date. The hearing is a legal procedure and is also recorded. The same individuals present at the pre-hearing may also be present at the hearing. In addition to the individuals involved in the pre-hearing others at the pre-hearing and hearing may include:

### **(PPS 33)**

- Those subpoenaed by the ALJ
- Witnesses brought in by either party

At the start of the hearing, the Administrative Law Judge will swear in all persons who will give testimony. The respondent (the facility) will start by stating the facility's reasons for the discharge and then the resident, or representative will be heard. Both parties have a right to bring witnesses, cross examine, and enter exhibits. After the ALJ has heard from both sides and after all of the information has been presented, the ALJ will submit a recommendation to the Department. It could take up to 90 days for a decision to be made by the Chief Administrative Law Judge at IDPH. During this time, the facility may not move the resident out of the facility. After a decision is made, appeal rights are still afforded to both the complainant and the respondent.

## **Complaints Regarding an Administrative Law Judge**

**TRAINER’S NOTE:** There are no slides on this topic.

If someone would like to file a complaint about an Administrative Law Judge the protocol is to e-mail the Deputy Director of the Illinois Department of Public Health. The Ombudsman should contact the Regional Ombudsman and the Office of the State Ombudsman if filing a complaint about an ALJ.

## **Facility Closures**

**TRAINER’S NOTE:** you will not have time to cover this information. Make sure you tell the trainees there is specific information in their manuals about facility closures and they are responsible for reading this material and to refer back should they have a closure in their area.

## **Involuntary Closures**

If a facility is being forced to shut down, there are several resources on the NORC website that will assist the Ombudsman. In those cases, the Ombudsman Program receives notification from IDPH and HFS (when applicable) when a facility is at risk of closure and updates are received on a regular basis. When facilities are shut down by the state, IDPH, HFS and the Ombudsman Program collaborate on the closures.

**TRAINER’S NOTE:** Refer trainees to the Appendices for the NORC resource (PPS 30)

## **Voluntary Closures In Illinois**

The majority of facility closures are facility-initiated closures and mostly due to financial reasons. While there are specific federal and state requirements for each facility type, not all facilities follow the regulations. Even when facilities do follow the requirements and are respectful of residents, facility closures are often emotionally and physically difficult on residents. “Transfer trauma” or “Relocation Stress Syndrome” are terms used to describe the stress and anxiety that a person feels when changing environments with no control or understanding of the move, usually in individuals with memory problems. Often, family members and facility staff struggle with the transition. Ombudsmen have the opportunity to ease some of the stress that individuals incur by promoting residents’ rights during a closure.

## **Requirements**

Federal Requirements:

Under the federal nursing home regulations 42 CFR 483.75(r) and (s) as well as under sections 1128(h) and 1819(h)(4) of the Social Security Act, facilities are required to provide a written notice of closure, including a plan for relocation, at least 60 days prior to the impending closure. The notice is required to be sent to the residents, legal representatives or other responsible parties of the residents, the State Ombudsman, CMS, and to IDPH.

#### State Requirements:

Under the Illinois Nursing Home Care Act 210 ILCS 45/3-423 a facility is required to give a 60-day notice of voluntary closure of a facility or any part of a facility (if more than 10% of the residents are to be transferred) prior to the impending closure. Notice is required to be given to residents, residents' representatives, a member of the resident's family, where practicable, the State Ombudsman, and IDPH. The notice is required to include the date of closure and the reason for closure. A closure plan must be submitted to IDPH for approval and shall be included in the notice. A facility closing in its entirety shall not admit new residents.

Under the ID/DD Community Care Act 210 ILCS 47/3-423 a facility is required to give a 90-day notice of voluntary closure of a facility or any part of a facility (if more than 10% of the residents are to be transferred) prior to the impending closure. This Act does not require a notice to be given to the State Ombudsman. Notice is required to be given residents, residents' representatives, a member of the resident's family, where practicable, and IDPH. The notice is required to include the date of closure and the reason for closure. \*

Under the Administrative Code Part 380 Specialized Mental Health Rehabilitation Facilities Code Section 380.220(c) the process for a SMHRF to close shall be in accordance with section 3-423 of the Nursing Home Care Act. The Specialized Mental Health Rehabilitation Act of 2013 does not specifically address SMHRF closures pertaining to residents' rights, which is why the SMHRF Admin Code is referenced here.

Under the Medically Complex for the Developmental Disabilities (MC/DD) Act Public Act 099-0180 section 3-423 the facility is required to give a 90-day notice of voluntary closure of a facility or any part of a facility (if more than 10% of the residents are to be transferred) prior to the impending closure. This Act does not require a notice to be given to the State Ombudsman. Notice is required to be given residents, residents' representatives, a member of the resident's family, where practicable, and IDPH. The notice is required to include the date of closure and the reason for closure.

The (210 ILCS 9/) Assisted Living and Shared Housing Act requires the establishment to give a 90-day notice of voluntary closure prior to the impending closure or all or part of an establishment. This Act does not require a notice to be given to the State Ombudsman. Notice is required to be given residents, residents' representatives, a member of the resident's family, where practicable, and IDPH. The notice is required to include the date of closure and the reason for closure.

Title 89 Chapter 1(d) 146.285 of the Administrative Code for Supportive Living Facilities states that an SLF is required to inform HealthCare and Family Services 90 days in advance if it intends to voluntarily surrender its certification from the Medicaid program. Notice to the residents shall be given pursuant to section 146.255. Section 146.255 contains the requirements for discharge. The facility must give a 30-day written notice of discharge to the residents and their designated representatives. The notice must include the reason for discharge and the effective date. There is no requirement to submit the notice to the Ombudsman. Specifically, 146.255 (d)4) relates to discharge due to voluntary surrender of certification.



Our Program's experience with facility closures has been that some facilities follow the regulations and some do not. It is important to get a sense early on if the facility is going to be respectful of residents' rights or not. Some facilities have closed without giving proper notice, while others have stayed open for months in order for those last few residents to find an appropriate placement. More often than not, once a facility determines it is closing, management works pretty quickly at getting residents out. Most closures do not take the full 60 or 90 days that residents are allowed to have in order to find an alternate living arrangement. In addition, some families move quickly to find a new placement for fear that all of the "better" facilities will fill up.

### **Ombudsman Responsibilities**

Once the Office receives notice of a facility closure, the notice is immediately sent to the Regional Ombudsman. Often, the Office does not receive notice from the facility even when required, but will be notified by IDPH or a local Ombudsman. If the Regional Program discovers that a facility is closing, the Regional Ombudsman should immediately contact the Office. Once the impending closure has been confirmed, the Ombudsman Program has responsibilities.

#### **1. Open a systemic case and call the administrator.**

Initial information to be gained:

- When and how were the residents, representatives, family members and staff notified?
- What is the date of closure?
- What is the reason for closure?
- Does the facility have sister-facilities that they plan to discharge the residents?
- Has the facility started moving residents out?
- Is there a plan to hold a "town hall" meeting and can the Ombudsman attend?

#### **2. Consult with the Office**

The Regional Ombudsman should consult with the State Ombudsman after learning much of the above information to develop a plan of action. Depending on the size of the facility, how many residents are still in the facility, and the potential risk of residents' rights being violated, it is likely that the Office will instruct the Regional Ombudsman to send as many Ombudsmen to the facility as possible for the initial visit after notification. The initial visit needs to be the same day, if possible, but no later than within 48 hours after notification

#### **3. Visit the facility immediately, not more than 48 hours after notification (unless we are notified on Friday, then a Monday visit is sufficient only if residents aren't in imminent danger of being moved against their will).**

##### **a. Residents**

Generally, during the first visit after notification of a closure, Ombudsmen should attempt to see every resident – or as many as possible to discuss their rights to choose a new facility and to visit that facility before making a decision. Ombudsmen should explain that the facility should not choose for them and should not make them feel rushed to decide. Ask residents if they have someone who is helping them with the move or with their decisions. Ask residents if they notice a difference with staffing, food,

or supplies. If all residents did not get a face to face meeting with an Ombudsman, then a second visit the next day should be conducted to visit the remainder of the residents. Proceed as you would with any concern and as indicated in the current policies in procedures and, of course with resident permission.

b. Administrator or other facility staff

During the initial visit, an Ombudsman should discuss the following with the administrator, or whomever is in charge. Sometimes, corporate comes to the facility and takes over some or all of the administrative tasks.

- Ask for the closure plan
- Ask for the facility to send you updated resident census, including the location of where the residents are being moved on a daily or weekly basis, depending on how quickly they are trying to get everyone out.
- Ask if staff are planning to stick around or if staff are leaving
- Ask if they are using temp staff
- Do they have enough food and for how long?
- Do they have enough supplies and for how long?
- When do they anticipate an actual closing date?

c. Family members

If there are family members around, strike up a conversation about the notification and plans to discharge. Explain residents' rights and offer to assist with resident permission. Give them a brochure with your contact information and invite them to call if they have concerns that may come up in the future.

d. Observations

Ombudsmen should take every opportunity to observe all areas of the facility. Is it running as usual or is the atmosphere more chaotic than usual? Check the quality of the food being served if you are there during meal time. Are residents participating in activities and therapy as usual? Are call lights being answered as usual? How are the staff responding to residents' concerns? Is the usual amount of staff around? Is the facility keeping up with laundry, housekeeping, etc.?

**After the initial visit**

Try to attend a resident council meeting and if the facility is hosting a meeting open to staff and family members, make every effort to have an Ombudsman attend that as well.

Continue to update the Office about the status of the closure.

Continue with frequent visits as directed by the Office. Immediately contact the Office if you are contacted by the media for an interview, if there are serious concerns about the health, safety and welfare of any resident, if the facility is running out of food or supplies or is low on staffing.

Once you start receiving the updated census from the facility, Ombudsmen should start visiting residents in their new facilities. If residents are being placed outside of your area, you must contact the Regional Ombudsman in that area and let them know the name of the resident and why they were relocated. The Regional Ombudsman should send an Ombudsman out to visit the resident. Newly admitted residents after a closure should be visited within 2 weeks or sooner if possible.

\* When visiting ICF/DDs during a closure, find out which residents have guardians and which residents would be able to understand and discuss the closure. You will likely need to get the contact information of the guardians so you can call them and discuss residents' rights during a closure.

ICF/DD closures may involve additional agencies and advocates responsible for relocating residents. It is imperative to find out who these key players are, what their role is and include them in on discussions about the closure. Information about Pre-Admission Screening Agencies/ Independent Service Coordination (PAS)/(ISC) can be found at <https://www.dhs.state.il.us/page.aspx?item=68911>.

DHS also offers Support Services Teams (SSTs) to provide technical assistance and training in difficult situations. An ICF/DD closure may invoke a referral from the Division of Developmental Disabilities (DDD) for an SST. For more information on SSTs, go to <https://www.dhs.state.il.us/page.aspx?item=50861>.

## Case Study

**TRAINER'S NOTE:** Do your best to make time for this activity. Have the participants use the Facility-Initiated Discharge Checklist to complete the activity. Break the trainees into groups of 4 and tell the groups to assign one person as the Ombudsman, one as the resident, one as the representative and one as the facility administrator. Give a copy of the checklist to the "Ombudsman". Have all trainees read the scenario and then ask the Ombudsman to interview all parties by following the checklist. Give the "resident", the "representative", and the "administrator" their script so they know how to answer the Ombudsman's questions. Ask the trainees to observe without interrupting when the others are being interviewed. After the interviews are finished, ask the group to come up with the next steps. There is not time to take this scenario all the way through the hearing process. The goal of this activity is to get them accustomed to using the checklist and to think about the necessary information needed to gather during an investigation involving financial exploitation as well as a facility-initiated discharge.

If there are not enough trainees to break into groups, do this as a large group activity and ask for 4 volunteers to be the individuals mentioned. The others can observe the interviews and then come up with the "next steps".

Make sure the next steps include: getting the Request for Hearing faxed into IDPH, getting permission from the resident to look at her bank statements together, having another

discussion with the Administrator about contacting law enforcement, talking to the resident about having her checks come to the facility again, asking the resident if she is okay with her niece living in her home, discussing the resident's right to change her POA, talking to the resident about her option to have her bank manage her finances, and hiring an attorney. (PM 165)

### **Mrs. Jones: "Facility-Initiated Discharge Due to Non-Payment" (PPS 35)**

Mrs. Jones is a 90-year-old who has lived in the facility for 5 years. She has several physical ailments and has a diagnosis of dementia. The facility issued a 30-day notice of discharge to Mrs. Jones on 1/5/19. The notice was also sent to the resident's representative (an Agent under a POA for Property), IDPH, and to the Ombudsman on the same date the resident received the notice. The notice was filled out in its entirety and the location the resident will be moved to on the notice states the address of the resident's representative. Both the resident and the representative received the Request for Hearing form. Mrs. Jones is capable of making decisions but is forgetful sometimes and relies on her representative to handle all of her finances, which are plentiful. Mrs. Jones is a widow and is unaware the bill was not being paid. The representative is the only person who visits Mrs. Jones. The Ombudsman received the notice on 1/7/19.

### **Administrator:**

The administrator is concerned about Mrs. Jones and doesn't really want her to be discharged. The facility is using the notice as a scare tactic to get the Agent to pay the bill. The administrator is uncomfortable calling the police and won't say for sure if this will be reported to the police. Administrator admits that the resident doesn't know the whole story, only that there is a "problem with the bill". Administrator indicates that \$32,000 is owed to the facility and the pharmacy bill is not getting paid either. The resident owes for October, November, December and January. Administrator is not aware of any other family members or friends who visit Mrs. Jones and believes the representative is the only person who visits Mrs. Jones. Administrator stated that the resident receives Social Security and Pension checks, but the checks do not come to the facility. Administrator reports that the visits with the representative are fine and there were no concerns. In fact, Mrs. Jones looks forward to visits from her representative. Lately the representative has only been visiting on the weekends and avoids phone calls from the facility. The Administrator believes that Mrs. Jones has substantial resources and heard a rumor that the representative may be living in Mrs. Jones' home. The Administrator stated that Mrs. Jones does have a diagnosis of dementia and is forgetful at times but is still capable of making decisions. The representative is the resident's niece.

### **Resident:**

Mrs. Jones is aware there is a problem with the bill and gave permission for the Ombudsman to check into the problem with her niece as well as with the administrator. Mrs. Jones believes there must be a misunderstanding about the bill because she trusts that her niece wouldn't do anything wrong. Mrs. Jones does not remember a discussion with the staff about a discharge and this worries her. Mrs. Jones wants to stay in the facility and is agreeable to signing a Request for Hearing, but she does not want her niece to get into trouble. Mrs. Jones stated that

she receives Social Security and two pension checks. Mrs. Jones indicates that she comes from a wealthy family and has inherited a significant amount of money so finances shouldn't be an issue. Mrs. Jones stated that her niece does not live in her home. Mrs. Jones is not interested in the facility being her representative payee at this time since she is sure her niece is handling everything appropriately.

**Representative:**

The representative stated that the notice was received via certified mail. The representative stated that the resident is running out of money, she's not sure how much is owed and the facility is badgering her about the bill. The representative stated that she and her children live in Mrs. Jones' home and that she cannot sell the home to pay the bill. The representative stated that she is going back to school and doesn't have any income, but that Mrs. Jones told her it was okay for her to live in her home. The representative stated that the Social Security and Pension checks are deposited in an account for Mrs. Smith at the local bank. The representative's name is not on the account, but she is signing checks as the Agent under the Power of Attorney. The Representative stated that she did not want any kind of hearing and that Mrs. Jones could just come home with her if she got kicked out.

Next Steps:

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**Tips and Closing Remarks**  
**(PPS 36) (PM 166)**

Working on cases regarding discharges and transfers can be very involved and challenging. Each case is different and will require critical thinking and a plan of action. Please utilize the checklist provided in this training as a tool to make sure all information is gathered and always check in with the resident to make sure you are acting according to their wishes. Also, consult with your Regional or State Ombudsman as necessary.

## Sources (PM 167)

Title 77 Chapter 1 Subpart c Administrative Rules Administrative Code Part 300 Skilled Nursing and Intermediate Care Facilities, available online at: <http://www.ilga.gov/commission/jcar/adminicode/077/07700300sections.html>

Title 42 Public Health CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES PART 483--REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES available online at (Code of federal Regulations) <https://www.gpo.gov/fdsys/pkg/CFR-2017-title42-vol5/xml/CFR-2017-title42-vol5-part483.xml>

210 ILCS 45/Nursing Home Care Act available online at <http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1225&ChapAct=210%20ILCS%2045/&ChapterID=21&ChapterName=HEALTH+FACILITIES&ActName=Nursing+Home+Care+Act>.

HFS 89 ILLINOIS ADMINISTRATIVE CODE Chapter 1, Section 146.255 Subchapter d Section 146.255 Discharge website:  
<https://www.illinois.gov/hfs/SiteCollectionDocuments/146.pdf>

Social Security Administration Website:  
[www.socialsecurity.gov](http://www.socialsecurity.gov)

Medicare Website:  
[www.medicare.gov](http://www.medicare.gov)

Office of Inspector General Website:  
<https://www2.illinois.gov/oeig/Pages/default.aspx>

Illinois State Police Medicaid Fraud Unit Website:  
<http://www.isp.state.il.us/crime/medicaidfraud.cfm>

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# DOCUMENTATION

(PM 169)

## MODULE 11

## **Introduction**

### **(PPS 3-5) (PM 170)**

**The Illinois Long-Term Care Ombudsman Policies and Procedures Manual states:**

*507: Documentation of Investigative Services*

- A. Every activity completed, complaint received, and all activities undertaken to investigate, verify, and resolve complaints by the Program shall be documented by Ombudsman staff as prescribed by the Office.
  - 1. Activities shall be entered within fifteen (15) calendar days of completion of the activity.
  - 2. Case journal entries shall be entered within thirty (30) calendar days of completion of the casework.
  - 3. Cases shall be reviewed and closed by the Regional Ombudsman or the Deputy State Home Care Ombudsman within thirty (30) calendar days of completion when no further action is needed on the complaints within the case.
- B. All Ombudsmen shall use the data collection system designated by the Office.
- C. No Ombudsman activities, case journals, resident records, or resident identifying information shall be entered into a Provider Agency's case management system, unless it is the system designated by the Office.
- D. Consent forms, notices of 30-day transfer or discharge, and any other written documents obtained by the Ombudsman through the course of an investigation should be scanned and attached electronically to the case file.
- E. Permission or refusal by the resident, participant or representative to consent to the Ombudsman providing investigative services shall be documented in every case.
- F. If a resident, participant, or complainant provides consent to release his or her identity, that consent shall be documented within a case journal entry and any consent forms shall be attached to the case file.

### **(PPS 6)**

**Complete and accurate documentation of the complaint resolution process is critical.** The federal government and state legislature evaluate the effectiveness of the Ombudsman program on data produced from program outcomes. It is important that the Ombudsman document all activities.

The complaint investigation record must be sufficiently clear that another Ombudsman can pick up where the last Ombudsman left off. Good documentation assists the Ombudsman in thinking through the information, which has been collected and helps develop or modify the investigation strategy. Good documentation is factual, objective and consistent.

## **Purpose of Documentation**

### **(PPS 7) (PM 171)**

The purpose of documentation is to:

- Help organize thoughts.
- Track the progress of a case (from point A to point Z).
- Monitor performance and identify patterns of behavior in facilities.
- Identify systemic problems (problems that affect more than one resident).

- Convey information.
- Provide a factual description of an event.
- Inform and refer to other agencies.
- Provide a safety net for the individual Ombudsman and the long-term care Ombudsman program.

### **(PPS 8)**

#### **Points to remember:**

- Complete and accurate documentation is critical.
- Concise documentation should be organized.
- Documentation must be sufficiently clear that another Ombudsman can pick up where the last Ombudsman left off.
- Do not assume the reader will know or understand the issue.
- Keep the vocabulary plain and easily understood.
- Use short sentences and be brief and concise.
- A lengthy case record does not equal good documentation.

## **Fact vs. Opinion**

### **(PPS 9) (PM 171)**

We have a natural tendency to simplify by recording our perceptions as opinions. For example, “The resident was depressed”. This is an opinion. What the Ombudsman actually saw was that the resident had her eyes downcast and spoke in a soft voice. The habit of “opinionating” may influence the conclusion. It is incorrect to let personal feelings, prejudices and interpretations filter into the documentation.

Objective language is the way we communicate the facts of what has happened. The following are some problem words to avoid: complaining, cranky, pretty, lazy, depressed, deserving, good, happy, crazy, nice, clean, dirty, filthy, friendly, hostile and stubborn.

Keys to turning opinion into factual statement:

- What did you actually see?
- Were there any other witnesses?
- What did they see?

**(PPS 10-11)**

Figure 24 - Fact vs. Opinion Table

Fact versus Opinion	
Use Objective Language	Avoid Subjective Language
Can be measured, counted and/or seen by more than one person. Two people would have the same understanding of exactly what happened.	Is open to different interpretations. Two people can describe or understand the meaning in different ways.
Word examples: Hit, run, cried, slept, does not speak, laughs, talks to other people, placed napkin on lap, touches others' genitals, wipes body with dry towel.	Word examples: depressed, dumb, abuse, confused, unable to relate, violent temper, stubborn, lack of respect, inconsiderate, typical, filthy, friendly.
Describes behaviors: Example: "Administrator said he had no comment when I asked about the training and supervision that certified nursing assistants receive. After I asked other questions related to the complaint, the administrator said the interview was over and escorted me to the door."	Labels behaviors. Example: "Administrator was rude and unresponsive to my interview."
Describes observations. Example: "I saw coffee and juice stains on the floor in the day room on Wing C and they felt sticky to the touch."	Interjects opinion, offers an interpretation. Example: "The floor was dirty and obviously had not been cleaned since breakfast."

Words to Avoid:

**(PPS 12)**

- |             |              |
|-------------|--------------|
| • Clean     | • Deserving  |
| • Dirty     | • Good       |
| • Filthy    | • Crazy      |
| • Lazy      | • Friendly   |
| • Depressed | • Happy      |
| • Stubborn  | • Relatively |
| • Hostile   | • Sad        |
| • Rude      | • Cranky     |

### **All Documentation Related to the 5 W's:**

**(PPS 13) (PM 173)**

- Who all was involved – name, title, relationship;
- What information was gleaned or obtained related to the issue at hand;
- Where did the event take place – what part of the facility, etc.;
- When did the event take place – date of contact, location; and
- Why, or purpose, of the event – only document information related to the issue or the “strategy” to resolve the problem.

Concise documentation should be organized. Do not assume the reader will know or understand the issue. Keep the vocabulary plain and easily understood. Use short sentences and be brief and concise. A lengthy case record does not equal good documentation.

### **Contents of Documentation/Case Notes**

**(PPS 14-15) (PM 173)**

All case notes must include at a minimum:

- Resident's name, birth date and payment source (if known);
- Clear definition of the issue, problem, concern or complaint;
- Resident's statement of the issue, problem, concern or complaint;
- Permission or refusal by the resident for the Ombudsman to continue the investigation and intervention;
- Resident's permission to release his identity if necessary, in the investigation and resolution of the complaint/concern;
- Detail the resident's involvement in the decision-making process;
- Services offered and resident's acceptance or refusal;
- Any related reports;
- Ombudsman activities involved in the investigation (meetings, interviews, etc.);
- All relevant information covering the case including phone calls; face-to-face interviews; review of records, letters (copies of letters sent, original letters received);

- All relevant complainant or witness statements or respondent statements;
- An assessment of the resident's ability to make a choice – a decision as to whether the resident is oriented to time, place and consequences;
- Resident's level of satisfaction with the outcome;
- Follow-up activities or actions;
- Changes in the course of action; and
- All decisions reached concerning the case.

### **Guidelines for Good Documentation** (PPS 16) (PM 174)

- Record activities in chronological order as soon as possible. Always record names, dates and type of contact and times of events.
- Attempt to use the vocabulary of the interviewee.
- Do not use abbreviations in the narrative unless they are well-known. Use names or titles of persons in the narrative rather than pronouns (e.g., she, him, they).
- Include all original copies of documents. Include an explanation of any absence of evidence.

The following checklist can be copied and used as a guide to review casework.

**(PPS 17)**

Figure 25 - Ombudsman Documentation Checklist

Case Handling Area	Yes	No	N/A	Comments
Response time appropriate, date open and first action				
Brief history of resident or situation				
Consent statement written or explanation of unable to receive content				
Release of information attached to case				
Date of Birth obtained				
Pay Status obtained				
Clear complaint statements				
Appropriate complaint codes used				
Action plan developed in conjunction with resident or legal representative				
Verification information included				
Appropriate investigative steps documented				
Full names, titles and relationships of persons involved				
Telephone numbers/email addresses documented if appropriate				
Appropriate resolution strategies developed				
Appropriate referrals to outside agencies				
Follow-up is timely and documented				
Sufficient information document to close case				
All case activities documented within 30 days of completion				
Closure statement, if complaints are closed				

### **Activities: (PPS 18)**

All direct service activities are recorded in PeerPlace. The list below contains some of the Activity Types in PeerPlace. Additional Activity Types are found in PeerPlace.

- Regular presence visits
- Consultations
- Resident council meetings
- Facility staff in-service
- Community education sessions
- Participation in facility surveys
- Ombudsman Training and Technical Assistance



Example:

(PPS 19)

Figure 26 - Example Activity

Date Completed (NORS) *:	03/14/2018	
Status *:	Completed	
Activity Type (NORS) *:	Consultation to Individuals	
Search Facilities:	Keyword Search	Search Facilities Clear
Facility Name :		
County:	Peoria	
Completed By *:	Jessica Belsly	
Activity Time (hrs.mins) *:		
Instances (NORS):	1	
Topic 1 (NORS) *:	Long Term Care Options/How to choose a facility	
Topic 2 (NORS):	Select One	
Topic 3 (NORS):	Select One	
# of Contacts - Residents:	0	
# of Contacts - Facility Staff:	0	
# of Contacts - Others:	0	
Contact Name (Last, First):	Brown, Mavis	
Contact Phone (###-###-####):	309	555 5555
Contact Email:	mavis.brown@email.co	
Other Ombudsman Present:	Chuck Miller Jamie Freschi Jessica Belsly Joe Danner Peerplace Admin	
Legislative Bill/Issue:		
Referred To:	Center for Independent Living DHS Long Term Care Ombudsman Program De-institutionalization/Transitional Services Home Care Provider	
Comments:	Caller requested info on how to choose a nursing home. Her grandmother is at the hospital after a fall at home and the Dr. said she'd need to go to a nursing home for rehab. Discharge planner give a list of facilities and suggested	

## **Narrative Text:**

The following documentation sample is based on the Anne Walker Video from Level I Ombudsman Certification Training. As you review the case, pay attention to the following terms:

**TRAINER'S NOTE:** The purpose of this example is for the trainer to be able to point out important pieces of documentation  
(PM 168)

- **Consent**
- **Narrative written clearly so the reader understands what steps have been taken**
- **How names and titles should be included in documentation and that abbreviations alone are not sufficient**
- **Plan of action developed with resident**

**(PPS 19-20)**

Figure 27 - PeerPlace Entries for Case Examples PAGE 1

Date of Action:	01/08/2018
Time of Action:	2:00 PM
Last Modified Date:	null
Entry Type:	Phone Call
Time Spent (hrs.min):	0.10
Entry Title:	Intake Call
Investigation:	Res. Anne Walker called LTCO Belsly and stated she would like to discuss an issue she is having with an early wake up and shower time. Res. Walker did not want to get into details as she was calling from the nurses station, but requested LTCO Belsly stop by on her next visit to the facility.
Date of Action:	01/10/2018
Time of Action:	1:10 PM
Last Modified Date:	null
Entry Type:	Face to Face
Time Spent (hrs.min):	0.15
Entry Title:	Met with Resident
Investigation:	LTCO Belsly met with Resident Walker in Resident's room. Res. Walker states she is very upset because the staff have been waking her up around 6am to shower over the past two weeks. Res. Walker would like to sleep in and would prefer to have her shower after breakfast. Res. Walker agreed to keep a record of the dates and times when staff wake her early. Res. Walker stated "they are not very nice about it either, so I am not very nice back". CNA's Velma and Sasha usually take her to the shower in the other hall. Res. Walker states CNA Velma rushes her to shower and get dressed within 15 minutes. Res. Walker doesn't know why the schedule changed. Res. Walker's neighbor, Jane Sunday is on the same shower schedule. LTCO Belsly requested permission to talk to staff about R's concern, but Res. walker didn't want the facility to know the complaint came from her due to fear of retaliation. LTCO Belsly will follow up with Res. Walker after investigating the shower situation on another visit.
Date of Action:	01/10/2018
Time of Action:	2:15 PM
Last Modified Date:	null
Entry Type:	Case Review
Time Spent (hrs.min):	0.10
Entry Title:	PC to RO
Investigation:	LTCO Belsly phone RO Diane to inform her of the plan to make an early visit at Res. Walker's facility and get additional input. RO Diane suggested observing the shower areas, talking to the charge nurse about how preferences are communicated, and check bathing policy and schedule.
Date of Action:	01/10/2018
Time of Action:	9:00 PM
Last Modified Date:	null
Entry Type:	Face to Face
Time Spent (hrs.min):	0.10
Entry Title:	Follow up with Res
Investigation:	LTCO Belsly reported back to Res. Walker that DON Smith would review the bathing schedule and follow up with Res. Walker and LTCO no later than Friday, 1/12/18 as to whether there is an alternative time in the schedule for Res. Walker to shower.
Date of Action:	01/15/2018
Time of Action:	6:00 AM
Last Modified Date:	null
Entry Type:	Face to Face
Time Spent (hrs.min):	0.10

Figure 28 - PeerPlace Entries for Case Examples PAGE 2

Date of Action:	01/15/2018
Time of Action:	8:30 AM
Last Modified Date:	null
Entry Type:	Face to Face
Time Spent (hrs.min):	0.10
Entry Title:	RC President Interview
Investigation:	LTCO Belsly spoke to RC President John Willis. LTCO Belsly asked if the RC has received any complaints about showering schedules. RC President Willis isn't aware of any problems but agreed to bring it up during the next RC Meeting.
Date of Action:	01/15/2018
Time of Action:	8:45 AM
Last Modified Date:	null
Entry Type:	Face to Face
Time Spent (hrs.min):	0.05
Entry Title:	Ms. Sunday FTF
Investigation:	LTCO Belsly spoke to Resident Jane Sunday, who is R. Walker's neighbor that is on a similar shower schedule. R. Sunday states staff has been waking her up between 5:45-6am for her shower, but she is a farm girl and used to getting up with the chickens, so she doesn't mind. R. Sunday stated "I think it bothers some other residents. I know my neighbor Anne has told the staff that she is none too happy about the early wake up time."
Date of Action:	01/15/2018
Time of Action:	8:50 AM
Last Modified Date:	null
Entry Type:	Face to Face
Time Spent (hrs.min):	0.20
Entry Title:	Follow up with Resident
Investigation:	LTCO Belsly spoke to R. Walker in her room. LTCO Belsly discussed the plan for the RC President to discuss shower schedules at the next RC Meeting to see if there are any concerns. LTCO Belsly also discussed observations from the review of the shower schedule and facility bathing policy. R. Walker agreed for LTCO Belsly to discuss the problem with the DON Carol Lee about the bathing schedule as long as LTCO is with her.



Figure 29 - PeerPlace Entries for Case Examples PAGE 2

Date of Action:	01/15/2018
Time of Action:	9:05 AM
Last Modified Date:	null
Entry Type:	Face to Face
Time Spent (hrs.min):	0.5
Entry Title:	Request for Meeting with DON
Investigation:	LTCO Belsly spoke to DON Carol Lee and requested she meet with R. Walker to discuss the bathing schedule.
Date of Action:	01/15/2018
Time of Action:	2:00 PM
Last Modified Date:	null
Entry Type:	Face to Face
Time Spent (hrs.min):	0.15
Entry Title:	Met with D.O.N.
Investigation:	LTCO Belsly met with R. Walker and DON Lee to discuss the bathing schedule for Res. Walker. LTCO Belsly explained R. Walker does not want to shower early. Res. Walker explained CNAs Velma and Sasha won't listen to her request for a later wake up and shower time. DON Lee states the resident failed to indicate a preferred bathing time on her initial assessment. DON Lee found an opening for Tuesday/Thursday/Saturday after breakfast. Res. Walker also requested to not be rushed and also stated CNA Velma "treats me like a child". DON Lee agreed to speak with the CNA about treating residents with dignity and respect. DON Lee agreed to speak to the charge nurse and have the schedule changed today. Res. Walker can expect to have her shower tomorrow after breakfast. CNAs Brenda and Maria will now be providing the shower and DON Lee will ask them to provide her with some private time.
Date of Action:	01/30/2018
Time of Action:	2:30 PM
Last Modified Date:	null
Entry Type:	Face to Face
Time Spent (hrs.min):	0.10
Entry Title:	Resolution FTF with R
Investigation:	LTCO Belsly spoke to Res. Walker in the lobby. Res. Walker states the new showering schedule "is just wonderful". She is no longer rushed and CNA Maria is respecting her privacy and dignity. Res. Walker is satisfied with the resolution.

**Additional Training required on how to document:  
(PPS 21) (PM 180)**

NORS Training Webinars

<http://www.ltcOmbudsman.org/Ombudsman-support/training#NORS>

[illegible]



