

# NATIONAL OMBUDSMAN REPORTING SYSTEM (NORS) TRAINING PART II

## Complaint Coding Quiz Answer Sheet

**REMINDER:** Throughout these training materials “Ombudsman” is used as a generic term that may mean the state Ombudsman, a representative of the Office, or the Ombudsman program. Use the NORS tables developed by the Administration for Community Living/Administration on Aging with these training materials when indicated (Table 1: NORS Case and complaint codes, values and definitions; Table 2: NORS Complaint codes and definitions; and Table 3 State Program Information, OMB Control Number 0985-0005, updated 10/1/21, expiration date 10/31/24). The NORS codes and definitions used in these materials are taken from the ACL tables 1-3 and are not to be modified.

**DIRECTIONS:** Each person taking the quiz needs to have a copy of the **NORS, Table 2: Complaint codes and definitions**. If questions arise regarding the Part II quiz answers, refer to the **Examples and Reporting Tips** column of **Table 2, Complaint codes and definitions** for additional information. For each complaint category, select the complaint code that best describes each scenario. For purposes of this training, assume that the resident gives consent to investigate if not otherwise indicated.

### A. Abuse, Gross Neglect, Exploitation

Use the A codes for complaints of abuse, gross neglect, and exploitation. Identify a perpetrator for each of the A codes.

The perpetrator is the person(s) who appears to be the cause of the abuse, neglect, or exploitation. *There can be multiple perpetrators for each complaint.*

Facility staff

Another resident

Family, resident representative, friend

Other

Complaint Code      Perpetrator

- |            |                                |   |
|------------|--------------------------------|---|
| <b>A04</b> | <b><u>Family</u></b>           | 1) A family member is making withdrawals of unusual amounts of funds that are not routine from the account of a bank customer who is a resident in a nursing facility.  |
| <b>A01</b> | <b><u>Another resident</u></b> | 2) Resident A hits Resident B because Resident B will not move out of the way.  |
| <b>A05</b> | <b><u>Staff</u></b>            | 3) A resident is found at a facility bedridden, non-communicative, extremely thin, with contracted limbs, and visible bedsores on his head and elbows.  |
| <b>A02</b> | <b><u>Staff</u></b>            | 4) One of the housekeeping staff tells the Ombudsman that she saw blood on the bed linens of a non-communicative resident whose undergarments had been removed. The staff member saw a nurse leaving the resident’s room. |

- A03**      **Staff**      5) A resident cries as she tells you that staff took her photo when she was in the bathroom and said they would post it online if she doesn't quit pushing her call bell.
- Use A03 when abuse is caused by taking or using photographs or recordings in a way that would demean or humiliate a resident; threatening or posting these photos on social media networks, or sending them through multimedia messages. Use D03, Dignity and respect, for less severe forms of staff rudeness or insensitivity.**

## **B. Access to Information**

Use this category for complaints against the facility regarding access to information made by or on behalf of the resident. Use for willful interference with ombudsman duties.

- B03**      1) An Ombudsman has a consent to access records form signed by a resident to review the resident's care plan. The charge nurse says that the Ombudsman must wait a week before access can be granted.
- B01**      2) The resident's representative and daughter says that the facility keeps putting off her request to see her mother's medical records.
- B01**      3) The residential care community did not give the resident information on residents' rights when he moved into the residence.
- B02**      4) A resident complains that she cannot understand anything the morning caregiver says when she comes in to help her get up and dressed for the day. The caregiver's primary language is not the same as the resident's.

## **C. Admission, Transfer, Discharge, Eviction**

Use this category for complaints against the facility involving issues regarding admission, transfer, discharge and/or eviction.

- CO4**      1) A nursing facility forces a resident to change rooms and roommates without telling her in advance.
- CO3**      2) A residential care community dropped off a resident at the local emergency room (ER); the ER could find no acute medical illness and wanted the resident to return to the facility. The provider tells the hospital they will have to find another home for the resident and refuses to pick up the resident.
- CO2**      3) A nursing facility sent a resident to another facility while she awaited her discharge appeal hearing.
- CO1**      4) When a resident moved into the residential care community, the home required her to sign a document stating that she would have to move out immediately if she is not approved for the State's home and community-based services program. The state has a 30-day discharge notice requirement regardless of payment source or length of time in the facility.

**This example illustrates that the resident is waiving a right, i.e., a right to a discharge notice and discharge planning, if she is not approved for a specific program. Use C-01 when the admission agreement or contract is missing or contains illegal provisions.**

## **D. Autonomy, Choice, Rights**

Use this category for complaints involving facility staff failure to honor and promote a resident's right or preferences.

- D06** 1) The Assistant Administrator of the residential care community threatened a resident with discharge from the home if he complained to the Ombudsman.
- D04** 2) Staff gives residents showers in the shower room without the curtains being drawn while other residents are wheeled in and out of the room.
- D03** 3) Staff does not knock-on residents' doors before entering their rooms, including closed doors.
- D09** 4) A resident continues to tell the staff that he does not want to take a shower, but they say that he is required to shower at least once a week.
- D09** 5) Residents are not allowed to smoke after 5:00 pm because a staff member is not available to monitor them on the front porch.
- D05** 6) Residents have made several reports to the nursing facility administrator that there are ants in residents' bedrooms, but nothing appears to have been done about it. They are unhappy that the administrator is unresponsive.

**The issue is that the administrator is not responding to complaints. If the complaint had been that there were ants in residents' bedrooms, the complaint would be coded, I05, Housekeeping, laundry and pest abatement. NOTE: it is quite possible that the Ombudsman program would have two complaints in this scenario – the unresponsiveness of the administrator and the underlying problem (i.e. ants in the bedroom).**

- D07** 7) The residential care community provider tells a resident's friends that they are a bad influence and cannot visit the resident again in the home. The provider tells the resident that he cannot meet those friends outside of the home.
- D08** 8) Residents say that the activities director runs the resident council and tells them that any complaints make the facility look bad. Attendance has been declining.
- D02** 9) A resident says she wants to move out of the nursing facility into an apartment. The facility staff tells her that she is not ready to do that and will not tell the resident who can help her with such a move. The resident has been asking to talk with someone about moving for six months.

**This complaint is about the facility's failure to assist a resident to transition to the community as opposed to complaint code L03 which is about barriers outside the control of the facility, such as unresponsive local contact agency, lack of services and supports, etc.**

## **E. Financial, Property**

Use this category for complaints involving facility staff mismanagement of residents' funds and property or billing problems.

- E02** 1) The home will not give a resident his personal needs allowance when he wants some money because they say he spends it all in the first week of the month.
- E01** 2) The residential care community administrator informed a resident that the cost for care will increase, but he did not provide written information as to how much and when the new charges will take effect.

## F. Care

Use this category for any complaint involving facility staff failure to provide care including poor quality care, planning and delivery.

- F05** 1) Several male residents are observed to be unshaven, female residents have long facial hair, and numerous residents have dirty, jagged fingernails.
- F03** 2) Nursing assistants do not help a resident walk with a walker four times a day as directed in the care plan, based on the physician's order.
- F01** 3) A resident has two bruises on the side of her face but the nursing staff does not seem to know what caused them.
- F02** 4) Staff does not respond to residents' call lights unless they yell for help.
- F04** 5) The residential care community did not keep track of when medications were given to the resident and the resident believes that he is not receiving all his medications as prescribed by his physician.
- F08** 6) The nursing facility always smells like urine and family members have complained to the Ombudsman that their relative is often found to be in a urine-soaked incontinence brief.
- F10** 7) A resident has not been able to straighten out his legs ever since the nursing facility staff stopped assisting him into his wheelchair each day.

**F10, Rehabilitation services, includes assisting and encouraging the resident to improve or maintain his function and/or to ambulate when appropriate. It also includes range of motion and exercise programs. After the staff stopped assisting the resident into his wheelchair daily, the resident lost the ability to straighten his legs. Had the allegation been that the facility staff did not follow resident's care plan, the code would be F03. Gross neglect (A05) is for complaints that the facility failed to protect a resident from harm or failed to meet needs for essential care, which result in a serious risk of compromised health. Initially, this scenario most closely relates to a change in and lack of rehabilitative services.**

- F09** 8) A section of the nursing facility's wall-mounted handrails is missing from the hallway near the dining room.

**F09 includes a facility's failure to maintain adaptive equipment. If the facility did not have wall-mounted handrails, the code would be Environment (I01).**

- F06** 9) A resident was not sent to the hospital for x-rays after falling in the dining room, although she complained several times that her wrist was hurting and asked the nurse to send her to the emergency room.

**Although F01, Accidents and falls, or F07, Symptoms unattended, might seem appropriate, the complaint was that the resident's wrist hurt, and the nurse did not arrange to send**

**her to the emergency room for an x-ray. The resident was clear in her request and the nurse disregarded the request.**

- F11** 10) A daughter says that her mother cannot move and adjust her position because staff put so many big pillows around her that she sits in a fixed position for hours.
- F12** 11) New medications given to a resident since moving into the nursing facility have made her lethargic and less responsive.
- F07** 12) A nursing facility resident continues to lose weight even though she is supposed to receive extra snacks throughout the day in order to gain weight.
- F13** 13) Several residents report that there is an infectious disease outbreak at their facility. Staff are not being provided or are not wearing personal protective equipment (PPE).

## **G. Activities, Community Integration, and Social Services**

Use this category for any complaint involving activities, community integration or social services.

- G02** 1) Residential care community staff will take residents to medical appointments but will not provide or arrange for transportation to church or other community events unless it is an activity for the whole group.
- G01** 2) A resident complains that there is nothing to do at the home except play Bingo; he has talked to the Activity Director (AD) about offering other activities but the AD is not following through.
- G04** 3) A resident's daughter has died. The resident asked the social worker for assistance to arrange a time and a room to meet with her family, but nothing was arranged.
- G03** 4) Some members of the nursing facility residents' council do not want to allow a particular resident to attend resident council meetings because he talks too much and disrupts the meetings. Staff asks the Ombudsman for assistance.

## **H. Dietary**

Use this category for complaints regarding food service, assistance.

- H02** 1) Several residents are observed in the dining room not being assisted with opening their food packaging, cutting their food, and seasoning their food.
- H01** 2) Residents report that they do not get snacks on the weekends and that they feel hungry between meals.
- H03** 3) A resident at the facility is served green beans at dinner and she does not eat them. Her son says he has told the dietary staff about her dislike of the green beans and asked that this be on her dietary card. He is concerned that she is not getting enough vegetables since she does not eat the green beans.

## **I. Environment**

Use this category for complaints involving the physical environment of the facility, including the resident's space.

- I01** 1) Several residents have complained and want to move to a different part of the facility because the staff smokes in the nearby break-room.
- I05** 2) Flies are present in the facility because the back door to the laundry room is always propped open and there is no screen door.
- I04** 3) The main entrance has steps up to the porch and does not have a wheelchair ramp.
- I02** 4) The smoke alarm beeps constantly, indicating that the battery is low.
- I03** 5) There is no soap or toilet paper in the bathrooms because the residential care community provider wants to control the amount of supplies used.

## **J. Facility Policies, Procedures, and Practices**

Use this category for acts of commission or omission by facility leadership/owners including administrators, resident managers, etc.

- J01** 1) Staff did not report suspected abuse because they did not want to lose their jobs.
- J02** 2) The residential care community's electricity has been cut off due to unpaid bills.
- J03** 3) Residents cannot go to bed when requested because the staff is busy assisting other residents.
- J01** 4) Facility does not routinely practice fire and tornado drills.

## **K. Complaints about an Outside Agency (non-facility)**

Use this category for complaints involving decisions, policies, actions or inactions by the programs and agencies listed in Table 2, section K, including private and public benefits.

- K02** 1) Families are upset because the Medicaid agency deemed residents ineligible for Medicaid after incorrectly calculating part of their Veteran's pension in their monthly income.

**This complaint is not a K05 Veterans Affairs complaint because it relates to a denial of Medicaid.**

- K01** 2) The Ombudsman program referred a discharge complaint to the survey agency and requested that it have a high priority, fast response. The state survey agency was not able to conduct a timely investigation, stating that they did not have staff capacity.
- K06** 3) A daughter says her mother complains of pain more often and is walking less since her medication was changed. The facility said that her insurance no longer covers the medication she previously received, and they have her on a generic drug that the insurance company covers.
- K05** 4) A veteran wants to change his assigned Veteran's Administration social worker because the social worker seems to side with the facility rather than him.
- K03** 5) A resident says her doctor has changed and she learned that she cannot have her vision checked this year. The social services staff said the changes were due to the resident moving into a managed care plan.
- K04** 6) A son is very upset because the facility said his mother's stay will not be covered by Medicare even though she entered the facility for rehab following a hospital stay and as part of her discharge orders.



## L. System: Others (non-facility)

Use this category for complaints involving decisions, policies, actions or inactions by systems other than the facility or the programs or agencies included in code K.

**L01** 1) A nursing facility resident would like to revoke the guardianship ordered during his illness.

**L03** 2) A nursing facility resident wants to move into his own apartment. He complains that the agency worker who met with him said that the services he needs would not be available. There is a long waiting list for those services.

**This complaint pertains to a system issue, necessary services are not available, and the response of the agency worker, so it is L03. The complaint is not against the facility. If the complaint was due to the facility's failure to assist the resident to move into an apartment, it would be coded D02.**

**L02** 3) A resident has not received a screening by the community mental health agency to address his mental health care needs since his admission to the nursing facility four months ago. The facility staff has called several times about the referral.