Office of the State Long-term Care Ombudsman
Annual Report

State fiscal years 2015-2016

A Report to the Texas Governor, Lieutenant Governor and Speaker of the House of Representatives

November 2016

TEXAS Health and Human Services

The Office of the State Long-term Care Ombudsman is independent within the Texas Health and Human Services system.

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Texas Long-term Care Ombudsman Annual Report

Patty Ducayet, LMSW

A long-term care ombudsman

- **Advocates** for increased consumer protections in state and federal laws and regulations.
- **Educates** residents about their rights.
- **Empowers** and supports residents and families to discuss concerns with facility staff.
- **Identifies** and seeks to remedy gaps in facility, government or community services.
- **Protects** the health, safety, welfare and rights of residents of nursing homes and assisted living facilities.
- **Provides** information and assistance about long-term services and supports.
- **Receives** and investigates complaints, and helps residents resolve problems.
- **Represents** residents' interests before governmental agencies.
- **Respects** the privacy and confidentiality of residents and complainants.

Highlights September 2014 – August 2016

Long-term care ombudsman accomplishments

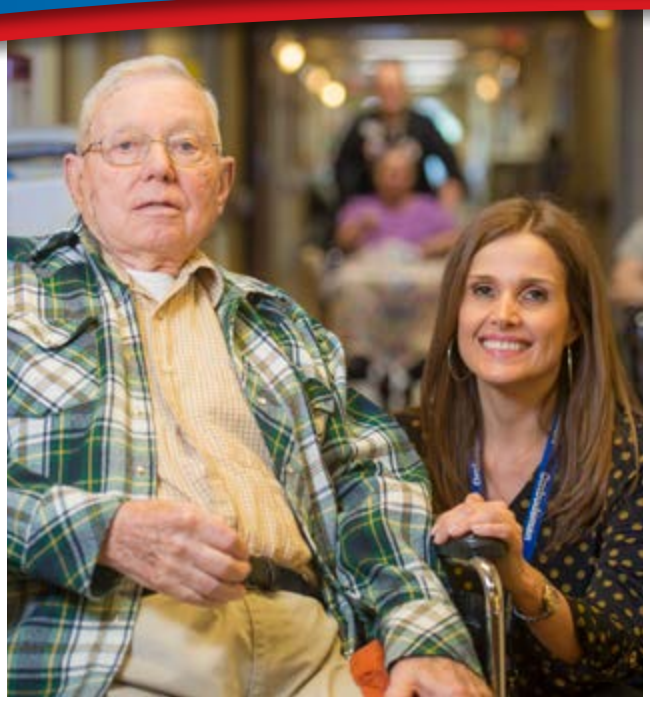
Accomplishment	2015	2016
Nursing home complaints	12,947 cases with 14,863 complaints	13,300 cases with 15,828 complaints
Assisted living facility (ALF) complaints	1,612 cases with 1,832 complaints	2,714 cases with 3,598 complaints
Nursing home visits	24,855 visits	25,893 visits
ALF visits	11,856 visits to ALFs and 382 visits to ALF residents in Adult Day Health Services	13,703 visits to ALFs and 630 visits to ALF residents in Adult Day Health Services
Volunteers	543 volunteers donated 31,728 hours in long-term care facilities	498 volunteers donated 29,467 hours in long-term care facilities
Consultations to residents or representatives	11,826 consultations	22,384 consultations
Councils attended	1,410 resident and 167 family	1,283 resident and 148 family
Consultations to facility staff	4,398 consultations	5,220 consultations
Training to facilities	236 sessions	255 sessions
Input provided to DADS surveyors	815 surveys	1,615 surveys

Ombudsmen also

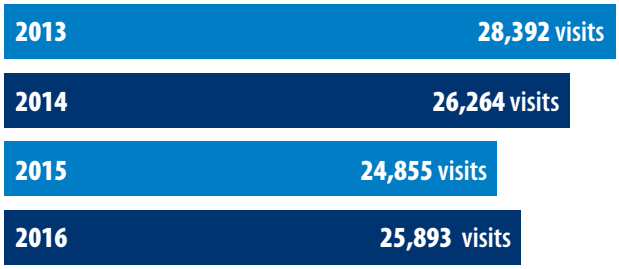
- Responded to complaints ranging from unresponsive staff to involuntary discharge.
- Resolved or partially resolved 91 percent of complaints in nursing homes and 88 percent of complaints in ALFs.
- Provided 619 community education sessions.

The mission of the Texas Long-term Care Ombudsman Program is to improve the quality of life and care for residents of nursing homes and ALFs by providing prompt, informal complaint resolution and promoting systemic change on behalf of residents' interests.

Ombudsmen in Nursing Homes



Visits



With more than 1,200 nursing homes in Texas, certified ombudsmen visited 86 percent of all nursing homes quarterly in 2015 and 97 percent in 2016.

Most frequent nursing home complaints

Complaint	2015	2016	Total
1. Failure to respond to requests for help, including call light	1,519	1,646	3,165
2. Building: cleanliness, pests, housekeeping	921	1,071	1,992
3. Food service: quantity, quality, variation, choice	858	986	1,844
4. Equipment or building: disrepair, hazard, fire safety	726	745	1,471
5. Dignity, respect, poor staff attitudes	651	710	1,361
6. Personal hygiene: bathing, nail and oral care, dressing, grooming	574	661	1,235
7. Medication: administration or organization	572	612	1,184
8. Symptoms unattended or unnoticed	586	589	1,175
9. Involuntary discharge: planning, notice, procedure	519	532	1,051
10. Odors	468	439	907
11. Assistive devices or equipment	339	403	742
12. Toileting, incontinent care	369	343	712
13. Activities: availability, choice, appropriateness	352	322	674
14. Personal property: lost, stolen, used by others, destroyed	330	316	646
15. Resident unable to exercise choice, rights, preference	282	341	623
Subtotal (of 15 most frequent complaints)	**9,066**	**9,716**	**18,782**
Total (of all complaints received)	**14,863**	**15,828**	**30,691**

Ombudsmen closed 12,947 cases with 14,863 complaints in 2015, and closed 13,300 cases with 15,828 complaints in 2016. In order of frequency, the most common complaints involved resident care; environment and safety concerns; dietary issues; rights, autonomy and choice; and rehabilitation.

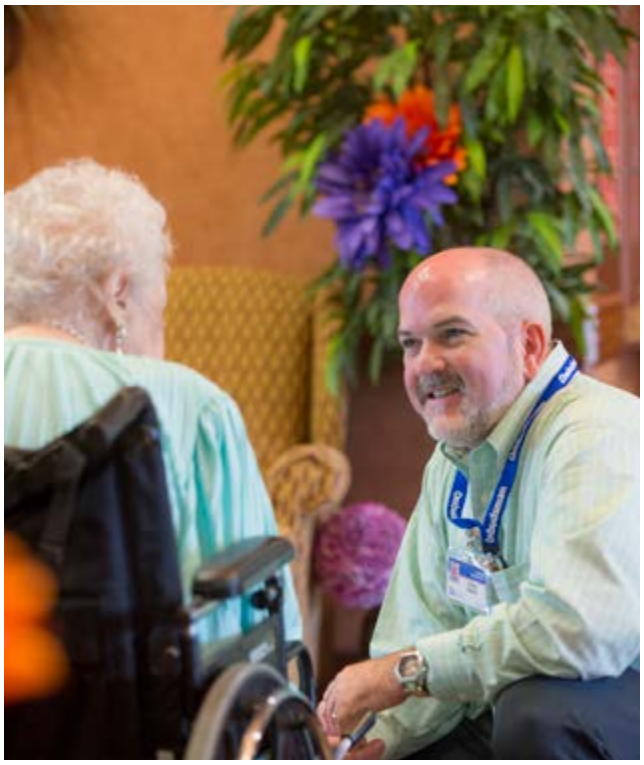
Sufficient, well-trained and well-supervised staff is critical to quality care in nursing homes. In 2015 and 2016, four of the 10 most common complaints related directly to direct-care facility staff: failure to respond to requests for help, including call lights; dignity, respect, and poor staff attitudes; bathing, nail and oral care, dressing, and grooming; and symptoms unattended or unnoticed. These four staffing complaints made up 23 percent of all nursing home complaints received, or 6,936 complaints over two years.

Nursing home complainants

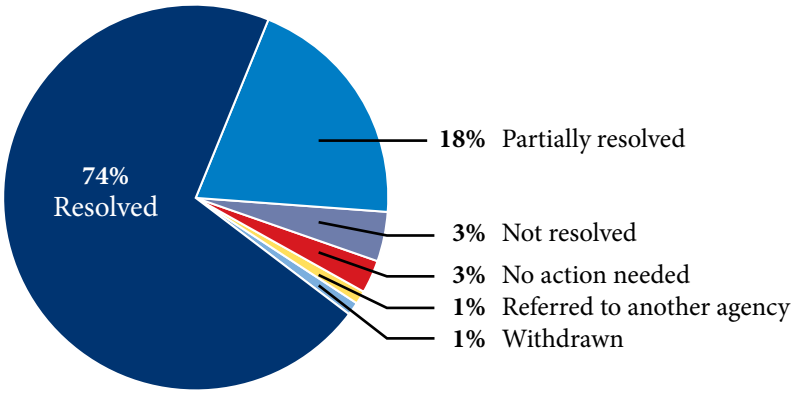
2015 and 2016	Percent	Complainant
15,210	58%	Resident
6,734	26%	Ombudsman
2,649	10%	Relative, friend
813	3%	Facility staff
608	2%	Anonymous
157	1%	Other

Verification of complaints

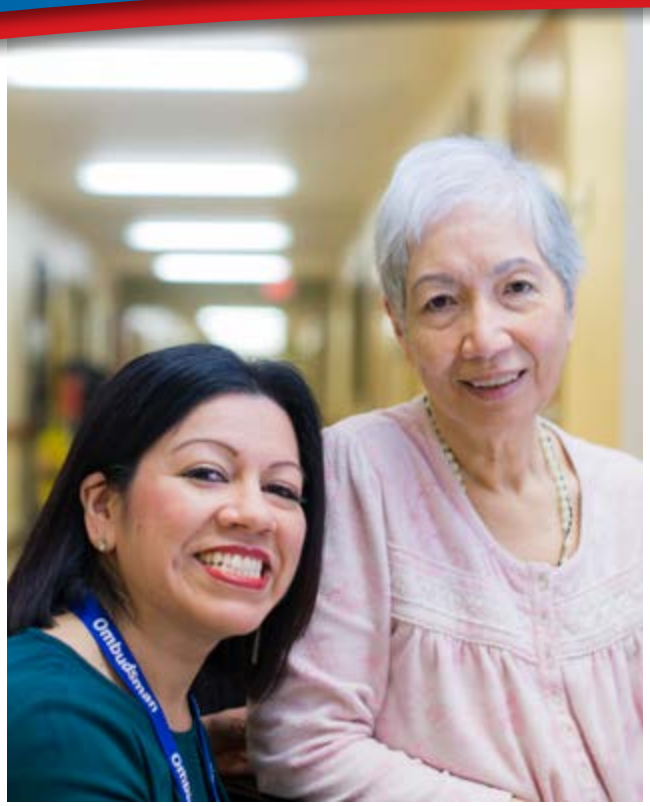
Ombudsmen verify complaints through observation, interviews and record review. Verification indicates that the circumstances described in the complaint existed or were generally accurate. In 2015 and 2016, 94 percent of nursing home complaints were verified.



Complaint outcomes (2015 and 2016)



Ombudsmen in Nursing Homes



Guardianship investigation helps residents avoid discharge

A nursing facility social worker reported that 15 residents were unable to contact their private, professional guardian. Residents needed shoes, couldn't access their personal needs allowance and were not represented by their guardian in their care plan meetings. In some cases, payments to the facility had not been made, and those residents were at risk of discharge. The guardian had moved 340 miles away, and calls from the ombudsman to the guardian were not returned.

The ombudsman interviewed those who could communicate and discovered that the same guardian was also unresponsive to several residents of another nursing home. Some residents risked losing their Medicaid eligibility due to renewal paperwork not being submitted.

On behalf of the residents, the ombudsman filed two complaints with the Texas Judicial Branch Certification Commission (JBCC) which oversees private, professional guardian conduct, and provided evidence to support her claims. While the complaints were being investigated, the ombudsman contacted the judge who had appointed the professional guardian. The judge notified the guardian of her duties and set a 30-day timeline to resolve the complaints or be called to a hearing to determine if the guardian should remain in this role. The judge also suspended appointment of this guardian to any new residents in his jurisdiction. An attorney was assigned to represent each of the residents' interests and report to the court. The judge requested the ombudsman report all additional complaints to him for consideration in the case and routinely forwarded communications from the ombudsman to the guardian to illustrate the concerns and source.

At the same time, there was no volunteer guardianship program, and finding people to serve as guardians was challenging. As residents were at risk of losing Medicaid, the facilities had a valid reason to give 30-day notice to the residents. The ombudsman communicated with facility administrators and corporate offices to ensure residents were not discharged under these circumstances. Assuring the corporate and facility management that the ombudsman was tracking the case was essential to protecting the residents from discharge. The ombudsman also explored options for valid signatures on Medicaid applications and arranged for the facility social workers to sign off on the applications on behalf of residents.

The ombudsman managed communications on several levels, including with the guardian, the guardian's attorney, probate judges, the facility that initiated the concerns and the residents. She worked with the JBCC, Adult Protective Services and county services to explore options for replacement guardians for any residents who would continue to need one. She also testified to the court about residents who appeared to be capable of limited guardianship and residents whose capacity might make them eligible for full restoration of their capacity to make decisions.

The court investigator confirmed the ombudsman's complaints on behalf of the wards, including failing to pay the facilities on time, withholding personal-needs allowances and not visiting as required by court order. The investigator used the ombudsman's testimony, written reports of resident complaints and other evidence gathered by the ombudsman to recommend removal of the guardian from all of the residents' cases.

Further, the JBCC compliance investigator used the ombudsman's evidence to recommend removal of the guardian's certification and disqualifying the person as a private professional guardian in Texas. Under its authority to issue sanctions, JBCC imposed a $25,500 fine (51 violations at $500 each) and did not renew the person's guardianship certification after it lapsed in July 2015.

Because of the ombudsman's advocacy, two counties and their judges with probate jurisdiction recognized the gravity of the situation. The loss of this professional guardian left several counties with no options other than family members, and each case in which the guardian was removed required a case review and determination of capacity. The county judge in the larger of the two counties asked the ombudsman to pull together key decision-makers and subject matter experts to meet in his chambers. She invited the neighboring judge, Adult Protective Services,

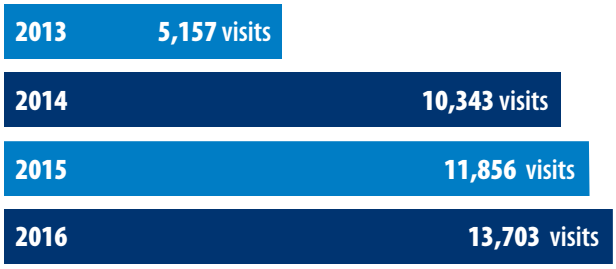
Regulatory Services, the local dispute resolution office and the state agency with limited guardianship authority.

After assessing the situation, the judges removed the guardian from all cases. For some residents who were unable to manage their own funds, the Social Security Administration made the facilities representative payees. At the close of the meeting, the ombudsman requested that the residents receive written communication explaining what had happened, how and who they could ask for help with their immediate concerns. The judges agreed to appoint a guardian in only the cases that were still necessary.

After 10 months of work, the ombudsman determined the residents' financial and personal situations were stabilized. Residents' basic needs were met, and they were able to access their own money. Additionally, the facilities were being paid, which resolved the risk of discharge.

Ombudsmen in Assisted Living Facilities

Visits



The 84th Texas Legislature approved additional funding for the long-term care ombudsman program, making it possible for local programs to hire ombudsmen to regularly visit ALF residents in the 1,824 facilities in 2015 and 1,849 facilities in 2016. As a result, ombudsman visits and casework increased between 2015 and 2016. For example, in 2014, ombudsmen visited quarterly 56 percent of ALFs, 78 percent in 2015, and 72 percent in 2016. This regular contact serves as the basis for building trust with residents and a productive working relationship with facility staff.

Because some ALFs use adult day services to provide weekday services to residents, ombudsmen also made 1,012 visits to residents in adult day settings in FY 15-16.

Most frequent assisted living facility complaints

Complaint	2015	2016	Total
1. Building: cleanliness, pests, housekeeping	186	300	486
2. Food service: quantity, quality, variety, choice	208	256	464
3. Equipment or building: disrepair, hazard, fire safety	144	271	415
4. Information not provided: rights, benefits, services, complaints	70	216	286
5. Medication: administration or organization	93	140	233
6. Odors	78	116	194
7. Dignity, respect, poor staff attitudes	58	128	186
8. Environment: air or water temperature, noise	39	139	178
9. Activities: availability, choice, appropriateness	60	109	169
10. Failure to respond to requests for help, including call light	24	116	140
11. Personal hygiene: bathing, nail and oral care, dressing, grooming	31	81	112
12. Personal property: lost, stolen, used by others, destroyed	49	56	105
13. Involuntary discharge: planning, notification, procedure	39	55	94
14. Resident conflict, including roommate conflict	35	53	88
15. Resident unable to exercise choice, rights, preferences	24	62	86
Subtotal (of 15 most frequent complaints)	**1,138**	**2,098**	**3,236**
Total (of all complaints received)	**1,915**	**3,598**	**5,513**

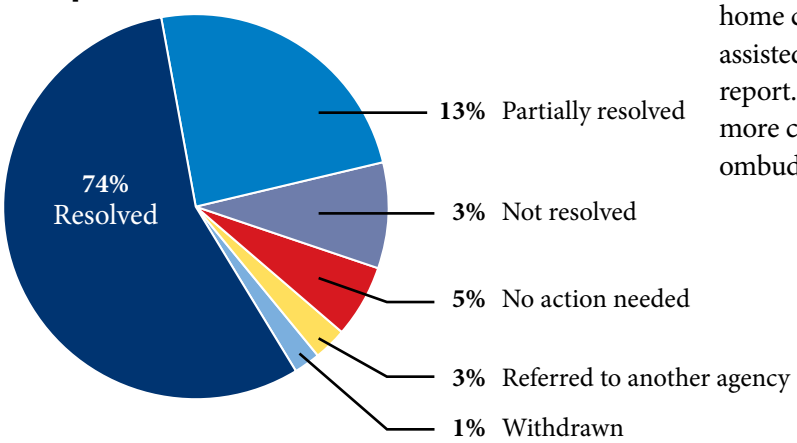
Ombudsmen closed 1,612 cases with 1,832 complaints in 2015 and closed 2,714 cases with 3,598 complaints in 2016. In order of frequency, the most common complaints involved environmental and safety concerns; resident care; dietary issues; autonomy and choice; and access to information.

The majority of the 15 most frequent complaints are consistent with complaints investigated in previous years.

Assisted living complainants

2015 and 2016	Percent	Complainant
2,008	47%	Resident
1,636	38%	Ombudsman
355	8%	Relative, friend
144	3%	Anonymous
140	3%	Facility staff
27	1%	Other

Complaint outcomes (2015 and 2016)



Compared to complaint outcomes reported in the 2013-14 long-term care ombudsman annual report, ombudsmen reported an increase in the number of resolved complaints, and a decrease in the number of partially resolved and not resolved complaints.

Verification of complaints

Ombudsmen verify complaints through observation, interviews and record review. Verification indicates that the circumstances described in the complaint existed or were generally accurate. In 2015 and 2016, 88 percent of ALF complaints were verified.

On average, ombudsmen closed ALF cases in 34 days, which is three days longer than an average nursing home case was closed, and nine days longer to resolve assisted living facility complaints than the previous report. This signals that ALF complaints are growing more complicated and require more time for an ombudsman to resolve.

Ombudsmen in Assisted Living Facilities

An assisted living resident's story

Since Mr. Aldridge* was diagnosed with Alzheimer's disease four years ago, his wife of 56 years had been his primary caregiver. When his condition worsened last year, she decided to move him into a large type B ALF near their home. Since the move, the ALF provided the safety and security he needed but his wife noticed gaps in his care.

Mrs. Aldridge called the ombudsman for help resolving her complaints. She explained that her husband had always been a night owl and disliked being idle. The door to his room locked when he left, which prevented him from coming and going as he pleased. He had become increasingly disoriented at night and had difficulty finding the bathroom. As a result, the carpet in his room was stained and had an odor.

The ombudsman set up a meeting with Mr. and Mrs. Aldridge at the facility. Before their meeting, the ombudsman observed the facility environment to witness interactions between staff and residents and to review the cleanliness of the facility. Mr. and Mrs. Aldridge and the ombudsman met privately in the resident's room to discuss the concerns. Mr. Aldridge was unable to answer questions directly.

The ombudsman offered ideas to accommodate Mr. Aldridge's needs and protect his rights as a resident while maintaining his safety. She suggested creating a schedule with facility staff to check on him at night. They discussed disabling the lock on his door to allow him to come and go at will. The ombudsman also suggested that his carpet be cleaned, and that the bathroom light be left on at night to make it easier for him to find his way in the dark.

Mrs. Aldridge was pleased with the ombudsman's ideas and wanted help implementing them. As her husband's legal representative, she gave the ombudsman permission to advocate on his behalf and organize a service plan meeting with the three of them and the director. In addition to keeping his bathroom light on, the director also agreed to have staff check on Mr. Aldridge regularly during sleeping hours and to offer to help him to the bathroom. The director also devised a check-off sheet to note each time staff checked on him. The sheet included a space for staff to make notes.

Mrs. Aldridge is very happy with the changes in her husband's care. When the ombudsman followed up with her, she reported that the facility is monitoring him at night. His room is much cleaner, his overall care has improved, and he is happier now that he can come and go as he pleases.

* Not his real name.

Consultation and Training

Resident and family councils

Ombudsmen attended 2,693 resident council and 315 family council meetings in nursing homes and assisted living facilities. Ombudsmen may attend meetings only at the invitation of the group and are often asked to provide information to councils about the role of an ombudsman, problem-solving techniques, facility rules and regulations, and residents' rights.

Consultation to residents and families

In addition to resolving complaints, ombudsmen work with residents, family members and friends to respond to questions. Resident requests are most frequently related to resident care, residents' rights, finding and interpreting regulations, and decision-making authority. Family members and friends often consult with ombudsmen about the role of the ombudsman, how to select a nursing home or assisted living facility, paying for care, relocation options and residents' rights. Ombudsmen provided a total of 34,210 consultations to residents and families.

One way ombudsmen provide support to a resident is by attending their care or service plan meeting. This meeting includes members of a resident's interdisciplinary care team and includes a review of the resident's total plan of care. Ombudsmen work to bring the resident's interests to the heart of the discussion and empower residents and families to participate in the process. Ombudsmen attended 974 care or service plan meetings at the request of a resident or legal representative and an additional 561 meetings with the purpose of resolving a complaint. Ombudsmen may also attend HHSC fair hearings to represent a resident in an appeal. Ombudsmen participated in 79 fair hearings to help residents facing discharge from a facility or denial of Medicaid benefits. Ombudsmen also attended five guardianship hearings to support residents retaining as many rights as possible and, in some cases, helping residents legally restore their capacity.

In-service training to facility staff

The majority of nursing home and assisted living facility staff receive in-service education where they work. Because at least 12 hours of continuing education is required for most nursing home staff and six hours is required for most assisted living staff, ombudsmen are often requested to provide onsite training. Frequent topics include relocation options using Money Follows the Person policy; residents' rights; person-centered dementia care; recognizing and preventing abuse, neglect and exploitation; and the role of the ombudsman. Ombudsmen provided 491 training sessions to facilities for a total of 782 hours. A total of 9,397 employees received training from an ombudsman.

Consultation to facility staff

Ombudsmen are a resource to staff — particularly management — who encounter complex problems as care and services are provided. Consultation is available on any subject that affects a resident's life in a facility. Common consultation subjects include residents' rights, Money Follows the Person policy, discharge procedures and planning, the ombudsman role, and interpretation of regulations. Ombudsmen provided a total of 9,618 consultations to facility staff.

Funding and Program Outcomes

Ombudsmen seek to resolve complaints to a resident's satisfaction. In 2015, ombudsmen resolved or partially resolved 88 percent of nursing home and assisted living facility complaints received, and in 2016, ombudsmen resolved or partially resolved 91 percent of complaints in both settings.

Six hundred and forty-eight volunteers served in the Long-term Care Ombudsman Program and contributed 61,195 hours in 2015-16. Local staff ombudsmen recruited, trained and supervised volunteers, while state office staff approved training and issued certification for each ombudsman. A total of 204 new volunteer ombudsmen completed a three-month internship and were certified between Sept. 1, 2014 – Aug. 31, 2016.

The state office trained 131 certified staff ombudsmen. The staff ombudsman position is a challenging one, and ongoing training is necessary to sharpen professional skills and maintain program integrity. Training included statewide in-person and webinar training and smaller intensive sessions provided by the state office for new staff. Twelve hours of annual continuing education is required for all staff and volunteers to maintain certification.

The initial certification training manual for staff and volunteer ombudsmen was updated to require six additional hours of training before certification is earned. New information includes requirements to consult with the state office on specific problems or situations an ombudsman encounters; recognizing and reporting on abuse, neglect and exploitation; additional exercises, role plays and case scenarios for practicing complaint resolution; the Centers for Medicare and Medicaid Services Hand in Hand dementia training series for nursing homes; and nursing home and assisted living facility licensing standards.

Sources of funding for the Texas Long-term Care Ombudsman Program

Source	2015	2016
Older Americans Act Title III	$2,608,661	$2,257,280
Older Americans Act Title VII	$1,254,969	$1,258,797
Other federal funds	$190,058	$187,693
State General Revenue	$1,239,378	$2,330,494
Local cash	$164,391	$177,765
Total	**$5,457,457**	**$6,212,029**

The increase in state dollars from 2015 to 2016 was due to the 84th Texas Legislature funding long-term care ombudsmen to regularly visit ALF residents.

Recommendations

As directed by the Older Americans Act, a long-term care ombudsman recommends improvements in the long-term care system to better the lives of nursing home and ALF residents. The following recommendations are based on the collective program experience of the state and local ombudsmen.

Develop ALF specialization standards.

ALFs serve residents with complex needs such as dementia, traumatic brain injuries (TBI), intellectual and developmental disabilities (IDD), and mental illness. Some ALFs specialize in providing care to residents with dementia and can obtain an Alzheimer's certification from the state to do so. However, some facilities are home to large concentrations of residents with other special needs, such as TBI, IDD or mental illness. There are no certifications specific to the needs of these residents. Licensing rules specific to these populations would better serve residents, inform the public on the services provided and help residents choose the appropriate level of care. Defining facilities with specializations would give DADS and other state agencies more information about the residents of and services provided by these facilities. Three ALF specializations should be created in Chapter 247 of the Health and Safety Code for facilities that serve primarily people with TBI, IDD and mental illness.

Study ALF employees who administer or supervise medications.

The medical needs of ALF residents are increasingly complex. However, state regulations allow unlicensed and uncertified employees, by delegation of a registered nurse (RN), to administer medications and supervise residents taking their medications. Ensuring

proper training for all employees who administer or supervise medications will help ensure the safety and well-being of residents. The ombudsman's office recommends a study of the scope of RN delegation in ALFs, a review of ALF violations involving medications, and an evaluation of the number of ALFs using licensed or certified professionals to administer or supervise medications.

Create a state fair hearing process for ALF residents facing discharge.

Unlike nursing home residents, ALF residents have no right to appeal their discharge to a state agency to ensure the reason is valid and to determine that the ALF is taking appropriate action. This leaves approximately 4,000 residents in the STAR+PLUS program without access to due process in situations in which they were retaliated or discriminated against. This issue would be addressed by adding language in Health and Safety Code §247.064(b) providing residents the right to a state fair hearing.

Recommendations

Prevent unnecessary discharge from an ALF.

While ALFs can be fined for discharging residents without proper reason or notice, the penalty for doing so is not a strong deterrent. It is a nominal fine and providers are often willing to pay the small penalty. Additionally, providers can appeal penalties and potentially avoid paying anything. To create a stronger deterrent, the administrative penalty for violations of discharge procedures should be increased to no less than $1,000, and the Right to Correct in Health and Safety Code §247.0452 should be removed.

Provide personalized food options to residents in ALFs.

For the past three years, food services in ALFs have been the primary complaint heard by ombudsmen. These include complaints about the quantity, quality, variation, choice and menu of the foods provided in ALFs. Residents have a right to be treated with respect, consideration and recognition of their dignity and individuality. Personalized food options that meet dietary needs and specific food preferences respect this right. Food is not only a basic necessity but also a vital part of a person's quality of life. The ombudsman's office recommends adding language to ALF rules that would require facilities to include food preferences in the resident assessment and provide person-centered meal options based on the those assessments.

Create more affordable ALF options.

ALFs offer a residential option that many prefer to nursing homes. Additionally, the state's Medicaid managed care program, STAR+PLUS, is a less expensive option and can save the state money. The ombudsman's office recommends a study to collect information about the cost of ALF services, analyze the location and availability of ALF STAR+PLUS beds, and make recommendations to increase ALF participation in the STAR+PLUS program.

Require ALF owners to report a facility closure to DADS Regulatory Services and the Office of the State Long-term Care Ombudsman 60 days prior to closing.

ALFs are required to notify residents 30 days before ceasing to operate. However, facilities are not required to notify DADS Regulatory Services or the Office of the State Long-term Care Ombudsman. Surveyors are often unaware of closures until they visit the facility, which may be months after the closure. Ombudsman and regulatory visits to closed facilities waste resources, and render DADS data used to inform residents and the public of ALF options inaccurate. Additionally, moving to a new facility can

be traumatic and challenging for residents. When the Office of Long-term Care Ombudsman is included in the process, residents are ensured an advocate to protect their rights and help them choose a new facility. The ombudsman office recommends adding language to ALF rules in Texas Administrative Code §92.125 requiring facility owners to report closures to DADS Regulatory Services and the Office of the State Long-term Care Ombudsman 60 days before ceasing to operate.

Expand the nursing facility direct care staff enhancement program.

Even the best caregivers cannot do their job without enough staff to care for residents. The Institute of Medicine, a national research organization that advises on health policy, recommends that nursing home residents receive 4.1 hours of direct care from a licensed nurse or certified nurse aide per day. Texas averages 12 minutes less than the national average of 4.1 hours per day. In 2000, Texas implemented the Nursing Facility Direct Care Staff Enhancement program to improve direct care staffing in nursing homes, but, due to limited funds, not all facilities can participate. Nursing home providers continue to say they cannot increase staffing at current Medicaid reimbursement rates. Fully funding the enhancement program is a practical way to raise quality of care to national standards.

Require nursing home staff training to reflect the needs of residents.

Staff education is an important strategy to protect residents' rights and prevent abuse and neglect. However, nursing homes get little guidance about the content of their staff training. Plans of care, dietary services and activity programs must reflect the needs of residents to be effective; accordingly, a staff training program should also reflect the individual needs of residents. For example, if one or more residents have behavioral health needs or are diagnosed with dementia, the nursing home training plan should reflect those needs and DADS surveyors should review training records to monitor compliance. This issue would be addressed by adding to Health and Safety Code §242.037(i) a requirement that initial and continuing education must address the needs of residents in the facility.

Increase enforcement penalties to deter nursing home discharge violations.

Involuntary discharge disrupts a resident's continuity of care and can distance the person from family and friends who could visit and advocate for them. Discharge rights are protected by federal law, but the penalty amount is set by the state. The current

amount is not a sufficient deterrent, and providers are often willing to pay the relatively small fine. Additionally, citations are subject to the right to correct, which results in no fine. The right to correct in a discharge case means that after improperly discharging a person, a facility could correct future facility practices but not allow the resident to return to the facility and still face no fine. If penalties for illegal discharge were increased and applied, and the citation were not subject to the right to correct, nursing home residents would be protected from unnecessary discharge. Penalties in Health and Safety Code §242.066 should be increased to $2,000 and violations related to transfer or discharge procedures should be ineligible to the right to correct in §242.0665(b).

Require nursing homes with locked units to be Alzheimer's certified.

In 2014, Ombudsmen identified more than 200 nursing homes in Texas with locked units that are not Alzheimer's certified, yet market themselves to care for residents with Alzheimer's disease and other forms of dementia. This results in many residents with dementia not getting appropriate care. The practice violates the spirit of existing law. Alzheimer's certification ensures adequate staffing, staff training and person-centered activities that are appropriate for people with Alzheimer's and related dementias. Changes to Health and Safety Code §242.040(b) would address the problem by requiring nursing facilities to be certified if they use a locked door to restrict residents' exit from a distinct part of or all of the building.

Allow consumer stakeholders the opportunity to review and provide feedback on amendments to the Uniform Managed Care Contract.

Nursing home residents on Medicaid are required to choose a managed care plan. Five managed care organizations (MCOs) contract with HHSC to serve nursing home residents in Texas. Many requirements for MCOs are listed in the contract, rather than in state rules. State rulemaking provides opportunities for both informal and formal stakeholder input; but the managed care contract is reviewed by representatives of MCOs, not resident and consumer advocates. Changes to contracts have a real effect on consumers, so there should be a process and opportunity for those consumers and advocates to review and provide feedback on contract changes in the same way an MCO can.

Office of the Texas Long-term Care Ombudsman

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