State Long-term Care Ombudsman Initial Certification Training

Texas Department of Aging and Disability Services
State Long-term Care Ombudsman Program
701 West 51st Street
Austin, Texas 78751
512-438-3111
www.dads.state.tx.us

September 2011

Long-term Care Ombudsman Program

Aging and Residents

Communications and Consent

Facilities

Resident Rights

Resident and Family Councils

Care Planning

Problem Solving
8a Program Communication
8b Resident Records

Regulators and Resources

Resident-directed Care

Systems Advocacy

Ombudsman Policies and Procedures

State Long-term Care Ombudsman Program

Initial Certification Training

Contents

Chapter 1 Long-term Care Ombudsman Program

How Long-term Care Ombudsman Programs Began
Long-term Care Ombudsman Role
Why Do Residents Need Advocacy?
Unique Aspects of Long-term Care Ombudsman Programs
Ombudsman Intern Activities

Supplement A-1: Ombudsman Program Milestones
Supplement B-1: Statutory and Rule References
Video: *Advocates for Residents Rights: The Older Americans Act Long-term Care Ombudsman Program and Discussion Questions*

Chapter 2 Aging and Residents

The Physical Aging Process
Attitudes about Aging
Demographic Information on Older Adults
Fourteen Myths and Stereotypes about Older Adults

Supplement A-2: Video: *And Thou Shalt Honor: Beloved Strangers*

Chapter 3 Communications and Consent

Communication
Listening
Communicating with Long-term Care Residents
Communicating with Adults Who Have Impairments
Consent

Video: *And Thou Shalt Honor: Voices from the Trenches*

Chapter 4 Facilities

Long-term Services and Supports
Ombudsman Role and Access
Assisted Living Facilities
Nursing Homes
Alternatives to Nursing Home Care
Advocacy Guide and Facility Contact Sheet

Activity: *The Elder Issues game*

Chapter 5 Resident Rights

Overview
Resident Rights Themes
Resident Rights under Law
Specific Rights

Supplement A-5: Nursing Home Resident Rights
Supplement B-5: Assisted Living Facility Bill of Rights
Video: *Residents Speak Out Against Retaliation*

Chapter 6 Resident and Family Councils

Resident and Family Councils
State and National Organizations
References in Texas Administrative Code for Resident Groups and Family Councils

Supplement A-6: Agenda Template for Resident Council Meetings
Supplement B-6: Sample Council Meeting Minutes
Supplement C-6: Sample Resident or Family Council Bylaws
Video: *Strength in Numbers*

Chapter 7 Care Planning

Individual Care Planning
Advance Care Planning
Long-term Care Ombudsman Role in Advance Care Planning

Supplement A-7: I Want to Tell You about My Mother
Supplement B-7: Agonizing Schiavo Case Shows Need to Put Medical Wishes in Writing

Chapter 8 Problem Solving

Overview
Problem Solving Process

Step

1. Identify the problem from the resident's perspective and research statutory support
2. Consider underlying causes and determine scope of the problem
3. Explore possible ways to resolve and take action
4. Check on progress and outcomes
5. Determine resident's or complainant's satisfaction with outcome

Barriers to Problem Solving
Negotiation Basics
Case Discussions
"Show Me the Money"
"Discharge – Unable to Meet Needs"
Video: *Basic Complaint Handling Skills*

Activity: *Walking the Fine Line* (PowerPoint) Ombudsman Role with Residents, Families, and Facility Staff

Subchapter 8a Program Communication

Communicating with the Ombudsman Program
Consulting with Ombudsman Program Staff
Reporting

Supplement A-8a: AoA Ombudsman Complaint Codes (1-132)
Supplement B-8a: LTC Ombudsman Activity Report, DADS Form 8620
Supplement C-8a: Instructions DADS Form 8620

Subchapter 8b Resident Records

Ombudsman Access
Medical Records

Supplement A-8b: Common Medical Chart Abbreviations
Supplement B-8b: Consent to Release Records to the Certified Ombudsman DADS Form 8624-O (oral)
Supplement C-8b: Consent to Release Records to the Certified Ombudsman DADS Form 8624-W (written)

Chapter 9 Regulators and Resources

Regulatory Agencies
Surveys and Licensures
Enforcement
Credentialing
Resources
- Department of Aging and Disability Services (DADS)
- Department of Family and Protective Services (DFPS)
- Health and Human Services Commission (HHSC)

Ombudsman Role

Supplement A-9: Program Agreement between DADS Long-term Care Ombudsman Program and Regulatory Services
Supplement B-9: Memorandum of Understanding between DFPS Adult Protective Services and DADS Long-term Care Ombudsman Program

Chapter 10 Resident-directed Care

Resident-directed Care and Culture Change
Reconciling Regulatory Requirements with Resident-directed Care

Supplement A-10: Language of Culture Change

Activity: *The Mystery Game*

Chapter 11 Systems Advocacy

What is Systems Advocacy?
The Older Americans Act and Systems Advocacy
Distinguishing Systems and Individual Change
Systems Advocacy Activities in Texas

12 Ombudsman Policies and Procedures

Ombudsman Policies and Procedures
Getting Acquainted with Ombudsman Policies and Procedures

Ombudsman Certification Training

CHAPTER 1

Long-term Care Ombudsman Programs

--This page intentionally left blank—

Long-term Care Ombudsman Programs

Chapter 1 provides an understanding of the Texas Long-term Care Ombudsman Program, its purpose, unique aspects, and history.

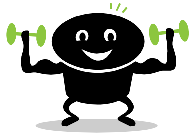
Learning Objectives

- Develop an understanding of the history and uniqueness of long-term care ombudsman programs
- Become familiar with a long-term care ombudsman's responsibilities
- Learn why residents need advocates and how ombudsmen can respond
- Review and follow the do's and don'ts for ombudsman interns

Contents

How Long-term Care Ombudsman Programs Began
Long-term Care Ombudsman Role
Why Do Residents Need Advocacy?
Unique Aspects of Long-term Care Ombudsman Programs
Ombudsman Intern Activities

Supplement A-1: Ombudsman Program Milestones
Supplement B-1: Statutory and Rule References

 Exercise: Get Acquainted

Use the following introductory questions to familiarize class members with one another. Depending on the number of participants, the class may break into groups to complete the exercise. Take turns asking each other these questions:

1. What is your name? ____
2. Why are you interested in being an ombudsman? _________________________

   ____
3. Have you visited a ____ nursing home or ____ assisted living facility?
4. What were your impressions of the last one visited? ______________________

   ____

How Long-term Care Ombudsman Programs Began

In 1965, Congress added Title XVIII - Medicare and Title XIX - Medicaid to the Social Security Act. These programs laid the groundwork to regulate and reimburse the nursing home industry, and the number of nursing homes grew tremendously. Before that, the government provided no public money as an incentive for private owners to build facilities. President Lyndon Johnson signed the Older Americans Act into law, which set objectives to maintain the dignity and welfare of older adults and to create the aging network for organizing, coordinating, and providing aging services and opportunities.

In the late 1960's and early 1970's, the government received reports of abuse, neglect, and substandard conditions in nursing homes at a growing rate. Congressional committees convened to hear testimonies, compile data, and propose reforms. Publicity attesting to poor care and personal profit for owners created a climate to enact specific federal regulations for standards of care.

In 1971, Dr. Arthur S. Flemming, U. S. Commissioner on Aging to President Nixon, developed the idea for the ombudsman program and envisioned it as an advocacy program for residents. In 1978, long-term care ombudsman programs were established in the Older Americans Act. Supplement A-1 provides a timeline of long-term care ombudsman programs.

The Older Americans Act requires all state units on aging to establish an ombudsman program to:

- investigate and resolve residents' complaints;
- promote the development of citizens' organizations and train volunteers;
- identify problems and work to resolve them;
- monitor development and implementation of federal, state, and local long-term care laws and policies;
- gain access to nursing homes and assisted living facilities and to residents' records; and
- protect confidentiality of residents' records, complainants' identities, and ombudsman files.

Each state has an office of the state long-term care ombudsman headed by a full-time state long-term care ombudsman. In Texas, the office is part of the Center for Consumer and External Affairs in the Department of Aging and Disability Services (DADS). Patty Ducayet is the Texas State Long-term Care Ombudsman.

My Managing Local Ombudsman is

____

My supervising staff ombudsman is

____

DADS contracts with regional government councils that house 28 area agencies on aging (AAAs). Twenty-five AAAs operate local ombudsman programs and 3 AAAs subcontract the ombudsman program: Dallas County through The Senior Source, Harris County through the University of Texas Health Sciences Center, and Tarrant County through the Mental Health Association.

The Older Americans Act connects individual advocacy services with the responsibility to publicly represent the needs of residents and work to effect change in laws, regulations, and policies. Individual complaints are the basis for changing systems.

Long-term Care Ombudsman Role

Understanding the history, development, and unique aspects of long-term care ombudsman programs provides a foundation to understand the role of ombudsmen.

Long-term care ombudsmen:

- Advocate for residents of nursing homes and assisted living facilities
  Although "resident" is used throughout this manual, long-term care ombudsmen also work with the families and friends of residents as well as facility staff with a complaint on behalf of a resident
- Provide information about how to select a facility and how to get quality care
- Investigate and resolve problems
- Represent the resident perspective in monitoring laws, regulations, and policies, and in making recommendations about needed changes

As required by the federal Older Americans Act, long-term care ombudsman programs operate in 50 states, the District of Columbia, Puerto Rico, and Guam. Many states, including Texas, utilize staff and volunteer ombudsmen to advocate for residents.

List some activities an ombudsman engages in

- ______________________________
- ______________________________
- ______________________________
- ______________________________

Ombudsman Mission Statement

The Texas Long-term Care Ombudsman Program within DADS advocates for optimal quality of life and quality of care for residents in nursing homes and assisted living facilities. Residents and their families are served by developing and using the talents and efforts of specially trained volunteers and paid staff to represent the interests of residents who live in nursing homes and assisted living facilities.

Ombudsman Philosophy

People who are unable to care for themselves are entitled to dependable and consistent care. Ombudsmen advocate for residents to enjoy quality of life and receive quality care. Regulations pertaining to assisted living facilities do not directly address quality of life or care. However, DADS Nursing Facility Requirements (NFR) provide a definition of quality of life and care, based on federal law, as summarized below.

Quality of Life - NFR §19.701

The nursing home must care in a manner and environment to maintain or enhance each resident's quality of life. If children are residents, care must be provided to meet their unique medical and developmental needs. Four quality of life aspects addressed are:

- Dignity and respect that fully recognize each resident's individuality.
- Self-determination and participation to:
    - choose activities, schedules, and health care consistent with the resident's interests, assessments, and plans of care;
    - interact with members of the community both inside and outside; and
    - make choices that are significant to him or her.
- Participation in social, religious, and community activities that do not interfere with the rights of other residents.
- Residence and services that reasonably accommodate individual needs and preferences, except when health or safety of the individual or other residents would be endangered.

Quality of Care - NFR §19.901

Each resident receives and the nursing home provides care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive assessment and plan of care. Unique medical and developmental needs of children should be met. Care and services to be addressed include aspects such as activities of daily living, pressure sores, urinary incontinence, mental and psychosocial functioning, accidents, nutrition, and medications.

The Texas Long-term Care Ombudsman Program advocates for quality of _______________ and quality of _______________ for people who live in nursing homes and __________________ _________________ facilities.

As advocates, ombudsmen educate, support, and encourage residents to engage in self-advocacy and to represent themselves. A resident's direction is the basis for every action taken by an ombudsman. This applies to volunteer ombudsmen, staff ombudsmen, and the state ombudsman.

Ombudsmen also respond to and work to resolve complaints from family, friends, and facility staff as long as the complaint pertains to residents. However, we always seek the resident's consent and take action based on resident direction, so resident wishes supersede another complainant's. Ombudsmen use a problem-solving process to analyze and resolve complaints. Chapter 8 describes the problem-solving process in detail.

The next page provides a table with long-term care ombudsman responsibilities. Using the table, determine whether each statement is True or False.

_____ Certified volunteer and staff ombudsmen, and the state office, have a role in ensuring residents have regular and timely access to an ombudsman.

_____ When acting as an ombudsman, volunteers and staff may comment on proposed laws in coordination with the Texas State Long-term Care Ombudsman.

_____ All staff and volunteers in the ombudsman program help to protect resident rights.

_____ Confidentiality applies to all residents and anyone who makes a complaint to the program.

Long-term Care Ombudsman Responsibilities

Review the chart to see distinctions among the state long-term care ombudsman (SLTCO), certified staff, certified volunteer, and ombudsman interns.

	SLTCO	Certified Staff	Certified Volunteer	Intern
Provide information to and visit residents; protect the confidentiality of all residents	✓	✓	✓	✓
Promote the Ombudsman Program	✓	✓	✓	
Provide technical support to develop resident and family councils	✓	✓ *	✓ *	
Provide residents with regular and timely access to ombudsman services	✓	✓	✓	
Assist residents to protect their rights and express a complaint pertaining to their health, safety, welfare, and rights within a facility	✓	✓	✓	
Identify, investigate, and resolve complaints made by, or on behalf of, residents	✓	✓	✓	
Seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of residents	✓	✓	✓	
Analyze, comment on, and monitor development and implementation of federal, state, and local laws, regulations, and other government policies and actions on behalf of residents; make recommendations about policies and laws to improve the system	✓	✓ *	✓ *	
The State Ombudsman prepares and submits an annual report describing program activities, noting problems residents experience, and making recommendations to improve quality of care and life. She makes recommendations in laws, regulations, and policies to solve identified problems and protect resident welfare.	✓	**	**	

* In accordance with the Older Americans Act and under direction of the SLTCO. Technical assistance to councils and commenting on laws, regulations, and policies requires coordination with the SLTCO to ensure the person's activities are consistent with statewide policies.

** The SLTCO report is comprised of reports made by volunteers, staff, and state office staff.

Why Do Residents Need Advocacy?

Advocacy is action by, or on the behalf of, individuals and groups. This action ensures benefits and services are received, rights are protected, and laws are enforced.

The Texas Long-term Care Ombudsman Program serves advocates for all individuals who live in the 1,182 nursing homes and 1,649 assisted living facilities in Texas. These licensed facilities have an average occupancy rate of 68 percent and 65 percent respectively; therefore, approximately 125,000 individuals are our clients.

Because people are living longer and many families live far away, residents often have few visitors other than long-term care ombudsmen.

__________ people live in a nursing home or assisted living
(number)
facility in Texas. There are ___________ nursing homes and
(number)
__________ assisted living facilities in Texas.
(number)

With 800 certified volunteer ombudsmen and the full-time equivalent of 56 certified staff ombudsmen, the Texas Long-term Care Ombudsman Program has an integral role in the long-term care system. Certified ombudsmen, as advocates for residents, protect resident rights.

When people live and work together, differences of opinion and preferences are normal parts of life. Routines and rules develop for facility convenience and efficiency. Facility operations can conflict with the needs of individual residents. Moreover, many residents are unable to express their needs without help from others.

What is advocacy?

____

____

____

Why do you think people who live in nursing homes and assisted living facilities need advocates?

____

____

____

Physical and cognitive barriers

- Cognitive impairment
- Effects of medications
- Loss of hearing, speech, sight
- Loss of physical strength

Lack of information about

- Alternative living options
- Authority within the facility
- How to improve their situation
- Legal and administrative remedies
- Rights, entitlements, benefits, including the right to complain

Psychological barriers

- Belief that this is the best it can be
- Fear of being labeled a "complainer"
- Fear of retaliation
- Lack of empowerment
- Lack of experience being assertive
- Loss of confidence
- Reluctance to question authority
- Sense of hopelessness or despair
- Sense of isolation

Individual problems that may surface in a facility

- Additional or high charges for “extra” services
- Barriers to attend community activities
- Barriers to leave the facility
- Boredom or few social activities
- Financial exploitation
- Insufficient medical or nursing care
- Involuntary discharge or room change
- Lack of privacy
- Loneliness
- Loss of dignity and feeling respected
- Neglect
- No rehabilitative care
- Physical or chemical restraints
- Physical or verbal abuse
- Poor food service or quality
- Problem with a roommate
- Use, accounting, and safe keeping of personal funds and possessions
- Inability to get services, care, or attention because of physical or communication problems

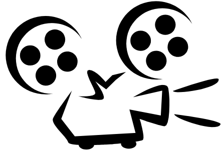
---

List two physical and cognitive barriers to self-advocacy

1. ____
2. ____

List two psychological barriers to self-advocacy

1. ____
2. ____



Video: Advocates for Resident Rights

Older Americans Act Long-term Care Ombudsman Program

Watch the video, Advocates for Residents Rights: The Older Americans Act Long-term Care Ombudsman Program. Describe what you learn below.

1. How does Older Americans Act describe the long-term care ombudsman role?

   ____

   ____

2. What is the purpose of long-term care ombudsman program?

   ____

   ____

3. What are some functions of a long-term care ombudsman?

   - ____
   - ____
   - ____
   - ____
   - ____

4. What are some complaints ombudsmen work to resolve?

   ____

   ____

5. What questions do you have about being an ombudsman?

   ____

   ____

Unique Aspects of the Long-term Care Ombudsman Program

Many organizations, companies, and agencies have ombudsmen. They act in the classical sense of being neutral and impartial. Long-term care ombudsmen are impartial and objective while investigating a complaint, but become an advocate and represent the interests of the resident when working to resolve a problem.

This is an important distinction. A long-term care ombudsman makes this distinction clear to families and facility staff. While we seek to find resolution that is satisfactory to all parties, resident wishes guide the actions of an ombudsman. As a resident advocate, our presence and role helps balance the difference of power in a nursing home or assisted living facility.

The long-term care ombudsman program's history and development set it apart from other programs and roles in the long-term care system. Because these are frequent sources of misunderstanding and tension when ombudsmen interact with others, it is very important to have a clear understanding of the ombudsman role based on the Older Americans Act. Explaining and clarifying ombudsman responsibilities to others is a routine part of an ombudsman's work.

The long-term care ombudsman is a resident advocate.

Classical Ombudsman vs. Long-term Care (Advocate) Ombudsman

Classical Ombudsman

Purpose: Impartial mediator, who receives complaints, determines pertinent facts, and seeks resolution
Setting: Many settings, both public and private
Focus: Neutral; makes sure the system works as it was designed to work
Scope: Varies, but usually within one organization

Long-term Care Ombudsman

Purpose: Impartial in investigation to:

- determine pertinent facts
- gather sufficient information to understand the problem in order to represent a resident's interests

Once facts are gathered, advocates for a resident-focused solution
Setting: Nursing homes and assisted living facilities
Focus: Seeks a resident-directed resolution and works to overcome bureaucratic barriers
Scope: Seeks resolution for individual and systemic issues

Ombudsmen help residents with resolution strategies that may include:

- persuading or negotiating with facility staff;
- filing a complaint on behalf of the resident;
- working with a resident council;
- getting a group of residents with similar concerns together to solve a problem; and
- bringing problems to the attention of outside systems, such as the Medicaid agency or DADS Regulatory Services.

Sometimes residents want an ombudsman to speak on their behalf. This may occur when:

- a resident is unable to communicate wishes and has no one else to call upon for help;
- family conflicts complicate the issue;
- legal services are needed;
- resources within a facility or community are unknown; and
- a resident fears causing tension between resident and staff relationships.

Ethical Issues

Ombudsmen must act ethically in behavior and decision-making because:

- Ombudsman work is filled with ambiguity regarding how to proceed.
- Ombudsmen typically encounter issues that are not clearly right or wrong.
- One ombudsman's actions can impact the credibility of the statewide program.

While many programs wrestle with ethical and confidentiality issues, long-term care ombudsman programs have a few unique elements.

- Jurisdiction is the *interest* of the resident.

- Resolution standard is to *resolve to the resident's satisfaction* — or in absence of an identified resident, the complainant's.

- Ombudsmen are mandated to *advocate on behalf of the broad interests of residents*, including public policy. This is often referred to as systems advocacy.

- Ombudsmen *promote the development of groups* such as citizen organizations to participate in the ombudsman program and support for resident and family councils.

Atypical Mandates

The ombudsman program has some atypical mandates. Much of the ombudsman program structure and operation is specified in the Older Americans Act.

Key Distinctions:

- A separate office of the state long-term care ombudsman is headed by a state long-term care ombudsman who is responsible for the statewide program.

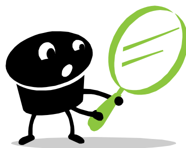
- The program can pursue administrative, legal, and other appropriate remedies on behalf of residents through in-house legal counsel or through coordination with other legal advocacy services such as Texas Legal Services Center.

- The program is clearly directed to represent residents and act as a surrogate voice for residents.

- To maintain confidentiality, ombudsmen must:
  - not identify residents or complainants without their consent;
  - not take action on behalf of a resident without the resident's consent;
  - not disclose confidential information about a resident or complainant; and
  - explain our confidentiality requirements to facility staff and other agencies who may expect that case information can be shared.

  The Older Americans Act requires strict protection of the identity of residents and complainants, and information obtained about residents and complainants, during the course of ombudsman duties. Several states, including Texas, require citizens to report suspected abuse, neglect, and exploitation. The Older Americans Act law supersedes state law.

  Ombudsmen may try to persuade residents to report or allow ombudsmen to report, but when the residents or complainants do not consent for ombudsmen to take action, ombudsmen must consult with the supervising staff ombudsman. Staff consults with the Texas State Long-term Care Ombudsman before taking action.



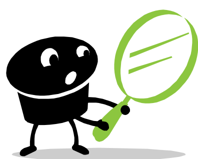
Reporting suspected abuse while abiding by the Older Americans Act requires ombudsmen to carefully analyze the situation and listen to the wishes of the resident.

- Program representatives are protected from willful interference. Interference with ombudsmen performing their duties is a class B misdemeanor, according to the Texas Human Resources Code. §101.064:
  (a) A person commits an offense if the person:
    (1) intentionally interferes with an ombudsman attempting to perform official duties; or
    (2) commits or attempts to commit an act of retaliation or reprisal against any resident or employee of a long-term care facility for filing a complaint or providing information to an ombudsman.

- Legal counsel must be provided to representatives of the program.

  If acting in good faith in performing ombudsman duties, representatives of the program, including interns and volunteers, are not liable for civil damages or subject to criminal prosecution.

  Texas Human Resources Code Chapter §101.055 says, "The department shall ensure the Office receives adequate legal advice and representation. The attorney general shall represent the ombudsman or a representative if a suit or other legal action is brought or threatened to be brought against that person in connection with the person's performance of the official duties of the Office."



If you need legal counsel to perform official ombudsman duties, contact your supervising staff ombudsman. DADS State Long-term Care Ombudsman will be consulted and an attorney arranged.

- The program has specific conflict of interest provisions for organizational placement of the state and local programs and for individuals representing the program.
  - Requirements underscore the importance of maximizing the long-term care ombudsman's ability to adequately and independently represent residents on all levels.
  - Ombudsmen need to speak honestly and publicly about conditions experienced by residents and the impact of actions, policies, and laws on residents.

In addition to prohibiting any direct or indirect financial gain in the course of ombudsman duties, state conflict of interest policies include three unique dimensions:

1. Loyalty - judgment and objectivity is eroded if ombudsmen act as facility consultants, serve as board members of a facility or management company, work as case managers to help individuals move into facilities, or serve in a facility where they previously worked.

2. Commitment - issues of time and attention can interfere with an ombudsman's ability to respond to the needs of residents; therefore, being a voice for residents takes precedence over being a voice for a sponsoring agency.

3. Control – program independence creates a shield from administrative or political forces interfering with an ombudsman's ability to act without fear of retaliation.

Accountability

Ombudsmen hold themselves accountable and continually seek input to determine if their advocacy makes a difference for residents. The program maintains accountability through documentation and reporting of ombudsman work. DADS requires ombudsmen to submit monthly reports to their local program office. These reports document ombudsman activities and casework on behalf of residents and serve as the basis for a statewide annual report. See Chapter 8A for detailed instruction on reporting.

Summary

By law, long-term care ombudsman programs provide an independent program of advocacy services for residents and their representatives. They support volunteer services and citizen action.

Supervising staff ombudsmen and state ombudsmen are to be good managers, communicators, and negotiators. All ombudsmen strive for these characteristics:

- Accessibility
- Adaptability
- Civility
- Courage
- Humility
- Tolerance
- Patience
- Professionalism

Citizens have high expectations for long-term care ombudsman programs to fulfill their mandated responsibilities. Ombudsmen serve a unique and necessary role as resident advocates.

Ombudsman Intern Activities

To become a certified ombudsman, a person must complete a training program that includes classroom training, one-on-one training in a facility, independent assignments, and practice exercises. The training phase is called an ombudsman internship. Ombudsman interns are restricted from certain activities while they practice the most fundamental skills of a resident advocate.

DOs

- Attend ombudsman training
- Be dependable by visiting on a regular basis; wear your badge
- Be a good listener and communicator
- Focus your time and attention on residents
- Respect resident dignity, choice, and self-determination
- Respect the confidentiality of all residents
- Knock before entering each resident room and introduce yourself
- Visit all residents, including residents who cannot speak with you
- Learn about resident and family council activities
- Be friendly and professional
- Immediately report safety concerns to the facility administrator and your supervising staff ombudsman
- Report visits each month to the local office and consult staff when needed
- Follow guidelines established by the Texas Long-term Care Ombudsman Program

DON'Ts

- Do not investigate complaints; immediately refer complaints to your supervising staff ombudsman
- Do not provide physical assistance or nursing care to residents
- Do not treat residents as children or talk down to them
- Do not advise residents on business or legal matters
- Do not make promises you are unable to keep
- Do not act as an inspector in the facility
- Do not visit or enter kitchen or medication rooms
- Do not enter rooms where active treatment is being provided, such as rooms with the door closed
- Do not solicit or accept any form of gift, loan, or gratuity from anyone in any capacity while associated with the Texas Long-term Care Ombudsman Program

If an ombudsman intern becomes a certified ombudsman, one “don’t” becomes a “do” - certified ombudsmen identify, receive, investigate, and work to resolve complaints on behalf of residents. Continue to follow all “dos” and all other “don’ts.”

Supplement A-1: Ombudsman Program Milestones

1972 To implement President Nixon's 1971 eight-point initiative to improve nursing home care, the Health Services and Mental Health Administration funded nursing home ombudsman demonstration projects in Idaho, Pennsylvania, South Carolina, Wisconsin and Michigan to "respond in a responsible and constructive way to complaints made by or on behalf of individual nursing home patients."

1973 Additional demonstration projects started in Massachusetts and Oregon. The Ombudsman Program transferred to the U.S. Administration on Aging (AoA).

1975 Amendments to the Older Americans Act authorized funding for state ombudsman programs.

Following an assessment of the findings and accomplishments of the seven demonstration projects, former Commissioner on Aging Arthur S. Flemming invited all State Units on Aging to submit proposals "to enable the State Agencies to develop the capabilities of the Area Agencies on Aging to promote, coordinate, monitor, and assess nursing home ombudsman activities within their services areas." All states except Nebraska and Oklahoma applied for and received one-year grants ranging from $18,000 for most states to $57,900 for New York, which was then the state with the largest elderly population. Total funding was about one million dollars.

The Texas Governor's Committee on Aging received its first grant for an ombudsman program.

1976 Dr. Flemming issued the first ombudsman program guidance, which said the program would be judged in the first year solely based on the number of community-based ombudsman programs launched and their effectiveness in receiving and resolving complaints.

In explaining this goal, he stated, "Our nation has been conducting investigations, passing new laws and issuing new regulations relative to nursing homes at a rapid rate during the past few years. All of this activity will be of little avail unless our communities organize in such a manner that new laws and new regulations deal with the individual complaints of older persons who are living in nursing homes. The individual in the nursing home is powerless. If the laws and regulations are not being applied to her or to him, they might just as well not have been passed or issued." (AoA Technical Assistance Memo 76-24)

The nationwide program relied on volunteer, rather than paid, ombudsmen.

1977 The AoA funded the National Paralegal Institute to provide the first training program for state ombudsmen, who were called "ombudsman developmental specialists."

1978 In June, the AoA Advocacy Assistance grant program provided additional help for state ombudsman and legal services programs to focus on both individual and systems advocacy. Grants ranged from $50,000 for most states to $135,390 for California, which by then had the largest elderly population. To support the state and area agencies, AoA

awarded contracts in 1979 and 1980 for 5 Bi-Regional Advocacy Assistance Resource Centers.

Older Americans Act amendments required every state to have an Ombudsman Program and specifically defined ombudsman functions and responsibilities.

1979 AoA awarded a grant to the newly formed National Citizens Coalition for Nursing Home Reform (now Consumer Voice) to promote citizen involvement to improve the quality of life for nursing home residents and strengthen linkages with the ombudsman network, including providing training and technical assistance.

1980 The Texas Nursing Home Program became operational in October.

1981 Older Americans Act amendments expanded ombudsman program coverage to include board and care homes, known as assisted living facilities in Texas. To reflect this expansion, the name Nursing Home Ombudsman changed to Long-term Care Ombudsman. Other duties remained substantially the same.

AoA issued a program instruction (AoA-PI-81-8) which provided substantial guidance and direction to the states in the implementation of the ombudsman provisions in the Older Americans Act.

1983-84 AoA issued a series of twenty-two papers, which constituted chapters of an Ombudsman Technical Assistance Manual.

The number of local programs and complaints and the amount of program funding increased substantially; and the number of state and local paid staff and volunteers increased 50% from 1982 levels.

1987 Older Americans Act amendments made substantive changes. They required states to provide:

a. ombudsman access to residents and resident records;
b. immunity for the good faith performance of ombudsman duties; and
c. prohibitions against willful interference with official ombudsman duties and/or retaliation against an ombudsman, resident, or other individual for helping ombudsman representatives perform their duties.

1988 AoA funded the National Association of State Units on Aging (now National Association of States United for Aging and Disabilities) to operate the National Center for State Long-term Care Ombudsman Resources, in conjunction with the Consumer Voice.

1989 The 71st Texas Legislature passed state enabling legislation for the Texas Department on Aging Ombudsman Program, effective September 1, 1989.

1992 Older Americans Act amendments strengthened the ombudsman program and transferred it to a new Title VII Vulnerable Elder Rights Protection Activities, which also included:

a. programs for the prevention of elder abuse, neglect and exploitation;
b. state elder rights and legal assistance development programs; and
c. outreach, counseling and assistance programs.

1993 The Consumer Voice received an AoA grant to operate the National Long-term Care Ombudsman Resource Center (NORC), in conjunction with the National Association of State United for Aging and Disabilities. NORC continues to operate under the same structure and provides support to all 53 long-term care ombudsman programs.

1994 AoA regional offices conducted on-site assessments of the state ombudsman programs, issuing their reports in January 1995.

AoA held four training conferences, issued program instructions, and proposed regulations on the new Title VII. AoA also held a major symposium on coordination between Long-term Care Ombudsmen and Adult Protective Services programs and related issues.

1995 AoA implemented the National Ombudsman Reporting System (NORS) that provided substantial state and national data on ombudsman cases, complaints, and program activities.

AoA convened a task force to discuss and develop ways to document the impact of the ombudsman program. The group issued a meeting report "An Approach to Measuring the Outcomes of the Long-term Care Ombudsman Program."

California, Florida, Illinois, New York, and Texas ombudsman programs participated in Operation Restore Trust, a federal pilot Medicare and Medicaid anti-fraud and abuse effort. For every $1 spent, $23 returned to the Medicare Trust Fund. In 1997, it expanded to all states as the Senior Medicare Patrol, which now operates separately from the Texas Long-term Care Ombudsman Program.

2000 The Older Americans Act was reauthorized. Amendments retained and updated ombudsman provisions in Titles II, III, and VII.

2003 Over 1,000 paid ombudsmen and 8,400 volunteers provide services to the 2.8 million residents in over 63,000 facilities. For complaints handled, 32% involve resident rights, 30% resident care, and 21% quality of life.

2009 Following 2008 work groups focused on systems advocacy and "charting the ombudsman role in a modernized long-term care system," AoA built substantive Title VII and ombudsman content into state plan guidance. They trained staff on Title VII programs, including the Long-term Care Ombudsman Program. In July, the National Association of State Ombudsman Programs (NASOP) released a white paper describing systems advocacy limits and restrictions placed on state ombudsmen.

2010 Assistant Secretary on Aging Kathy Greenlee created a new position, National Director of Long-term Care Ombudsman Programs. Assistant Secretary Greenlee hired Becky Kurtz, former Georgia State Long-term Care Ombudsman and former president of NASOP.

NASOP developed and approved aspirational standards to address all areas of program implementation. Standards align with ombudsman authority granted by the Older Americans Act.

2011 National Director of LTC Ombudsman Programs Becky Kurtz hired Louise Ryan, former Washington State LTC Ombudsman, as Aging Specialist for the LTC Ombudsman Program at the AOA.

Supplement B-1: Statutory and Rule References

Texas Long-term Care Ombudsman Program

Older Americans Act

As Amended In 2006 (Public Law 109-365)

(*FEDERAL LEGISLATION*)

TITLE VII, Chapter 2

http://www.aoa.gov/AoARoot/AoA_Programs/OAA/oaa_full.asp

Human Resources Code

(*STATE LEGISLATION*)

TITLE 6. Services for the Elderly
CHAPTER 101. Texas Department on Aging
SUBCHAPTER D. Office of Long–term Care Ombudsman (§101.056 – §101.064
http://www.statutes.legis.state.tx.us/Docs/HR/htm/HR.101.htm#101.051

Texas Administrative Code

(*STATE RULES*)

Implementation of Older Americans Act – Long-term Care Ombudsman Program

TITLE 40. Social Services and Assistance
PART 1. Department of Aging and Disability Services
Chapter 85. Implementation of the Older Americans Act
Subchapter A. Definitions
RULE §85.2 Definitions
Subchapter E. Long-term Care Ombudsman Program
§85.401 Long-term Care Ombudsman Program
http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=4&ti=40&pt=1&ch=85

Nursing Facility Requirements

TITLE 40. Social Services and Assistance
PART 1. Texas Department of Human Services
CHAPTER 19. Nursing Facility Requirements for Licensure and Medicaid Certification
Handbook: http://www.dads.state.tx.us/handbooks/nfr-lmc

Licensing Standards for Assisted Living Facilities 21

TITLE 40. Social Services and Assistance
PART 1. Texas Department of Human Services
CHAPTER 92. Licensing Standards for Assisted Living Facilities (92.801)
Handbook: http://www.dads.state.tx.us/handbooks/ls-alf

Patty Ducayet, LMSW
State Long-term Care Ombudsman MC - W 250
Department of Aging and Disability Services
P. O. Box 149030, Austin, TX 78714
512-438-4356 Fax: 512-438- 3233
http://www.dads.state.tx.us

OLDER AMERICANS ACT of 1965 as Amended in 2006 (Public Law 109-365)

TITLE 42 – The Public Health and Welfare
CHAPTER 35 – Programs for Older Americans
SUBCHAPTER XI – Allotments for Vulnerable Elder Rights Protection Activities
CHAPTER 2 – Ombudsman Programs

Section 711. DEFINITIONS.
As used in this chapter:

(1) OFFICE. — The term ''Office'' means the office established in section 712(a)(1)(A).
(2) OMBUDSMAN. — The term ''Ombudsman'' means the individual described in section 712(a)(2).
(3) LOCAL OMBUDSMAN ENTITY.— The term ''local Ombudsman entity'' means an entity designated under section 712(a)(5)(A) to carry out the duties described in section 712(a)(5)(B) with respect to a planning and service area or other substate area.
(4) PROGRAM. — The term ''program'' means the State Long-Term Care Ombudsman Program established in section 712(a)(1)(B).
(5) REPRESENTATIVE. — The term ''representative'' includes an employee or volunteer who represents an entity designated under section 712(a)(5)(A) and who is individually designated by the Ombudsman.
(6) RESIDENT. — The term ''resident'' means an older individual who resides in a long-term care facility.

(42 U.S.C. 3058f)

Section 712. STATE LONG-TERM CARE OMBUDSMAN PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL. —In order to be eligible to receive an allotment under section 703 from funds appropriated under section 702 and made available to carry out this chapter, a State agency shall, in accordance with this section—
    (A) establish and operate an Office of the State Long-Term Care Ombudsman; and
    (B) carry out through the Office a State Long-Term Care Ombudsman Program.
(2) OMBUDSMAN.— The Office shall be headed by an individual, to be known as the State Long-Term Care Ombudsman, who shall be selected from among individuals with expertise and experience in the fields of long-term care and advocacy.
(3) FUNCTIONS. — The Ombudsman shall serve on a fulltime basis, and shall, personally or through representatives of the Office—
    (A) identify, investigate, and resolve complaints that—
        (i) are made by, or on behalf of, residents; and
        (ii) relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the residents (including the welfare and rights of the residents with respect to the appointment and activities of guardians and representative payees), of—
            (I) providers, or representatives of providers, of long-term care services;
            (II) public agencies; or
            (III) health and social service agencies;
    (B) provide services to assist the residents in protecting the health, safety, welfare, and rights of the residents;

(C) inform the residents about means of obtaining services provided by providers or agencies described in subparagraph (A)(ii) or services described in subparagraph (B);
(D) ensure that the residents have regular and timely access to the services provided through the Office and that the residents and complainants receive timely responses from representatives of the Office to complaints;
(E) represent the interests of the residents before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;
(F) provide administrative and technical assistance to entities designated under paragraph (5) to assist the entities in participating in the program;
(G)
(i) analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other governmental policies and actions, that pertain to the health, safety, welfare, and rights of the residents, with respect to the adequacy of long-term care facilities and services in the State;
(ii) recommend any changes in such laws, regulations, policies, and actions as the Office determines to be appropriate; and
(iii) facilitate public comment on the laws, regulations, policies, and actions;
(H)
(i) provide for training representatives of the Office;
(ii) promote the development of citizen organizations, to participate in the program; and
(iii) provide technical support for the development of resident and family councils to protect the well-being and rights of residents; and
(iv) carry out such other activities as the Assistant Secretary determines to be appropriate.
(4) CONTRACTS AND ARRANGEMENTS.—
(A) IN GENERAL.— Except as provided in subparagraph (B) the State agency may establish and operate the Office, and carry out the program, directly, or by contract or other arrangement with any public agency or nonprofit private organization.
(B) LICENSING AND CERTIFICATION ORGANIZATIONS; ASSOCIATIONS.— The State agency may not enter into the contract or other arrangement described in subparagraph (A) with—
(i) an agency or organization that is responsible for licensing or certifying long-term care services in the State; or
(ii) an association (or an affiliate of such an association) of long-term care facilities, or of any other residential facilities for older individuals.
(5) DESIGNATION OF LOCAL OMBUDSMAN ENTITIES AND REPRESENTATIVES. —
(A) DESIGNATION.— In carrying out the duties of the Office, the Ombudsman may designate an entity as a local Ombudsman entity, and may designate an employee or volunteer to represent the entity.
(B) DUTIES.— An individual so designated shall, in accordance with the policies and procedures established by the Office and the State agency —
(i) provide services to protect the health, safety, welfare and rights of residents;
(ii) ensure that residents in the service area of the entity have regular, timely access to representatives of the program and timely responses to complaints and requests for assistance;
(iii) identify, investigate, and resolve complaints made by or on behalf of residents that relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the residents;

(iv) represent the interests of residents before government agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;

(v) (I) review, and if necessary, comment on any existing and proposed laws, regulations, and other government policies and actions, that pertain to the rights and well-being of residents; and

(II) facilitate the ability of the public to comment on the laws, regulations, policies, and actions;

(vi) support the development of resident and family councils; and

(vii) carry out other activities that the Ombudsman determines to be appropriate.

(C) ELIGIBILITY FOR DESIGNATION.— Entities eligible to be designated as local Ombudsman entities, and individuals eligible to be designated as representatives of such entities, shall—

(i) have demonstrated capability to carry out the responsibilities of the Office;

(ii) be free of conflicts of interest and not stand to gain financially through an action or potential action brought on behalf of individuals the Ombudsman serves;

(iii) in the case of the entities, be public or nonprofit private entities; and

(iv) meet such additional requirements as the Ombudsman may specify.

(D) POLICIES AND PROCEDURES.—

(i) IN GENERAL.— The State agency shall establish, in accordance with the Office, policies and procedures for monitoring local Ombudsman entities designated to carry out the duties of the Office.

(ii) POLICIES.— In a case in which the entities are grantees, or the representatives are employees, of area agencies on aging, the State agency shall develop the policies in consultation with the area agencies on aging. The policies shall provide for participation and comment by the agencies and for resolution of concerns with respect to case activity.

(iii) CONFIDENTIALITY AND DISCLOSURE.— The State agency shall develop the policies and procedures in accordance with all provisions of this subtitle regarding confidentiality and conflict of interest.

(b) PROCEDURES FOR ACCESS.—

(1) IN GENERAL. — The State shall ensure that representatives of the Office shall have—

(A) access to long-term care facilities and residents;

(B)(i) appropriate access to review the medical and social records of a resident, if—

(I) the representative has the permission of the resident, or the legal representative of the resident; or

(II) the resident is unable to consent to the review and has no legal representative; or

(ii) access to the records as is necessary to investigate a complaint if—

(I) a legal guardian of the resident refuses to give the permission;

(II) a representative of the Office has reasonable cause to believe that the guardian is not acting in the best interests of the resident; and

(III) the representative obtains the approval of the Ombudsman;

(C) access to the administrative records, policies, and documents, to which the residents have, or the general public has access, of long-term care facilities; and

(D) access to and, on request, copies of all licensing and certification records maintained by the State with respect to long-term care facilities.

(2) PROCEDURES.— The State agency shall establish procedures to ensure the access described in paragraph (1).

(c) REPORTING SYSTEM. — The State agency shall establish a statewide uniform reporting system to —

(1) collect and analyze data relating to complaints and conditions in long-term care facilities and to residents for the purpose of identifying and resolving significant problems; and

(2) submit the data, on a regular basis, to —

(A) the agency of the State responsible for licensing or certifying long-term care facilities in the State;

(B) other State and Federal entities that the Ombudsman determines to be appropriate;

(C) the Assistant Secretary; and

(D) the National Ombudsman Resource Center established in section 202(a)(21).

(d) DISCLOSURE.—

(1) IN GENERAL.— The State agency shall establish procedures for the disclosure by the Ombudsman or local Ombudsman entities of files maintained by the program, including records described in subsection (b)(1) or (c).

(2) IDENTITY OF COMPLAINANT OR RESIDENT.— The procedures described in paragraph (1) shall—

(A) provide that, subject to subparagraph (B), the files and records described in paragraph (1) may be disclosed only at the discretion of the Ombudsman (or the person designated by the Ombudsman to disclose the files and records); and

(B) prohibit the disclosure of the identity of any complainant or resident with respect to whom the Office maintains such files or records unless—

(i) the complainant or resident, or the legal representative of the complainant or resident, consents to the disclosure and the consent is given in writing;

(ii) (I) the complainant or resident gives consent orally; and

(II) the consent is documented contemporaneously in a writing made by a representative of the Office in accordance with such requirements as the State agency shall establish; or

(iii) the disclosure is required by court order.

(e) CONSULTATION. — In planning and operating the program, the State agency shall consider the views of area agencies on aging, older individuals, and providers of long-term care.

(f) CONFLICT OF INTEREST. — The State agency shall —

(1) ensure that no individual, or member of the immediate family of an individual, involved in the designation of the Ombudsman (whether by appointment or otherwise) or the designation of an entity designated under subsection (a)(5), is subject to a conflict of interest;

(2) ensure that no officer or employee of the Office, representative of a local Ombudsman entity, or member of the immediate family of the officer, employee, or representative, is subject to a conflict of interest;

(3) ensure that the Ombudsman —

(A) does not have a direct involvement in the licensing or certification of a long-term care facility or of a provider of a long-term care service;

(B) does not have an ownership or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility or a long-term care service;

(C) is not employed by, or participating in the management of, a long-term care facility; and

(D) does not receive, or have the right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility; and

(4) establish, and specify in writing, mechanisms to identify and remove conflicts of interest referred to in paragraphs (1) and (2), and to identify and eliminate the relationships described in subparagraphs (A) through (D) of paragraph (3), including such mechanisms as —

(A) the methods by which the State agency will examine individuals, and immediate family members, to identify the conflicts; and

(B) the actions that the State agency will require the individuals and such family members to take to remove such conflicts.

(g) LEGAL COUNSEL.— The State agency shall ensure that—

(1)(A) adequate legal counsel is available, and is able, without conflict of interest, to —

(i) provide advice and consultation needed to protect the health, safety, welfare, and rights of residents; and

(ii) assist the Ombudsman and representatives of the Office in the performance of the official duties of the Ombudsman and representatives; and

(B) legal representation is provided to any representative of the Office against whom suit or other legal action is brought or threatened to be brought in connection with the performance of the official duties of the Ombudsman or such a representative; and

(2) the Office pursues administrative, legal, and other appropriate remedies on behalf of residents.

(h) ADMINISTRATION.— The State agency shall require the Office to —

(1) prepare an annual report —

(A) describing the activities carried out by the Office in the year for which the report is prepared;

(B) containing and analyzing the data collected under subsection (c);

(C) evaluating the problems experienced by, and the complaints made by or on behalf of, residents;

(D) containing recommendations for —

(i) improving quality of the care and life of the residents; and

(ii) protecting the health, safety, welfare, and rights of the residents;

(E)(i) analyzing the success of the program including success in providing services to residents of board and care facilities and other similar adult care facilities; and

(ii) identifying barriers that prevent the optimal operation of the program; and

(F) providing policy, regulatory, and legislative recommendations to solve identified problems, to resolve the complaints, to improve the quality of care and life of residents, to protect the health, safety, welfare, and rights of residents, and to remove the barriers;

(2) analyze, comment on, and monitor the development and implementation of Federal, State, and local laws, regulations, and other government policies and actions that pertain to long-term care facilities and services, and to the health, safety, welfare, and rights of residents, in the State, and recommend any changes in such laws, regulations, and policies as the Office determines to be appropriate;

(3)(A) provide such information as the Office determines to be necessary to public and private agencies, legislators, and other persons, regarding —

(i) the problems and concerns of older individuals residing in long-term care facilities; and

(ii) recommendations related to the problems and concerns; and

(B) make available to the public, and submit to the Assistant Secretary, the chief executive officer of the State, the State legislature, the State agency responsible for licensing or certifying long-term care facilities, and other appropriate governmental entities, each report prepared under paragraph (1);

(4) not later than 1 year after the date of the enactment of this title, establish procedures for the training of the representatives of the Office, including unpaid volunteers, based on model standards established by the Director of the Office of Long-Term Care Ombudsman Programs, in consultation with representatives of citizen groups, long-term care providers, and the Office, that —

(A) specify a minimum number of hours of initial training;

(B) specify the content of the training, including training relating to —

(i) Federal, State, and local laws, regulations, and policies, with respect to long-term care facilities in the State;

(ii) investigative techniques; and

(iii) such other matters as the State determines to be appropriate; and

(C) specify an annual number of hours of in-service training for all designated representatives;

(5) prohibit any representative of the Office (other than the Ombudsman) from carrying out any activity described in subparagraphs (A) through (G) of subsection (a)(3) unless the representative —

(A) has received the training required under paragraph (4); and

(B) has been approved by the Ombudsman as qualified to carry out the activity on behalf of the Office;

(6) coordinate ombudsman services with the protection and advocacy systems for individuals with developmental disabilities and mental illnesses established under —

(A) subtitle C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000[; and

(B) the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10801 et seq.);

(7) coordinate, to the greatest extent possible, ombudsman services with legal assistance provided under section 306(a)(2)(C), through adoption of memoranda of understanding and other means;

(8) coordinate services with State and local law enforcement agencies and courts of competent jurisdiction; and

(9) permit any local Ombudsman entity to carry out the responsibilities described in paragraph (1), (2), (3), (6), or (7).

(i) LIABILITY.— The State shall ensure that no representative of the Office will be liable under State law for the good faith performance of official duties.

(j) NONINTERFERENCE.— The State shall —

(1) ensure that willful interference with representatives of the Office in the performance of the official duties of the representatives (as defined by the Assistant Secretary) shall be unlawful;

(2) prohibit retaliation and reprisals by a long-term care facility or other entity with respect to any resident, employee, or other person for filing a complaint with, providing information to, or otherwise cooperating with any representative of, the Office; and

(3) provide for appropriate sanctions with respect to the interference, retaliation, and reprisals.

(42 U.S.C. 3058g)

HUMAN RESOURCES CODE

TITLE 6 - Services for the Elderly
CHAPTER 101 – Texas Department on Aging
SUBCHAPTER D – Office of Long-Term Care Ombudsman

§101.051. DEFINITIONS. In this subchapter:

(1) "Elderly resident" means a resident of a long-term care facility who is 60 years of age or older.
(2) "Long-term care facility" means a facility that serves persons who are 60 years of age or older and is licensed or regulated or is required to be licensed or regulated by the Department of Aging and Disability Services under Chapter 242 or 247, Health and Safety Code.
(3) "Office" means the office of the state long-term care ombudsman.
(4) "Representative" means an employee or volunteer specifically designated by the office as a representative of the office.
(5) "State ombudsman" means the chief administrator of the office.

Amended by: Acts 2007, 80th Leg., R.S., Ch. 809, § 2, eff. September 1, 2007.

§101.052. ESTABLISHMENT OF OFFICE. (a) The department shall establish and operate the office of the state long-term care ombudsman.

(b) The department may operate the office directly or by contract or memorandum of agreement with a public agency or other appropriate private nonprofit organization. The department may not use an agency or organization that is:
  (1) responsible for licensing or certifying long-term care services; or
  (2) an association of long-term care facilities or of any other residential facility that serves persons who are 60 years of age or older, or an affiliate of such an association.
(c) The department shall consider the views of elderly persons, provider organizations, advocacy groups, and area agencies on aging in planning and operating the office.
(d) The department shall ensure a person involved in designating the state ombudsman or in designating an employee or representative of the office does not have a conflict of interest.

§101.053. ROLE OF OFFICE. (a) The office and the ombudsman program shall operate in cooperation with any regulatory agency funded and mandated by the Older Americans Act of 1965 (42 U.S.C. Section 3001 et seq.), and state statute.

(b) This subchapter does not affect the authority of the Texas Department of Health and the Texas Department of Human Services to regulate long-term care facilities.

§101.054. POWERS AND DUTIES. (a) The state ombudsman and the office have the powers and duties required by state and federal law.

(b) The office may use appropriate administrative, legal, and other remedies to assist elderly residents as provided by department rules.

§101.055. LEGAL ASSISTANCE. The department shall ensure that the office receives adequate legal advice and representation. The attorney general shall represent the ombudsman or a representative if a suit or other legal action is brought or threatened to be brought against that person in connection with the person's performance of the official duties of the office.

§101.056. OMBUDSMEN. (a) The office shall recruit volunteers and citizen organizations to participate in the ombudsman program. A paid staff member of an area agency on aging network or a nonprofit social service agency may be an ombudsman.
An ombudsman is a representative of the office.

(b) The office shall provide training to ombudsmen as required by this subchapter and federal law.
(c) The office shall coordinate ombudsman services with the protection and advocacy systems that exist for persons with developmental disabilities or mental illness.

§101.057. INVESTIGATIONS. (a) The office shall have access to elderly residents and shall investigate and resolve complaints made by or on behalf of elderly residents.

(b) The department shall ensure that each ombudsman who investigates complaints has received proper training and has been approved by the office as qualified to investigate complaints.

§101.058. ACCESS TO RECORDS AND CONFIDENTIALITY.

(a) The state ombudsman or his designee, specifically identified by the executive director of aging, shall have access to patient care records of elderly residents of long-term care facilities defined in Section 101.051(2) of this code. Certified volunteer ombudsmen are not entitled access to medical or other confidential information from the patient care records. The department, by rule, shall establish procedures for obtaining access to the records. All records and information to which the state ombudsman or his designee obtains access remain confidential.
(b) The office shall ensure that the identity of a complainant or any facility resident may be disclosed only with the written consent of the person or the person's legal representative or on court order.
(c) The information in files maintained by the office may be disclosed only by the ombudsman who has authority over the disposition of the files.

§101.059. REPORTING SYSTEM. The office shall establish a statewide ombudsman uniform reporting system to collect and analyze information relating to complaints and conditions in long-term care facilities as long as such system does not duplicate other state reporting systems and shall provide the information to the department, Texas Department of Health, and Texas Department of Human Services.

§101.060. ANALYSIS OF LAWS. The office shall analyze and monitor the development and implementation of federal, state, and local laws, rules, regulations, and policies relating to long-term care facilities and services and shall recommend any changes the office considers necessary.

§101.061. PUBLIC INFORMATION. The office shall provide information to public agencies, legislators, and others that relates to the problems and concerns of elderly residents.

§101.062. ANNUAL REPORT. (a) The office shall prepare an annual report that contains:

(1) information and findings relating to the problems and complaints of elderly residents; and
(2) policy, regulatory, and legislative recommendations to solve the problems, resolve the complaints, and improve the quality of the elderly residents' care and lives.

(b) The report must be submitted to the governor and the presiding officer of each house of the legislature not later than November 1 of each even-numbered year. The report may be combined with the report required by Section 101.008.

§101.063. LIMITATION OF LIABILITY. An ombudsman or a representative is not liable for civil damages or subject to criminal prosecution for performing official duties unless the ombudsman or representative acts in bad faith or with a malicious purpose.

§101.064. CRIMINAL PENALTY. (a) A person commits an offense if the person:

(1) intentionally interferes with an ombudsman attempting to perform official duties; or

(2) commits or attempts to commit an act of retaliation or reprisal against any resident or employee of a long-term care facility for filing a complaint or providing information to an ombudsman.

(b) An offense under this section is a Class B misdemeanor.

(c) The department shall assure that criminal sanctions will be initiated only after all administrative procedures are exhausted.

TEXAS ADMINISTRATIVE CODE

TITLE 40 - Social Services and Assistance
PART 1 - Department of Aging and Disability Services
CHAPTER 85 - Implementation of the Older Americans Act

SUBCHAPTER A - DEFINITIONS

RULE §85.2 – Definitions

(6) Certified ombudsman--A certified staff ombudsman or a certified volunteer ombudsman.

(7) Certified staff ombudsman--A person who:
- (A) meets the qualifications described in §85.401(g)(1) of this chapter (relating to Long-Term Care Ombudsman Program);
- (B) is employed by or is contracting with a AAA or nonprofit organization designated in accordance with §85.401(b) of this chapter; and
- (C) performs activities for the AAA or designated nonprofit organization to implement the Long-Term Care Ombudsman Program.

(8) Certified volunteer ombudsman--A person who:
- (A) meets the qualifications described in §85.401(g)(1) of this chapter;
- (B) is not employed by or contracting with a AAA or nonprofit organization designated in accordance with §85.401(b) of this chapter; and
- (C) voluntarily performs activities for the AAA or designated nonprofit organization to implement the Long-Term Care Ombudsman Program.

(19) Friendly visitor--A volunteer for a AAA or nonprofit organization designated in accordance with §85.401(b) of this chapter who:
- (A) is not a certified ombudsman or ombudsman intern;
- (B) meets the qualifications described in §85.401(g)(2) of this chapter; and
- (C) performs activities to further the mission of the Long-Term Care Ombudsman Program such as visiting residents and coordinating social activities.

(21) Local ombudsman entity--A AAA or other entity designated by DADS to provide services in the Long-Term Care Ombudsman Program in accordance with the Older Americans Act, §712(a)(5)(A).

(22) LTC facility--Long-term care facility. A nursing facility licensed or required to be licensed in accordance with Texas Health and Safety Code, Chapter 242, and Chapter 19 of this title (relating to Nursing Facility Requirements for Licensure and Medicaid Certification) or an assisted living facility licensed or required to be licensed in accordance with Texas Health and Safety Code, Chapter 247, and Chapter 92 of this title (relating to Licensing Standards for Assisted Living Facilities).

(24) Office--The Office of the State Long-Term Care Ombudsman. A division of DADS established to oversee the statewide implementation of the Long-Term Care Ombudsman Program.

(26) Ombudsman intern--A person who is being trained to be a certified volunteer ombudsman in accordance with DADS Ombudsman Certification Training Manual but has not been approved by the Office to be a certified volunteer ombudsman.

(29) Resident--A person who resides in an LTC facility.

(34) State Long-Term Care Ombudsman--The person designated by DADS to be the administrator of the Office.

SUBCHAPTER E - Long-Term Care Ombudsman Program
RULE §85.401 - Long-Term Care Ombudsman Program

(a) **Purpose**. This section establishes the requirements of the Long-Term Care Ombudsman Program, a program established under the Older Americans Act, §712 and funded, in whole or in part, by DADS.

(b) **Designation**.
   (1) DADS designates AAAs as local ombudsman entities.
   (2) A AAA may contract with a nonprofit organization to perform the duties of the local ombudsman entity, as described in this section, in the AAA's planning and service area.
   (3) The requirements of this section apply to a AAA in its role as the local ombudsman entity.

(c) **Description of program**. The Long-Term Care Ombudsman Program provides services to protect the health, safety, welfare, and rights of residents. Such services include investigating and resolving complaints made by or on behalf of such residents, providing assistance and information to persons in choosing an LTC facility, and promoting a variety of means to ensure that residents' rights are protected, including conducting training programs and supporting the development of resident and family councils that advise LTC facilities.

(d) **Eligibility**.
   (1) Except as provided in paragraph (2) of this subsection, a AAA must ensure that a program participant who receives services from the Long-Term Care Ombudsman Program is a resident and 60 years of age or older.
   (2) A AAA may respond to a complaint of a resident who is under 60 years of age if such response:
      (A) benefits the residents of that facility or residents of other LTC facilities who are 60 years of age or older; and
      (B) will not significantly diminish the effectiveness of the Long-Term Care Ombudsman Program in assisting residents who are 60 years of age or older.

(e) **Managing local ombudsman**. A AAA must appoint a certified staff ombudsman to act as a managing local ombudsman. The managing local ombudsman must:
   (1) oversee the administration of the Long-Term Care Ombudsman Program in the AAA's planning and service area; and
   (2) be the primary contact for the local ombudsman entity.

(f) **Adequate number of certified ombudsman**. In order to implement the Long-Term Care Ombudsman Program as described in this section, a AAA:
   (1) must have an adequate number of certified ombudsmen; and
   (2) may have friendly visitors.

(g) **Qualifications for certified ombudsmen and friendly visitors**.
   (1) A person may be a certified ombudsman only if:
      (A) the person has not been convicted of an offense listed under Texas Health and Safety Code, §250.006;
      (B) the person successfully completes a certification training provided by the AAA in accordance with DADS Ombudsman Certification Training Manual;
      (C) for a certified volunteer ombudsman, the person successfully completes an internship in accordance with DADS Ombudsman Policies and Procedures Manual;

(D) the AAA recommends to the Office, in writing, using DADS *Certified Ombudsman Application,* that the person be approved as a certified ombudsman;
(E) the Office signs the DADS *Certified Ombudsman Application* approving the person to be a certified ombudsman; and
(F) the person completes continuing education provided by the AAA in accordance with DADS Ombudsman Policies and Procedures Manual.

(2) A person may be a friendly visitor only if the person successfully completes an orientation provided by the AAA in accordance with DADS Ombudsman Policies and Procedures Manual.

(h) Access to residents and records.

(1) In accordance with §19.413 of this title (relating to Access and Visitation Rights) and §92.801 of this title (relating to Access to Residents and Records by the Long-Term Care Ombudsman Program), a representative of the Office, as described in subsection (r) of this section, is entitled to immediate access to a resident.

(2) In accordance with §19.413 of this title and §92.801 of this title a certified ombudsman and a staff person of the Office are entitled to access:
(A) the medical and social records of a resident, if the certified ombudsman or staff person of the Office has the consent of the resident or the legally authorized representative of the resident;
(B) the medical and social records of a resident 60 years of age or older, if such access is necessary to investigate a complaint made to the Long-Term Care Ombudsman Program and:
(i) the resident is unable to consent to access and has no legally authorized representative; or
(ii) the following circumstances occur:
(I) the legal guardian of the resident refuses to give consent for access to the records;
(II) the certified ombudsman or staff person of the Office has reasonable cause to believe that the guardian is not acting in the best interest of the resident; and
(III) the certified ombudsman or staff person of the Office obtains the approval of the State Long-Term Care Ombudsman to access the records without the guardian's consent; and
(C) to the administrative records, policies and documents of the LTC facility to which the residents or general public have access.

(i) Conflict of interest and identity of certain relationships.

(1) A AAA must ensure that a certified ombudsman, an ombudsman intern, and a member of the immediate family of the managing local ombudsman are not subject to a conflict of interest.

(2) A conflict of interest includes the following:
(A) having a direct involvement in the licensing or certification of an LTC facility or of a home and community support services agency (HCSSA) licensed to provide home health services or hospice services in accordance with Chapter 97 of this title (relating to Licensing Standards for Home and Community Support Services Agencies);
(B) having an ownership or investment interest (represented by equity, debt, or other financial relationship) in an LTC facility or a HCSSA licensed to provide home health services or hospice services in accordance with Chapter 97 of this title;

(C) being employed by, or participating in the management of, an LTC facility or a HCSSA licensed to provide home health services or hospice services in accordance with Chapter 97 of this title;
(D) receiving, or having the right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of an LTC facility or a HCSSA licensed to provide home health services or hospice services in accordance with Chapter 97 of this title; and
(E) a certified ombudsman or ombudsman intern having a relative who is a resident in or an employee of an LTC facility in which the certified ombudsman or ombudsman intern provides Long-Term Care Ombudsman Program services.

(3) a conflict of interest described in paragraph (2)(A) - (D) of this subsection exists only if an LTC facility is in a AAA's planning and service area or a HCSSA is providing services to an LTC facility in a AAA's planning and service area.

(4) A AAA must specify, in writing, the mechanisms to:
(A) identify and remove conflicts of interest; and
(B) identify and address, if necessary, a familial or personal relationship that a certified ombudsman or ombudsman intern has with:
(i) a staff person of an LTC facility in the AAA's planning and service area; or
(ii) a staff person of DADS.

(j) Complaints. A AAA must:

(1) ensure that a person is allowed to make a complaint about circumstances that may adversely affect the health, safety, welfare, or rights of a resident in the following ways:
(A) in writing, including by electronic mail;
(B) in person; and
(C) by telephone, either by:
(i) a toll-free telephone number established by the AAA; or
(ii) acceptance by the AAA of a collect telephone call;

(2) initiate a complaint if the AAA becomes aware of circumstances that may adversely affect the health, safety, welfare, or rights of a resident;

(3) unless a complaint is initiated by the AAA in accordance with paragraph (2) of this subsection, respond to the person who makes a complaint, within two business days after receipt of the complaint or sooner, if possible, if the complaint presents an emergency situation;

(4) require a certified ombudsman to initiate an investigation of a complaint as soon as practicable after receipt of the complaint;

(5) require a certified ombudsman to investigate and resolve a complaint in a fair and objective manner; and

(6) report information about complaints to DADS in accordance with instructions promulgated by the Office.

(k) Disclosure of information.

(1) For a resident for whom a AAA maintains files or records, the AAA may disclose confidential information, including the identity of the resident or information from the files or records, only if:
(A) the resident or legally authorized representative consents to the disclosure in writing;
(B) the resident or legally authorized representative consents to the disclosure orally and the consent is documented by a certified ombudsman, in writing, at the time the oral consent is given; or
(C) the disclosure is required by court order.

(2) A AAA may disclose the identity of a person who files a complaint only if:

(A) the complainant, or legally authorized representative of the complainant, consents to the disclosure in writing;
(B) the complainant, or legally authorized representative, consents to the disclosure orally and the consent is documented by a certified ombudsman, in writing, at the time the oral consent is given; or
(C) the disclosure is required by court order.

(3) A AAA must disclose Long-Term Care Ombudsman Program information, other than the information described in paragraphs (1) and (2) of this subsection, in accordance with Texas Government Code, Chapter 552 (the Public Information Act).

(l) Representation of residents. A AAA may represent the interests of a resident before government agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the resident, if requested by a resident or another person on behalf of the resident.

(m) Review of proposed laws, regulations, and policies. A AAA may review and comment on existing and proposed laws, regulations, and other government policies and actions that pertain to the rights and well-being of a resident; and facilitate the ability of the public to comment on the laws, regulations, policies, and actions.

(n) Community relations. A AAA must:
(1) ensure that the local Ombudsman entity is visible within a AAA's planning and service area;
(2) coordinate with public and private organizations to involve residents in the community;
(3) be a knowledgeable resource about:
(A) community services and supports for residents;
(B) LTC facilities (including having information about facility operations and Ombudsman complaint history) without recommending a specific facility;
(C) DADS regulatory system regarding LTC facilities; and
(D) resident-centered care (that is, care based on a resident's needs, choices, and preferences);
(4) provide training to LTC facility staff regarding quality of care provided to residents as requested by a facility;
(5) support the development of resident and family councils in LTC facilities; and
(6) coordinate with DADS Regulatory Services, at least quarterly, and the Department of Family and Protective Services, as needed, to resolve issues regarding LTC facility operations and the quality of care for and the quality of life of residents.

(o) Recruitment, supervision, and retention of certified volunteer ombudsmen. If a AAA determines that certified volunteer ombudsmen are needed, the AAA must:
(1) determine the number of certified volunteer ombudsmen needed to comply with DADS performance measures;
(2) make a good faith effort to recruit the number of certified volunteer ombudsmen needed;
(3) ensure that a certified volunteer ombudsman meets the qualifications described in subsection (g) of this section and is not subject to a conflict of interest as described in subsection (i) of this section;
(4) supervise and routinely communicate with a certified volunteer ombudsman to:
(A) monitor performance;
(B) support effective volunteer conduct; and
(C) identify training needs.
(5) promote retention of a certified volunteer ombudsman by:

(A) providing continuing education in accordance with subsection (g)(1)(F) of this section;
(B) providing recognition and motivational activities;
(C) conducting annual evaluations; and
(D) conducting exit evaluations for a certified volunteer ombudsman leaving volunteer service.

(**p) Grievance procedures for certified volunteer ombudsmen and friendly visitors**. A AAA must have a process that:
(1) allows a certified volunteer ombudsman or friendly visitor to file a grievance with the AAA regarding the Long-Term Care Ombudsman Program; and
(2) requires a staff person of the AAA to review and resolve the grievance.

(q) Compliance with documents of the Office. A AAA must comply with the following documents promulgated by the Office:
(1) DADS Ombudsman performance measures;
(2) DADS Ombudsman Policies and Procedures Manual;
(3) DADS Program Instructions; and
(4) DADS Ombudsman Certification Training Manual.

(r) Representatives of the Office. In accordance with Texas Human Resources Code, §101.051(4), DADS designates the following persons as representatives of the Office:
(1) staff persons of the Office;
(2) certified ombudsmen; and
(3) ombudsman interns.

(s) Contractor compliance. If a AAA contracts with a nonprofit organization as described in subsection (b) of this section, the AAA must ensure that the organization complies with the requirements for a AAA described in this section.

(t) Ombudsman maintenance of effort.
(1) A AAA must comply with the Older Americans Act, §306(a)(9) regarding adequate expenditures for the Long-Term Care Ombudsman Program.
(2) A AAA may request, in writing, by September 30 of each year, that DADS waive the requirement described in paragraph (1) of this subsection for the next federal year.
(3) DADS may grant such a request if the AAA demonstrates adequate justification.

Source Note: Provisions of §85.401 adopted to be effective September 1, 2008, 33

TEXAS ADMINISTRATIVE CODE

TITLE 40 - Social Services and Assistance
PART 1 - Department Of Aging and Disability Services
CHAPTER 19 - Nursing Facility Requirements for Licensure and Medicaid Certification

Subchapter B, Definitions

§19.101 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(92) Ombudsman — An advocate who is a certified representative, staff member, or volunteer, of the DADS Office of the State Long Term Care Ombudsman.

Subchapter E, Resident Rights

§19.403 Notice of Rights and Services

(a) The facility must inform the resident, the resident's next of kin or guardian, both orally and in writing, in a language that the resident understands, of the resident's rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. This notification must be made prior to or upon admission and during the resident's stay if changed.

(b) The facility must also inform the resident, upon admission and during the stay, in a language the resident understands, of the following:

(4) a written description of the services available through the DADS Office of the State Long Term Care Ombudsman. This information must be made available to each facility by the ombudsman program. Facilities are responsible for reproducing this information and making it available to residents, their families, and legal representatives; and

§19.413 Access and Visitation Rights

(a) A resident has the right to have access to, and the facility must provide immediate access to a resident to, the following:

(4) a representative of the Office of the State Long Term Care Ombudsman (the Office), as described in §85.401(r) of this title (relating to Long-Term Care Ombudsman Program);

(b) A facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(c) A facility must allow a certified ombudsman, as defined in §85.2 of this title (relating to Definitions), and a staff person of the Office access:

(1) to the medical and social records of a resident, including an incident report involving the resident, if the certified ombudsman or staff person of the Office has the consent of the resident or the legally authorized representative of the resident;

(2) to the medical and social records of a resident 60 years of age or older, including an incident report involving the resident, in accordance with the Older Americans Act, §712(b); and

(3) to the administrative records, policies, and documents of the facility to which the facility residents or general public have access.

Subchapter F, Admission, Transfer, and Discharge Rights In Medicaid-Certified Facilities

§19.502 Transfer and Discharge in Medicaid-Certified Facilities

(f) Contents of the notice. For nursing facilities, the written notice specified in subsection (d) of this section must include the following:

(5) the name, address, and telephone number of the regional representative of the Office of the State Long Term Care Ombudsman, Texas Department on Aging, and of the toll-free number of the Texas Long Term Care Ombudsman, 1-800-252-2412;

Subchapter K, Nursing Services

§19.1001 Nursing Services

The facility must have sufficient staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Nursing services to children must be provided by staff that have been instructed and have demonstrated competence in the care of children. Care and services are to be provided as specified in §19.901 of this title (relating to Quality of Care).

(3) Waiver of requirement to provide licensed nurses on a 24-hour basis.

(D) The state agency granting a waiver of these requirements provides notice of the waiver to the state long term care ombudsman (established under §307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the state for the mentally ill and mentally retarded.

(4) Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week in a Medicare skilled nursing facility (SNF).

(B) The secretary provides notice of the waiver to the state long term care ombudsman (established under §307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the state for the mentally ill and mentally retarded.

Subchapter T, Administration

§19.1901 Administration

A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

§19.1923 Incident or Accident Reporting

(e) The facility must make incident reports available for review, upon request and without prior notice, by representatives of DHS, the U.S. Department of Health and Human Services, if applicable; and the Texas Department of Protective and Regulatory Services. Reports related to specific incidents must be available to the designated regional staff ombudsman, Office of the State Long Term Care Ombudsman, Texas Department on Aging.

Subchapter U, Inspections, Surveys, and Visits

§19.2002 Procedural Requirements - Licensure Inspections and Surveys

(f) Persons authorized to receive advance information on unannounced inspections include:

(2) representatives of the Texas Department of Aging serving as ombudsmen or authorized to attend or participate in inspections;

(g) DHS will conduct at least two unannounced inspections during each licensing period of each institution licensed under Health and Safety Code, Chapter 242, except as provided for in this subsection.
    (2) For at least two unannounced inspections each licensing period, DHS will invite to the inspections at least one person as a citizen advocate from the American Association of Retired Persons, the Texas Senior Citizen Association, the Texas Retired Federal Employees, the Texas Department on Aging Certified Long Term Care Ombudsman, or any other statewide organization for the elderly. DHS will provide to these organizations basic licensing information and requirements for the organizations' dissemination to their members whom they engage to attend the inspections. Advocates participating in the inspections must follow all protocols of DHS. Advocates will provide their own transportation. The schedule of inspections in this category will be arranged confidentially in advance with the organizations. Participation by the advocates is not a condition precedent to conducting the inspection.

Subchapter V, Enforcement

Division 1, Enforcement Generally
§19.2102 Enforcement Generally

The Texas Department of Human Services (DHS), as the state licensing agency and the survey and certification agency for the Medicaid program, may impose concurrently licensing remedies and Medicaid remedies on Medicaid-certified facilities.

Division 2, Licensing Remedies
§19.2119 Open Hearing

(a) The Texas Department of Human Services (DHS) will hold an open hearing in a facility if DHS:
    (1) has taken a punitive action against the facility in the preceding 12 months, or
    (2) receives a complaint that DHS has reasonable cause to believe is valid from an ombudsman, advocate, resident, or relative of a resident relating to a serious or potentially serious problem in the facility.

Subchapter Z, Preadmission Screening and Resident Review

§19.2500 Preadmission Screening and Resident Review (PASARR)

(d) Determination Process.
    (5) DADS or its designee notifies all individuals and their legal representative or surrogate decision maker (SDM) of the results of their PASARR determination through a letter sent to them, the nursing facility administrator, the attending physician, the local mental retardation authority (MRA) or local mental health authority (MHA) as applicable, the Office of the State Long-Term Care Ombudsman, and Texas Health and Human Services Commission (HHSC) Medicaid eligibility staff. Individuals who have undergone a preadmission screening or change in condition are notified within 10 calendar days of the determination.
(e) Specialized Services and Alternate Placement.
    (6) The nursing facility must allow Office of the State Long-Term Care Ombudsman staff or representatives from Advocacy, Inc., to counsel and inform affected residents of their rights and options under PASRR.

TEXAS ADMINISTRATIVE CODE

TITLE 40 – Social Services and Assistance
PART 1 – Department of Aging and Disability Services
CHAPTER 92 - Licensing Standards for Assisted Living Facilities

§92.125 Resident's Bill of Rights and Provider Bill of Rights

(a) Resident's bill of rights.

(3) Each resident in the assisted living facility has the right to:

(AA) have access to the service of a representative of the State Long Term Care Ombudsman Program, Texas Department on Aging;

§92.127 Required Postings

Each facility must prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees, and visitors: (7) the telephone number of the Office of the State Long Term Care Ombudsman

Subchapter I, Access to Residents and Records by the Long-Term Care Ombudsman Program

§92.801 Access to *Residents and Records by the Long-Term Care Ombudsman Program*

(a) A resident has the right to be visited by, and a facility must provide immediate access to any resident to:

(1) a staff person of the Office of the State Long-Term Care Ombudsman (the Office) employed by DADS;
(2) a certified ombudsman; and
(3) an ombudsman intern.

(b) A facility must allow a certified ombudsman and a staff person of the Office access:

(1) to the medical and social records of a resident, if the certified ombudsman or the staff person has the consent of the resident or the legally authorized representative of the resident;
(2) to the medical and social records of a resident 60 years of age or older, in accordance with the Older Americans Act, §712(b); and
(3) to the administrative records, policies, and documents of the facility to which the facility residents or general public have access.

Ombudsman Certification Training

CHAPTER 2

Aging and Residents

--This page intentionally left blank—

Aging and Residents

Chapter 2 provides basic information about aging, demographic information, and dispels some myths and stereotypes about aging.

Learning Objectives

- Become aware of the continuous process of aging
- Discover your attitudes about aging
- Understand common myths and stereotypes as well as facts about residents and aging

Contents

The Physical Aging Process
Attitudes about Aging
Demographic Information on Older Adults
Fourteen Myths and Stereotypes about Older Adults

Supplement A-2: And Thou Shalt Honor: Beloved Strangers

The Physical Aging Process

Aging is a complex natural process potentially involving every molecule, cell, and organ in the body. Gerontology, the study of aging, is a relatively new science. Gerontologists identify two main aging categories:

- Programmed – certain genes switch on and off over time; and
- Error – environmental damages to our body systems accumulate over time.

Over time, body organs and other systems make changes. These changes alter susceptibility to various diseases. Understanding these processes is important because many of the effects of aging are first noticed in our body systems. Review the following overview of how some body systems age.

- Heart: The heart muscle thickens with age as a response to the thickening of the arteries. This thicker heart has a lower maximum pumping rate, and the body's ability to extract oxygen from blood both diminish with age.

- Immune system: T cells take longer to replenish in older people and their ability to function declines.

- Arteries: Arteries usually stiffen with age. In turn, the older heart needs to supply more force to propel the blood forward through less elastic arteries.

- Lung: The maximum breathing (vital) capacity of the lungs may decrease as much as 40% between 20 – 70 years of age.

- Brain: As the brain ages, some connections between neurons seem to be reduced or less efficient. This is not yet well understood.

- Kidney: Kidneys gradually become less efficient at cleaning waste from the blood.

- Bladder: Total capacity of the bladder declines and tissues may atrophy, causing incontinence. Through exercise and behavioral techniques, adults can often manage incontinence.

- Body fat: Body fat gradually increases until middle age and then in late life body weight tends to decrease. With age, body fat redistributes in the body, shifting from just beneath the skin to deeper organs.

- Muscle: Muscle tone declines about 22% by age 70. Exercise can slow this rate of loss.

- Bone: Bone mineral is lost and replaced throughout life. Around age 35, loss begins to outstrip replacement. Regular weight bearing exercise, such as walking, running, and strength training can slow bone loss.
- Sight: Starting in the 40s, difficulty focusing close up may begin. From age 50, susceptibility to glare, greater difficulty in seeing at low illumination levels, and more difficulty in detecting moving objects increases. Ability to distinguish fine details may begin to decline in the 70s.
- Hearing: It becomes more difficult to hear high frequencies. Even with good hearing, older adults may have difficulty understanding speech especially where there is background noise. Hearing declines more quickly in men than in women.

Describe one physical change associated with aging.

____

____

____

If you met someone like …

> *Bess C (60) has always lived in Austin. She was a hairdresser. After her stroke, she requires 24-hour care. However, she remains active in the community. She has a cell phone and likes to write. She uses her power wheel chair as a mobility device. To visit friends and her sister as well as enjoy other activities, she uses the city's special transit service. She writes poetry and contributes to the nursing home newsletter. She self-advocates but doesn't hesitate to seek the ombudsman's help if needed. Her faith is very important to her.*

… Ask yourself, how would you build a relationship with her?

Attitudes about Aging

Aging is an ongoing process, but people see the value of aging differently at different points in the process. People anticipate some changes with joy, such as a baby's first tooth or first step. They greet other changes with a less positive response, such as pulling out their first gray hairs.

The American culture values youth. Americans mask signs of aging with face-lifts, wrinkle creams, and hair dyes. Physical maturation so eagerly anticipated in the first stages of life is often viewed negatively in later stages of life.

These prevailing attitudes lead to a denial of aging and can perpetuate stereotypes of aging and ignore positive aspects. At each stage of life, people perceive pros and cons. Some people think that in old age the balance tips to more negatives than positives, but this is not true for everyone.

Activity: Attitudes about Aging

True (T) or False (F)

__ 1. The majority of adults over 65 have memory loss, disorientation, or dementia.

__ 2. All five senses tend to decline in old age.

__ 3. Lung capacity tends to decline in old age.

__ 4. Physical strength tends to decline in old age.

__ 5. Older adults have no interest in sexual relations.

__ 6. Older drivers have fewer accidents per person than drivers under age 65.

__ 7. Older workers are less effective than younger workers.

__ 8. About 80% of older adults are healthy enough to carry out normal activities.

__ 9. Older adults are set in their ways and unable to change.

__ 10. Older adults usually take longer to learn something new.

__ 11. Most older adults' reaction time tends to be slower than younger adults.

__ 12. It is almost impossible for most older adults to learn new things.

__ 13. In general, most older adults are much alike.

__ 14. Older workers have fewer accidents than younger workers do.

__ 15. The majority of older adults are socially isolated and lonely.

__ 16. Over 20% of the U.S. population is now aged 65 or over.

__ 17. Most medical professionals tend to give low priority to older adults.

__ 18. The majority of older adults have incomes below the poverty level.

__ 19. The majority of older adults work or would like to do some kind of work, including volunteering.

__ 20. In the U.S., families provide about 80% of the care for older family members.

__ 21. People tend to become more religious as they age.

__ 22. Most American workers receive private pensions and Social Security when they retire.

Exercise: Choice or Restriction

List three morning activities you routinely do.

- ____
- ____
- ____

How might you feel if others changed your routine? ______________________________

True (T) or False (F):

___ 1. Nursing home staff must provide services and care in ways that help each resident live to his or her fullest potential physically, mentally, and emotionally.

___ 2. Supporting each resident's individuality is an important standard of care.

___ 3. Residents may experience disconnection and loss of identity.

___ 4. Staff should support each resident's life patterns.

___ 5. Facilities need rules that determine everyone's routines, such as when to go to bed, when to turn the TV off, when to take baths, and when visitors can come and go.

___ 6. A major loss to residents might be losing their daily routines.

___ 7. All residents are entitled to participate in planning their own care.

Give examples of what you believe privacy means in a facility setting.

____

____

____

Why should residents be able to control their lives after moving to an assisted living facility or nursing home? ____

____

____

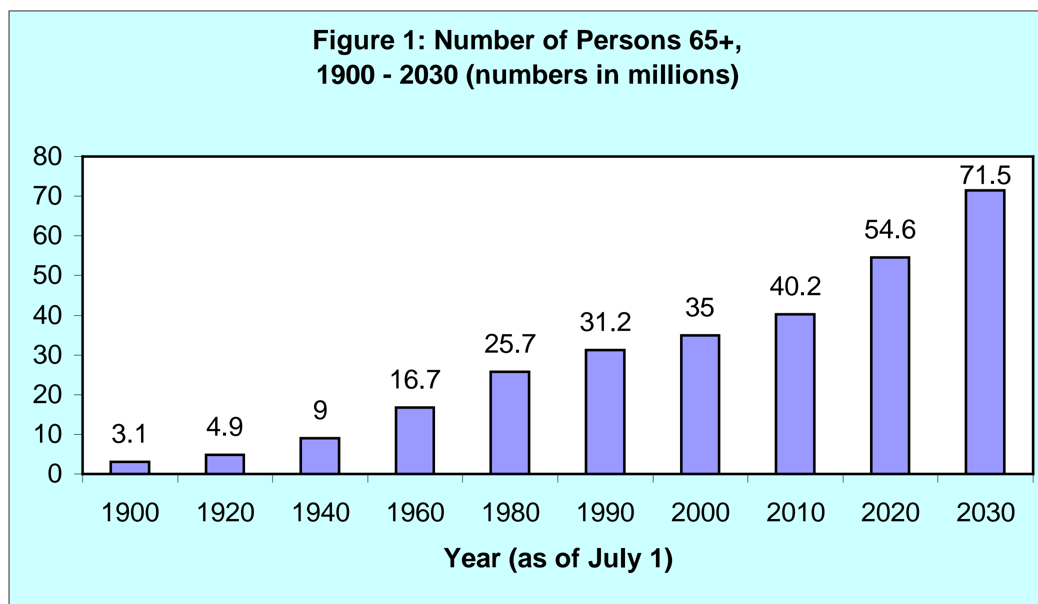
If you met someone like …

> *Lora F (94), widow, diagnosed with dementia, needs help with all personal care. She has been hospitalized a few times with urinary tract infections due to poor hydration. She was a homemaker who operated a boarding house and a charter member of the local garden club. One son and four daughters live nearby and visit at different times – the son helps her with breakfast; the daughters come at lunch and on weekends. While there, they check on her roommate whose only daughter lives in California. Since Mrs. F cannot communicate, her roommate tells the family what happens between their visits.*

… Ask yourself, how you would build a relationship with Mrs. F and her roommate?

Demographic Information on Older Adults

Knowing a person's chronological age tells you almost nothing about that person's feelings or abilities. Nevertheless, we tend to categorize individuals by chronological age. Some key statistics to describe the United State aged 65+ populations:



The 65+ population totaled 38.9 million in 2008

- 1 person in every 8

Average life expectancy after reaching age 65 is another 18.6 years
- 19.8 for females and 17.1 for males

22.4 million older women outnumber 16.5 million older men
- 72% of older men are married, while 42% of older women are married
- About 31% (8.3 million women, 2.9 million men) of older adults live alone

The 65+ population will increase from 40 million in 2010 and 55 million in 2020
- The 85+ population: from 5.7 million in 2010 to 6.6 million in 2020
- Minority populations are projected to increase from 8.0 million in 2010 (20.1% of older adults) to 12.9 million in 2020 (23.6% of older adults).

Median income of older adults in 2008 was $25,503 for men and $14,559 for women. Their major sources of income were
- Social Security (87%),
- income from assets (52%),
- private pensions (28%),
- government employee pensions (13%), and
- earnings (25%).

About 3.7 million older adults (9.7%) were below the poverty level in 2008

SOURCE: Administration on Aging prepared A Profile of Older Americans 2009

Nursing Homes and Assisted Living Facilities

While a small number (1.56 million) and percentage (4.5%) of the 65+ population lived in nursing homes in 2000, the percentage increases dramatically with age.
- 1% for people 65-74
- 5% for people 75-84
- 18% for people 85+

Because no national standards for assisted living services and settings exist, national statistics about people living in assisted living are not reliable.

In Texas, about 88,000 people live in nursing homes on any given day and about 33,000 people live in assisted living facilities.

What percentage of adults age 65+ live in nursing homes?

____

If you met someone like …

> *Jack K (76), a widower, had a stroke (medically known as CVA - cerebrovascular accident) with right side hemiplegia (paralysis on one side of the body) four months ago. He has expressive aphasia and cannot communicate his needs verbally so he gestures and uses a communication board. Living in a small town, he was an auto mechanic and his hobby was gardening. He was a leader in his church and loves to sing and hear gospel music. One son lives in a nearby town and visits once a week. Mr. K has fallen several times at night but not suffered any serious injury. Staff finds him on the floor near his bed. He prefers to use the bathroom without help.*

… Ask yourself, how would you start to build trust with Mr. K?

Fourteen Myths and Stereotypes about Older Adults

Many people, including older adults, think some generalizations about older adults are truths. Myths, stereotypes, and negative attitudes greatly influence our interactions with older adults. Paid and family caregivers are naturally influenced by these same myths and stereotypes, which can affect the way they treat older adults. As an ombudsman, it is important to recognize your biases and work to overcome them in order to be resident-directed and protect resident rights.

Myth 1: Older adults are disengaged. They live by themselves or with other older adults, lose interest in life, become more introspective and withdrawn, and do not want to associate with other people.

> Reality: Opportunities to be with others may be limited. Physical disabilities, lack of transportation, lack of alternatives, and the death of a spouse or friends may cause older adults to appear disengaged. Other people may have chosen to stay away from them. Most older adults prefer to stay involved in their communities.

Myth 2: Older adults are sick. Disease and disability are automatic with advancing age.

> Reality: Chronic conditions, such as arthritis and diabetes, usually begin in middle age and worsen with age. Disabilities have many causes and can be influenced by diet, exercise, and lifestyle. Older adults do not suddenly become sick just because they age. They may need or want encouragement to participate in activities.

Myth 3: “Once a man, twice a child.” Older adults become childish, return to a second childhood, and must be treated like children.

Reality: Adults remain adults and want to be treated as such.

List two reasons why older adults might disengage from their community? ____

____

Myth 4: Older adults are dependent. They need someone to take care of them.

Reality: Most older adults are independent, caring for themselves and living in the community. Younger adults often try to do things for an older person because they lack patience to wait for the older adult to do it themselves. Older adults can gradually become dependent on others because they received unnecessary assistance.

Myth 5: Older adults are unproductive.

Reality: The majority of older adults remain actively and productively involved in their community. However, opportunities for meaningful work, education, or leisure activities may be less available. Incapacity is directly linked to loss, disease, and circumstance rather than aging. Sharing knowledge and reminiscing are important aspects of an older adult’s productivity.

What is at risk if an older adult has someone do everyday tasks for them? ________________________________

Myth 6: Sexual function ceases in old age.

Reality: Sexual desire continues throughout life. Sexual function may change with advancing age, but it does not automatically cease. If people have been sexually active throughout adulthood, they are likely to be in later years.

Myth 7: Old people become senile. Eventually all older adults become forgetful, confused, and lose attention span.

Reality: "Senility" is one of the most misused words to describe older adults; it has little meaning. Similarly, "Alzheimer's" has become a general term used to describe all types of memory loss that may have different causes and different intervention strategies.

Myth 8: If people live long enough, they will end up in nursing homes.

Reality: About 5% of older adults live in a nursing home. About 25% of older adults will need nursing home care at some point in their lives. The vast majority of older adults live outside of nursing homes.

Myth 9: Serious health problems are unavoidable in older adulthood.

Reality: Three reasons make health deterioration or decline unavoidable:

- new disease or condition, such as heart disease in addition to Parkinson's disease;
- disease progression, such as the medicine for Parkinson's no longer works and the person loses mobility; and
- choosing to decline treatment or care.

One reason decline in a person's health might be unavoidable is if ____.

Myth 10: Given their frail condition, movement for long-term care residents is not as important as it is for other adults. A decline in mobility is an inevitable part of aging.

> Reality: The ability to move may change with physical and mental ability. Even older residents with frail bones keep their instinct for movement, just as they do for all basic needs. Nursing homes and assisted living facilities may fail to recognize — and encourage — movement as a basic human need, but the need to move is important to maintain physical and mental health.

Myth 11: Pressure ulcers are an unfortunate part of normal aging for nursing home residents.

> Reality: A pressure ulcer, sometimes called a bed sore, is an injury caused primarily by unrelieved pressure that damages the skin and underlying tissue. They are painful. Pressure ulcers can require hospitalization or nursing home treatment and cause death. People who are most at-risk of skin breakdown have limited mobility, incontinence, diabetes, decreased mental capacity, and confusion. Pressure ulcers can be prevented.

Another term for “bed sore” is _____________ _________.

Myth 12: Involuntary loss of urine is a normal signal of advanced age. Once it occurs, nothing can be done except to keep clean and dry.

> Reality: Incontinence is not a normal part of aging. Urinary incontinence is a symptom of a medical problem. Continence depends on many factors such as a well functioning urinary tract, ability to reach the toilet on time, ability to remove clothing, cognitive function, and motivation.

Myth 13: Older adults tend to withdraw and become depressed. Depression is normal.

Reality: Depression is treatable and not a normal part of aging. A depressed mood may not be as noticeable a symptom as other symptoms, such as sleeplessness, sleeping too much, loss of appetite, lack of energy, and loss of enjoyment of normal life interests. The risk of depression among women is twice that of men. Older adults with depression are at risk of committing suicide; white men over age 80 are at greatest risk. Proper assessment, detection, and intervention are critical.

Myth 14: Older adults and individuals with disabilities need protection. Environmental risks must be minimized. Restraints can keep nursing home and assisted living residents safe.

Reality: Life is full of risk. Our willingness to live with risks is individualized. Care decisions made solely for a person's safety should be carefully scrutinized. Resident rights need to be factored into each care decision. Restrained residents often try to get out of restraints. Physical restraints create new risks, including increased risk of death and serious injury. Restraints also increase isolation and negatively affect an individual's mood.

Using a restraint on a person puts them at risk of serious ________________________ and death.

If you met someone like …

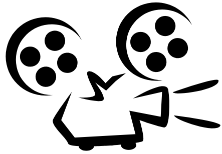
William E (81), a Marine veteran of World War II, smoked most of his life but quit several years ago. He has lung cancer and was given six weeks to live. He was transferred from the hospital to the nursing home rather than to his home because his wife was not physically strong enough to care for him. While not happy with the choice, Mr. E accepted the situation and appreciated his wife being by his side almost 24/7.

… Ask yourself, how can I build trust while visiting this family?

Exercise: Your Perfect Long-term Care Home

If you became unable to care for yourself in your private home, describe the home in which you would want to live and how staff will care for you.

Supplement A-2: And Thou Shalt Honor: Beloved Strangers



Video: And Thou Shalt Honor, Beloved Strangers

Four million people in America have Alzheimer’s disease. Caring for a person with Alzheimer’s can be challenging. This video profiles three stories about preparing for and living with this illness.

1. In Dr. Deutsch’s story, he had early onset Alzheimer’s disease. What are some things to consider in advocating for a younger than average resident?

   ____

   ____

   ____

2. In the Block story, Ms. Block had a unique way of dealing with her father Arthur’s wandering. What are some challenges facility staff may face with caring for a resident who wants to leave the facility?

   ____

   ____

   ____

3. In the Franco-Figueroa story, the family struggles with their decision to move the family member to a nursing home. Describe some challenges of making that decision and choosing a nursing home.

   ____

   ____

   ____

4. Several people compare caring for a person with Alzheimer’s to caring for a child. How might thinking of an adult as a child affect the adult’s right to dignity and respect?

   ____

   ____

   ____

Ombudsman Certification Training

CHAPTER 3

Communication and Consent

--This page intentionally left blank—

Communication

Chapter 3 is about communication, active listening, and consent. It has tips for communicating with people who have impairments and provides a structured approach to communicate effectively with people who live in nursing homes and assisted living facilities. This chapter addresses important long-term care ombudsman consent requirements.

Learning Objectives

- Recognize the importance of active listening
- Develop a protocol for communicating with residents
- Learn strategies for successful communication with a person with a disability
- Understand consent requirements for long-term care ombudsmen

Contents

Communication
Listening
Communicating with Long-term Care Residents
Communicating with Adults Who Have Impairments
Consent

Communication

Communication is a four step process.

1. Message is sent.
2. Message is received.
3. Sender gets feedback.
4. Another message is sent.

Communication includes verbal and nonverbal messages. To communicate effectively, it is important for the sender of the message to express him or herself in a way that the receiver knows what the message means. A mixed message is when verbal and nonverbal messages appear to contradict each another.

Verbal communication

- Tone of voice
- Word choice

Nonverbal communication (examples)

- Facial expressions
- Eye contact
- Touch
- Body language and gestures
- Spatial distance
- Silence
- Head nodding

Listening

Listening means comprehending what the other person is saying. It is one of the most neglected communication skills.

Active listening is the act of hearing what the other person is saying and responding both to I content and I feeling of what is being said. Tips for active listening are:

- Give the person your full attention.
- Be patient.
- Listen for the intent and feeling of what is being said as well as the words.
- Be sincerely interested in what the other person is talking about.
- Restate what you heard the person say.
- Ask questions to clarify.
- Be aware of your own feelings and opinions.
- State your views only after you listen.
- Focus your energy on the conversation.
- Validate what the person said.
- Address inconsistencies in nonverbal and verbal messages.

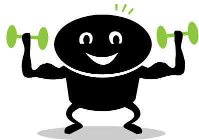
Giving feedback is a good way to confirm the information you received is an accurate representation of what the sender intended. When you are unsure if the receiver understood your message, ask for feedback.

Active Listening requires concentration and sincerity. One goal is to _______________ what the person says by listening for ________________ and restating what you heard.

Seven Rules of Good Listening

1. Get ready to listen.
2. Take responsibility for comprehending.
3. Listen to understand rather than to refute.
4. Control your emotions.
5. Listen for the main ideas.
6. Be mentally alert.
7. Take notes.

Role Play Exercise: Introduction to a Resident



Roles: Ombudsman
Resident

The ombudsman visits a resident for the first time.

Questions for role play observers:

- How did the ombudsman describe the role of the ombudsman?

  ____

  ____

- What listening techniques were used?

  ____

  ____

Exercise: Rate Your Listening Skills

Below are a number of poor listening habits. Some behaviors seem unconscious, some purposeful, some trivial, some important, some remediable, and some deeply rooted in the personality of the person.

Think about how you listen and rank your behaviors in the list with a 1, 2, 3, 4, or 5 (1 - you rarely do, 3 - neutral, 5 - you often do). Total the numbers for your score.

___ Talking too much, not giving the other person a chance to talk

___ Interrupting others when they are talking

___ Not looking at the person talking

___ Fidgeting with pencil and paper, tapping your legs, etc. when someone is talking

___ Having a “poker face,’ blank look, or manner which makes it difficult for another to know if you are listening

___ Trying to do other things while another is talking

___ Letting emotional-laden words arouse personal ill feelings

___ Daydreaming or thinking about other things while another is talking

___ Blaming the speaking habits or mannerisms of another

___ Finishing the other person’s statements

___ Drawing conclusions about the subject before actually listening to it

___ Cleaning fingernails, glasses, etc. while the other person is talking

___ Listening only to the facts being said, not to emotional aspects

___ Sitting too close, being in another’s personal space

___ Looking frequently at your watch or clock while another is talking

___ Letting your feelings get in the way while listening

___ Asking many questions while another is talking

___ *Total score*

The lower the score, the better listener you are.
If your score is high, you need to work on your listening skills.

Communicating with Long-term Care Residents

Residents and certified ombudsmen build trusting relationships through honest, respectful communication. For effective communication, a message must be given and received with a common understanding of what the message means. The following communication methods are tried and true:

1. Begin with a proper introduction, addressing residents as the adults they are.
   - Greet by Mr., Mrs., or other title and given name, unless they suggest another name.
   - Avoid using words that are too simple.
   - Avoid using overly complicated words and acronyms.
   - Adapt your conversation to the resident's level of understanding.

2. Request permission to talk.
   - "Is now a good time to talk?"
   - "Do you feel like talking?"

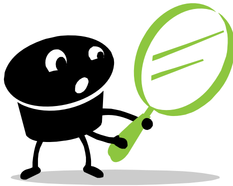
3. Always respect the rights and dignity of each resident.

4. Make it clear who you are and why you are there.
   - "Hello, my name is ________ and I am your ombudsman. I work for you."

5. Remember their room is their home.
   - Knock on open doors and receive permission before entering.
   - Try to sit at eye level and sit where offered.
   - Respect privacy by offering to close the door.
   - Excuse yourself if care or services are needed and never interrupt a resident who is receiving care. Closed doors often signal that care is being provided.

6. Establish a level of physical and verbal warmth and trust. Be attentive and let them know you are interested in them.
   - Do not be in a rush to discover issues; use small talk to establish rapport, such as "Are you from this area? What caused you to move here? Do you have family around here? Are these pictures of your family?"
   - Allow the conversation, whenever possible, to go where the resident wishes. Gently look for openings to address potential issues. Don't rush!
   - Let residents set the pace of the conversations.
   - Resist the impulse to talk rather than listen.

7. Be mindful about your personal reactions and feelings.
   - Be honest and professional.
   - Act from the residents' values; do not impose your values on them.
   - Be aware of your communication to ensure you are not inserting your opinions.



One of the most helpful things an ombudsman can do is listen without judgment and without imposing values on the resident.

8. Do not undermine your trusting relationship with a resident.
   - Do not ask questions of facility staff or take action that is inconsistent with resident wishes.
   - When you feel conflicted about your role, consult your supervising staff ombudsman.
   - Maintaining confidentiality is the foundation of your integrity.

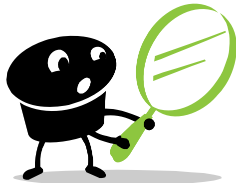
9. Discover residents' support systems.
   - Ask about contacts with family, friends, and other visitors.

10. Explore their personal history.
    - Without prying, discover residents' personal interests and life history.
    - Mention interests you have in common to build rapport.

11. Discuss the history of their stay.
    - After developing rapport, talk about their feelings about living in the nursing home or assisted living facility.
    - Ask specific questions that may give "clues" to their feelings about where they live, such as "Does everyone here treat you well? Do you feel safe? Do you have family that visits? Do you every feel lonely."
    - If they express dissatisfaction about their life in the facility, probe for more information.
    - Listen carefully. Write down important information to remember. Ask permission to take notes or make notes later in a private place.
    - Observe residents. Are they nervous or shaking? Do they cry easily or get angry? Do they appear fearful of being overheard by staff?
    - Pursue concerns; do not ignore concerns that residents share.

12. Ask for permission before you talk to anyone about a complaint. This is also called “obtaining consent.”
    - Explain the reason you want to talk with someone else and who the person is.
    - Respect confidentiality; protect resident identity if they ask you. Complaints can be investigated and resolved without using a resident’s name. Some complaints affect several people in the facility.

13. Use residents as resources to resolve their problems. They can provide helpful information about whom you should approach and how you might attempt to resolve a problem.
    Contact members of a resident council, such as the president of the council, as especially helpful resources.



Read how Resident Councils may be a good resource for resolving problems on behalf of residents in Chapter 6.

14. Do not make promises you cannot keep.
    Avoid making promises in general about what you will accomplish.

15. Be honest and direct about your intentions and any risks involved in any course of action.
    - Take resident concerns about retaliation seriously.
    - Respect confidentiality by visiting several residents and not identifying a resident as a complainant without consent to do so.
    - Refer to complainants as “resident or complainant” and avoid using identifying terms she as “he or she, resident’s son or daughter or wife.”
    - Offer alternatives to residents about how you can investigate or work to resolve the problem without using their name.
    - Protect identities by visiting many residents before addressing a complaint or even returning another day to address a non-critical complaint.

16. Be patient, dependable, and honest.
    Build friendly, trusting relationships over a period of time.

Communicating With Adults Who Have Impairments

Each individual who lives in an assisted living facility or nursing home is unique in physical, mental, and psychosocial capacity. With an individual who has physical and mental impairments, communication can be challenging.

If you are unable to communicate with a resident for some reason, your supervising staff ombudsman is a good resource for information and ideas. Facility staff may also have helpful tips.

Ombudsmen strive to use “people first” language to avoid perpetuating stereotypes and creating barriers. For example, describing a person as an “individual with a disability” is considered more respectful than a “disabled person.” Watch and listen for descriptions of a person by the disability, such as, “she’s a diabetic.” Ombudsmen can model respect by using more respectful language.

Listen, speak clearly and slowly, and use helpful non-verbal communication. For specific impairments, use some of the following techniques.

Visual Impairment and Blindness

- Encourage and communicate using whatever vision remains.
- Identify yourself and anyone who accompanies you.
- Tell the person whom you are addressing when you speak.
- Leave things where they are unless the person asks you to move something.
- Allow the person to negotiate the surroundings, such as finding the door handle or locating a chair.
- Always wait for a response if offering any assistance and then follow the person’s instructions.
- Explain what you are doing as you are doing it.

Hearing Impairment

- Before speaking, be directly in front and have the person’s attention.
- Approach from the front or within the line of vision.
- Face directly and be on the same level whenever possible.
- Ask if the person has a hearing device and would like to use it.
- Reduce or eliminate background noise.
- Speak normally without shouting.
- Allow time.
- Use simple, short sentences. Consider writing messages.

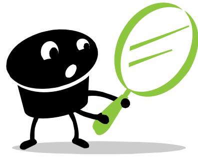
It is always a good idea to approach any resident from the ________________.

Deafness

- Ask if the person reads lips, has an assistive device, or prefers written communicate.
- Use a picture, communication board, or other device if available.
- Be concise with your statements and questions.
- Use nonverbal communication and gestures.
- Take time.
- Seek help from an interpreter if the person signs.
- Ask if the resident would like the door shut before speaking to you.

Dementia and Related Disorders

- Approach from the front or within the line of vision.
- Greet the person as you normally would.
- Face the person. Maintain eye contact.
- Smile.
- Use a friendly voice and expression.
- Respect personal space.
- Minimize hand movements.
- Avoid environments with a lot of sensory stimulation.
- Lower the pitch of your voice and speak slowly.
- Help end the conversation if needed.



Dementia and delirium are distinct conditions, characterized by impaired cognitive function. While they have common symptoms, the significant difference is delirium is quick onset but responsive to treatment and dementia is permanent.

Dementia is a progressive decline in memory and at least one cognitive area such as abstract thinking, attention, personality, and judgment. Brain damage as a result of head injury or disease such as alcoholism, Alzheimer's disease, or Parkinson's disease causes dementia.

Delirium is sudden severe confusion and rapid changes in brain function usually as a result of physical or mental illness. Symptoms include confusion, difficulties with short-term memory, wandering attention, physical restlessness, and changes in personality, sleep patterns, and alertness.

Aphasia (difficulty speaking or understanding)

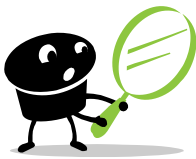
- Be patient and allow plenty of time to communicate.
- Assure the resident it is okay to take as much time as needed.
- Ask the person how best to communicate.
- Avoid being too quick to guess what the person is trying to express.
- Use gestures, pictures, or touch.

Confusion

- Ask simple "yes" or "no" questions. Speak slowly.
- Smile.
- Use positive statements.
- Assume the person has capacity to understand.
- Don't interrupt or appear impatient.
- Write down positive or reassuring information. Avoid giving information that may produce anxiety.
- Don't correct mistakes made by the person.
- Ask why they think or ask in that way or make that statement,

Aggression

- Use short, clear, and concrete statements. Give step-by-step instructions.
- Speak softly. Be calm and reassuring.
- Avoid quick, sudden, or erratic moves.
- Never argue or try to reason with the person.
- Be empathetic.
- Keep out of striking distance. Never strike back.
- Leave and report behavior to facility staff if the situation is beyond your control.



Visitors to nursing homes have a tendency to speak loudly when it is not needed. Ombudsmen should use a regular volume.

Non-responsive

- Never assume a non-responsive resident cannot hear or understand.
- Try to include the non-responsive resident in the conversation if family members or others are visiting in the room.
- Don't speak of these residents in the third person. Use their name.
- Use your "in plain sight" observational skills to determine any environmental or care issues.

Verbal Behaviors

- Feel free to ask staff how they handle verbal behaviors.
- Avoid being oversensitive to profanity or yelling.
- Ask resident permission to speak and always speak in a normal voice and tone, even if the resident is not.
- Listen carefully for meaningful information mixed with the uncontrolled verbal behavior.
- Treat the resident in a friendly, courteous and professional manner.

Redirection

- Sometimes the resident may become angry or upset. Be alert for ways to gently change the subject, reduce the intensity of resident reaction or remove the stimulus (yourself) from the exchange.
- Do not continue to try to calm a resident who is out of control. Ask staff for help.
- Be sensitive to the resident's reality and allow it to be what it is. Never argue or attempt to correct his or her reality.

General

- When talking to people with a disability, talk directly to them, not the friend, companion, or interpreter who may be present.
- Respect all assistive devices such as canes, wheelchairs, crutches, and communication boards as personal property. Unless given permission, do not move, touch, or use them.
- If people have trouble shaking hands with the customary right hand, shake with your left or follow their lead on another greeting.
- If talking with people using a wheelchair for any length of time, try to place yourself at their eye level.
- Do not shout or raise your voice unless asked to do so.
- Do not pet or make a service dog the focus of conversation.
- Let individuals know if you need to end the conversation.
- Treat adults as adults. Address people with disabilities by their first name only when extending the same familiarity to all others.

In general, let a resident tell you if they need any help with their physical impairment. And, respect assistive devices as ____________________ ________________________.

Consent

Consent is required from a resident or complainant to:

- work on a resident's behalf;
- reveal a resident's or complainant's name or identifying characteristics; or
- access a resident's record or other confidential information.

Unless a resident is unable to consent or a complaint applies to a group of residents, an ombudsman always needs consent from the resident to which a complaint or request applies.

For all situations in which consent is obtained, permission applies to the immediate case or request and does not extend to future work. A resident may withdraw consent at any time and that stops the ombudsman's actions.

DADS requires ombudsmen to document resident or complainant consent. Ombudsmen use release forms, case notes, or monthly reports to document consent. Your supervising staff ombudsman will provide the appropriate items.

When a resident does not have capacity to consent, document using the phrase, "Resident is unable to consent."

Consent is required for an ombudsman to work on a ______________ ______________, reveal a resident's or complainant's name, or access a resident's record or other ______________________________ information.

Unless the court has ruled (adjudicated) the resident is incapacitated, the resident speaks for himself or herself. When a resident is unable to consent, an ombudsman seeks consent from a legally authorized representative (LAR), if applicable. An LAR may be a guardian or power of attorney. If the resident is unable to consent and there is no LAR, an ombudsman consults with the supervising staff ombudsman, and then:

- seeks information about a resident's previous expressed wishes;
- assumes, in the absence of resident direction, the resident wishes her health, safety, and welfare to be protected; and
- takes action to protect those known or assumed wishes.

Guardian (of the Person)

Confirm with facility staff or the guardian that there are current letters of guardianship of the person. Review the documents to determine scope of the guardian's authority. Work with the guardian, who speaks for the resident and may consent on the resident's (incapacitated person's) behalf, per the court orders.

If a complainant is someone other than the guardian and the guardian refuses consent, consider if the guardian is acting in the resident's best interest. If you believe the guardian is not acting in an incapacitated person's best interests, an ombudsman must obtain approval from the State Long-Term Care Ombudsman to take action on behalf of the resident.

An ombudsman may work with the guardian of the estate regarding financial issues.

Unless a court rules a resident is ___________________,

a resident speaks for himself or herself.

Power of Attorney

A medical power of attorney (MPOA) assigns an agent to exercise authority only if the resident's attending physician certifies in writing that the resident is incapacitated. The resident may revoke the MPOA. Revocation is made by oral or written notification to the agent, the provider or by any other act evidencing intent to revoke the MPOA. If a resident requests assistance or files a complaint, consider the resident as the client. Coordination or consultation with the MPOA is not required.

A durable power of attorney (DPOA) takes effect in accordance with the terms of the DPOA document. Depending on how the document is written, the agent may exercise authority when the resident is able to make decisions, when the resident is incapacitated, or both. Determining the resident’s incapacity may be established in the language of the DPOA, but not always. Revocation of a DPOA is not addressed in law and if the DPOA document does not address revocation, assume the resident can revoke either orally or in writing as with an MPOA. Coordination or consultation with the DPOA is not required.

Consent to Work on a Resident or Complainant's Behalf

A resident or complainant must provide consent for an ombudsman to work on the resident's behalf.

If the complainant is not a resident, seek agreement from the resident to work on the issue. If the resident declines consent, the resident's wishes supersede the complainant's and an ombudsman may:

- Advise non-resident complainant of alternate resolution strategies. Options may include providing consultation to the complainant for self-advocacy with facility management or having the complainant work through a family council. If the complainant's concern involves a regulatory violation, provide information on how to file a complaint with DADS Consumer Rights and Services.
- Determine the concern impacts other residents and file a complaint with facility management or DADS Consumer Rights and Services with the ombudsman as the complainant and no identification of specific residents. If an ombudsman plans to file a complaint contrary to the original resident's wishes, notify the resident of this decision and inform the resident that his or her identity will not be revealed.

If an ombudsman determines a problem affects other residents but the resident does not give consent, the ombudsman could take action with the ombudsman as the complainant, but must

____

____.

Consent to Reveal Identity

For each case in which identity cannot be protected, the complainant must provide consent to disclose or the ombudsman clearly identifies him or herself as the complainant. All complainants, both residents and others, are afforded protection of identity in ombudsman laws and rules; therefore, protect the identity of non-resident complainants the same as residents.

A facility staff person may speculate about the identity of a resident or complainant. Without consent of the resident or complainant, do not confirm such speculation. Instead, redirect the conversation to information that is relevant and not confidential. If necessary, inform facility staff of the Long-Term Care Ombudsman Program's confidentiality law or inform staff that the question arises from the ombudsman, rather than a resident or other complainant.

Exercise: Discuss these situations with your ombudsman trainer

1. Several younger residents engage in activities that intimidate older residents. Younger residents say they are exercising their choices and preferences. The older residents ask the ombudsman to represent them in making the younger residents change their behavior.
   - How does the ombudsman decide whom to represent? ______________________

     ____
   - What are some strategies to consider when residents have problems with other residents? ____

     ____

2. A resident with dementia has no legal representative. Some of her behaviors and statements lead the ombudsman to wonder if her care plan needs changes.
   - What is the role of the ombudsman? ______________________________________
   - What authority, if any, does the ombudsman have to seek changes for the resident? ____

     ____
   - What if there are negative to the resident based on the ombudsman's actions?

     ____

3. A facility asks the ombudsman what to do with a resident they are discharging.
   - What is appropriate for the ombudsman to say and do? ______________________

     ____
   - What should the ombudsman avoid doing in this case? ______________________

     ____
   - How does the facility's request for help affect the ombudsman's actions? _______

     ____
   - Will the ombudsman instill in other residents if he helps facility staff in discharging the resident? ____

     ____

Facility staff might guess who lodged the complaint. Without the complainant's permission, do not confirm.

Consent to Access Confidential Information

Access to records and the information within a record is essentially the same circumstance. Facility staff members have an obligation to protect each resident's record from inappropriate access. Not only do laws pertaining to nursing homes and assisted living facilities protect privacy of a resident's record, the Health Insurance Portability and Accountability Act (HIPAA) establishes standards to protect individuals' medical records and personal health information.

HIPAA protects patient information from being released without the person's consent. HIPAA directs a facility to take certain precautions before releasing records. However, an ombudsman accesses confidential information in accordance with the Older Americans Act.

Under the HIPAA Privacy Rule, a long-term care ombudsman program is a "health oversight agency." Therefore, it does not prevent releasing resident clinical records to ombudsmen, with or without authorization of the resident or resident's legal representative. Nursing homes may share other information without fear of violating HIPAA.

In anticipation of any questions of your authority, be prepared with applicable law and rules. If facility staff denies access, consult your supervising staff ombudsman. Subchapter 8b describes the process for obtaining consent to access a resident record.

Do not disclose outside of the ombudsman program any information about a resident unless you have the resident's consent. Treat the information you read in a written record the same as information you hear from a resident, medical, professional, or other caregiver. Everything you read and hear about a resident should be carefully guarded to protect the identity and privacy of a resident.

Information acquired within a record or disclosed orally is essentially the same. It is ___________________________.

- HIPAA applies to ______________________.
- Older Americans Act applies to ________________________.

Ombudsman Certification Training

CHAPTER 4

Facilities

--This page intentionally left blank--

Facilities

Chapter 4 is about nursing homes and assisted living facilities. People who live in either type of facility have a right to our services. Nursing homes and assisted living facilities are two living options in a continuum of long-term services and supports in Texas.

Learning Objectives

- Understand the long-term care ombudsman roles and responsibilities associated with facilities and helping people choose them
- Describe nursing homes and assisted living facilities
    - Laws and rules
    - Typical resident
    - Types
    - Management, Operation, and Staff Perspectives
    - How to pay for services
- Gain insight into the perspective of direct caregivers in order to communicate effectively with them

Contents

Long-term Services and Supports
Ombudsman Role and Access
Assisted Living Facilities
Nursing Homes
Alternatives to Nursing Home Care
Advocacy Guide and Facility Contact Sheet

Activity: Elder Issues Game

Long-term Services and Supports

Long-term services and supports is a term to describe a range of services that can be provided in a variety of settings. Supports include home delivered meals, geriatric care management, financial planning and money management, home health care, assisted living facilities, continuing care retirement communities, nursing homes, and hospice.

Ombudsmen give information (never recommendations) on nursing homes and assisted living facilities based on a person's needs and preferences. National and state resources, such as the options below, can also be shared.

How to choose a facility:

- A Consumer Guide to Choosing a Nursing Home by National Consumer Voice for Quality Care, www.ltcombudsman.org
- Guide to Choosing a Nursing Home by Centers for Medicare and Medicaid Services, www.cms.gov
- Guide to Choosing an Assisted Living Community by Assisted Living Federation of America , www.alfa.org

Quality of facilities:

- Nursing Home Compare by Centers for Medicare and Medicaid Services, www.medicare.gov
- Quality Reporting System for assisted living facilities, nursing homes, home health care, and adult day care by Texas Department of Aging and Disability Services (DADS), www.dads.state.tx.us

Home Health and Hospice Agencies

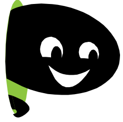
DADS licenses home health and hospice agencies as Home and Community Support Services Agencies (HCSSAs). People receive services in private homes, assisted living facilities, or nursing homes. Medicare, Medicaid, and other insurance may reimburse providers for services to eligible individuals.

Home health agencies provide services such as:

- nursing, including blood pressure monitoring and diabetes treatment;
- physical, occupational, speech, or respiratory therapy; and
- medical equipment and supplies.

Hospice agency services include:

- services provided by unlicensed personnel under the delegation of a registered nurse or physical therapist;
- palliative care (to soothe or relieve pain) for terminally ill clients; and
- support services for clients and their families that are available 24 hours a day, 7 days a week, during final stages of illness, death, and bereavement.



Ombudsman Tip: Nursing homes choose whether to offer hospice services. A contract between the facility and a hospice agency is required by state law. Staff in each provider type must define and practice their respective responsibilities. If issues occur, the contract can provide answers. Assisted living facility residents directly contract with home health and hospice agencies. While facilities and agencies coordinate care and services, the assisted living facilities hold overall responsibility.

Assisted Living Facilities

Assisted living facilities provide individualized health and personal care assistance in a homelike setting that is designed to emphasize dignity, autonomy, privacy, and independence.

DADS licenses an assisted living facility (ALF) under Health and Safety Code Chapter 247. The ability of residents to evacuate, types of services provided, or both determine licensure type. An assisted living facility must be licensed as:

- Type A. Residents must be to evacuate the building without physical assistance from staff and do not require routine attendance during night hours.
- Type B. Residents may require staff help to evacuate; they may require assistance during night hours, and may have difficultly following directions under emergency conditions.
- Type C. Contracts with DADS to provide adult foster care services and is licensed with a capacity of four beds.

As of May 2011, Texas has 1,636 assisted living facilities: 634 Type A, 926 Type B, and 76 Type C. Assisted living is further categorized as large or small as determined by the licensed bed capacity. If fewer than 17 beds, Type A and B facilities are designated as small; if more than 17 beds, facilities are designated as large.

Nursing Homes

Nursing homes are facilities that provide health care and must be licensed. For Medicaid and Medicare to reimburse for care provided to eligible residents, nursing homes must also be certified.

All nursing homes must be licensed by DADS. If they choose to participate in government reimbursement programs, DADS *certifies* them as nursing facilities, skilled nursing facilities, or both based on management's participation decision.

- If Medicaid program, they are nursing facilities.
- If they participate in the Medicare program, they are skilled nursing facilities (free standing or hospital-based).
- If they choose not to participate in government reimbursement, DADS designates them as Licensed Only (often known as private pay).

As of June 2011, Texas has a total of 1,178 nursing homes. Most are licensed and certified for Medicaid and Medicare reimbursement. Forty-six homes are certified only for Medicare reimbursement. Medicare certification allows the home to bill for “skilled nursing” services and the facility is referred to as a SNF. Fifteen homes are licensed-only, meaning they only receive private pay and private insurance to pay for services. There are 26 hospital-based skilled nursing facilities, usually rehabilitation units within a hospital. Services are paid for by Medicare and private insurance.

DADS Regulatory Services licenses, certifies, and monitors compliance of each of these license and certification types. Certification Training Chapter 9 has more information about regulators and an ombudsman’s relationship to their work.

Ombudsman Role and Access

In a facility, long-term care ombudsmen:

- Advocate for residents
- Provide information about how to select a facility
- Provide information on how to get quality care
- Identify problems in facilities and work to resolve them
- Investigate and resolve complaints made by a resident or by another complainant on behalf of a resident

In Texas, ombudsman services are available to residents living in nursing homes or assisted living facilities that are licensed or regulated by DADS. Ombudsmen have access to long-term care facilities, residents, and resident records if a resident gives consent. State rules describing this authority include:

- Texas Administrative Code
  - Chapter 85, Subchapter E Long-term Care Ombudsman Program
  - Chapter 19, Subchapter E Residents Rights Access and Visitation Rights
  - Chapter 92, Subchapter I Access to Residents and Records by the Long-term Care Ombudsman Program

Assisted Living Facilities

Assisted living facilities provide individualized health and personal care assistance in a homelike setting with an emphasis on personal dignity, autonomy, privacy, and independence. Facilities can be large apartment-like settings or private residences. Services often include meals, bathing, dressing, toileting, and administering or supervising medications.

Assisted living as it exists today emerged in the 1990s as an alternative for people who do not need 24-hour skilled nursing care provided by a nursing home but independent living is no longer appropriate. The assisted living philosophy emphasizes personal dignity and autonomy to age in place while receiving increasing or decreasing levels of services as needs change.

In Texas, a licensed assisted living facility is an establishment that:

- furnishes, in one or more facilities, food and shelter to four or more persons who are unrelated to the proprietor of the establishment;
- provides personal care services; and
- may provide help with or supervision of the medication administration.

DADS considers one or more facilities to be part of the same establishment and, therefore, subject to licensure, based on the following factors:

- common ownership;
- shared services, personnel, or equipment in any part of the facilities' operations;
- physical proximity; and
- any public appearance of joint operations or a relationship between the facilities.

Laws and Rules

There is no national assisted living facility definition. Each state determines a description of care that does not meet requirements for nursing home licensure. More than two-thirds of the states use the term "assisted living." Other states use terms such as personal care homes, board and care, adult family homes, and residential care homes.

DADS licenses and regulates assisted living facilities in Texas.

- Law - Health and Safety Code, Title 4, Chapter 247, Assisted Living Facilities
- Rule – Licensing Standards for Assisted Living Facilities

Typical Resident

General characteristics indicate a resident in an assisted living facility may:

- exhibit symptoms of mental or emotional disturbance, but is not considered at risk of imminent harm to self or others;
- need assistance with movement;
- require assistance with bathing, dressing, and grooming;
- require assistance with routine skin care;
- need reminders to encourage toilet routine and prevent incontinence;
- require temporary services by professional personnel;
- need assistance with medication, supervision of self-medication, or administration of medication;
- be hearing impaired or speech impaired;
- be incontinent without pressure sores;
- require a therapeutic diet;
- require self-help devices;
- require encouragement to eat or monitoring due to social or psychological reasons of temporary illness; and
- need assistance with meals, which may include assistance with dining.

Types

Texas licenses assisted living facilities based on residents' physical and mental ability to evacuate the facility in an emergency and whether nighttime attendance is necessary. An assisted living facility must be licensed as a Type A, B, or C. The ability of residents to evacuate, types of services provided, or both determine licensure type.

- Type A. In a Type A facility, night shift staff in a small facility must be immediately available. In a large facility, the staff must be immediately available and awake. In addition, a resident:
  - must be physically and mentally capable of evacuating the facility without physical assistance from staff, which may include an individual who is mobile, although non-ambulatory, such as an individual who uses a wheelchair or an electric chair, and has the capacity to transfer and evacuate him- or herself in an emergency;
  - does not require routine attendance during nighttime sleeping hours;
  - must be capable of following directions under emergency conditions; and
  - must be able to demonstrate to DADS they can travel from their living unit to a centralized space, such as lobby, living or dining room on the level of discharge within a 13-minute period without continuous staff assistance. Elevators cannot be used as an evacuation route.
- Type B. In a Type B facility, night shift staff must be immediately available and awake, regardless of the number of licensed beds. In addition, a resident may:
  - require staff assistance to evacuate;
  - require attendance during nighttime sleeping hours;
  - be incapable of following directions under emergency conditions; and
  - require assistance in transferring to and from a wheelchair, but must not be permanently bedfast.
- Type C. A Type C facility is a four-bed facility that:
  - has an active contract with DADS to provide adult foster care services; and
  - must be contracted with DADS to provide adult foster care services before it can be licensed.

Management and Operation

Each assisted living facility is unique. The organizational structure differs from one property to another. Corporations with boards of directors own some facilities and hire managers. Depending on size, a small facility may operate with a manager and attendants while a large facility may have a variety of departments. Many assisted living facilities are small, privately-owed homes with one staff typically on the premises.

Assisted Living Facility Manager

- Has authority over all operational and financial aspects;
- Abides by rules described in Licensing Standards for Assisted Living Facilities §92.41 (a)(1); and
- Ensures state regulations are met, develops policies and procedures, and hires, trains, and terminates staff.

Attendants

- Full-time attendants must be at least 18 years old or a high-school graduate.
- An attendant must be in the facility at all times when residents are in the facility.
- Attendants may perform other functions as required by the facility.
- Attendants are not required to be certified or licensed.

Financing Assisted Living Facility Care

Assisted living care is generally paid for with a person's private funds.

A facility can choose to accept residents who are eligible for Medicaid-waiver services, such as Community Based Alternatives (CBA). These services require a CBA contract with DADS and include contractual requirements that create additional oversight and enforcement options to the assisted living facility license. When an assisted living has a Medicaid-waiver contract, the Medicaid-eligible resident pays part of the cost, known as "co-pay," and Medicaid pays the remainder of the costs.

Home health care paid by Medicare, Medicaid, or other insurance may provide services to a resident who lives in an assisted living facility. A physician prescribes the home care and the agency arranges care for the resident. While the assisted living facility staff maintains authority for the resident's total care, a home health agency provides medical care.

---

1. Most assisted living staff is not ___________________ or _________________________.
2. In Texas, assisted living services emerged in what decade? ________
3. Assisted living can only be paid for with private funds (not Medicaid). True or False
4. Since residents can require help to evacuate, the highest level of care available is in a Type _____.

Comparing Assisted Living Facilities

DADS requires each licensed facility to complete an Assisted Living Disclosure Statement using DADS Form 3647 and to make it available to anyone who requests it. A disclosure statement describes facility policies and services. Sections include:

- Basic facility information
- Pre-admission process
- Admission process
- Discharge and transfer
- Planning and implementation of care
- Change in condition issues
- Staff training
- Physical environment
- Staffing patterns
- Residents' rights

Ombudsman tip: The assisted living facility disclosure statement, in addition to the agreement or contract signed at admission, is an important document for ombudsmen to be familiar with and to encourage residents and family to use as they work on resolving complaints.

Nursing Homes

Nursing homes are residences where people live who are rehabilitating from illness or injury, or who have chronic disabilities, and can receive services for their medical, social, and psychosocial needs. Businesses operate as either for-profit or not-for-profit. Building owners and operations managers may be different business entities. All nursing homes must be licensed and they can choose to be certified for Medicaid and Medicare reimbursement.

Residents require 24-hour nursing care and have significant needs with activities of daily living such as personal hygiene, dressing, and medicine administration. Whether old or young, they have physical or cognitive disabilities, and often both. A nursing home must meet additional requirements if children live there. In a Medicare-certified home, residents requiring skilled nursing services receive additional rehabilitative therapies to recover and regain functioning following an accident, injury, or illness.

A commonly held myth is that people go to nursing homes to die.

- Most move to a nursing home because their ability to care for themselves has deteriorated and they require around-the-clock nursing care. Needs vary with a wide range of cognitive impairments, mental illnesses, and physical disabilities. Many residents will live for years in a nursing home, while others may only live there for days or weeks.
- Some go for therapy following surgery. After rehabilitation, they return home.
- Others go for respite care, staying temporarily while caregivers rest or recover.

Residents have different care needs and different care outcomes. Through the care planning process, staff and residents individualize goals of care and direct how staff will care for the person. Details on care planning are discussed in Chapter 7 of this manual.

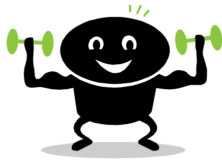
Prior to admission, physicians and residents (sometimes with the help of family) complete a Resident Transaction Notice, DADS Form 3618. When admitted, residents sign admission agreements that detail what residents pay and what nursing homes provide, such as room, board, and specific services. Costs vary based on level of care, setting, and location. At admission, residents also receive information about eligibility for Medicaid and Medicare benefits and rights, including a description of the long-term care ombudsman program.

Ombudsman tip: When meeting new residents and families, ask if they understood information in their admission packet, including bed-hold policy and Medicaid application process. Admission paperwork can be daunting; few people remember everything they sign and receive. As a reminder about our services, ombudsmen can explain their role in-person to new residents and families. Ombudsmen can review admission agreements for policies that appear inappropriate or misleading. Watch for requirements in admission agreements that assign a family member or other person to act as a "third-party pay source" for a resident. It is illegal for the facility to require such arrangement, and the family can seek legal advice about how to handle it.

DADS contracts with nursing home operators. Operators provide care to Medicaid clients whose medical conditions regularly requires the skills of licensed nurses. Medicaid services include:

- Nursing home care – meeting medical, nursing, and psychosocial needs of each client, to include room and board, social services, administration of medications, medical supplies and equipment, and personal needs items;
- Rehabilitative services - physical, occupational, and speech therapy to eligible residents who are recovering from an acute illness or an injury; if a Medicaid-eligible resident needs SNF services, Medicaid pays for the remaining costs not covered by Medicare;
- Hospice services - palliative care of medical, social, and support services for persons with a terminal illness diagnosis of six months or less to live;
- Emergency dental services - reimbursement for emergency dental services; routine dental services (such as cleaning or dentures) may be paid for using the resident's monthly income as an incurred medical expense; and
- Specialized services - therapies and restorative nursing services to residents determined to need these services in the Pre-admission Screening and Resident Review (PASRR) process.

Role Play Exercise: Introduction to a Nursing Home Administrator



Roles: Ombudsman Intern, Staff Ombudsman, Administrator

A staff ombudsman goes with an ombudsman intern to a nursing home. After the staff ombudsman introduces the intern, the administrator says, “You know we haven’t needed an ombudsman for a long time. DADS Regulatory Services surveys us and thinks we’re doing a great job. You probably won’t have much to do here.”

Questions for role play observers:

1. Why do you think the administrator made the statement above?

   ____

2. What are some positive aspects of the program you would stress to the administrator? ____

   ____

Laws and Rules

- United States: Code of Federal Regulations, Title 42 Chapter IV, Part 483 Requirements for States and Long Term Care Facilities
- Texas law: Health and Safety Code, Title 4 Chapter 242 Convalescent and Nursing Homes and Related Institutions
- Texas rule: Nursing Facility Requirements for Licensure and Medicaid Certification

Typical Resident

- Is a widowed, separated, or divorced woman in her mid 80's who shows mild forms of memory loss and dementia
- Requires assistance with 4 of 5 activities of daily living, such as eating, dressing, bathing, transferring and mobility, and going to the bathroom
- Recently in a hospital before entering a nursing home
- Has 3 to 5 medical diagnoses
- Most common diagnosis at admission is heart disease, followed by cognitive impairment and physical injuries
- Most common conditions reported are cognitive impairment and mental disorders
- Takes 9 medications
    - 6.7 routine prescription medications per day
    - 2.7 additional medications on an "as needed" basis

- Most commonly prescribed medications
    - gastrointestinal agents, such as laxatives, acid secretion reducers
    - analgesics, such as acetaminophen, aspirin
    - cardiovascular medications, such as Digoxin, diuretics, nitrates
    - vitamins and supplements, such as multivitamins, potassium
    - psychoactive medications, such as sedatives, hypnotics, antidepressants

SOURCE: American Medical Directors Association

While meeting the physical, mental, and psychosocial needs of residents, the nursing home also operates as a business. Typical management positions and direct care staff positions are described below.

Board of directors

- A board governs most facilities, either as a for-profit or not-for-profit home.
- In corporations, the board typically hires regional staff to ensure administrators and facility staff adheres to corporate policy. These regional managers are another level of management for an ombudsman to work with to resolve problems on behalf of residents.

Administrator

- The board of directors or regional director hires a licensed administrator. DADS oversees the credentialing of administrators.
- The administrator responsibilities include ensure state and federal regulations are met, develop policies and procedures, and hire, train, and terminate staff. He or she is responsible for all operational and financial aspects.
- Administrators have a high turnover rate; the average stay is 1½ years.

Ombudsman tip: Learn how the administrator wants you to communicate concerns, such as bring complaints and concerns directly to him or her, or give complaints to the matching department, such as food complaints to dietary or nursing complaints to nursing. Facilities must have a process to receive written complaints, so ombudsmen may use the written grievance policy as a more formal method to bring attention to some concerns.

Medical Services

Medical director

- A physician, licensed by the Texas Medical Board, hired by the nursing home to assist in and advise regarding the provision of nursing and health care.
- Residents may select their own physician, who may or may not be the facility's Medical Director.

Physician

- A resident or responsible party designates an attending physician to have primary responsibility for treatment and care.
- The physician signs all orders relating to resident care, such as medications and treatments.
- Physicians must see residents at least once every 30 days for the first 90 days after admission, and once every 60 days thereafter in Medicaid- and Medicare-certified facilities. Private pay residents must have a medical examination annually by their physicians.

Pharmacist

- An individual, licensed by the Texas State Board of Pharmacy to practice pharmacy, prepares and dispenses medications prescribed by a physician, dentist, or podiatrist.
- Based on size of the facility and other factors, the facility may employ a pharmacist or enter into a contract for services. Contracts are more common.

Nursing Services

Director of nursing (DON)

- The DON must be a Registered Nurse (RN). He or she:
  - Ensures nursing services are provided
  - Has administrative and personnel duties
  - Sets the nursing tone of the facility
  - Has a high turnover rate and stay on average 1½ years.

Licensed vocational nurse (LVN) / charge nurse

- A nurse currently licensed by the Texas Board of Nursing as a licensed vocational nurse.
- A charge nurse (an RN or LVN) is in charge of an area of the home; each shift must have a nurse who is in charge.

Ombudsman tip: Build professional working relationships with the DON and charge nurses since you will often bring care issues to that person's attention for resolution.

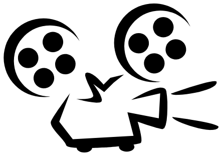
Certified nurse aide (CNA or aide)

- An individual who provides nursing or nursing-related services to residents under the supervision of a licensed nurse. CNAs are not authorized to provide nursing and/or nursing-related services for which a license or registration is required under state law.
- CNAs provide a majority of direct resident care.
- CNAs have a very high turnover rate and stay on average 6 months. They often work in more than one facility or care setting.

Medication aide

- An individual permitted by DADS to administer medications to residents.
- Medication aides must comply with CNA requirements.
- A medication aide holds a current permit and acts under the authority of a person whose license authorizes him or her to administer medication.

Ombudsman tip: CNAs can provide immediate help to residents and provide insight into a person's needs and preferences. Some view the CNA as the hardest-working staff. Many CNAs appreciate praise for a job well done. "Walk the Fine Line" in Chapter 8 provides ideas on how to give praise without crossing limits with CNAs and other facility staff.



Video: And Thou Shalt Honor, Voices from the Trenches

Examine the relationship between CNAs and those they care for in private homes and care facilities. The caregivers don't mince words. Underpaid, over worked, and under appreciated, CNAs from Florida, Minnesota, and New York describe the frustration and joy of this intimate, challenging work.

1. What are some reasons families need professional caregivers?

   ____

   ____

   ____

2. Name one challenge facing professional caregivers.

   ____

3. Name a problem created for residents by high turnover rates of workers.

   ____

   ____

4. One nursing home caregiver uses language that seems disrespectful. Write examples and suggest how to say it differently.

   ____

   ____

   ____

Other Services

Business office manager (BOM)

- A person who handles the bookkeeping and billing for each resident.
- He or she maintains demographic information of residents, including their payment source and location in the building.
- The BOM sometimes helps residents complete their Medicaid application or file long-term care insurance claims.

Ombudsman tip: Visit the business office once a month for a list of residents, their rooms, and to learn of new residents, discharges, or residents who are in the hospital.

Admissions director

- A person who oversees the admissions process in a nursing home. He or she is a resource for admissions materials.
- Sometimes the admissions director also serves as the facility social worker.

Social worker / social services director

- A qualified social worker is licensed, or provisionally licensed, by the Texas State Board of Social Work Examiners. Some staff who fill this role are not licensed but must be seeking licensure and operate under the supervision of a licensed social worker.
- Social services staff is often responsible for meeting psychosocial needs of residents and responding to family issues related to residents. Facilities with more than 120 beds must employ a full-time social worker. Those with 120 beds or fewer may contract or employ a part-time social worker.
- Social workers should be advocates for individualized resident needs. They may be an important link for an ombudsman between the home and resident.
- Social workers may also be the admissions coordinator or marketing director.
- The social worker frequently:
  - Functions as the staff liaison to the family council;
  - Serves as primary point of contact for making medical (including vision, hearing, and dental) appointments; and
  - Organizes and schedules care plan meetings.

Ombudsman tip: The social worker may be a resource for you to learn about newly admitted residents or those who may benefit from your visit.

Dietary supervisor

- The person who supervises cooks, helpers, and dishwashers.
- The dietary supervisor works with corporate dieticians to ensure dietary compliance and specialty diets for residents.

Activity director

- A qualified individual appointed by the facility who directs the activities program as described in Nursing Facility Requirements §19.702. This position may also be called Life Enrichment Director or similar title.
- An activity director provides an ongoing program of activities to meet the interests and abilities of each resident. Activities should include more than the 3 B's - birthday, bible, and bingo. This area of nursing home life should take its cue from resident direction and address each resident's individual needs.
- The activity director or assistant is often a staff liaison to the resident council.

Housekeeping

- The housekeeping staff oversees many environmental factors in the building related to resident rooms, cleaning, and laundry.

Maintenance

- Staff who are responsible for the interior and exterior of the physical plant including call lights operation; electrical outlets and lighting; air conditioning and heating; hallway railings and grab bars; physical condition of the walls, ceilings, and floors; ventilation, and other requirements.

Contracted Services

Facilities enter into contracts with agencies or professionals to provide specific services. These may include the following:

- Therapist: Physical, Occupational, and Speech
- Podiatrist
- Dentist
- Pharmacist
- Ophthalmologist
- Psychologist
- Psychiatrist

Exercise: Help! – Identify the Right Person

Identify the best person to help solve each problem. Assume you obtained consent from the resident in order to take action.

Activities director	Certified nurse aide	Housekeeping staff
Administrator	Director of nursing	Medical director
Business office staff	Dietary staff	Social worker
Charge nurse	Family member	Staff ombudsman

1. Mrs. Ortiz speaks Spanish, and you need an interpreter to communicate with her ____
2. You notice Mr. Smith's drinking water container is empty ____________________
3. Mrs. McMillan reports that she lost a sweater ______________________________
4. Mr. Jones appears to be uncharacteristically depressed _____________________
5. There is something extremely sticky on the floor of the main entrance ____
6. Several call bells are answered slowly and some not at all ____
7. Mr. Jenkins is worried about his bills ____________________________________
8. A resident tells you the aide named "Mary" hit her _________________________
9. Mrs. Nelson tells you she does not get her personal needs allowance ____
10. A number of residents tell you they have not seen the doctor this month ____
11. The social worker asks if you can help with a resident's Power of Attorney who is not paying the nursing home bill ____
12. After speaking several times with the Director of Food Services, you find that complaints are not getting resolved. _____________________________________
13. You notice a resident is sliding out of a chair ______________________________
14. Mr. Sims appears lonely and bored _______________________________________
15. Two roommates are arguing with each other ______________________________

Financing Nursing Home Care

Personal

- Private pay: individuals or legal representatives use the residents' personal funds
- Insurance: some companies allow clients to use life insurance policies to pay for long-term care. Some Medicare-eligible individuals may have a supplemental insurance policy to pay costs beyond the basic Medicare skilled nursing benefit. Each policy is different so nursing homes must work with an insurance agent to understand the scope of coverage.
- Long-term care insurance: this insurance can provide coverage to pay for care in nursing homes and some assisted living facilities. A policy may include skilled and non-skilled care. Each policy is different, so nursing homes must work with the insurance company to bill for reimbursement.

Government

- Medicare
  - An insurance program for individuals are 65 years old, disabled, or people with end stage renal disease
  - Beneficiaries share costs through deductibles and monthly premiums that help cover inpatient care in hospitals, skilled nursing services, hospice, and home health care
  - Pays for skilled care of residents who were admitted to a hospital (not just under observation) for at least 72 hours prior to nursing home admission. Pays 100% for 1-20 days, then 80% for 21-100 days; if the person is also Medicaid-eligible, the remaining 20% of costs is paid by Medicaid

- Medicaid
  - Assistance program covers low-income individuals regardless of age
  - To be eligible, a resident must have some form of monthly income
  - Has no monthly insurance fee
  - Paid by state and federal taxes
  - A majority of nursing home residents are on Medicaid

- Veterans' Administration (VA)
  - Admission and eligibility criteria varies by program
  - National programs
    - VA owned and operated Community Living Centers
    - State veterans' homes owned and operated by the states; Texas Veterans Land Board in Texas General Land Office operates Texas state veterans homes
    - VA contracts with other nursing homes to provide services to veterans

Medicaid eligibility has many terms associated with the process. Ombudsmen need to understand these basics:

> About 70% of residents are eligible for Medicaid to pay for their care. Though many nursing homes will help, the person is responsible for completing paperwork to determine financial and medical eligibility.
>
> A Medicaid eligibility worker in the Health and Human Services Commission (HHSC) determines financial eligibility. Workers are assigned to several nursing homes and conduct their work by phone and mail. Some nursing homes have a Medicaid worker located in their facility; this HHSC employee is called an *out-stationed worker.* Financial eligibility is based on criteria set for an individual's maximum allowed monthly income and resources.
>
> To determine medical eligibility, DADS contracts with Texas Medicaid & Healthcare Partnership (TMHP) to evaluate assessment information. To be eligible, a resident needs to meet state criteria for "medical necessity." TMHP bases the determination on a resident's Resident Assessment Instrument and sets a Resource Utilization Group (RUG) reimbursement rate. That rate is the amount Medicaid reimburses a nursing home each day it delivers care to that resident.
>
> Once eligible, a resident pays the nursing home each month with their monthly income, usually a Social Security check, which is called "applied income." Sixty dollars per month is reserved to pay for incidental items. The remainder of the cost of the resident's care is paid for by Medicaid, which includes 60% federal funds and 40% state funds. Medicaid is considered a state program, even though the federal government provides matching funds. The $60 dollars a resident receives each month is called Personal Needs Allowance.

Humans determine eligibility, and as such, may make mistakes. A frequent problem is incomplete paperwork that does not sufficiently describe a resident's medical needs or a failure to provide necessary financial documentation. Ombudsmen can help by reminding parties to submit complete information and persuading facility staff to communicate with TMHP. If barriers are found in the system, ombudsmen can help identify state resources to overcome problems.

Ombudsman tip: When a resident is away for more than 72 hours, the nursing home temporarily stops receiving Medicaid reimbursement until the resident returns. For example, lengthy hospital stays place the facility in situations of empty beds and that impacts revenue. Federal law requires a nursing home to provide written information about the resident right to pay for a "bed-hold." The hold reserves a resident's bed in the nursing home. Learn the bed-hold policy in your assigned facility and share any concerns with your supervising staff ombudsman.

Resident Trust Funds

- Residents whose care is paid for with Medicaid receive $60 per month. With authorization from the resident or legal representative, the facility must hold, safeguard, manage, and account for the personal funds in a trust fund account.
- The facility must deposit funds:
  - in excess of $50 in an interest bearing account that is separate from the facility's account; and
  - less than $50 in a non-interest bearing account, interest bearing account, or petty cash fund.
- To remain Medicaid-eligible, a resident's resources must not exceed $2000. If savings are reaching the $2000 mark, the resident has an opportunity to purchase something needed or wanted, like clothing, a phone, or a television. Purchases are the property of the resident. The facility must not make charges to resident's funds for items or services paid for by Medicare or Medicaid, such as bath soaps, deodorants, moisturizing lotions, tissues, and incontinent supplies, unless the resident authorizes it and the resident prefers to purchase a specific brand of supplies.

Access to Personal Funds

If the facility is holding a resident's personal funds, these are available to the resident during normal working hours on regular business days. Upon a resident's request, transfer, or discharge, the nursing home must return the full balance of his or her personal funds within 30 days. The facility must respond to requests received after hours immediately at the beginning of the next normal business hours.

---

1. On average, how many nursing home residents pay with Medicaid? ________%
2. A person using Medicaid to pay for nursing home care keeps $_______ each month. This is called a ____________ _________ ______________________.
3. What is "applied income?" ______________________ ____
4. DADS contracts with TMHP to determine a resident's __________________ ________________________.

Activity: Elder Issues Game

Learn about points of view of different facility staff. Increase awareness of issues relating to elders who live in nursing homes.

Play for 20 minutes or a set number of scenarios. Divide players into groups of six (if not enough people, take more than one role). Give each group a set of “scenario” cards (description of an issue, concern, or situation based on real life situations), “role” cards (six facility staff positions), and one die.

Assign each player a role.

- Administration (green)
- Dietary (blue)
- Nursing (orange)
- Family/caregiver (yellow)
- Social service (light blue)
- Resident (cream)

Players read "key" card role descriptions to the group and place cards in front of them.

To start, the Resident rolls the die and then draws a color-coded scenario card.

After drawing a card, the player reads the scenario to the group. The facilitator turns the three-minute timer over. The group discusses the scenario with each player speaking from the view point of the assigned role.

After time expires, the group discusses that scenario. The next player draws an ALL PLAY card and reads it to the group. The facilitator turns the timer over and play continues. After an ALL PLAY, the player rolls the die and continues as above.
Play continues with each player reading an ALL PLAY scenario, then rolling the die for the next scenario.

After the game, discuss:

- Were there issues that surprised you? If so, which ones?
- How did it feel playing your assigned role?
- Was your group “stuck” on any of the scenarios?
- Could you understand the different perspectives in each scenario?
- What challenges did you recognize about caring for people in a long-term care facility?
- What did you learn from playing the game?

Notes: Some groups may finish a scenario discussion before time expires. Decide before play begins whether they will continue with another scenario. The kit includes “situation” card sets, name “role” cards, four dice, and a three-minute timer.

Alternatives to Nursing Home Care

A range of options exist for long-term services and supports. Financing those options is at the heart of any decision. Texas has a policy and initiative, called Money Follows the Person. It allows funding for Medicaid-eligible nursing home residents to be used in settings other than nursing homes. If residents wish to exercise this option, they use a Medicaid waiver to relocate.

The federal government approves waivers to use the money that would be paid to nursing homes to instead pay for services in other settings that in theory less costly. Texas most commonly used waivers to relocate from nursing homes are Community Based Alternative (CBA) and Community Care for Aged and Disabled (CCAD). For Medicaid-eligible people who are elderly, have a long-lasting illness, or have a disability, Texas uses Star+Plus in many counties. Star+Plus offers health care and long-term care services provided through a health plan (also called a health maintenance organization or HMO).

Residents can use these waivers in private homes or in assisted living facilities under contract with DADS to provide such services. Relatively few assisted living facilities have a contract to provide waiver services, so a majority of people live in apartments or houses. They may have family living with them, other roommates, or live alone. The waiver program can pay for nursing services, attendant care for getting a bath, meal preparation, housekeeping services, and for help getting in and out of a bed or chair.

Unfortunately in Texas, Medicaid-financed alternatives to nursing home care are most easily accessed by moving into a nursing home first, bypassing a waiver interest list, and then relocating to an independent setting. During the process, individuals can lose housing and other natural supports.

Federal and state governments appear motivated to “rebalance” the Medicaid payment system. Rebalancing refers to changing government policies biased towards institutional care to policies that allow individual choice to direct where a person lives.

It is likely there will always be a need for nursing homes, but changes in the overall system and more options appear to be on the horizon. Chapter 11 describes systems advocacy and offers guidance to ombudsmen on how to affect change for residents to live in settings other than a nursing home.

Ombudsman tip: Provide information to residents who indicate they want to transition to the community. Tell them how to contact their Relocation Specialist.

Advocacy Guide for Ombudsmen

The regular presence of staff and volunteer ombudsmen improves resident care and quality of life. Remember these, "Things to look for…," during visits to help you focus on residents and avoid becoming desensitized to concerns in the facility where you visit.

Things to look for in residents

Are residents:

- Clean and dressed?
- Participating in regular activities?
- Receiving meals and snacks?
- Asked about individual preferences?
- Restrained*?
- Treated with kindness and respect?

*Learn the facility's restraint policies.

  - Is each restraint medically necessary?
  - What alternatives are tried first?
  - Can a staff ombudsman provide training on the risks of restraint use?
  - Is the facility actively trying to remove restraints?

Things to look for in staff

Do staff:

- Make eye contact and smile with residents and with you?
- Know the residents by name?
- Respond quickly to call lights?
- Knock on doors before entering a resident's room?
- Treat residents with respect, courtesy, and dignity?
- Ensure residents are covered for privacy when being moved in the hallway for a bath and while providing care?
- Wear name badges?

Things to look for in the physical environment

- Are there odors in the rooms and halls?
- Do residents have outside spaces to enjoy?
- Are there private areas for conversations and phone calls?
- Are there safety features such as door alarms on exits, smoke alarms and detectors, and warning signs displaying wet floors?
- Do residents have ample access to water in their rooms and in public areas access to water, coffee, and other fluids?
- Are public restrooms and other public areas accessible to residents?

Things to look for in administration

- Are resident rights posted?
- Is the ombudsman poster visible?
- Are visiting hours enforced against resident wishes and family schedules?
- Are resident policies fair and within resident rights?
- Is the menu posted and followed?
- Do residents help direct menu choices?
- Are resident menu preferences followed?
- Are there flexible dining hours?
- Is the activity calendar posted and followed?
- Are activities varied, meaningful, and connected with the outside community?
- Are DADS survey results accessible?

Facility Contact Sheet

Facility Name ____ ID# _______________

Owner ____

Administrator or Manager ____

Medical Director ____

Director of Nursing ____

Social Worker ____

Activity Director ____

Housekeeping / Laundry ____

Resident Council Contact ____

Family Council Contact ____

Specialized Care ____

____

Community Involvement ____

Ombudsman tip: Be aware of changes in ownership or key personnel. Keep your staff ombudsman updated through your monthly activity report.

The most recent survey was conducted on __________________

Once a year, ask for a copy of the admissions packet given to residents. Review it and check that it is easy to understand and complete with the required notices:

- Resident rights
- Current information about the ombudsman program; and
- Current policies about safety and resident responsibilities.

Inform your supervising staff ombudsman of any concerns.

Observed and prepared by:

____ ________________

Ombudsman Date

Ombudsman Certification Training

CHAPTER 5

Resident Rights

--This page intentionally left blank—

Resident Rights

Chapter 5 is about understanding resident rights and the ombudsman role to support residents in exercising their rights.

Learning Objectives

- Become familiar with the scope of resident rights
- Recognize the importance of empowering residents rather than creating dependency
- Connect resident rights to applicable complaints

Contents

Overview
Resident Rights Themes
Resident Rights under Law
Specific Rights

Supplement A-5: Nursing Home Resident Rights
Supplement B-5: Assisted Living Facility Bill of Rights

When asked what they consider most important to the quality of their lives, residents say:

"Give me kind, caring staff who respect my dignity and privacy and treat me as a person. Recognize I am an adult and let me make choices in all areas of my life."

Overview

Long-term care ombudsmen have a responsibility to:

- provide information about resident rights; and
- help residents to exercise their rights.

Understanding resident rights and an ombudsman's role to support residents in exercising their rights is essential. The ombudsman process and approach is much the same regardless of whether a resident lives in a nursing home or assisted living facility. Laws and regulations are not.

Ombudsmen use laws and regulations as advocacy tools. Some regulations referenced in this chapter apply only to nursing homes that accept Medicaid or Medicare. Rely on state laws and regulations for people who live in assisted living facilities and licensed-only nursing homes.

You have daily routines and preferences.

- How and when do you wake up?
- What is your usual bathroom routine?
- How do you get ready for bed?
- When, what, where, and how do you like to eat?

If you were a resident,

- What must staff know about you to have a good relationship?
- How would you feel if you had to change your routines?

How might individual routines impact resident rights?

____

____

____

Empowerment

Empowerment means to take power for oneself or give your power to another. This concept can be applied to help a disadvantaged person or group to self-advocate.

Empowerment is a foundation of ombudsman work. As a primary way of relating to residents, ombudsmen always encourage residents to:

- speak on their own behalf; and
- have direct, open communication with other residents, family, and staff.

Everyone has their own way of expressing personality, participating in groups, and dealing with problems. How we express ourselves depends on how we see and exercise our power in a given situation. Many factors affect a person's way of living in a facility. Personal factors may include:

- Individual's history or life experience
- Current health
- Current support system
- Facility size, culture, and physical environment

Living in a facility can dampen a person's sense of self and capabilities. Residents are thrust into a new environment with new rules and new social standards.

Living in a facility can "disempower" residents. Residents may not want to upset caregivers. They may not have the health, mobility, or energy to figure out how to get help. Conversations and interactions with people they know, that can strengthen a sense of self, may be infrequent. This can lead to feeling powerless, disoriented, or despondent. Generational, gender, and ethnic differences can affect a person's sense of empowerment. Individuals may have:

- Used indirect or direct approaches to work out problems
- Depended traditionally on others to speak for them
- Accepted the status quo

Describe Empowerment.

____

____

Once disempowered, a person may feel powerless,

____________________ or ____________________.

Residents may not choose to fully exercise their rights because they:

1. Feel intimidated by the idea of appearing critical
2. Lack information about rights or not think about concerns as rights
3. Prefer to choose battles and put up with daily limitations of their dignity and individuality because:
   - It requires too much strength to challenge
   - They may be labeled a troublemaker
   - They depend on caregivers to provide for their basic care
   - They feel defeated
4. Accept that their rights are limited as a part of the daily routine and stop seeing these limits as a problem
5. Have physical, emotional, psychological, social, and cognitive disabilities that make it difficult to voice concerns
6. Fear they may be discharged if they speak up

What are some reasons residents might not complain when their rights are violated?

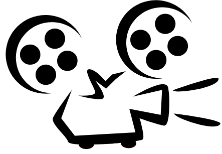
- ______________________________
- ______________________________
- ______________________________
- ______________________________
- ______________________________

Ombudsman Role

Residents can regain personal power and voice. If a resident:

- Finds it easy to speak up, an ombudsman can point them in the right direction and reassure them of their rights
- Needs more support, an ombudsman can be present as the resident expresses the need or speak on the resident's behalf
- Is severely impaired or unable to communicate needs, an ombudsman may need to carry more of the load

First, get to know residents as individuals. With that connection, residents may share concerns about their experiences. How you respond and work with these concerns can go a long way to empower residents and restore their sense of self. Relate honestly and authentically to the resident and to the situation.



Video: Voices Speak Out Against Retaliation

Five people tell stories about their lives, the changes when they moved into a nursing home and their fears. Then they share how they found their voices and became empowered to live life to its fullest. Listen to Helen, Kramer, Mary, Rich, and Ronnie speak in their own words.

When speaking about fear of retaliation, what did the residents tell you?

____

____

____

____

What can you do as an ombudsman to reduce fear of retaliation?

____

____

____

____

Resident-Directed

Take residents experiences and viewpoints seriously. Proceed at their pace and in the direction they choose. Promote an environment in which residents, families, and staff can talk with each other to make life work well for residents living and staff working in the facility. In this environment, ombudsmen can address problems at the earliest stages before they become major problems.

Empowering residents takes patience and persistence. Control the urge to take over and problem solve. Take the lead from residents and with their permission, help carry their message. This helps residents maintain control over their own lives.
Encourage residents to communicate with the staff who can resolve problems. If residents feel they can tell their problems to staff and have those problems addressed, residents are truly empowered.

Resident direction is the key to an ombudsman helping to empower residents because…

____

____

____

Possible Obstacles to Implementing Resident Rights

1. Residents who assert their rights may face resistance from every level. Staff may discourage them or create barriers to a resident's efforts.
2. Many residents do not have social supports inside or outside to encourage or help them to exercise their rights.
3. Resident councils rarely receive the leadership development needed to function effectively.
4. Some facilities are run as strictly controlled institutions with little room for individuality, choice, free expression, or personal autonomy.
5. Staff is not always sufficiently trained and may not understand resident rights.
6. Short staffing prevents staff from taking the time to treat residents respectfully.
7. Staff is expected to provide care and may not know how to empower residents to care for themselves.
8. It takes longer to help residents do some things for themselves than to do it for them.
9. Staff may sense residents' concerns and recommendations as another demand on their work schedule.
10. Many staff and others see residents' impairments instead of abilities.
11. Residents may fear the unknown.

SOURCE: Consumer Voice, Nursing Home Resident Rights Project

How can short staffing negatively affect resident rights? Short staffing prevents staff from taking the time to

- ____
- ____
- ____
- ____

Resident Rights Themes

One way to consider resident rights is to categorize them into four themes.

- Communication
- Choice
- Decision-making
- Participation

Communication

Effective, ongoing communication between residents and facility staff is essential. The facility must communicate with residents in languages they understand. This includes information about their rights, health status, plan of care, activities, and other aspects of life in the nursing home and assisted living facility.

A resident may say, "I don't want this food." What does it really mean? It could be -

- a way to say she dislikes the food because it is cold, bland, or she never liked it;
- the resident is refusing a special diet; or
- a different, unrelated meaning behind refusing the food.

When residents exercise their right to say "No," staff should ask questions and observe until they fully understand what the resident is really expressing. Residents who have cognitive impairment can also express choice and need to be asked.

Choice

State and federal law challenges each facility to focus on meeting the needs and desires of each individual resident, not on maintaining the customary routines of an institution. Residents make choices based on various reasons such as culture, ethnicity, health, and religion.

Exercising choice is a continual process.

- Making a choice is not a time-limited event.
  For example, if a resident does not care what clothes she wears one day, her choice does not mean she will never have a preference about her clothes.
- An individual's choices and preferences may change.
  For example, after a person has lived in the facility awhile, or if her condition changes, she may make different choices than previous ones.
- An individual's choices and preferences may remain constant.
  For example, if a person holds specific religious beliefs, he wants his diet to continue to adhere to that faith.

Ask the Trainer: Meal times

A nursing home changed breakfast time from 8:00 to 7:00 a.m., but a group of residents don't want to get up that early.

1. Do residents have a say in this policy? ___________________________

2. How would you approach this problem as the ombudsman?

____

____

____

Decision-Making

Unless a court determines a person is incapacitated (unable to make decisions), he or she exercises all of his or her personal rights. To exercise decision-making, a person needs two things:

- Full information. To make an informed decision, a person needs accurate information about alternatives and short- and long-term consequences about the decisions being considered.
- An encouraging and supportive environment. Residents should feel free to make decisions without fear of being declared incapacitated or discharged if their decisions differ from what professionals recommend or their family wants.

Participation

Residents are encouraged by law to participate in

- Planning their care and treatment;
- Care plan meetings;
- Resident groups such as a resident council if they choose;
- Social, religious, and community activities; and
- The survey process.

If residents want to move out of nursing homes, they participate in making decisions about the transition. Medicaid-eligible residents can work with a relocation specialist to use the Money Follows the Person program. More details about this program are in Chapter 9 Regulators and Resources and Chapter 11 Systems Advocacy.

Residents with cognitive impairment or other disabilities can participate in planning care and exercising choice. If staff cannot honor resident preferences, they need to problem solve with the resident to find a solution as close as possible to what the resident wants.

Resident Rights under Law

The United States Constitution sets forth certain rights for all citizens. People do not lose these rights when they move to an assisted living facility or nursing home. In fact, federal and state laws guarantee additional rights specific to their status as nursing home residents and state law protects rights specific to assisted living residents.

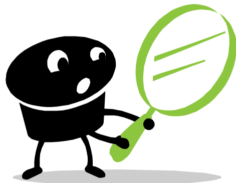
The United States Congress and Texas Legislature pass laws. Agencies interpret laws with rules and regulations. If there is a discrepancy, the law provides a definitive answer.

Federal

- Nursing Home Reform Law: Omnibus Budget Reconciliation Act of 1987 (OBRA '87), as amended, Medicaid Provisions §1396r and Medicare Provisions §1395i-3
- Regulation: Medicare and Medicaid Requirements for Long Term Care Facilities, 42 U.S. Code of Federal Regulations, §483

State of Texas

- Laws: Health & Safety Code
  - Chapter 242 Convalescent and Nursing Homes
  - Chapter 247 Assisted Living Facilities (see also Chapter 102 of the Texas Human Resources Code, Rights of the Elderly)
- Regulations: Texas Administrative Code, Title 40, Part 1
  - Chapter 19 Nursing Facility Requirements
  - Chapter 92 Licensing Standards for Assisted Living Facilities



Foundation of nursing home resident rights

1. Quality of care: provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care.
2. Quality of life: care for residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

Ask the Trainer: Late Night Television

A resident wants to watch television in the living room of his assisted living facility in the late hours of the evening. The manager said the TV must be off at 8:00 p.m. because it keeps other residents awake.

1. Whose rights need to be protected, the complainant or those who go to bed at 8:00? ____________________________________
2. Are there differences in resident rights in an assisted living facility as opposed to a similar situation in a nursing home? ____________________________

   ____

   ____

Specific Rights

Resident rights safeguard and promote dignity, choice, and self-determination.

Nursing homes must comply with the Nursing Facility Requirements and assisted living facilities must comply with the Licensing Standards for Assisted Living Facilities. Both sets of rules include resident rights provisions.

Resident rights may be restricted only to the extent necessary to protect the resident or other residents, or to protect the rights of others, particularly rights relating to privacy and confidentiality. The following rights pertain to nursing home residents and are in addition to other rights and remedies people may be entitled to, according to rules and under the law.

Dignity and Respect

Residents have the right to:

- Live in safe, decent, and clean conditions
- Be free from abuse, neglect, and exploitation
- Be treated with dignity, courtesy, consideration, and respect
- Be free from discrimination based on age, race, religion, sex, nationality, disability, marital status, or source of payment
- Practice your own religious beliefs
- Keep and use personal property, secure from theft or loss
- Choose and wear your own clothes
- Be free from any physical or chemical restraints used for discipline or convenience and not required to treat your medical symptoms
- Receive visitors

Freedom of Choice

Residents have the right to:

- Make choices regarding personal affairs, care, benefits, and services
- Choose their physician at their own expense or through a health care plan
- Manage personal financial affairs in the least restrictive method, or delegate that responsibility to another person
- Access money and property deposited with the facility and have an accounting of that money and property and of all financial transactions made with or on their behalf
- Participate in activities inside and outside the facility
- Place in their room an electronic monitoring device that is owned and operated by them or provided by their guardian or legal representative
- Refuse to perform services for the person or facility providing services
- Use advance directives as in Health and Safety Code §166.002
- Designate a guardian or representative to ensure quality stewardship of their affairs, if protective measures are required

---

1. Residents can leave their nursing home for visits and can stay overnight. True or False
2. Residents have the right to determine their personal care schedule, such as activities, bathing, and bedtime. True or False
3. Residents have the right to keep money in their room. True or False

---

Ask the Trainer: Love and Marriage

A nursing home administrator told marriage-bound residents, “You can get married, as long as your children give permission. I’m not sure you’ll be able to share a room.”

1. Do residents need permission to marry? ______________________

2. Will the newlyweds be entitled to their own room? What if a couple is not married, can they room together?

   ____

   ____

Privacy and Confidentiality

Residents have the right to:

- Privacy, including during visits, phone calls, and attending to personal needs
- Have facility information about them maintained as confidential
- Send and receive unopened mail and receive help in reading or writing correspondence

---

1. Residents have the right to receive their mail unopened, including government benefit checks that will pay for their care at the facility. True or False

2. Facility staff may monitor resident visits with a long-term care ombudsman. True or False

---

Participation in Care

Residents have the right to:

- Receive all care necessary to have the highest possible level of health
- Participate in developing a care plan and refuse to participate in experimental research
- Refuse treatment, care, or services
- Receive information about prescribed psychoactive medication from the person who prescribes the medication or that person's designee
- Have psychoactive medications prescribed and administered in a responsible manner and refuse to consent to the prescription of psychoactive medications
- Access personal and clinical records, which will be maintained as confidential and may not be released without their consent
- Communicate in native languages to get or receive treatment, care, or services

---

1. A resident has the right to review all medical and financial records pertaining to them. True or False
2. Residents have the right to refuse food, medicine, therapy, and other services. True or False

---

Transfers and Discharges

Residents have the right to:

- Not be relocated within the facility, except in accordance with rules
- Discharge themselves unless the courts adjudicated them incapacitated
- Not be discharged from the facility, except as provided in regulations
- Receive a 30-day written notice sent to them and a legally authorized representative or family member
- Appeal a discharge within 10 days of receiving notice in a Medicaid facility
- Be readmitted to the facility as provided by regulations
- Notice of immediate discharge in the event the resident becomes a threat to the health and safety of himself or others
- Right to notice of bed hold policy

---

1. Residents should receive a __-day notice of a home's intent to discharge them. It must be in ____________.
2. The resident has __ days to appeal.

Information

Residents have the right to:

- Receive a written statement or admission agreement describing services provided by the facility and related charges
- Be informed of Medicare or Medicaid benefits
- Receive a Statement of Resident Rights and be informed of revisions
- Be informed in a language they understand about total medical condition, recommended treatment and expected results (including reasonably expected effects and risks), and be notified when their condition significantly changes

Complaints

Residents have the right to:

- Complain about care or treatment without fear of reprisal or discrimination
- Receive a prompt response to resolve complaints from the facility
- Organize or participate in any group that presents residents' concerns to the administrator of the facility

---

1. Residents have a right to complain only about situations that directly affect them. True or False

2. Only approved residents have the right to attend and participate in resident council meetings. True or False

---

Exercise: Residents Have Rights

Use Supplement A or B to choose the resident right to help resolve the complaint.

1. My doctor won't listen to me. He is always in a rush. I want to see another doctor.

   ____

   ____

2. No one will tell me why I have to take so many pills every day.

   ____

   ____

3. Tomorrow they are moving me to another hallway. I don't want to move.

   ____

   ____

4. My mother is very frail and I don't want her to fall. Yet they won't put side rails up on her bed at night.

   ____

   ____

5. My friend is very critical of staff when she comes. The administrator says if she doesn't stop, she cannot visit any more.

   ____

   ____

6. The staff who feed my Dad shoves food into his mouth without care or attention.

   ____

   ____

7. My sister stopped eating and is losing weight. The doctor wants to insert a feeding tube, but my sister always said she didn't want one.

   ____

   ____

8. The activities are boring here … TV, bingo, or playing with paint like children!

____

____

9. My hearing aid is lost. They won't get me another.

____

____

10. Someone is spying on me. My mail is opened before I get it.

____

____

11. I told the nurse last week there's a sore on my leg. No one has checked it yet.

____

____

12. This place is like a prison. I want to go home and they won't let me.

____

____

13. The housekeeping staff always barges in when I'm undressed. No one ever knocks before they come into my room.

____

____

14. When I visit Dad, he's usually sitting in a soiled brief. When I tell the nurse, she says, "I'm busy now. I'll come as soon as I can," and then comes an hour later.

____

____

Rights of Families and Legal Representatives

Federal law provides family and legal representatives with certain rights related to information and participation. Legal representatives include guardians and individuals acting as agents, such as an agent authorized by a Medical Power of Attorney. Family, subject to the resident's direction, and legal representatives have the right to:

- Be notified:
  - within 24 hours of an accident resulting in injury, a significant change in the resident's physical, mental or psychosocial status, a need to alter treatment significantly, or a decision to transfer the resident;
  - of appeal rights related to loss of benefits, services, or discharge;
  - promptly of a change in room, roommate, or in resident rights provisions; and
  - if the facility receives a waiver of licensed nurse staffing requirements;
- Participate:
  - in the care planning process; and
  - in a family council that may meet privately in space provided by the facility, and have a facility staff person serve as liaison to the council;
- Have immediate access to the resident, subject to the resident's rights to deny or withdraw consent at any time; and
- Make recommendations to the facility. The facility must listen to the views and act on grievances and recommendations by residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

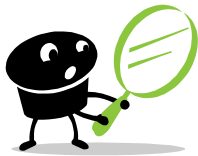
---

1. Family has a right to be notified within 24 hours of an ________________________or a significant change in ________________________.
2. Family also has a right to participate in the _______________ _____________________ process.

Incapacitated Residents

If a court determines a person is incapacitated, resident rights are exercised by the person appointed under Texas law to act on his or her behalf. Even with a guardian, an incapacitated person should be encouraged to make as many decisions as they are able. Frequently, family members and facility staff use the label of guardian incorrectly. Many family members are authorized as a medical or financial decision-maker by a Power of Attorney (POA). A majority of family members act as decision-makers with no legal authority to do so.

Ombudsmen should not assume a person is a legal guardian of a resident unless a letter of guardianship, dated within the current year, is made available. Powers of Attorney are important advance care planning documents, but as long as residents can speak for themselves, the resident's wishes supersede the agent's. Read Chapter 10 for more information about advance care planning.



Unless a court determines a resident is legally incapacitated, residents speak for themselves

Enforcement of Resident Rights

The primary mechanism to enforce resident rights is the survey and certification process performed by DADS Regulatory Services and described in Chapter 8. Having resident rights as part of federal and state laws gives emphasis to the rights. However, a lack of understanding and sensitivity to resident rights can hinder enforcement.

Resident rights can be difficult to quantify compared with other regulations. Violations may be challenging to document and prove. Surveyors may fail to understand the seriousness, and correction of the violation may be less black and white for the surveyor to monitor.

The primary method to discover resident rights violations is through resident interviews. To help surveyors, ombudsmen can give examples of violations and with resident permission, point surveyors to particular residents as sources for more information.

How Facilities Can Promote Rights

1. Educate residents and their families about rights (beyond the minimum requirement when a resident is admitted).
2. Educate and sensitize every level of staff about resident rights; take time at each staff meeting to promote and describe at least one resident right.
3. Incorporate resident participation and self-determination into every aspect of services, such as resident advisory committees for food services, activities, and housekeeping.
4. Provide support to workers, such as sufficient staffing, training, supervision, mentoring, and increased salaries and benefits.
5. Take time to introduce staff to the residents they will work with.
6. Promote relationships between management and direct care staff.
7. Use the information and wisdom of residents and their representatives to help develop and conduct training programs for staff.
8. Help staff, residents, and families focus on empowerment. Residents need assistance, but the help received should strive to increase their ability to help themselves.
9. Establish a grievance committee comprised of residents, family, staff, and management.
10. Encourage and promote an open exchange of ideas, recommendations, and concerns throughout the facility.
11. Build more private rooms for individual residents and public rooms for private use by residents.
12. Promote a sense of community within the facility. Organize activities in different areas and design activities that promote interaction and intellectual stimulation.

SOURCE: Consumer Voice, Nursing Home Resident Rights Project

Supplement A-5: Nursing Home Resident Rights

Residents of Texas nursing facilities have all the rights, benefits, responsibilities, and privileges granted by the Constitution and laws of this state and the United States. They have the right to be free of interference, coercion, discrimination, and reprisal in exercising these rights as citizens of the United States.

Dignity and Respect

You have the right to:

- live in safe, decent, and clean conditions
- be free from abuse, neglect, and exploitation
- be treated with dignity, courtesy, consideration, and respect
- be free from discrimination based on age, race, religion, sex, nationality, disability, marital status, or source of payment
- practice your own religious beliefs
- keep and use personal property, secure from theft or loss
- choose and wear your own clothes
- be free from any physical or chemical restraints used for discipline or convenience and not required to treat your medical symptoms
- receive visitors

Freedom of Choice

You have the right to;

- make your own choices regarding personal affairs, care, benefits, and services
- choose your own physician at your own expense or through a health care plan
- manage your own financial affairs in the least restrictive method, or to delegate that responsibility to another person
- access money and property you have deposited with the facility and to have an accounting of your money and property that are deposited with the facility and of all financial transactions made with or on your behalf
- participate in activities inside and outside the facility
- place in your room an electronic monitoring device that is owned and operated by you or provided by your guardian or legal representative
- refuse to perform services for the person or facility providing services
- use advance directives as defined in the Texas Health and Safety Code, §166.002
- designate a guardian or representative to ensure quality stewardship of your affairs, if protective measures are required

Privacy and Confidentiality

You have the right to:

- privacy, including privacy during visits, phone calls and while attending to personal needs
- have facility information about you maintained as confidential
- send and receive unopened mail and to receive help in reading or writing correspondence

Participation in Your Care

You have the right to:

- receive all care necessary to have the highest possible level of health
- participate in developing a plan of care, to refuse treatment, and to refuse to participate in experimental research
- refuse treatment, care, or services
- receive information about prescribed psychoactive medication from the person who prescribes the medication or that person's designee
- have any psychoactive medications prescribed and administered in a responsible manner as mandated by the Texas Health and Safety Code, §242.505, and to refuse to consent to the prescription of psychoactive medications
- access personal and clinical records, which will be maintained as confidential and may not be released without your consent
- communicate in your native language to acquire or to receive treatment, care, or services

Transfers and Discharges

You have the right to:

- not be relocated within the facility, except in accordance with nursing facility regulations
- discharge yourself from the facility unless you have been adjudicated mentally incompetent
- not be discharged from the facility, except as provided in the nursing facility regulations
- receive a 30-day written notice sent to you, your legally authorized representative, or a family member
- appeal the discharge within 10 days of receiving notice in a Medicaid facility
- be readmitted to the facility as provided by nursing facility regulations

Information

You have the right to:

- receive a written statement or admission agreement describing the services provided by the facility and the related charges
- be informed of Medicare or Medicaid benefits
- receive a copy of the Statement of Resident Rights and to be informed of revisions
- be informed in a language you understand about your total medical condition, recommended treatment and expected results (including reasonably expected effects, side effects and associated risks), and be notified whenever there is a significant change in your condition.

Complaints

You have the right to:

- complain about care or treatment and receive a prompt response to resolve the complaint without fear of reprisal or discrimination
- organize or participate in any group that presents residents' concerns to the administrator of the facility

---

Your rights may be restricted only to the extent necessary to protect you or others, or to protect the rights of others, particularly those rights relating to privacy and confidentiality.

These described rights are in addition to other rights or remedies an individual may be entitled to, according to rules and under the law.

Supplement B-5: Assisted Living Resident Rights

A resident has all the rights, benefits, responsibilities, and privileges granted by the constitution and laws of this state and the United States, except where lawfully restricted. The resident has the right to be free of interference, coercion, discrimination, and reprisal in exercising these civil rights.

Dignity and Respect

You have the right to:

- be free from physical and mental abuse, including punishment or physical and chemical restraints not required to treat medical symptoms
- be treated with respect, consideration, and recognition of dignity and individuality, without regard to race, religion, national origin, gender, age, disability, marital status, or source of payment. This means that your have the right to:
    - make choices regarding personal affairs, care, benefits, and services
    - be free from abuse, neglect, and exploitation and
    - designate a guardian or representative to ensure the right to quality stewardship of your affairs
- achieve the highest level of independence, autonomy, and interaction with the community
- a safe and decent living environment
- communicate in your native language with residents or employees
- complain about care or treatment. The complaint may be made anonymously or communicated by a person you designate. The provider must:
    - promptly respond to resolve the complaint
    - not discriminate or take other punitive action against a resident who makes a complaint
- participate in a behavior modification program involving restraints with the consent of the person's guardian, as described in TAC § 92.125

Privacy and Confidentiality

You have the right to:

- receive and send unopened mail, and have mail sent and delivered promptly
- access to a telephone
- privacy while attending to personal needs and receiving medical treatment
- a private place for receiving visitors or associating with other residents, including written communications, telephone conversations, meeting with family, and access to a resident council or group
- share a room with a spouse receiving similar services
- unrestricted communication, including visits with family members, representatives of advocacy groups and community service organizations, and other visitors at any reasonable hour
- have access to a representative of the State Long Term Care Ombudsman Program

Freedom of Choice

You have the right to:

- participate in activities of social, religious, or community groups and practice religion of your choice
- manage financial affairs, including written authorization of another person to manage your money. You may choose how your money is managed, including a money management program, a representative payee program, a financial power of attorney, a trust, or similar method, and may choose the least restrictive of these methods
- if the facility accepts written delegation to manage any portion of a resident's finances, the resident must be given, upon request and at least quarterly, an accounting of financial transactions made on the resident's behalf
- retain and use personal possessions, including clothing and furnishings. The number of personal possessions may be limited only for the health and safety of other residents
- choose dress, hair style, and other personal effects according to individual preference; the resident is responsible for maintaining personal hygiene
- retain and use personal property in your immediate living quarters and to have an individual locked area to keep personal property
- refuse to perform services for the facility, except as contracted for by the resident and operator
- have access to a representative of the State Long Term Care Ombudsman Program

Participation in Your Care

You have the right to:

- choose and retain a personal physician
- participate in developing an individual service plan that describes your medical and psychological needs and how the needs will be met
- access to personal records, which are confidential and may not be released without your consent, except:
    - to another provider, if the resident transfers residence or
    - if the release is required by another law
- refuse medical treatment or services after:
    - being advised by the person providing services of the possible consequences of refusing treatment or services and
    - acknowledging that you understand the consequences of refusing treatment or services
- execute an advance directive, under Chapter 166 of the Health and Safety Code, or designate a guardian in advance of need to make decisions regarding your health care

Information

You have the right to:

- be informed by the provider no later than the 30th day after admission:
  - whether the resident is entitled to benefits under Medicare or Medicaid and
  - which items and services are covered by these benefits, including items or services for which the resident may not be charged
- be fully informed in advance about treatment or care that may affect the resident's well-being

Transfer and Discharge

You have the right to:

- leave the facility temporarily or permanently, subject to contractual or financial obligations
- not be transferred or discharged unless:
  - the transfer is for the resident's welfare, and the resident's needs cannot be met by the facility
  - the resident's health is improved sufficiently so that services are no longer needed
  - the resident's health and safety or the health and safety of another resident would be endangered if the transfer or discharge was not made
  - the provider ceases to operate or to participate in the program that reimburses for the resident's treatment or care or
  - the resident fails, after reasonable and appropriate notice, to pay for services
- not be transferred or discharged, except in an emergency, until the 30th day after the date the facility provides written notice to the resident, the resident's legal representative, or a member of the resident's family, stating:
  - the facility intends to transfer or discharge the resident
  - the reason for the transfer or discharge
  - the effective date of the transfer or discharge
  - the location to which the resident will be transferred and
  - any appeal rights available to the resident

This list of rights is based on the Licensing Standards for Assisted Living Facilities, Residents Bill of Rights § 92.125

Ombudsman Certification Training

CHAPTER 6

Resident and Family Councils

--This page intentionally left blank-

Resident and Family Councils

Chapter 6 describes resident and family councils and their purpose. It provides an understanding of the ombudsman role with both council types and in similar group meetings.

Learning Objectives

- Become familiar with resident and family council requirements.
- Understand the typical roles and responsibilities of resident and family council members.
- Distinguish between an ombudsman's and facility staff's responsibilities with councils.

Contents

Resident and Family Councils
State and National Organizations
References in Texas Administrative Code for Resident Groups and Family Councils

Supplement A-6: Agenda Template for Resident Council Meetings
Supplement B-6: Sample Council Meeting Minutes
Supplement C-6: Sample Resident or Family Council Bylaws

Resident and Family Councils

Resident and family councils can impact quality of life and care for residents. It is a constitutional right for any private citizen to organize. In nursing homes, laws and regulations support the residents' right to meet as a group and the family's right to form a council. A resident right to meet privately is supported by rules §19.706 and §92.125.

Fear of retaliation is one of the most significant barriers to residents and family members voicing their concerns. Meetings and councils can help individuals find strength in numbers and overcome that fear. Some councils plan joint meetings in a larger geographic area to share information, talk about challenges and successes, and address systemic problems.

Residents and families communicate and keep in touch by traditional communication such as phone calls, newsletters, and mail but they may explore social networking such as e-mail lists, Facebook, and Google groups.

Residents have the right to prompt efforts by the facility to resolve grievances. During annual and complaint surveys, Regulatory Services surveyors may review minutes of resident and family council meetings. Surveyors examine how facility staff handled grievances and kept residents and families apprised of efforts. Well documented grievances can help alert surveyors to concerns and how they were addressed.

At the end of the chapter, sample materials are supplements to share with resident and family councils who request ombudsman assistance. Note Supplement C-7 on sample minutes provides specific on concerns and any response by management.

Resident Council

A resident council is a group of residents with a purpose. These residents, with or without the help of staff, identify a common need or request and take action. Resident councils have the potential to evolve into any number of types and adopt any combination of functions, any of which are correct if desired by residents. Above all else, resident councils are about residents. The needs and desires of residents should drive council activity.

Nursing homes are not legally required to have a resident council, but they must ensure:

- residents have the opportunity to meet as a group or council;
- no interference occurs with council activities;
- residents are afforded privacy during meetings;
- group and individual complaints are responded to; and
- services and activities are based on the individual needs of residents.

A resident council is a practical way to obtain resident input in a variety of services, such as meal planning, social activities, and policies affecting residents. In management terms, a council might enhance a facility by offering to residents and staff the benefits of problem-solving; facility, resident, and staff communications; and empowerment for residents through opportunities to make decisions.

When successfully implemented, the benefits of a resident council far outweigh any administrative costs. The resources spent on a council are an investment that provides short-term gains and long-term dividends in the wellbeing of residents.

Councils provide a forum for residents to:

- Voice concerns directly to staff
- Hold a facility accountable for its promises
- Identify problems and solutions from the residents' perspective
- Recognize staff they feel deserve it
- Discuss topics of interest
- Contribute and shape their world

Since residents are different, councils are different too. A strong resident council has:

- broad participation;
- agenda set by residents;
- freely expressed concerns and suggestions; and
- staff who are responsive to residents' concerns

Source: Resident Councils of Washington, 2001

Ask the Trainer: Resident Council

What is the key to success of a resident council?

____

____

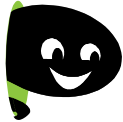
How do I learn when the council meets in the home where I am assigned?

____

____

Ombudsman Role with Resident Councils

Ombudsmen can help start new councils or support existing resident councils and other resident groups. Councils can bring grievances to the attention of management, thus providing another option to solve problems at the facility level.



Ombudsman tip: Watch for facility staff who appear to control the council agenda or who limit resident input. Be an advocate for the group by letting your staff ombudsman know about any concerns.

As a new ombudsman, seek out the following information:

- Does the facility have an active council?
- How often and when does it meet?
- Who is the president?
- Who did the facility designate as staff support to the council?
- About how many residents attend?
- Are meetings resident-directed?

Building a relationship with the council president is an important first step to make. Ombudsmen may ask for an invitation to attend a council meeting and attend when invited. Offer to introduce yourself to the council and to describe your ombudsman role.

As ombudsmen develop relationships with councils, promote the idea of the council bringing group concerns to management as a means of problem-solving. Share information as requested, but be aware the ombudsman presence changes the group dynamic. Since a resident council is for residents, respect this concept and avoid attending council meetings every time they are scheduled. Taking the role of the council seriously models for residents and facility staff to take it seriously too.

If requested, ombudsmen help council leaders develop skills to make meetings productive and structures to generate and maintain interest and involvement. In the chapter supplements, see samples of an agenda, minutes, and bylaws.

Ombudsman tip: Be a source of information on specific laws, rights, services, and health issues. Search your community for resources to share. Ask your staff ombudsman for help if needed.

Ombudsmen can encourage residents to attend council meetings and talk about the meetings with residents. Encourage them to bring concerns to the council to determine if others have the same concerns. If they are reluctant, find out why. While protecting resident confidentiality, share feedback with the president of any identified barrier that should be addressed to help meetings meet the needs of all residents who want to participate.

More ombudsman tips:

- Occasionally attend council meetings (if invited). After suggesting that councils can be a means to solve problems, tell residents you can attend with their permission. Some residents will welcome this support.
- Come early. Arrive about 30 minutes before the meeting. Visit residents who said they would like to attend, as they may need a reminder. If staff has not helped residents get to the meeting, your presence can be a needed prompt.
- Suggest writing concerns down. Some residents might write concerns and issues before the meeting. At the meeting, they have their concerns ready to share.
- Offer information about resident rights and regulations.

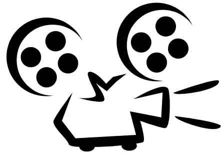
---

1. Ombudsmen attend council meetings if _____________.

2. A facility must assign a __________ _______________ to support council needs.

3. Appropriate ways ombudsmen support councils (mark the ones that apply):
   — Encourage residents to attend
   — Explain the ombudsman program at a meeting
   — Create and distribute minutes
   — Attend every month

4. A new ombudsman should make contact with the ______________________.



Video: Strength in Numbers: The Importance of Nursing Home Family Councils

Family councils led by families benefit residents, family members, and facility staff alike. This video gives an overview of the focus, techniques, and strategies to develop effective councils. It shows how families and friends become empowered to improve the quality of care. Watch the video and answer the questions that follow.

1. On a scale from 1-10, how well do you think the administrator ___ and staff ___ would receive a family council in your assigned home?

2. How could the council recruit more family members? _______________________

   ____

   ____

   ____

3. What guidelines might help a first meeting be successful?

   ____

   ____

   ____

4. Do you have any concerns about the family council at your assigned home?

   ____

   ____

Identify a barrier to starting a family council __________________________________

____

____

Identify a facility staff that supports a family council ___________________________

____

____

Family Council

A family council is an organized group consisting of family members, legal guardians, and friends of residents in a nursing home or assisted living facility. The council usually governs itself, but a facility must provide some support and assistance. Not all facilities have family councils.

With the exception of laws and rules that are specific to resident groups, family councils function in a similar way and serve similar purposes to resident councils. The role of the ombudsman is also essentially the same.

Family councils:

- Help link the facility to the local community
- Support facility operations through suggestions and activity support
- Bring complaints on behalf of residents or members to management

One barrier to an active family council is time. Family members and friends may not have time to visit the residents and attend a meeting.

Family councils can provide needed validation for complaints and support and education to family and friends.
Family members may believe they are the only ones who experience a problem. But in the meeting, they may learn others experience similar problems. When a council submits complaints, the administrator is less likely to ignore the problem and more likely to take action.

Ombudsman tip: The greatest benefit of attending meetings for some family members is the opportunity to build friendships. When family cannot visit, they can ask others to look in on their relatives or friends. This “looking out” for each other contributes to a feeling that residents are safe and secure even when family cannot visit.

Some facilities hold information-sharing sessions, support groups, or host evening meetings for families. These events can be a starting point for a family council to evolve. But, family councils are groups run by family and friends with support from staff. Staff and other people, like ombudsmen, attend by invitation only.

Ombudsman Role with Family Councils

The ombudsman role with family councils is similar to resident councils.

- Encourage family, guardians, and friends of residents to attend.
- Occasionally attend council meetings (if invited).
- Come early. Arrive about 30 minutes before the meeting and greet people. Introduce yourself to members you have not met.
- Help members understand what is productive to discuss in a group forum or what might be better handled individually.
- Offer information about resident rights and regulations.

As a new ombudsman, find out if the facility has a family council, who serves as president, and who serves as the facility support staff. Seek out the president and ask:

- How often does the council meet?
- How well attended are the meetings?
- What are typical agenda items?
- How do families and friends learn about the council?

If the facility does not have a family council, but there is a group of people who want to start one, an ombudsman can help. Encourage creation of a council that:

- Meets at a time convenient for a majority of members
- Has structure, including designated leadership and a grievance procedure
- Focuses on improving the quality of care and life for residents
- Educates members on topics of interest
- Creates opportunities for dialogue between staff and council members
- Provides a forum for family members to voice concerns

Members will likely participate only if the council seems worthwhile. Councils may benefit from help to develop their organization and elect leadership. Ombudsmen help members stay involved after the initial energy wanes. Work on particular issues so they see the value of their continued involvement.

Often families focus on personal situations without a greater understanding of how the facility and system work. Help them distinguish between personal concerns and:

- concerns of others;
- general issues about the facility; and
- issues affecting many residents or families.

Ombudsman tip: Encourage family council participation as a means to resolve problems. For example, a family member is concerned facility staff is not meeting her relative’s needs. Root causes may include under-staffing, lack of staff training, or insufficient management. Educate families about possible underlying causes to consider and help them recognize the benefit of working with the family council.

State and National Organizations

Some family members may want to connect to advocacy organizations with state or federal scope. The Consumer Voice for Quality Long-term Care is a national membership organization for residents, family members, long-term care ombudsmen, and other advocates. Many resources are available free on their website and help is available by telephone. Refer family members to this organization as a start to connecting with national resources. Ombudsmen can become members too.

Another good national resource for specific quality improvement tools is the campaign for Advancing Excellence in America's Nursing Homes. Residents, family members, ombudsmen, and others can join the campaign as a consumer for free. Their website has tools to promote consistent assignment of caregivers to residents, measure resident and family satisfaction, and implement change based on the results, as well as ideas to improve clinical outcomes.

Some family members find the Texas Advocates for Nursing Home Residents to be a helpful resource. Meetings are usually held in the Dallas-Ft. Worth area, but they take calls from family members statewide and publish a newsletter for all members.

References in the Texas Administrative Code

Nursing Facility Requirements for Licensure and Certification
§19.706 Resident Group and Family Council

(a) A resident has the right to organize and participate in resident groups in a facility.
(b) A facility must assist residents who require assistance to attend resident group meetings.
(c) A resident's family has the right to meet in the facility with the families of other residents in the facility and organize a family council. A family council may:
    (1) make recommendations to the facility proposing policy and operational decisions affecting resident care and quality of life; and
    (2) promote educational programs and projects intended to promote the health and happiness of residents.
(d) If a resident group or family council exists, a facility must:
    (1) listen to and consider the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility;
    (2) provide a resident group or family council with private space;
    (3) provide a designated staff person responsible for providing assistance and responding to written requests that result from resident group and family council meetings; and
    (4) allow staff or visitors to attend meetings at the resident group's or family council's invitation.

(e) If a family council exists, a facility must:
   (1) upon written request, allow the family council to meet in a common meeting room of the facility at least once a month during hours mutually agreed upon by the family council and the facility;
   (2) provide the family council with adequate space on a prominent bulletin board to post notices and other information;
   (3) designate a staff person to act as the family council's liaison to the facility;
   (4) respond in writing to written requests by the family council within five working days;
   (5) include information about the existence of the family council in a mailing that occurs at least semiannually; and
   (6) permit a representative of the family council to discuss concerns with an individual conducting an inspection or survey of the facility.

(f) Unless the resident objects, a family council member may authorize, in writing, another member to visit and observe a resident represented by the authorizing member.

(g) A facility must not limit the rights of a resident, a resident's family member, or a family council member to meet with an outside person, including:
   (1) an employee of the facility during the employee's nonworking hours if the employee agrees; or
   (2) a member of a nonprofit or government organization.

(h) A facility must not:
   (1) terminate an existing family council;
   (2) prevent or interfere with the family council from receiving outside correspondence addressed to the family council or open family council mail; or
   (3) willfully interfere with the formation, maintenance, or operation of a family council, including interfering by:
      (A) denying a family council the opportunity to accept help from an outside person;
      (B) discriminating or retaliating against a family council participant; or
      (C) willfully scheduling events in conflict with previously scheduled family council meetings, if the facility has other scheduling options.

Licensing Standards for Assisted Living Facilities

§92.125 Resident's Bill of Rights and Provider Bill of Rights (Excerpt)

(a) Resident's bill of rights.
   (3) Each resident in the assisted living facility has the right to:
      (J) unrestricted communication, including personal visitation with any person of the resident's choice, including family members and representatives of advocacy groups and community service organizations, at any reasonable hour; and

(R) privacy, while attending to personal needs and a private place for receiving visitors or associating with other residents, unless providing privacy would infringe on the rights of other residents. This right applies to medical treatment, written communications, telephone conversations, meeting with family, and access to resident councils. If a resident is married and the spouse is receiving similar services, the couple may share a room.

Supplement A-6: Agenda Template for Resident or Family Council Meetings

Date
Time (beginning and ending)
Location

I. Welcome and Introductions
   a. Members
   b. Guests (facility staff, ombudsman, other)

II. Minutes and Correspondence
   a. Review minutes from the previous meeting
   b. Review any correspondence from or to the council since the last meeting

III. Officer or Committee Reports (as applicable)

IV. Report from Facility Support Staff or Administrator

V. Old Business

VI. New Business

VII. Guest Speaker / Program

VIII. Concerns (includes status of issues submitted by the council to management and new concerns)

IX. Adjourn
   a. Announce date, time, and location of next meeting
   b. Reminder of other upcoming council events

X. Social Time

Adapted from the Resident Council Handbook, Resident Councils of Washington and Nursing Home Family Council Manual, Texas Advocates for Nursing Home Residents

Supplement B-6: Sample Council Meeting Minutes

Date
Time
Location of meeting

Welcome and Introductions

The meeting was called to order by [name and time].
Present: list the names of attendees; identify titles of officers and guests

Minutes and Correspondence

[Example] The December minutes were approved as distributed. Correspondence included a letter from Happy Elementary thanking the resident council for their donation of decorations for the school's annual carnival and a letter inviting our resident council to participate in Senior Days in our community.

Officer and Committee Reports

[Example] President Davis reported she was invited to participate in Happy Elementary board of directors meeting scheduled February 5 to provide ideas on how the school and nursing home can plan meaningful activities for the residents and students. The list of ideas was discussed, additional ideas were included, and all ideas were prioritized by the council.

Treasurer Smith reported the barbeque fundraiser earned $211 for the activities department.

The Welcoming Committee reported we have 6 new residents since the last meeting. There will be a write-up in our newsletter next month about them. They were introduced to the council board.

The Dietary Committee is pleased to announce the Dietitian will be a guest speaker at our next meeting and we have made progress with residents choosing when they prefer to eat breakfast with more menu options.

The Sunshine Committee announced that Mr. Sound is better and returned from the hospital. Mrs. Valley is still in the hospital and a card is being sent.

Report from Facility Support Staff or Administrator

Old Business

[Example] Building remodeling continues. The Bluebonnet hallway is being gutted and flooring, furniture, and fixtures will be replaced. Administrator Montana reports staff moved all the residents and personal items to their temporary rooms on Monday according to the contractor's schedule, and he is shopping for an aquarium for the sitting room. See concern listed below.

The idea generated from the last meeting regarding a suggestion box is being pursued by the maintenance department as to size and location. We suggested the box is placed at chair height for easy access.

New Business

[Example] Campaigning for mid-term elections will be starting soon. The council decided to invite candidates to our home on September 1 for dialogue. We discussed inviting residents from nearby nursing homes to join us. The activity director and President Davis will extend an invitation.

Guest Speaker / Program

[Example] John Willis was introduced as our guest speaker. Mr. Willis is Executive Director of the local Alzheimer's organization. A copy of his presentation is available at the front desk and highlights will be published in the next newsletter.

Concerns

[Example] Concerns included:

- People on Bluebonnet hallway were not given enough notice about being relocated. Staff told them Friday that they would be moved to other rooms on Monday.
- Weekend access to management staff. If a serious problem occurred on the weekend, we are unsure how to reach the administrator and regional director. President Davis agreed to speak with the administrator about this concern and get everyone access to phone numbers for emergencies.

Adjournment

The meeting was adjourned at 2:30 p.m.

Respectfully submitted,
[Name], title

Supplement C-6: Sample Resident or Family Council Bylaws

I. Name

The name of our council shall be __________________.

II. Purpose

The purpose of our council is: [Example] to provide a tool from which residents can communicate their needs and interests in the affairs of their home.

III. Membership

Every resident is a member of the ____________ resident council. Each resident can vote. In the case of a family council, specify who can serve on the council.

IV. Officers and their duties

Officers of the council shall be:

- President (Chair) – presides over all meetings
- Vice President (Vice Chair) – presides in the absence of the president
- Secretary – takes minutes and writes correspondence as directed by the council
- Treasurer – responsible for all financial business of the council

[Recruiting for officer positions can be a challenge. Members might be willing to serve as co-chairs to share the leadership role. Using a standard agenda each month will make it easy to update and use.]

V. Committees

The council shall have the following committees as needed:

- Executive (officers and committee chairs)
  Purpose: to give direction and organization to the council
- Food
  Purpose: to serve as a liaison between dietary services and the residents for suggestions and improvements.
- Grievance
  Purpose: to serve as a sounding board for grievances and to follow up on complaints with administrator or ombudsman
- Program
  Purpose: to coordinate guest speakers and refreshments for meetings
- Sunshine
  Purpose: to prepare cards for residents in the hospital, for birthdays and other important events
- Volunteer
  Purpose: to enlist members to organize and volunteer for special projects in the community and to improve quality of life in the facility
- Welcoming
  Purpose: to greet new members, orient them to the facility, and encourage participation in the council

VI. Elections
Elections of officers and other representatives will be held every _____________________ (date, month).

VII. Meetings
Meetings will be held every ______________________________ (day, time and location). If committees will meet, include these dates as well.

VIII. Amendments
Amendments may be made to the bylaws at any regular or special meeting of the council by vote. Amendments are announced at least one month prior to a vote.

IX. Rules of Order
Each meeting will be conducted according to a written agenda. [Rules could also follow Robert's Rules of Order or be determined by the group.]

Ombudsman Certification Training

CHAPTER 7

Care Planning

--This page intentionally left blank—

Care Planning

Chapter 7 is about the care planning process for individuals in nursing homes and assisted living facilities and about advance care planning. Individual care planning includes assessments, care or service plan meetings, and care or service plan documents. Advance care planning is about making decisions to direct future health care decisions should a person have physical or mental incapacity.

Learning Objectives

- Understand the care (nursing home) and service (assisted living facility) planning process
- Know the advance care planning concept and documents to communicate future health care wishes
- Understand who may serve as a surrogate decision maker and under what circumstances

Contents

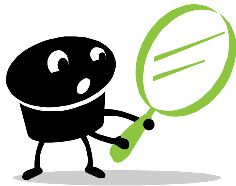
Individual Care Planning
Advance Care Planning
Ombudsman Role in Advance Care Planning

Supplement A-7: I Want to Tell You about My Mother
Supplement B-7: Agonizing Schiavo Case Shows Need to Put Medical Wishes in Writing

Individual Care Planning

According to federal and state laws, each nursing home must “provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which … is initially prepared, with participation to the extent practicable, of the resident, the resident’s family, or legal representative.” A person should not decline in health or wellbeing because of the way a nursing home provides care.

With no federal oversight of assisted living facilities, and relatively few state standards, a written plan of care in an assisted living facility (ALF) has special significance. The plan, known as a service plan, is the basis for many other ALF standards, including meeting the needs of the resident to which the plan pertains.



“I Want to Tell You about My Mother”

Family members learn ways to introduce their relative to staff and to help staff know who their relative is. It can address being in strange surroundings where “nobody knows who I am.” It can make a difference in staff understanding the resident’s actions and responses. Staff will know some thoughts, life experiences, habits, and feelings that lie behind resident actions and responses.

Carter Catlett Williams, ACSW

See Supplement A-7 for the complete document

Assessment and Care Planning

To give good care, staff must assess each resident and plan care and service to support each person's life-long patterns, current interests, strengths, and needs. Resident and family involvement gives staff information to assure residents get good care.

Assessments gather information about how well residents can take care of themselves and when they need help in functional abilities, such as walking, talking, eating, dressing, bathing, seeing, hearing, communicating, understanding, and remembering. Staff should ask and learn about habits, activities, and relationships to help residents live more comfortably and feel more at home. Assessments help staff look for what causes a problem. Assessments should also pay attention to strengths.

Assessments must be done within 14 days of admission and at least once a year, with reviews every three months and when a resident's physical or mental condition changes.

Plan of care

A plan of care for nursing home residents must be developed within seven days after an assessment. It describes a strategy for how staff will help a resident and what each staff will do and when it will happen, such as, “The nurse aide will help me walk to each meal to build my strength.” Staff should be familiar with all care plans, document services provided according to them, and revise as needed.

In assisted living, a service plan must be developed, in accordance with Texas Administrative Code §92.41(c), within 14 days of a resident’s admission to the facility. The plan must be updated annually and upon a change in condition.

Meeting to develop the plan

Staff, residents, and families talk about life in the nursing home or assisted living facility, including meals, activities, therapies, personal schedule, health care, and emotional needs. Residents and families bring up problems, ask questions, and offer information to help staff provide care. All staff who works with a resident should be involved such as nurse aides, nurses, physician, social worker, activities staff, dietician, and therapists. To the degree possible, residents should talk about what they need and how they feel. They can ask questions about care, daily routines, food, activities, interests, staff, personal care, and medications. They should be persistent about concerns and choices. Staff must discuss treatment and only do what a resident agrees to.

Ombudsman Tip: Ombudsmen attend care meetings at the invitation of a resident or legal representative. Ombudsmen can help residents and family prepare for a meeting by giving information on how a meeting typically works and helping them practice discussing specific comments, questions, or concerns. Staff generally leads a care conference, but residents, family, and ombudsmen can direct discussion of issues most pertinent to the resident. Ombudsmen may also suggest a care plan meeting as a strategy for resolving a problem.

Participation

Residents have the right to make choices about care, services, and daily life and be involved in the care-planning meeting.

Before the meeting, residents can:

- Tell staff their concerns, needs, and goals.
- Ask the doctor or staff or know about their condition, care, and treatment.
- Ask to meet when family can come, if they want them there.

During the meeting, residents can:

- Discuss options for treatment and for meeting needs and preferences. They ask for terms and procedures to be explained if needed.
- Decide if they agree with the plan and feel it meets their needs.
- Ask for a copy.
- Get the name of a person to talk to if they want changes.

After the meeting, residents can:

- Monitor how the plan is followed.
- Talk with nurse aides, other staff, or their doctor about it.

Good care or service plans:

- Are specific, individualized, and written in common language
- Reflect resident concerns and support well-being, functioning, and rights
- Do not label resident choices or needs as "problem behaviors"
- Use a multi-disciplinary team approach and use outside referrals as needed
- Are re-evaluated and revised routinely (watch for care plans that never change)

Adapted from a Consumer Voice fact sheet

Comparison: Nursing Home and Assisted Living Facility Regulations

The Department of Aging and Disability Services requires nursing homes to develop care plans and assisted living facilities to develop service plans. Compare the requirements in the section below.

Nursing Facility Requirements §19.801 Resident Assessment

A facility must conduct initially and periodically a comprehensive accurate, standardized, reproducible assessment of each resident's functional capacity. The facility must electronically transmit admission, annual, quarterly and significant change assessments to DADS.

(1) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

(2) Comprehensive assessments.

(A) A facility must make a comprehensive assessment of a resident's needs, using the Resident Assessment Instrument, including the Minimum Data Set (MDS), specified by DADS.

(B) The assessment must include at least the following information:

(i) identification and demographic information;
(ii) customary routine;
(iii) cognitive patterns;
(iv) communication;
(v) vision;
(vi) mood and behavior patterns;
(vii) psychosocial well-being;
(viii) physical functioning and structural problems;
(ix) continence;
(x) disease diagnoses and health conditions;
(xi) dental and nutritional status;
(xii) skin condition;
(xiii) activity pursuit;
(xiv) medications;
(xv) special treatments and procedures;
(xvi) discharge potential;
(xvii) documentation of summary information regarding the additional assessment performed through the resident assessment protocols;
(xviii) documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.

(C) A facility must conduct a resident comprehensive assessment as follows:

(i) within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.
(ii) within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.
(iii) not less often than once every 12 months.

Nursing Facility Requirements §19.802 Comprehensive Care Plans

(a) A facility must develop a comprehensive care plan for each resident that includes measurable short-term and long-term objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment. The plan must describe:
  (1) the services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being as required under §19.901; and
  (2) any services that would otherwise be required under §19.901 but are not provided due to the resident's exercise of rights, including the right to refuse treatment under §19.402(g).

(b) The comprehensive care plan must be:
  (1) developed within 7 days after completion of the comprehensive assessment;
  (2) prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by resident needs, and, to the extent practicable, with the participation of resident, resident's family, or legal representative;
  (3) periodically reviewed and revised by a team of qualified persons after each assessment; and
  (4) for a resident under 22 years of age, annually reviewed at a comprehensive care plan meeting between the facility and the resident's LAR.

(c) A comprehensive care plan must include:
  (1) for a resident under 18 years of age, activities, services, and supports when provided or facilitated by the facility will enable the resident to live with a family; or
  (2) for a resident 18-22 years of age, the activities, supports, and services that when provided or facilitated by the facility will result in the resident having a consistent and nurturing environment in the least restrictive setting, as defined by the resident and LAR.

(d) A comprehensive care plan may include a palliative plan of care. It may be developed only at the request of resident, surrogate decision maker, or legal representative for residents with terminal conditions, end stage diseases, or other conditions for which curative medical interventions are not appropriate. It must have goals that focus on maintaining a safe, comfortable, supportive environment in providing care to a resident at the end of life.

(e) For a resident under 22 years of age, facility must provide written notice to the LAR of a meeting to conduct an annual review of the resident's comprehensive care plan no later than 21 days before the meeting date and request a response from the LAR.

(f) The services provided or arranged by the facility must:
  (1) meet professional standards of quality; and
  (2) be provided by qualified persons in accordance with each resident's written plan of care.

(g) Comprehensive care plan must be made available to all direct care staff.

Licensing Standards for Assisted Living Facilities §92.41(c) Resident assessment

Within 14 days of admission, a resident comprehensive assessment and an individual service plan for providing care, based on the comprehensive assessment, must be completed. The assessment must be completed by appropriate staff and documented on a form developed by the facility. When a facility is unable to obtain required information, the facility should document its attempts to obtain the information.

(1) The comprehensive assessment must include:
- (A) location from which resident was admitted;
- (B) primary language;
- (C) sleep-cycle issues;
- (D) behavioral symptoms;
- (E) psychosocial issues;
- (F) Alzheimer's/dementia history;
- (G) activities of daily living patterns;
- (H) involvement patterns and preferred activity pursuits;
- (I) cognitive skills for daily decision-making;
- (J) communication;
- (K) physical functioning;
- (L) continence status;
- (M) nutritional status;
- (N) oral/dental status;
- (O) diagnoses;
- (P) medications;
- (Q) health conditions/ possible medication side effects;
- (R) special treatments and procedures;
- (S) hospital admissions within the past 6 months or since last assessment; and
- (T) preventive health needs.

(2) The service plan must be approved and signed by the resident or a person responsible for the resident's health care decisions. The facility must provide care according to the service plan. The service plan must be updated annually and upon a significant change in condition, based upon an assessment of the resident.

(3) For respite clients, the facility may keep a service plan for six months from the date on which it is developed. During that period, the facility may admit the individual as frequently as needed.

(4) Emergency admissions must be assessed and a service plan developed for them.

Basics of Individualized Quality Care

Traditionally, care plans are developed using a medical model. They are written from a staff perspective rather than a resident's perspective. This model is not suited to individualized care. Individualized plans provide care and service that supports quality of life for each resident.

Example: Fred is an 84-year old man with osteoarthritis. He is very pleasant and social, frequently visiting staff and residents. He ambulates with minimal assistance or moves independently in a wheelchair. His wife was a resident. They were happily married for 61 years and did not have children. They shared a room until she died 6 months ago. He is now in a private room. Recently he began acting out sexually (grabbing at staff and residents). He is alert and aware of his surroundings, has minimal cognitive impairment, and is hearing impaired.

Traditional Care Plan

Problem	Goal	Approaches
Inappropriate sexual behavior	Resident will not touch staff or residents against their wishes.	• 15-minute checks to monitor location. • Praise appropriate behavior. • Re-direct and allow time alone in room when sexual behavior occurs. • Private room.

Individualized Care Plan

Needs	Goal	Approaches
I need companionship.	I will choose a roommate by next resident care plan meeting.	• I prefer to have a roommate. • When I'm in my room, I like to watch action movies. Share any action DVDs you have with me. • I like to read books. • I look up words in my dictionary. • I enjoy wild birds. I have a bird feeder outside my window. Leave shades open and ensure I have birdseed so I can fill the feeder. • When I'm out of my room, I enjoy eating in the dining room. • Offer opportunities to be around staff and other residents. I may not talk a lot, but I like company. • Speak clearly and directly to me, hearing is difficult. • Introduce me to single women who are seeking companionship and friendship.

SOURCE: Susan Misiorski and Lynn MacLean, Apple Health Care Inc. Avon, CN

Exercise: Create Wilma's Care Plan

Wilma is an 88-year old woman with dementia. She has a short attention span and usually has a cheerful demeanor. Wilma likes to walk around the facility for most waking hours. She is unable to distinguish between areas she is allowed to enter and those that she should not. Her ambulation skills are excellent; she requires no assistance. Wilma disturbs some residents because she may enter their rooms against their wishes. She prefers to be with staff at all times; she does not tolerate being alone very well. She and her husband raised eleven children. They owned a hardware store and were respected business owners in town.

Traditional Care Plan

Problem	Goal	Approaches
Wanders due to dementia	Resident will not wander into other resident rooms through next resident care plan meeting.	Redirect resident to appropriate areas of facility. Praise for cooperation. Teach not to go into rooms with sashes across the door.
Short attention span	Resident will participate in one group program per week for 15 minutes through next care plan meeting.	Invite to group activities. Praise for participation.

Individualized Care Plan

Needs	Goal	Approaches

Advance Care Planning

Advances in health care and the growing number of Americans who are living longer create some challenges when people can no longer make decisions or express their needs. Sometimes when people are in accidents or have terminal illnesses, they are not able to talk or let others know how they feel. Directing how a person wants to be treated at the end of life, regardless of capacity, can be achieved through certain legal documents. Directions on what a person does or does not want can be included.

Advance care planning requires an individual to:

1. determine what wishes need to be shared;
2. direct choices about care if staying home, in a nursing home, or in a hospital;
3. talk with family and doctors about what treatment is desired and what is not;
4. document treatment wishes in the event of a serious accident, illness, or terminal condition; and
5. tell others what is decided.

Some advance care planning documents are legal forms. They may be completed with the help of an attorney, but one is not required. The most common forms are:

- Medical Power of Attorney — Except to the extent a person states otherwise, this document authorizes a named agent to make any and all health care decisions in accordance with the person's wishes, including religious and moral beliefs, when a person is no longer capable to make them
- Directive to Physicians and Family or Surrogates — Communicates wishes to doctors, family, and others about medical treatment at some time in the future when a person is unable to make wishes known because of illness or injury
- Out-of-Hospital Do Not Resuscitate — Instructs emergency medical personnel and health care professionals to not attempt resuscitation and to allow natural death; it does not affect receiving other emergency care and treatment including comfort care
- Statutory Durable Power of Attorney — Designates an agent who is empowered to take certain actions regarding property and finances; It does not authorize anyone to make medical and other healthcare decisions

In a Medical Power of Attorney form, the named person (called an "agent") speaks for the individual when they are no longer able to. A Directive to Physicians or Medical Power of Attorney may include a person's written wishes about specific medical procedures. The documents can be updated by marking through an area and writing in current wishes or completing a new form and destroying the old one. It is the individual's responsibility to inform family members and doctors about any changes.

The person named in a Medical Power of Attorney to make decisions is called the ___________________.

Other advance care planning forms include:

- Consent to Medical Treatment — This form is for a person who has not issued a directive and needs medical care. It does not include withholding or withdrawing life sustaining treatment.
- Declaration for Mental Health Treatment — Allows a person to make decisions in advance about mental health treatment and specifically three types of mental health treatment: psychoactive medication, convulsive therapy, and emergency mental health treatment. The instructions in this declaration will be followed only if a court believes a person is incapacitated to make treatment decisions. Otherwise, a person is considered able to give or withhold consent for the treatments.
- Procedure When Person Has Not Executed or Issued a Directive and Is Incompetent or Incapable of Communication — This form can be used if an adult patient has not executed or issued a directive and is incapacitated, or mentally or physically incapable of communication. In that case, the attending physician and the resident's legal guardian or an agent under a medical power of attorney may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment from the resident.

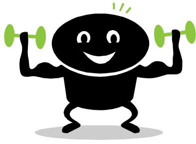
If help is needed to understand advance care planning forms, facility and hospital staff can explain them. Benefits counselors at area agencies on aging are trained to help complete Medical Powers of Attorney. The Texas Legal Services Center can provide information about legal forms and under some circumstances attorneys to assist in the completion of these documents.

Regulations pertaining to advance care planning:

- Nursing Facility Requirements §19.419
- Licensing Standards for Assisted Living Facilities §92.41(g)

Health care professionals cannot ignore the wishes expressed in an advance care planning document. If a doctor, nurse, hospital, assisted living facility, or nursing home is not able or willing to follow a person’s instructions, they must transfer care for the person to someone who will.

Ask the Trainer: Family Members Disagree



The doctor told a resident there are no more treatments to improve her health and he recommends hospice care. One daughter agrees but the other wants aggressive treatments to continue.

1. Whose wishes do you advocate for? ________________________________
2. What should an ombudsman do when family members disagree?

   ____

   ____

Surrogate Decision Makers

If a person can no longer make medical decisions and did not appoint an agent through an advance directive, a surrogate can consent to medical care. A surrogate is a substitute, or proxy, who acts on behalf of a person who needs medical care and decision-making.

Texas Health and Safety Code §313.004, Consent for Medical Treatment sets situations under which others make medical decisions for people unable to decide on their own. After two physicians certify in writing the person's incapacity to make medical decisions, the law allows the following people in order of priority to be surrogate decision makers:

1. patient's spouse;
2. adult child of the patient who has the waiver and consent of all other qualified adult children of the patient to act as the sole decision-maker;
3. majority of the patient's reasonably available adult children;
4. patient's parents; and
5. individual clearly identified to act for the patient by the patient before the patient became incapacitated, patient's nearest living relative, or a member of the clergy.

Surrogates can give informed consent for all medical decisions needed, except:

- voluntary inpatient mental health services;
- electro-convulsive treatment; and
- appointment of another surrogate decision-maker.

Surrogates try to make decisions based on what people would want by considering:

- Current diagnosis
- Prognosis
- Any preference expressed about the treatment
- Religious or personal beliefs
- Feeling about similar treatment for other people
- Expressed concerns about effects of illness and treatment on family or friends

If surrogates have no information about a person's wishes, they use the standard of best interest. They look at the benefits and burdens of treating and not treating, such as:

- Effects of treatment on the physical, emotional, and mental functions
- Pain suffered from the treatment
- Pain suffered without treatment
- Humiliation, loss of dignity, and dependency suffering because of the condition or would suffer because of the treatment
- Effect of the treatment on life expectancy
- Potential for recovery, with and without the treatment
- Risks, side effects, and benefits of the treatment
- Religious beliefs and values

Name one person who can be a surrogate decision maker?

____

Ombudsman Role in Advance Care Planning

Ombudsmen should encourage residents to exercise their right to develop an advance care plan that directs their care when they are no longer able to make decisions for themselves. If residents ask for help to complete or revoke a form, direct them to the facility social worker or facility management for assistance. Ombudsmen may also coordinate with Texas Legal Services Center, AAA Benefits Counselors, and other public legal options for a resident who requires legal advice or representation. Some residents prefer to arrange for legal services on their own or may prefer to use a private attorney.

Ombudsmen support residents' decisions about their care and life. Unless courts specifically authorized, or residents named their agents in advance directives, family members and professional caregivers do not have legal authority to make decisions for them. This is true regardless of a person's incapacity. If consent for medical treatment procedures are followed in accordance with Texas Health and Safety Code §313.004, a family member may make medical decisions in accordance with the law.

To serve as decision-makers, such as a guardians or agents in a Medical Power of Attorney, would create a conflict of interest for an ombudsman. Decline any such request and explain our role as an advocate. This limit does not apply to an ombudsman serving as a decision-maker for a family member or friend in a facility where the ombudsman does not serve residents. If you ever have any questions, speak with your supervising staff ombudsman or state ombudsman.

Family members make decisions for a resident even if the courts have not granted them legal authority. True or False

---

Supplement A-7: I Want to Tell You about My Mother

Guide developed by Carter Catlett Williams, MSW, ACSW

Family members can give a variety of information to give staff at admission and anytime. Tell facts about your mother's:

- Birth date and place
- Number of sisters and brothers; her place in birth order; siblings still living
- Rural or urban childhood
- Your mother's ethnic community
- Schooling
- Marriage and date of marriage; Date of widowhood or divorce
- Children
- Employment outside of home before and after marriage
- Religious affiliation
- Hobbies
- Living arrangements during marriage and afterwards
- Reason for entering the nursing home

A person's story includes hopes, accomplishments, disappointments, losses, and things that didn't go so well. It includes his or her ways of handling the “ups and downs” of life.

Suggestions to help you think over your mother's life and tell her story:

- What she looked forward to in life: as a child, as a teenager
- How much she was able to realize her dreams
- If she had an outside career, what it meant to her; how she and her family coped with the Great Depression; how wars affected her life (World Wars I and II, Korean and Vietnam)
- What she wanted for her children
- Her relationships with her family
- Was religious faith important and how does she express that: prayer, reading scripture, attending church, synagogue, or mosque, volunteer activity
- What she had, and now has, the most fun doing: cooking for family; hosting family gatherings; gardening; singing; reading; fishing; playing bingo; handwork; going to the movies; sports as a player or spectator; enjoying nature; seeing family and old friends
- Whether she likes to crack jokes or enjoys other's jokes
- How she handled money
- Whether she had pets and what they meant to her
- What angers her
- What pleases her
- What saddens her
- What comforts her
- Whether she generally has an optimistic attitude or sees the darker side of things
- Her major satisfactions and disappointments
- What she values most in life
- What you value most about her

To add further richness to your mother's story, collect photographs in an album for her room and take others to hang on her walls.

What makes a good day for your mother?

Daily schedule

- When she likes to get up and go to bed, times of rest and quiet
- How she prefers to spend her day
- What her mornings and evenings are like at home
- Times of her favorite radio and/or TV programs
- When and what she likes for snacks
- When and how often she likes to go outside
- Her usual bowel and bladder patterns
- Her patterns with: bathing, eating, and food preferences

Particular things that give her satisfaction and pleasure

- Particular foods at certain meals
- Careful grooming in the style she prefers
- The chance to be alone at least some part of each day
- Activities she enjoys: music, movies
- Attendance at worship service or other expression of her faith
- Where she prefers to place things in her room and at her bedside
- How she typically expresses affection and is comfortable receiving affection such as hugs, kisses, touching?

Remember no detail is too small if it's significant to your relative!

For your father, the same information is important. In addition, be sure activities and staff responses consider things from a man's perspective. The facility might need to offer more physical outlets or more traditionally masculine pursuits for your father.

SOURCE: Nursing Homes Getting Good Care There, Appendix 4

Supplement B-7: Agonizing Schiavo Case Shows Need to Put Medical Wishes in Writing

by Bruce Bower, Texas Legal Services Center

Love within families is a complex fabric woven from pride, tenderness and countless other shades of human emotion. It's a tough love, too, reinforced with unbreakable threads of trust and mutual responsibility. Most of us will do whatever it takes to avoid letting family down. So imagine the special sadness of failing them, not through betrayal or weakness, but omission.

The Terri Schiavo case in Florida epitomizes all that family caregivers dread. Ms. Schiavo had been in a coma since a 1990 heart attack. Husband Michael said, well before her heart attack, she told him to refuse offers of artificial life support if she ever became unable to make her own medical decisions. Nothing was ever put in writing, though.

Without taking sides, we can agree this is about Terri Schiavo and her right to direct her own health care. The trouble is, as she lay in her hospital bed with tubes nourishing a robust body that houses a lifeless cerebral cortex, there was little hope she could ever make those calls on her own.

DADS and Legal Hotline for Texans urge all Texans to assure their loved ones never face such a snarl. If you're 60 or older, contact a AAA benefits counselor for free advice and access to legal documents that spell out all your preferences in advance:

- Whether you want emergency personnel to resuscitate you
- How far doctors should go to save or sustain your life
- Treatment or medication you don't want to receive
- Who will be your designated legal proxy or guardian if you become incapacitated

Most advanced planning documents can be prepared free of charge. Either way, it's a more than fair exchange for the power you have to assure someone who shares your personal value system is making medical decisions on your behalf.

Don't wait until the need arises; incapacitation often is sudden and unexpected. Worried that you'll change your mind after the papers are completed? Don't be. You can change the documents at any time.

Before calling the AAA, consult your physician who can discuss commonly used resuscitation techniques and life-sustaining treatments. This will help you make a more informed decision.

After you sign the legal documents, give copies to your physician to add to your medical records. Be sure to give copies to the person(s) you've named as decision-maker and agent. Keep the originals and at least one copy of each document.

Whom should you designate? Most typical are family members, friends, spouses, and attorneys. Just be sure the person knows you well enough to fully understand and be able to attest to your beliefs and preferences. (Important: never assume familiarity with your wishes guarantees willingness to carry them out.)

Procrastination can be forgivable, even endearing, in some life situations. But not when it brings pain and unnecessary stress to the people you love. Do right by them and specify in writing all of your life- and health-care preferences. Do it today.

Bruce Bower is an attorney for the Texas Legal Services Center that operates the Legal Hotline for Texans.

Ombudsman Certification Training

CHAPTER 8

Problem Solving

--This page intentionally left blank—

Problem Solving

Chapter 8 describes an ombudsman's approach to resolving complaints on behalf of residents. This chapter includes cases for discussion and practice using ombudsman problem solving steps.

Learning Objectives

- Understand how long-term care ombudsmen approach problem-solving
- Identify investigation and resolution skills
- Learn basic negotiation strategies
- Practice the problem-solving process with case examples
- Understand how to research statutory support – find the laws and regulations that uphold resolution outcomes.

Contents

Overview
Problem Solving Process
Step
1 Identify the problem from the resident's perspective and research statutory support
2 Consider underlying causes and determine scope of the problem
3 Explore possible ways to resolve and take action
4 Check on progress and outcomes
5 Determine resident's or complainant's satisfaction with the outcome
Barriers to Problem Solving
Negotiation Basics
Case Discussions
"Show Me the Money"
"Discharge – Unable to Meet Needs"
Walking the Fine Line: Ombudsman Role with Residents, Families, and Facility Staff

Overview

Ombudsmen use a five-step basic problem-solving process. They work to solve problems after getting the resident or complainant's consent unless the problem affects multiple residents and the system created the problem. The following example shows a resolved complaint from start to finish: "I don't want a bath."

Presenting problem per the administrator: Mr. Flynn will not bathe and wears the same clothes every day. His body odor is unpleasant for his roommate, caregivers, and others. The ombudsman opens a case and begins to collect information.

Step

1 Identify the problem from the resident's perspective and research statutory support

Mr. Flynn really likes to wear overalls. The pair he prefers fit well and he likes the color best. Several old favorite outfits were lost and damaged in the laundry, so he doesn't trust that he will get this pair back if he lets laundry take them. Bathing is not something he looks forward to because the aides rush, use water that isn't hot enough, and do not let Mr. Flynn wash himself.

Direct caregivers report he refuses a bath no matter what they try, including letting him bathe himself. He used to let one CNA bathe him, but she quit. Other residents complain of Mr. Flynn's odor. His roommate does not view it as a problem.

- Residents have the right to refuse treatment and care
- Residents have a right to a decent living environment
- Residents have a right to have their choices and preferences respected and to secure their personal property from theft or loss
- The facility must help maintain Mr. Flynn's highest practicable level of functioning, allow him to participate in his care plan, and maintain or enhance his quality of life.

2 Consider possible underlying causes and determine scope of the problem

- Bathing environment is unpleasant.
- Mr. Flynn is embarrassed by some part of the bathing process.
- Bathing times do not match his preferences.
- Caregivers are not well trained.
- Caregivers do not know or respect Mr. Flynn's bathing preferences.
- He needs some new clothes that are clearly labeled.
- Laundry sorting process does not ensure residents get their laundry returned.
- Scope: the problem primarily affects Mr. Flynn.

3 Explore possible ways to resolve and take action

- Mr. Flynn identifies he wants to bathe in the afternoons and to have all the time he wants in the shower. He agrees to allow a CNA to check on him at regular intervals and to pull the call light when he is finished or if he needs help.
- Mr. Flynn agrees to the purchase of new overalls and shirts of the same brand and size, using his trust fund. He will allow the activity director to label his clothing. Laundry bags will be used to distinguish his clothes.
- The ombudsman sets a meeting with the social worker in Mr. Flynn's room and lets Mr. Flynn take the lead with these requests. The social worker says they may need to set a limit on the shower time and Mr. Flynn agrees to 20 minutes.
- The social worker confirms the nursing home should replace any items lost in the laundry.

4 Check on progress and outcomes

- The first day of Mr. Flynn's requested scheduled bath is successful. He has to persuade staff to allow him to bring his soiled clothes back to his room for the laundry, but is also successful. He wears a temporary pair of overalls since no one had shopped for his new clothes.
- The social worker writes down a procedure for bathing with his input and gives him a copy. She places a copy in his medical records and updates his care plan. His direct caregivers are briefed on the procedures.
- Later that week, the administrator brings Mr. Flynn his new clothes to approve and sign receipts for the purchases. He likes all the shirts and four pairs of overalls.

5 Determine resident's or complainant's satisfaction with the outcome

Mr. Flynn reports he is very satisfied with the outcome. If he encounters problems, he plans to speak with the social worker or administrator first, then the ombudsman if needed.

Problem-Solving Process

On behalf of residents, long-term care ombudsmen can:

- receive complaints from residents and others acting on behalf of residents;
- receive complaints in person or by other means;
- identify complaints during visits; and
- obtain permission to work on the problem from the resident.

To solve problems for residents, ombudsmen use a basic problem-solving process. Above all else, use common sense and stay resident-directed throughout the process.

--

Common sense is instinct, and enough of it is genius.
Henry Wheeler Shaw

Step 1 Identify the problem from the resident's perspective and research statutory support

Identifying a problem from the resident's perspective requires an ombudsman to:

- receive or identify a complaint;
- investigate; and
- determine if any resident right or other laws relate to the problem.

Receive a Complaint

Listen more than talk. Allow the complainant to vent without responding positively or negatively. Remember you are hearing only one side of the story. Be careful not to promise anything. Avoid saying anything judgmental like "That's horrible." or "That should not have happened."

Gather information. Ask for names and dates to help you investigate more thoroughly. Note questions that come to mind as the complainant talks and ask after the complainant has a chance to initially describe the concern.

Acknowledge the complainant's feelings. Especially when the person struggles to talk, listen actively to validate the person's feelings and establish rapport. In some cases, the complainant may need you to direct the conversation. He or she may be overwhelmed by the situation, or feel very emotional or confused. In those cases, ombudsmen can help by taking the lead. Ask open-ended questions for someone who is not offering much detail; ask closed questions and redirect for someone who is overly talkative or lacks focus. Do not hurry the process.

Tell the complainant how you plan to proceed. Let the person know a realistic time frame when you will investigate and follow up. If the complainant names a specific resident, let the person know you are required to involve the resident and take action according to the resident's wishes.

When receiving a complaint from anyone other than a resident, let that person know you take _______________ according to a resident's ____________________.

To identify a complaint requires an ombudsman to recognize a problem. Identification stems from an ombudsman's senses: sight, hearing, smell, taste, and touch. Listen to the problem as the complainant describes it. Ask questions about when, where, and how the problem occurs. Also ask if the person has spoken with facility staff or taken any steps to try and resolve the problem.

Investigate

Ombudsmen can investigate by gathering additional information through interviews, observation, and review of relevant documentation. However, all three activities are not required in every situation. An interview is a conversation with a purpose. Preparation for an interview includes knowing:

- Whether you have permission to identify the resident or complainant during the conversation;
- Who you need to talk to; and
- What information you need from the person you interview.

Ombudsmen use their five senses as a part of any investigation. Depending on the problem, what do you see, hear, smell, taste, and touch that provides relevant information about the complaint. To gather information successfully, do the following:

- Take the time needed to observe activities related to the problem
- Determine how many residents the problem potentially or actually affects
- Look beyond what is obvious
- Ignore what is irrelevant
- Consider verbal and nonverbal communication

An ombudsman gathers information through

________________________, _________________________, and

review of relevant documentation.

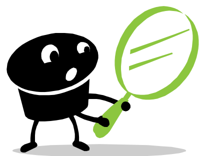
Observations also help determine if the complaint is considered verified or not. For ombudsmen, verified means that after work such as interviews, record inspection, observation and other actions, the circumstances described in the complaint are generally accurate. Regardless of whether a complaint is verified, ombudsmen try to resolve any complaint made by a resident. When a complainant, especially a resident, tells an ombudsman something happened and there is no evidence to the contrary, take the complainant's word for it.

Review of relevant documentation may be necessary to thoroughly investigate a problem. Documents most frequently reviewed are confidential resident records and public facility policies. Accessing a resident record requires the resident's consent and is described in Subchapter 8b. Facility policies and admissions information are public and available by request.

Chapter 5 provides an overview of resident rights. Refer to laws or rules that apply to a situation. Contact your supervising staff ombudsman for research assistance or search the assisted living facility or nursing facility handbooks online.

Step 2 Consider underlying causes and determine scope of the problem

Once a complaint is investigated, analyze the information to determine the reason the problem occurred. This helps to more effectively resolve a problem by getting to the root cause.



Finding the root cause of a problem is essential to a lasting solution

Analyze why the problem occurred. Information gathered during investigation should provide some idea about what caused the problem. It may reveal the root cause is not the problem that was originally reported. Factors for ombudsmen to consider are:

- Was the problem an oversight or does it seem deliberate?
- Is the problem related to facility policies or procedures?
- What is the resident's role in the problem?
- What roles do family or visitors have in the problem?
- Does the facility offer any justification for the problem?

Responsibility may rest with one or more of the following:

- Facility staff failing to perform their duties properly
- Unclear regulations regarding the issue
- Services cannot be reimbursed
- Outside professionals gave unclear instructions
- Resident or family may contribute to the problem

Scope refers to how many residents are affected by a complaint. The scope determines who needs to be involved in an investigation and may steer an ombudsman towards the best approach to resolution.

Step 3 Explore possible ways to resolve and take action

Information gathered during an investigation is used to resolve the complaint. Before jumping to resolution, take time to analyze and plan by:

- analyzing the information collected;
- planning resolution strategies; and
- exploring resolution strategies with the resident or complainant.

To identify possible solutions, ask yourself:

- What might resolve the problem?
- What will it take to keep the problem from recurring?
- What obstacles might be encountered with each solution?
- What are the resident's options regarding their medical and physical needs?

Sometimes there are several ways to resolve a problem. Having options helps ombudsmen be prepared with ideas and prevent obstacles to resolution.

Example: A resident complains, "I pay a lot to live here, but I can't even get a baked potato for lunch," and asks for help from the ombudsman.

Possible Solutions: Changing menu options
Potential Obstacles:

- Cost or supply issues
- No other similar requests have been made
- Resident preferences have not determined menu decisions in the past

Suggestions to Overcome Obstacles:

- Temporary use of another supplier or alternate purchase source
- Seeking assistance from the resident council
- Put concern in writing
- Create Dietary Council or Food Council

Possible Solutions: Updating the resident's food preferences
Potential Obstacles:

- Dietary manager unavailable
- Dietary manager unwilling
- Decision making is delegated to a family member

Suggestions to Overcome Obstacles:

- Speak with manager with authority over dietary manager
- Educate on resident rights

Possible Solutions: Changing dietary orders
Potential Obstacles:

- There is a medical reason potatoes are not provided
- The resident has an order for mechanically softened foods

Suggestions to Overcome Obstacles:

- Facilitate communication between resident and dietary staff
- Explore options with physician or dietitian

Possible Solutions: Staff training
Potential Obstacles:

- Time lag to next training
- Not all staff in attendance
- Staff turnover

Suggestions to Overcome Obstacles:

- Request interim training, ongoing training, and training across all shifts

Exercise: Consider possible solutions, obstacles, and ways to overcome obstacles

Ms. Garcia wants to stay up late at night. The charge nurse knows her preference and will accommodate, but how will a lasting solution be reached?

Possible Solutions: ______________________________

Potential Obstacles: ______________________________

Suggestions to Overcome Obstacles: ______________________________

____

____

Possible Solutions: ______________________________

Potential Obstacles: ______________________________

Suggestions to Overcome Obstacles: ______________________________

____

____

Possible Solutions: ______________________________

Potential Obstacles: ______________________________

Suggestions to Overcome Obstacles: ______________________________

____

____

Possible Solutions: ______________________________

Potential Obstacles: ______________________________

Suggestions to Overcome Obstacles: ______________________________

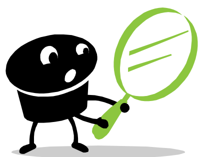
____

____

Sometimes, ombudsmen develop a solution and suggest it to all parties. Other times, they bring people together to discover the best solution. Complaints can be resolved in a number of ways, but try to find a solution that addresses the root cause and supports the resident's wishes.

Ombudsmen resolve many complaints by bringing the problem to the attention of staff or the administrator. When appropriate to resolve problems, use:

- Care planning to focus attention on resident needs, routines, strengths, and preferences;
- Resident and family councils; and
- Laws and rules that support the resident, especially resident rights.



Individual plans of service should be updated to meet a resident's needs. Ombudsmen can suggest a care plan to resolve a variety of problems.

Three resolution skills can be used in nursing homes and assisted living facilities

- Self-advocacy skills

  Self-advocacy works for residents who are empowered. Encourage residents to advocate for themselves as much as they are able. They may prefer to work with the ombudsman being present for support or the ombudsman taking the lead.

- Conflict resolution skills

  Formal mediation requires a mediator to be impartial and all parties to have equal power. Mediators are not decision-makers; they help the parties agree to mutual resolution. Ombudsmen use conflict resolution skills, but do not serve as mediators, because:
  - Ombudsman work is on behalf of residents. Although impartial in investigating, ombudsmen are resident advocates when resolving a problem.
  - Parties are not usually equal in power. Mediation can be appropriate when two residents or two family members are the parties in conflict. For ombudsmen to resolve conflicts, the problem and the parties need to fall within the scope of the ombudsman program.

  If the conflict cannot be resolved by an ombudsman, the parties could work with a mediation organization to help resolve the issues.

- Negotiation skills

  Negotiation is the most frequently used strategy by ombudsmen.

Negotiation Basics

Negotiating is bargaining with the focus on interests rather than positions. Interests are what cause you to make decisions, such as “I want to be treated with dignity and respect.” Positions are things you decide upon, such as “That nurse cannot come into my room.” Some negotiation principles are especially relevant for ombudsmen to support the goal of a “win-win” for the resident and the facility. When it comes to resident rights, *how* a resident right is met can be negotiated, but not *if* it is met.

- Negotiate on the merits
  - Recognize people are problem-solvers
  - Concentrate on achieving a wise outcome, reached efficiently and agreeably
    - Focus on solving the problem
    - Do not try to score debate points or outsmart the other party

  “You have a huge responsibility and it is difficult to please everyone. However, having residents receive clothes that do not belong to them and are the wrong size is a problem. It can be solved if we work together.”

- Separate the people from the problem
  - Be soft on the people and hard on the problem
  - Be aware the other person probably sees the situation differently
  - Do not react to emotional outbursts; allow the other side to let off steam
  - Phrase ideas in terms you think will solve a problem, not in terms of what someone should do

  “It seems like discussing meal trays being served to residents upsets you. Trays left without giving help and removed without the resident being able to eat is a serious issue. Let’s focus on ways to avoid this. It could help if the aides were clear about which residents need help with eating and drinking, whose responsibility it is to help, and how to assist the residents.”

- Focus on interests, not positions
  - Explore interests
  - Each side may have multiple interests; try to find similar interests to form the basis of a win-win solution
  - Avoid having a bottom line

  “Your facility’s reputation is important to you. I’d like to discuss what one resident needs to feel at home and be comfortable with her care routine.”

The difference between a position and an interest is:

____

____

- Invent options for mutual gain
    - Develop multiple options and decide later
    - Look for solutions that allow both sides to gain something, in contrast to compromises where both sides lose something
    - Do not be wedded to a single solution
    - Try to develop a win-win solution based on shared interest

  "Based on our discussion, we agree Mr. Dillard needs more opportunities to move around and to be outdoors. Can we brainstorm some ideas about how his needs can be met while considering his safety and need for supervision?"

- Insist on using objective criteria
    - Try to reach a result based on standards independent of will, such as laws, written rules, and outside experts
    - Reason and be open to reason
    - Yield to principle, not pressure

  "I understand your concern that Mrs. Everett's health will decline if she doesn't take the medicine her doctor ordered. You have done an excellent job of explaining the consequences of her decision and offering other options. Nevertheless, residents have the legal right to refuse treatment."

Source: Getting to Yes: Negotiating Agreement without Giving In
by Roger Fisher and William Ury

When negotiating with management, separate the _______________ from the problem.

Check with the Resident

Once an ombudsman has investigated a complaint, identified the underlying problem, identified possible solutions, obstacles, and resolution strategies, it is time to pause and check with the resident. Reasons for this are to:

- Share with the resident what the ombudsman learned
- Be sure the resident wants you to continue trying to resolve the problem
- Confirm the outcome the resident seeks
- Discuss ideas regarding how to resolve the problem
- Encourage the resident to participate in the resolution process
- Discuss potential consequences to the resident, if any
- Discuss potential outcomes; determine what will satisfy the resident

Before taking action to resolve, be sure you know what the ______________________ _______________.

Take Action

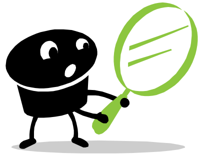
To take action requires resident consent. Seek resident-directed resolutions, which mean ombudsmen:

- Take a complaint as far as possible to accomplish the desired outcome
- Follow up with other agencies and the resident when a complaint is referred
- Check back with the resident later if a complaint was withdrawn

Once the resident is consulted and an approach is chosen, act to resolve. Be respectful, reasonable, confident, and have a good attitude. The Older Americans Act authorizes ombudsmen to resolve complaints, but our authority is only as good as our power of persuasion.

A meeting may be necessary to get the right parties in the same room to discuss a resolution. To prepare for a resolution meeting, have a plan of action:

1. Investigate first
2. Know what the resident wants
3. Determine who needs to be involved and request their participation
4. Establish who will lead the meeting
5. Rehearse
    - Visualize the meeting and what to do and say
    - Be clear what your role is
    - Set the time and place and be sure parties are aware
    - Anticipate obstacles and have potential solutions ready
    - Be aware of style
        - Body language, eye contact, facial expression, gestures, voice tone
        - Submissive vs. assertive vs. aggressive
6. Anticipate surprises
    - Do not agree to something under pressure if it does not fit with resident direction
    - Ask for time if needed
    - Trust your gut
    - Call all parties the day before to confirm



As you prepare for a meeting, visualize a cooperative environment where you serve as a guide toward resolution.

Other Strategies

If a complaint cannot be resolved by interventions at the facility, it may be necessary to use more adversarial strategies. These might include:

- regulatory agencies – investigations, citations, penalties;
- legal services – advice, litigation;
- courts – judgments, enforcement, recovery, damages;
- elected officials – add, edit, or delete laws and rules; and
- local media – publicity, news, opinions.

Volunteer ombudsmen refer these complaints to the supervising staff ombudsman He or she works with the Managing Local Ombudsman who coordinates with the State Long-term Care Ombudsman and serves as the lead in these strategies.

Step 4 Check on progress and outcomes

The resident should always be an ombudsman's first source to check progress. This is often done in person but may be by phone calls. Be careful not to identify any resident as a complainant if he or she requested anonymity. A volunteer and staff ombudsman may work together to resolve and follow-up on a complaint.

Staff and volunteer ombudsmen can work together to investigate and resolve complaints.

If the complainant is someone other than a resident, ombudsmen have an obligation to inform the complainant of progress, according to the resident's direction. If a resident does not perceive the complaint as a problem, the ombudsman informs the complainant of the resident's perception and direction.

At this stage, and at any point, things may fall apart or there may be little or no progress toward resolution. In such cases, investigate the cause and take action to restart the process or attempt a new strategy for resolution.

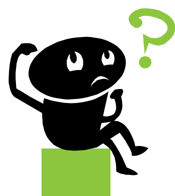
Resident communication styles and abilities guide follow-up strategy. Some residents do not hesitate to report to an ombudsman that the problem is getting worse or not improving. Others wait until an ombudsman visits or may hesitate to report bad news. An ombudsman listens, interprets nonverbal communication, redirects conversations, or probes for more information, depending on each resident's needs.

How much follow-up, and how long, varies with each case. Follow-up depends on how responsive the facility is, how successful staff implements change, and complexity of the problem. Depending on the nature of complaints, check back one or two times from a few days to several months after resolution.

Step 5 Determine resident or complainant satisfaction with outcome

When an ombudsman has done all the work they can toward resolution, identify an outcome for each complaint and close the case. Ombudsmen call the outcome a disposition. The resident or complainant determines the outcome so contact the person to check whether the problem was resolved to his or her satisfaction.

In the beginning, an ombudsman checks with the supervising staff ombudsman to determine when to close a case. With experience, ombudsmen often determine when to close a case on their own, but consulting the supervising staff ombudsman is always an option.



Close a case when you have done all the __________ you can reasonably do.

If the complaint was referred to another agency to investigate, check with your supervising staff ombudsman on the status of investigation or action. If the problem continues, contact the agency again as necessary.

Ombudsmen report the outcome of actions (disposition) as follows:

- Resolved (include referred complaints with a resolved outcome)
- Partially resolved, part of the problem remains (include referred complaints that are partially resolved)
- Withdrawn
- Referred to another agency
    - Disposition not obtained
    - Agency failed to act in accordance with policy
    - Agency did not substantiate
- No action needed or appropriate
- Not resolved
- Cannot be resolved and requires regulatory or legislative action

Remember two factors while working to resolve complaints:

- Some complaints cannot be resolved. It can happen in spite of thorough investigation, unquestionable verification, and wise and persistent efforts to resolve by the ombudsman.

- Complaint resolution is not always clear-cut.
  - A problem may go away and then reappear.
  - Parts of the problem will be taken care of but not others.
  - The complainant will not be completely convinced the situation is as good as it should be.
  - The complainant will say everything has been solved even if the ombudsman would prefer to continue pursuing the matter.

Barriers to Problem Solving

Ombudsmen engage in conflict on a routine basis. Conflict resolution requires work with authority figures. Review the following common reactions to people in authority.

- Awe (respect, admiration, or intimidation)

  Feeling awed or intimidated by a person in authority is frequently experienced. Sometimes the professional title or social status associated with an individual can lead to us feeling intimidated about our training or capabilities.

- Avoidance

  It is common for people to avoid directly confronting a problem. It can feel safer to avoid face-to-face communication to solve a problem, especially if a past experience was negative.

- Anger or fear

  Working with authority figures who may not share the complainant's point of view can lead to feelings of anger or fear. Confronting authority figures who lack empathy can be stressful and take a toll on the person confronting the problem.

Awe, anger, and _____________________ are common responses to authority figures. Ombudsmen must overcome them all in order to effectively advocate.

To most effectively work with authority figures, use the following strategies:

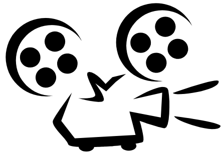
1. Make an objective assessment of the person. Authority figures can be potential allies or opponents.

2. Evaluate perceived prejudices, preferences, and decision-making patterns shown by authority figures. Study their personalities and adjust your responses to communicate better. For example, knowing four personality types known by terms, such as controller, promoter, feeler, and thinker, you can build better relationships. If they are thinkers, give them facts; if they are feelers, share personal stories; and so on.

3. Know the lines of communication if a person in authority makes an unfavorable decision. Be aware of even higher authority, appeal rights, or opportunities.

4. Be aware of policies, guidelines, rules, regulations, and laws that govern the authority figure. Know which ones the person has authority to control.

5. Use resident rights and other laws when they apply. Laws are powerful tools that ombudsmen must know and use. Refer to nursing home and assisted living facility rules cited in Chapter 1.



Video: Basic Complaint Handling for Ombudsmen

Ombudsman Mary works with resident Mrs. Woods. Observe the actions Mary takes to understand the complaints, reach resolutions, and follow-up. Listen for how Mary seeks Ms. Woods' consent. Remember complaints are confidential.

Situation 1: Interviewing skills with Ms. Woods

- What do you like about Mary's approach to interviewing? ______________________
  ____
- What complaints do you identify? ____
  ____
  ____
- Identify the investigation methods described by Mary to Ms. Woods
  ____
  ____
  ____

Situation 2: Observation skills

- Identify concerns based on what you hear
  - ____
  - ____
  - ____
- Identify concerns based on what you see
  - ____
  - ____
  - ____

Situation 3: Discussing investigation results and planning

- What skills do you notice Mary using in her meeting with Ms. Woods? ____________
  ____
  ____

Situation 4: Preparation and resolution meeting

- What does Mary do to prepare Mr. Bernstein and Ms. Woods? __________________
  ____
  ____

- How does Mary contribute to a positive and effective meeting? __________________
  ____
  ____

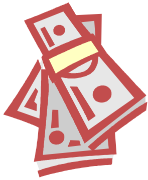
Situation 5: Resident conflict

- How does Mary respect each resident during the course of her visit?
  ____
  ____
  ____

Situation 6: Communicating with an administrator

- How does Mary diffuse the situation with Mr. Delgado? ________________________
  ____
  ____
  ____

Case Discussion: “Show me the Money”



Ms. James lost several clothing items. Her sister Ms. Martin visits often. On the last visit, Ms. James was wearing clothes that did not belong to her. She told her sister some clothes had been taken out of her dresser. When Ms. Martin asked, the administrator said Ms. James is confused.

Ms. Martin heard that her sister should be able to keep some money out of her check each month. Ms. James doesn’t know about this. Ms. Martin suggests the administrator use the money to buy a new dress for her sister. He says there isn’t any money left after bills are paid each month. When Ms. Martin asked where the money was kept, staff replied that only the legal guardian could have that information.

Other residents report their funds are not accounted for. The administrator reports:

- Because of theft, personal needs allowances are given on an as-needed basis.
- At admission, every resident signs a form authorizing the facility to administer funds for security purposes. For residents who have a diagnosis of dementia, a family member is asked to agree to this procedure by signing the form.

Step 1: Identify the problem and research statutory support

____

____

Step 2: Consider causes and scope

____

____

Step 3: Explore ways to resolve and take action

____

____

____

Step 4: Check on progress and outcomes

____

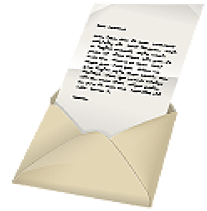
____

Step 5: Determine satisfaction

____

____

Case Discussion: “Discharge – Unable to Meet Needs”



Lacey Dalton is married and 45 years old. Her husband lives in their home and she lives in a nursing home. The administrator issued her a 30-day discharge notice stating they cannot meet her needs.

The facility contacted Mr. Dalton numerous times to discuss his wife’s behaviors, but he changed his phone number and address. Mrs. Dalton reportedly gave her husband Power of Attorney when she was in the hospital, but the facility does not have a copy. The facility reports Mrs. Dalton is noncompliant with treatment and has placed her health at risk. Mrs. Dalton says her husband cannot take care of her. She calls the ombudsman to help her stay in the nursing home.

Step 1: Identify the problem and research statutory support

____

____

Step 2: Consider causes and scope

____

____

Step 3: Explore ways to resolve and take action

____

____

____

Step 4: Check on progress and outcomes

____

____

Step 5: Determine satisfaction

____

____

Walking the Fine Line: Ombudsman Role with Residents, Families, and Facility Staff

Based on long-term care ombudsman experiences, Jana Tiefenwerth, former East Texas staff ombudsman, created “Walking the Fine Line.” This perspective helps create positive working relationships that lead to successful advocacy.

During the presentation, think about - How to:

- Walk the fine line between residents and staff in a way that increases their trust in an ombudsman?
- Help residents see an ombudsman as a resident advocate, but not cross the line and create a dependent relationship?
- Develop relationships with staff that improves quality of life and care for residents, without crossing a boundary with staff?

Give three examples of an ombudsman being pro-facility?

- ____
- ____
- ____

Role Play Exercise: Patient Abuse

Roles: Ombudsman
Resident
Resident's Daughter

A resident's daughter asks to meet at her mother's nursing home. She says she frequently sees bruises on her mother's wrists, but her mother insists on not reporting.

Questions for role play observers:

- What is the ombudsman's responsibility in this situation?

  ____

- What did you see the ombudsman do?

  ____

- The resident says she will not cooperate with reporting abuse. Who should take action? ____

Confidential

Texas Department of Aging
and Disability Services

Long-Term Care Ombudsman Activity Report

Form 8620
August 2010

Ombudsman: ______________________ Facility: __________________________________ Month/Year: ____________

Visit Date	No. of Contacts			Time – Hrs:Mins		Mileage Optional
	Resident	Family/Other	Staff	On Site	Travel Optional	
Totals						

Date	Activity
	Family council
	Resident council
	Survey
	Care plan meeting

Notes

Cases and Complaints

Date Opened	Complainant	Resident / Complainant (name or description)	Consent		Complaints		Verified		Disposition	Date Closed
			Yes	No	(1-132)	Notes optional	Yes	No		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		

Complainant

1 Resident
2 Relative/friend
3 Guardian/legal rep
4 Ombudsman
5 Facility staff
6 Medical staff
7 Social/health agency
8 Unknown/anonymous
9 Banker, clergy, law

Disposition

a Govt./legislative
b Not resolved
c Withdrawn
d1 Referred: disposition not obtained
d2 Referred: failed to act on complaint
d3 Referred: complaint not substantiated
e No action needed
f Partially resolved
g Resolved

Date Opened	Complainant	Resident / Complainant (name or description)	Consent		Complaints		Verified		Disposition	Date Closed
			Yes	No	(1-132)	Notes optional	Yes	No		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		

Complainant

1 Resident
2 Relative/friend
3 Guardian/legal rep
4 Ombudsman
5 Facility staff
6 Medical staff
7 Social/health agency
8 Unknown/anonymous
9 Banker, clergy, law

Disposition

a Govt./legislative
b Not resolved
c Withdrawn
d1 Referred: disposition not obtained
d2 Referred: failed to act on complaint
d3 Referred: complaint not substantiated
e No action needed
f Partially resolved
g Resolved

Ombudsman Certification Training

SUBCHAPTER 8a

Program Communication

--This page intentionally left blank—

Program Communication

Subchapter 8a is about a certified ombudsman's communication with the Long-term Care Ombudsman Program.

Learning Objectives

- Recognize the importance of strong communications among ombudsman volunteers and staff
- Understand the conditions when consultation with the ombudsman program is required
- Learn how to complete and submit a monthly report to the ombudsman program office

Contents

Communicating with the Ombudsman Program
Consulting with Ombudsman Program Staff
Reporting

Supplement A-8a: AoA Ombudsman Complaint Codes (1-132)
Supplement B-8a: LTC Ombudsman Activity Report, DADS Form 8620
Supplement C-8a: Instructions DADS Form 8620

Communicating with the Ombudsman Program

Good communications between volunteers, local ombudsmen, and state office staff are essential to an effective ombudsman program. This communication ensures all ombudsmen feel supported and have access to help when needed. Good program communications also help residents receive the advocacy they need, when they need it.

Ombudsman program communications are vital to our effective advocacy.

- *Training*. In addition to training received for initial certification, every ombudsman must earn 12 hours of continuing education each year. Continuing education keeps ombudsmen informed of changes in the long-term care system and builds upon the foundation of initial training.
- *Visits*. A staff ombudsman makes periodic visits with a volunteer. Joint visits allow ombudsmen to learn from one another. Take advantage of these visits to ask questions, make observations, and exercise critical thinking skills while observing another ombudsman in action.
- *Consultation*. Ombudsmen should never feel alone. Call your supervising staff ombudsman for problem-solving ideas and for guidance about ombudsman procedures. Request a joint visit when needed.
- *Reporting*. As a federally- and state-funded program, reporting is required. Reports communicate the real needs of residents and serve as the basis for legislative advocacy. To maintain certification, every ombudsman must report their activities monthly.

---

1. Every certified ombudsman is required to earn ____ hours of continuing education each year.
2. Volunteers and staff can visit residents together for training or working to resolve a case. On these visits, ask ________________ and make _____________________.
3. Staff ombudsmen are partners with volunteers and the state ombudsman. Asking for ___________ is encouraged in the ombudsman program.
4. Staff ombudsmen report daily and volunteers report every ____________.

In addition to required forms of communication, programs may issue newsletters, send letters, and use website communications. These efforts keep a strong connection among ombudsmen and maintain the statewide program's effectiveness.

Consulting with Ombudsman Program Staff

Consultation provides all ombudsmen the support they need while ensuring ombudsmen follow procedures to protect resident rights and the integrity of the ombudsman program. In some circumstances, consultation is advised. At other times, it is required.

Consultation is encouraged for many situations, including when ombudsmen:

- need information about possible resources;
- are unsure about laws and rules that may apply to a problem;
- have questions about ombudsman procedures;
- feel stuck on a case or problem; or
- suspect facility staff are not taking a complaint seriously.

Consultation is <u>required</u> when ombudsmen:

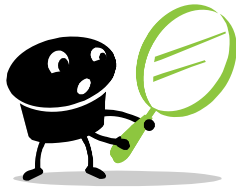
- suspect abuse, neglect, or exploitation of a resident and the resident does not consent to reporting;
- feel uncomfortable helping a resident or has a personal belief that may interfere with their ability to assist a resident with a particular problem;
- have a conflict of interest related to any person associated with the facility where they serve;
- need access to a resident's medical record and the resident cannot consent;
- believe a person is interfering with them in the course of official duties;
- are asked to disclose confidential information and consent from the resident or complainant cannot be obtained;
- feel a serious risk to resident health and safety exists in the facility where the ombudsmen serve; and
- are directed to consult with their supervising staff ombudsman as described in this training manual or in other written procedures.

---

1. Consultation with program staff ensures compliance with ombudsman ______________________ and maintains the ____________________ of the program.
2. Two circumstances that require consultation involve resident consent: when ombudsmen suspect __________, ______________, or ____________________ and when asked to disclose _____________________ information.

Reporting

On a daily basis, staff ombudsmen report their activities in a statewide reporting database. The database stores confidential information about ombudsman work and supports communication among ombudsman program representatives. The system protects all documentation from release to anyone other than an ombudsman involved in a case unless permission is given by the resident or by court order. The statewide database makes it possible for the state ombudsman and local ombudsman programs to analyze and report work in order to meet federal and state requirements.



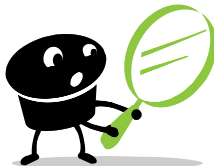
The state long-term care ombudsman creates a biennial report for the Texas Legislature and Governor and reports annual program accomplishments. Reports are available on the Long-term Care Ombudsman Program website.

Volunteers report their work monthly to the local ombudsman program using the Long-term Care Ombudsman Activity Report (DADS Form 8620). Starting with the first month of visiting residents in a facility as an ombudsman intern, volunteers fill out this report to describe activities completed on behalf of residents.

The first step in reporting is to get familiar with codes that describe problems an ombudsman encounters. A list of 132 codes is at the end of Subchapter 8A, followed by a detailed description of each. To categorize each complaint, codes are organized into separate headings that include:

- Resident Rights,
- Resident Care,
- Quality of Life,
- Administration, and
- Problems with Outside Agency, System, or People.

Under the headings are subheadings indicated by letters A through Q and titled for additional guidance, such as M. Staffing.



Example of a complaint subheading and complaints:

M. Staffing

- 096 Communication, language barrier
- 097 Shortage of staff
- 098 Staff: training, lack of screening
- 099 Staff: turnover, registries
- 100 Staff: unresponsive, unavailable
- 101 Supervision
- 102 Eating assistants

Exercise: Find the Best Complaint Code

Use the list of 132 codes to assign the best code to describe a complaint. Circle the complainant in each complaint.

Example: An ombudsman observed a resident with fingernails and hair that appeared dirty. The best ~~complaint~~ category and code is: F 45, personal hygiene.

____ 1. A resident tells you "a CNA is mean. I get nervous when she comes to my room."

____ 2. A daughter reports the nursing home is moving her Mom to make room for a special rehabilitation unit. She has lived in the same room for two years and doesn't want to move. "The social worker is harassing us."

____ 3. A resident says, "My roommate hollers out and keeps me up at night. I want him moved."

____ 4. A facility staff tells you, "Breakfast looks awful. The pancakes are rubbery, the eggs are powdered, and the coffee is cold." You ask residents and they agree.

____ 5. A resident reports the facility held her care plan meeting without her.

____ 6. The social worker reports, "Mr. Jones is going into resident rooms and stealing."

____ 7. A resident reports, "Rehab has stopped physical therapy because they say I am no longer improving enough, but I know I can progress with more therapy."

____ 8. The daughter said, "Mom called me very upset. The blouse and pants they put on her are not hers."

____ 9. The ombudsman observes the bathroom in a resident's room has feces, standing water, and live roaches.

____ 10. The ombudsman notices several call lights are not within residents' reach in bed.

Exercise: Practice Completing a Monthly Report

Use the information provided to complete a May 2012 Ombudsman Activity Report.

May 1, 2012 (2.5 hours)
Ms. Green reports it is too noisy at night and she can't sleep. Reported to administrator and discussed changes in nighttime supervision.
Mr. White says his roommate keeps his light on until midnight and it keeps him awake. His sheets have not been changed in a week. Housekeeping changes sheets while I am there. Visited 29 residents.

May 10 (2 hours)
Mr. Mustard tells me, "I don't know why I am here, I want to go home." We speak with the social worker who calls the relocation contractor for an assessment.
Ms. Scarlet reports never having a water pitcher and says she is thirsty. Three other rooms do not have water available and two hallways have only one CNA working.
Attended Family Council meeting in p.m. Visited with 9 family members.

May 13 (1 hour)
Ms. Brown wants to get outdoors but says everyone is too busy. Activities assistant helps her outside while I was there.
Mr. White and I discuss his relationship with his roommate who was sent to the hospital last night. He reports several housekeeping staff quit. Trash cans are full and the restroom needs attention. Requested housekeeping services.

Called Mr. White on May 14. Housekeeping cleaned his room yesterday afternoon.

May 21 (1.5 hours)
Followed up with all residents on complaints. Visited with 10 residents and 2 family.

- Ms. Green says nights are quieter. Other residents report the same. I reported to the administrator improvements and thanked her for intervention.
- Mr. Mustard hasn't seen the relocation contractor for an assessment. Asks me to call and find out the status of his request.
- Ms. Brown reports not getting outside since last week. Calendar includes no outdoor activities. Activity director is not available to talk; left a note for administrator to call me.
- Mr. White's roommate has returned from the hospital and is sleeping more. Room has been quiet at night, but he feels it is temporary.
- Observed water pitchers being distributed to each resident. Ms. Scarlet reports she has received water every day since I reported it. Close case, but watch for how often water is replenished and if solution lasts next month.
- Housekeeping still looks behind – beds not made at noon. Trash overflowing.

Confidential

Texas Department of Aging
and Disability Services

Long-Term Care Ombudsman Activity Report

Form 8620
August 2010

Ombudsman: ____________ Facility: ____________ Month/Year: ____________

Visit Date	No. of Contacts			Time – Hrs:Mins		Mileage Optional
	Resident	Family/Other	Staff	On Site	Travel Optional	
Totals						

Date	Activity
	Family council
	Resident council
	Survey
	Care plan meeting

Notes

Cases and Complaints

Date Opened	Complainant	Resident / Complainant (name or description)	Consent		Complaints		Verified		Disposition	Date Closed
			Yes	No	(1-132)	Notes optional	Yes	No		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		

Complainant
1 Resident
2 Relative/friend
3 Guardian/legal rep
4 Ombudsman
5 Facility staff
6 Medical staff
7 Social/health agency
8 Unknown/anonymous
9 Banker, clergy, law

Disposition
a Govt./legislative
b Not resolved
c Withdrawn
d1 Referred: disposition not obtained
d2 Referred: failed to act on complaint
d3 Referred: complaint not substantiated
e No action needed
f Partially resolved
g Resolved

Confidential

Texas Department of Aging
and Disability Services

Form 8620
Page 2, 08-2010

Date Opened	Complainant	Resident / Complainant (name or description)	Consent		Complaints		Verified		Disposition	Date Closed
			Yes	No	(1-132)	Notes optional	Yes	No		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		
			☐	☐			☐	☐		

Ombudsman tip: Start your monthly report after your first visit of the month and add to it each time you visit. As soon as you make your last visit in the month, e-mail or mail it to your ombudsman program.

More Practice

Circle the source of the complaint and write the complaint code that best describes the complaint.

____ 1. Daughter: “My mother is allergic to fish and she couldn’t eat what was served. No one told her she could order something else so she went to bed hungry.”

____ 2. The facility calls for ombudsman intervention. A resident wants to go home but the nursing home does not think he can live safely at home.

____ 3. Ombudsman is aware a resident is diagnosed with an anxiety disorder. Son was not informed that his father’s doctor order two psychotropic drugs and is concerned after reading about serious side effects.

____ 4. Ombudsman notices the living room smells of smoke. The smoking area is off the living room and has a large ashtray full of cigarette butts in the corner.

____ 5. Daughter: “Every time I visit my mother, she is sitting in the wheelchair in the hall staring at the walls.”

____ 6. Ombudsman observes a resident looks very thin and does not eat lunch. The resident calls out for milk, but no one gets it for her.

____ 7. A resident reports, “My dentures got lost three months ago. I am still waiting for them to be replaced.”

____ 8. Ombudsman learns a resident is Spanish speaking, but no one who provides her care understands or speaks Spanish.

____ 9. Resident: “I’m in terrible pain. The nurse is giving me Tylenol but it doesn’t help. I told her but no one pays attention.”

____ 10. Resident: “Last evening I called the CNA to use the bathroom. CNA told me, ‘I’m busy now. Go in your diaper.’”

Supplement A-8a: AoA Ombudsman Complaint Codes (1-132)

RESIDENTS' RIGHTS

A. Abuse, Gross Neglect, Exploitation

1. Abuse: physical (including corporal punishment)
2. Abuse: sexual
3. Abuse: verbal / psychological (including punishment, seclusion)
4. Financial exploitation (severe complaints)
5. Gross neglect (use categories F & G for non-willful forms of neglect)
6. Resident-to-resident physical or sexual abuse

B. Access to Information by Resident or Resident's Representative

8. Access: own records
9. Access by or to ombudsman / visitors
10. Access to facility survey, staffing reports, license
11. Information: advance directive
12. Information: medical condition, treatment and any changes
13. Information: rights, benefits, services, the resident's right to complain
14. Information communicated in understandable language

C. Admission, Transfer, Discharge, Eviction

16. Admission contract and/or procedure
17. Appeal process: absent, not followed
18. Bed hold: written notice, refusal to readmit
19. Discharge / eviction (including abandonment)
20. Admission discrimination: condition, disability
21. Admission discrimination: Medicaid status
22. Room assignment / change, intra-facility transfer

D. Autonomy, Choice, Preference, Exercise of Rights, Privacy

24. Choose personal physician, pharmacy, hospice, other health care provider
25. Confinement of facility against will (illegally)
26. Dignity, respect, staff attitudes
27. Exercise preference and choice and/or civil and religious rights, individual's right to smoke
28. Exercise right to refuse care / treatment
29. Language barrier in daily routine
30. Participate in care planning by resident and/or designated surrogate
31. Privacy: telephone, visitors, couples, mail
32. Privacy: treatment, confidentiality
33. Response to complaints
34. Reprisal, retaliation

E. Financial, Property (except for exploitation)

36. Billing and charges: notice, approval, questionable, accounting wrong or denied (includes overcharge of private pay residents)
37. Personal funds: mismanaged, access and information denied, deposits and other money not returned (report criminal-level misuse of personal funds under A.4)
38. Personal property lost, stolen, used by others, destroyed, withheld from resident

RESIDENT CARE

F. Care

40. Accidental or injury of unknown origin, falls, improper handling
41. Failure to respond to requests for assistance, call lights
42. Care plan / resident assessment: inadequate, failure to follow plan or physician orders
43. Contracture
44. Medications: administration, organization
45. Personal hygiene (includes nail care & oral hygiene) and adequacy of dressing & grooming
46. Physician services (including podiatrist)
47. Pressure sores, not turned
48. Symptoms unattended (including pain, pain not managed), no notice to others of changes in condition
49. Toileting, incontinent care
50. Tubes: neglect of catheter, gastric, NG tube
51. Wandering, failure to accommodate / monitor exit seeking behavior

G. Rehabilitation or Maintenance of Function

53. Assistive devices or equipment
54 Bowel and bladder training
55. Dental services
56. Mental health, psychosocial services
57. Range of motion, ambulation
58. Therapies: physical, occupational, speech
59. Vision and hearing

H. Restraints: Chemical and Physical

61. Physical restraint: assessment, use, monitoring
62. Psychoactive drugs: assessment, use, evaluation

QUALITY OF LIFE

I. Activities and Social Services

64. Activities: choice and appropriateness
65. Community interaction, transportation
66. Resident conflict (including roommates)
67. Social services: availability / appropriateness (use G.56 for mental health, psychosocial counseling / service)

J. Dietary

69. Assistance in eating or assistive devices
70. Fluid availability / hydration
71. Food service: quantity, quality, variation, choice, condiments, utensils, menu
72. Snacks, time between meals, late / missed meals
73. Temperature of food
74. Therapeutic diet
75. Weight loss due to inadequate nutrition

K. Environment / Safety

77. Air / environment: temperature and quality (heating, cooling, ventilation, water), noise
78. Cleanliness, pests, general housekeeping
79. Equipment / buildings: disrepair, hazard, poor lighting, fire safety, not secure
80. Furnishings, storage for residents
81. Infection control
82. Laundry: lost, condition
83. Odors
84. Space for activities, dining
85. Supplies and linens
86. Americans with Disabilities Act (ADA) accessibility

ADMINISTRATION

L. Policies, Procedures, Attitudes, Resources

87. Abuse investigation / reporting (including failure to report)
88. Administrator(s) unresponsive, unavailable
89. Grievance procedure (use C for transfer, discharge appeals)
90. Inappropriate or illegal policies, practices, record-keeping
91. Insufficient funds to operate
92. Operator inadequately trained
93. Offering inappropriate level of care (for ALFs)
94. Resident or family council interfered with, not supported

M. Staffing

96. Communication, language barrier
97. Shortage of staff
98. Staff training
99. Staff turn-over, over-use of nursing pools
100. Staff: unresponsive, unavailable
101. Supervision
102. Eating assistants

PROBLEMS WITH OUTSIDE AGENCY, SYSTEM, OR PEOPLE (not against the facility)

N. Certification / Licensing Agency

103. Access to information (including survey)
104. Complaint, response to
105. Decertification / closure
106. Sanction (including intermediate)
107. Survey process
108. Survey process: ombudsman participation
109. Transfer or eviction hearing

O. State Medicaid Agency

111. Access to information, application
112. Denial of eligibility
113. Non-covered services
114. Personal Needs Allowance (PNA)
115. Services

P. System / Others

117. Abuse, neglect, abandonment by family member, friend, guardian or, while on visit out of facility, any other person
118. Bed shortage: placement
119. Facilities operating without a license
120. Family conflict; interference
121. Financial exploitation or neglect by family or other not affiliated with facility
122. Legal: guardianship, conservatorship, power of attorney, wills
123. Medicare
124. Mental health, developmental disabilities (including PASRR)
125. Problems with resident's physician / assistant
126. Protective Service agency
127. SSA, SSI, VA, other benefits / agencies
128. Request for less restrictive placement

Q. Complaints about services in settings other than long-term care facilities or by outside provider

129. Home care
130. Hospital or hospice
131. Public or other congregate housing not providing personal care
132. Services from outside provider

Long-Term Care Ombudsman Program Complaint Codes

A complaint is about a problem of commission or omission.

Each case may have more than one complaint. However, each problem will have only one code. Use only one category for each type of problem (i.e., do not check both A.3 and D.26 for the same staff behavior - determine which category is most appropriate to the particular problem).

Residents' Rights

A. ABUSE, GROSS NEGLECT, EXPLOITATION

Use categories in this section only for serious complaints of willful mistreatment of residents by facility staff, management, other residents (use category 6), or unknown or outside individuals who have gained access to the resident through negligence or lax security on the part of the facility or for neglect which is so severe that it constitutes abuse. Use P.117 and P.121 for complaints of abuse, neglect, exploitation by family members, friends, and others whose actions the facility could not reasonably be expected to oversee or regulate.

*For **all** categories in this part, use the broad definitions of abuse, neglect and exploitation in the Older Americans Act (OAA), which is almost identical to that in regulations for nursing homes participating in the Medicare and Medicaid programs (42 CFR 488.301): The term*

Abuse means the willful
(A) infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain or mental anguish; or
(B) deprivation by a person, including a caregiver, of goods or services necessary to avoid physical harm, mental anguish, or mental illness. (OAA, Section 102 [13])
(Financial) exploitation means the illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit or gain. (OAA, Section 102[24])

In addition to the above broad definitions, use the definitions for specific categories below from the Centers for Medicare and Medicaid Services (CMS) Interpretive Guidelines, section 483.13(b) and (c). The guidelines are available at https://www.cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf See page 61 and surveyor guidance at deficiency tags F223 to F226.

Use resident-to-resident physical or sexual abuse (A.6) only for willful abuse of one resident by another resident, not for unintentional harm or altercations between residents who require staff supervision, which should be coded in category I-66, "Resident conflict, including roommates." (For example, a confused resident who strikes out is categorized at I.66 and an alert resident who strikes out is A.6.)

1. Abuse, physical (including corporal punishment)
Includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.

2. **Abuse, sexual**
Includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

3. **Abuse, verbal/psychological (including punishment, seclusion)**
Use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or to their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability. (Use D.26 for less severe forms of staff rudeness or insensitivity; use M.100 if staff is unavailable, unresponsive to residents.) Psychological or mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Involuntary seclusion means the separation of a resident from other residents or from his/her room against the resident's will or the will of the resident's legal representative. Emergency or short term monitored separation is not considered involuntary seclusion if used for a limited period of time as a therapeutic intervention to reduce agitation.

4. **Financial exploitation (use categories in Section E for less severe financial complaints)**
The illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit or gain.

5. **Gross neglect (for non-willful forms of neglect, use Care, Sections F & G)**
The willful deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness. (Use only for the most extreme forms of willful neglect. Use the appropriate categories under Resident Care, Quality of Life or, in some cases, Administration for less severe forms or manifestations of resident neglect.)

6. **Resident-to-resident physical or sexual abuse**
Use only for complaints of abuse by a resident against one or more other residents which meet the definitions of abuse provided above. (For unintentional harm or altercations between residents who require staff supervision, use category I-66, "Resident conflict, including roommates.")

7. **Not Used**

B. ACCESS TO INFORMATION BY RESIDENT OR RESIDENT'S REPRESENTATIVE

Use categories in this section for complaints involving access to information or assistance made by or on behalf of the resident or the resident's representative. Use B.9 if the ombudsman is denied access in response to a complaint. If there is a general problem with ombudsman access to one or more particular facilities or types of facilities, but no complaint has been filed, do not use complaint categories. Describe the access problem under Part III, B - Statewide Coverage. Categories B.14, D.29, and M.96 all involve communication /language barriers and yet are different. Use B.14 if information regarding rights, medical condition, benefits, services, etc. is not communicated in an understandable language.

8. **Access to own records**
Use if complainant is denied or delayed access to resident's record.

9. **Access by or to ombudsman/visitors**
Use if access to the facility or certain parts of the facility is denied to the ombudsman. Use also if ombudsman or visitors are denied access to a resident.

10. Access to facility survey/staffing reports/license

Use if the licensing and certification agency's survey is not posted in a prominent place or not provided when requested. Use also when the facility's license is not posted or available. Use if the facility daily staffing report is not posted.

11. Information regarding advance directive

Use related to advance health care directive, living will, do not resuscitate (DNR) order, and similar problems.

12. Information regarding medical condition, treatment and any changes

Use if information is denied, delayed.

13. Information regarding rights, benefits, services, the resident's right to complain

Use related to resident rights (including the right to complain), Medicaid information/process, social services, staff not wearing name badges, and similar problems.

14. Information communicated in understandable language

Use if information is not provided in a language which the resident or her representative can understand or the staff speaks in a confusing manner.

15. Not Used

C. ADMISSION, TRANSFER, DISCHARGE, EVICTION

Use the appropriate category for complaints involving placement, whether into, within or outside of the facility. If resident requests assistance in transferring to another facility and there is no stated problem (complaint), record as information and assistance to individuals in Part III, Other Ombudsman Activities. If a resident requests assistance in moving out of the facility but there are no feasible alternative options, record as P.128 "Request for less restrictive placement," since the problem is a lack of care alternatives within the long-term care system.

16. Admission contract and/or procedure

Use if no contract; contract contains illegal wording requiring waiver of rights or guarantee of payment; admission procedure not followed; admission procedure does not contain required elements, and similar problems.

17. Appeal process - absent, not followed

Use if resident/representative not given required number of days to appeal a discharge; facility failed to follow appeal ruling; no appeal process in place; and similar problems.

18. Bed hold - written notice, refusal to readmit

Use if bed not held required number of days; resident/representative not advised of bed hold policy; incorrect bed hold procedure; bed held but resident not readmitted and similar problems.

19. Discharge/eviction- planning, notice, procedure, implementation, including abandonment

Use if no discharge notice; required notice not given to resident/representative; required notice not given to the ombudsman program in required time frame; required notice lacks documentation, is incomplete, incorrect; discharge is for inappropriate reasons; discharge planned or implemented to inappropriate environment; level of care is changed against resident's will, and similar problems.

20. Discrimination in admission due to condition, disability
Use for refusal to admit resident due to medical condition, disability.

21. Discrimination in admission due to Medicaid status
Use if resident not admitted due to Medicaid status or pending Medicaid status.

22. Room assignment/room change/intra-facility transfer
Use if resident wants room change or resident objects to planned room change; no notice or inadequate notice of change; excessive room changes; or similar problems.

23. Not Used

D. AUTONOMY, CHOICE, PREFERENCE, EXERCISE OF RIGHTS, PRIVACY
Use for any complaint involving the resident's right, as stated in the category. If it is a related problem, but not one specific to this heading, use a category under another heading. For example, if the resident is permitted to choose her personal physician but that physician is unavailable, use P.125.

Note that D.29, B.14 and M.96 all involve communication/language barriers and yet are different. Use D.29 if the resident has a communication or language barrier. Use M.96 if staff have the communication or language barrier.

Use D.27 for right to smoke. Use K.77 for smoke-polluted air.

24. Choose personal physician/pharmacy/hospice/other health care provider
Use when the resident is denied the right to choose his own physician/pharmacy/hospice or other outside health care provider.

25. Confinement of facility against will (illegally)
Use when the resident is denied the right to leave the facility or go outside of the facility. (Use P.128 "other" for resident requests for assistance in moving out of the facility when feasible alternative options are not available.)

26. Dignity, respect - staff attitudes
Use when resident is treated with rudeness, indifference or insensitivity, including failure to knock before entering room, facility posts signs relating to individual's care and similar problems.

27. Exercise preference/choice and/or civil/religious rights, individual's right to smoke
Use when the resident is denied choice and exercise of rights; for example: voting; speaking freely; access to a smoking area, preference in sleeping and rising times, community activities, the outdoors, television program of choice and similar problems. (Use D. 31 for rights involving privacy.)

28. Exercise right to refuse care/treatment
Use if the resident is denied the right to refuse care/treatment; including resident's right to refuse eating, bathing, or taking medication.

29. Language barrier in daily routine
Use if caregiver does not speak the resident's language, resident cannot communicate.

30. Participate in care planning by resident and/or designated surrogate
Use if the resident or the resident's legal representative is denied access to or not informed of a care plan/care plan meeting.

31. Privacy - telephone, visitors, couples, mail
Use if the resident is denied access to a telephone, visitors or mail; phone calls are monitored; mail is opened by someone other than the resident or the resident's legal representative; couples denied privacy.

32. Privacy in treatment, confidentiality
Use if the resident is denied privacy in treatment; confidential information has been disclosed.

33. Response to complaints
Use if complaints are ignored or trivialized by facility staff: administrator, social worker, nurses, and other staff.

34. Reprisal, retaliation
Use if the resident has experienced reprisal/retaliation (threat of discharge, lack of care, requests ignored, call lights unanswered, rough handling, etc.) as a result of a complaint.

35. Not Used

E. FINANCIAL, PROPERTY (EXCEPT FOR FINANCIAL EXPLOITATION)
Use the appropriate category for complaints involving non-criminal mismanagement or careless with residents' funds and property or billing problems. Use A.4 for complaints involving willful financial exploitation, including, but not limited to, criminal activity.

36. Billing/charges - notice, approval, questionable, accounting wrong or denied (includes overcharge of private pay residents)
Use if complainant alleges resident does not owe the amount billed; the resident never received the bill for amount owed; bill in error, supplies not provided as part of the daily rate and similar problems.

37. Personal funds - mismanaged, access/information denied, deposits and other money not returned (report criminal-level misuse of personal funds under A.4)
Use for problem with personal funds, for example, staff denies a resident use of her personal needs allowance; staff uses a nursing home resident's trust fund without consent, and similar problems.

38. Personal property lost, stolen, used by others, destroyed, with-held from resident
Use for property (including prostheses, dentures, hearing aid, glasses, radio, watch) missing/stolen at the facility or if the facility withholds or mismanages personal property (non-monetary). Use K.82 for loss of laundry.

39. Not Used

Resident Care

F. CARE
Use appropriate category for complaints involving negligence, lack of attention and poor quality in care of residents. If the care situation is so poor the resident is in a condition of overall neglect which is threatening to health and/or life, use A.5, "gross neglect."

40. Accidental or injury of unknown origin, falls, improper handling
Use for unexplained bruises, scratches, cuts, skin tears; falls from bed, wheelchair, or when standing; when resident is handled improperly or dropped during transfer or other assistance; and similar problems.

41. Failure to respond to requests for assistance
Use for call lights or requests for assistance not answered, or not answered in a timely manner. Includes requests for going/returning to resident's room, transfers to chairs/bed, etc.

42. Care plan/resident assessment - inadequate, failure to follow plan or physician orders (put lack of resident/surrogate involvement under D. 30)
Use for problem related to care plan: plan is incomplete or not reflective of resident's condition; staff has disregarded or is not informed of the plan; staff fails to respond, or responds slowly, to physician orders and similar problems.

43. Contracture
Use for problem related to resident's hands, arms, feet, or legs being drawn up and contorted.

44. Medications - administration, organization
Use for medications not given on time or not at all, medication administration not documented or incorrectly documented, medications not secured, incorrect medication or dosage; negligence, lack of attention or poor quality in care related to medication that is: run out; expired; not filled in a timely manner; incorrectly labeled, and similar problems.

45. Personal hygiene (includes nail care & oral hygiene) and adequacy of dressing & grooming
Use for resident: not bathed in a timely manner, not clean, not bathed at all, allowed to remain in soiled clothing, diaper, bed, chair; hands and face not washed after meals; teeth/dentures not cleaned; and similar problems.

46. Physician services, including podiatrist
Use for failure of facility to obtain physician services upon a change in resident's condition, or if medical attention, including podiatrist service, is not obtained in a timely manner or not obtained at all.

47. Pressure sores, not turned
Use for pressure sore(s) that may have occurred at the facility or elsewhere. Use when facility fails to treat, document, monitor pressure sores. Use if resident is not turned per medical order or treatment standard, or when turning is undocumented.

48. Symptoms unattended, including pain, pain not managed, no notice to others of changes in condition
Use if facility fails to accommodate, notice, or provide services related to a change in resident's condition.

49. Toileting, incontinent care
Use when resident is not toileted in a timely manner, as needed or requested, or as directed by the care plan; facility is using diapers or catheters rather than toileting. Use G.54 for inadequate or non-existent bowel and bladder plan/training.

50. Tubes - neglect of catheter, gastric, NG tube (use D.28 for inappropriate, forced use)
Use if tube is not cleaned, changed, or monitored appropriately.

51. Wandering, failure to accommodate/monitor exit-seeking behavior
Use for resident wandering, failure to redirect wanderers.

52. Not Used

G. REHABILITATION OR MAINTENANCE OF FUNCTION

Use appropriate category for complaints involving failure to provide needed rehabilitation or services necessary to maintain the expected level of function.

53. Assistive devices or equipment
Use if facility lacks, fails to maintain or has problems with Hoyer lift, handrails/grab bars, toilet seat, elevators, ambulation aids, wheelchair (no brakes or footrests, etc.), hearing or visual aids, and other assistive devices or equipment.

54 Bowel and bladder training
Use if facility fails to provide training, has no schedule, or schedule not maintained. See F.49.

55. Dental services
Use if dental services not provided or arranged for resident.

56. Mental health, psychosocial services
Use if these services not provided, arranged for resident.

57. Range of motion/ambulation
Use if services not provided; resident not assisted or encouraged in ambulation as appropriate; no appropriate exercise available; exercise resident wants is unavailable.

58. Therapies, physical, occupational, speech
Use for failure to provide or arrange for therapies with outside agency or provider.

59. Vision and hearing
Use for failure to provide or arrange for vision and hearing services or for problems with services.

60. Not Used

H. RESTRAINTS - CHEMICAL AND PHYSICAL

Use the appropriate category for any complaint involving the use of physical or chemical restraint.

61. Physical restraint - assessment, use, monitoring
Use for any physical restraint: lap buddy, bed rail(s), bindings, placement of furniture, resident not released from restraints for a specified time; no order in file; and similar problems including locked units.

62. Psychoactive drugs - assessment, use, evaluation
Use for any chemical restraint including excessive or unnecessary medication.

63. Not Used

Quality of Life

I. ACTIVITIES AND SOCIAL SERVICES

Use categories under this heading for complaints involving social services for residents and social interaction of residents. Note transportation is included in category I.65 because community interaction sometimes (not always) depends upon transportation.

64. Activities - choice and appropriateness

Use for lack of activities appropriate for each resident; facility fails to consider residents ability to perform certain activities/and preferences; variety limited; no activities; posted activities not conducted.

65. Community interaction, transportation

Use for any complaint involving the resident's need for transportation, for whatever reason and/or when facility does not assist residents in participating in community services or activities or curtails community interaction.

66. Resident conflict, including roommates

Use for any complaint involving conflict between residents, including roommate conflict and inappropriate behaviors that impact another resident's quality of life.

67. Social services – availability/appropriateness (use G.56 for mental health, psychosocial counseling/service)

Use if social services department fails to provide social services or encourage social interaction; fails to provide services if resident isolates himself or refuses to participate in activities, and similar problems.

68. Not Used

J. DIETARY

Use the appropriate category for complaints involving food and fluid intake. Use the appropriate category under A (A.1 or A.5) for willful cases of food deprivation.

69. Assistance in eating or assistive devices

Use for failure to provide assistance in eating; facility has not provided tools to assist resident in self-feeding, meal set-up, i.e., opening milk cartons, tray not within reach.

70. Fluid availability/hydration

Use for complaint that resident is not reminded to drink; bedside water is not provided, not fresh or not in reach; fluids are not readily available; resident is dehydrated.

71. Food service - quantity, quality, variation, choice, condiments, utensils, menu

Use for posted menu not served; alternate selections not offered; servings too small; no variety; quality is poor; food has little nutritional value, nutrients out of date, condiments or utensils not provided, presentation, timely delivery and/or removal of trays.

72. Snacks, time span between meals, late/missed meals

Use for snacks not readily available or offered between meals; excessive time span between dinner and breakfast.

73. Temperature

Use for food or beverage not served at appropriate temperature.

74. Therapeutic diet
Use for complaint resident's therapeutic diet is not served as ordered; resident's dietary needs not accommodated.

75. Weight loss due to inadequate nutrition
Use A.1 or A.5 for willful food deprivation.

76. Not Used

K. ENVIRONMENT/SAFETY
Use the appropriate category for complaints involving the physical environment of the facility and resident's space.

77. Air/environment: temperature and quality (heating, cooling, ventilation, water), noise
Use for complaints about building, room or water temperature too hot or cold; ventilation inadequate; indoor cigarette smoke; noise in the facility; and similar problems.

78. Cleanliness, pests, general housekeeping
Use for uncleanliness or pests (insects, vermin - live or dead) in resident's room or other facility area. Also use for ant, snake, rat or mosquito bite.

79. Equipment/Buildings - disrepair, hazard, poor lighting, fire safety, not secure
Use for elevator malfunctioning/not maintained; paint/wallpaper peeling; lights burned out or insufficient lights; exterior not maintained, littered; inaccessible entrances/exits or hallways; inadequate/non-functioning/expired fire extinguishers; malfunctioning automatic doors; fire alarms, smoke detectors, and other emergency equipment not present, malfunctioning or inadequate; and any other building maintenance problem. Also use for premises not secured; lacking or broken window bars; unauthorized person gained entrance to facility; unauthorized weapon in facility, and similar problems.

80. Furnishings, storage for residents
Use for furnishing in disrepair; lack of furnishings; inadequate storage space for belongings, including valuables.

81. Infection control
Use for insufficient measures to prevent infection; spread of infection; resident at risk; infection unreported or not treated appropriately, and similar problems.

82. Laundry - lost, condition
Use for no clean clothes available; clothing lost, damaged.

83. Odors
Use for urine, feces, any other offending odor or any odor which is a detriment to the health of the resident.

84. Space for activities, dining
Use for: inadequate space for scheduled activity or residents' attendance/participation in activity; dining area does not promote resident interaction; inadequate space for wheelchair or other assistive devices while dining; activity, dining areas converted to other uses.

85. Supplies and linens
Use for no clean linens available or in poor condition; shortage of supplies, for example, soap, gloves, toilet paper, incontinence pads, and nursing supplies.

86. Americans with Disabilities Act (ADA) accessibility
Use for complaints regarding the facility's compliance with the ADA; for example, no handicapped access.

Administration

L. POLICIES, PROCEDURES, ATTITUDES, RESOURCES

Categories under this heading are for acts of commission or omission by facility managers, operators, or owners in areas other than staffing or specific problems included in previous sections.

87. Abuse investigation/reporting, including failure to report
Use for failure of facility to report or investigate suspected resident abuse/neglect or exploitation to the specified authority, no matter where alleged abuse occurred.

88. Administrator(s) unresponsive, unavailable
Use for failure of administrator or administrative staff to respond to or communicate with others.

89. Grievance procedure (use C for transfer, discharge appeals)
Use if there is no grievance procedure for handling complaints or if the procedure is not made known to residents or not complied with by the facility.

90. Inappropriate or illegal policies, practices, record keeping
Use if records are incomplete, missing, or falsified, including staff references not checked, or when required background screening has not been performed. Use also for complaints about health care fraud, waste, and abuse.

91. Insufficient funds to operate
Use if there is a substantiated complaint of shortage of staff, lack of food, utilities cut off, etc. that could indicate bankruptcy or insufficient funds. Also use if a complainant alleges the facility has insufficient funds to operate.

92. Operator inadequately trained
Use for complaint that owner/administrator has no documentation of administrator's license, training or updates, and other certifications required by the state.

93. Offering inappropriate level of care (for B&C/similar)
Use if facility admits or retains resident whose medical and/or care needs are greater than the facility can meet or arrange to have met and similar problems.

94. Resident or family council/committee interfered with, not supported
Use if facility interferes with or fails to support resident or family councils, attempts to organize councils and related problems.

95. Not Used

M. STAFFING

Use appropriate categories under this heading for complaints involving staff unavailability, training, turnover, and supervision.

96. Communication, language barrier

Use for staff language or other communication barrier. Use D.29 if problem involves resident inability to communicate.

97. Shortage of staff

Use for insufficient staff to meet the needs of the resident(s); staffing is below the minimum standard.

98. Staff training

Use when staff has not received training sufficient to meet the needs of the resident(s); including basic care and technical training, including the use of a Hoyer lift, CPR, first aid, mental health, and dementia training.

99. Staff turnover, over-use of nursing pools

Use when there is no continuity of care for the residents; new staff on board and pool/agency staff are regularly used.

100. Staff unresponsive, unavailable

Use if staff is unresponsive or unavailable. Use D.26 if staff is available but rude or otherwise disrespectful to resident. Use A.3 or other category under A if rudeness or disrespect is so severe that it qualifies as abuse.

101. Supervision

Use when the staff duties are not overseen or not reviewed by a supervisor. Use when there is no ALF staff monitoring residents.

102. Eating Assistants

Use for complaints about inappropriate use of and training of eating assistants. Use J. 69 for failure to provide assistance in eating or facility has not provided tools to assist resident in self-feeding, meal set-up, i.e., opening milk cartons, tray not within reach.

Problems with Outside Agency, System, or People (Not Against the Facility)

Use these categories for all complaints involving decisions, policies, actions or inactions by the state agencies which license facilities and certify them for participation in Medicaid and Medicare.

N. CERTIFICATION/LICENSING AGENCY

103. Access to information (including survey)

Use if licensing agency does not provide facility information to ombudsmen, public.

104. Complaint, response to

Use when agency fails to respond adequately to any complaint or referral, from the resident, ombudsman or public.

105. Decertification/closure
Use for individual complaints about decertification/closure and if agency fails to decertify/close a facility when within residents' best interests or with disregard to residents' rights.

106. Sanction, including Intermediate
Use if licensing agency fails to sanction facility appropriately.

107. Survey process
Use if agency fails to survey facility as required by law.

108. Survey process - Ombudsman participation
Use if ombudsmen not notified and/or included in survey process.

109. Transfer or eviction hearing
Use for complaints of decisions, policies, actions or inactions by the licensing agency regarding resident discharge hearings.

110. Not Used

O. STATE MEDICAID AGENCY

Categories in this section are for complaints about Medicaid coverage, benefits and services.

110. Access to information, application
Use if information is denied or delayed to resident or legal representative; case worker is unavailable, or unresponsive to requests for information or application status.

112. Denial of eligibility
Use for complaint that resident is denied Medicaid.

113. Non-covered services
Use for complaints about services not covered by Medicaid.

114. Personal Needs Allowance
Use for complaints about the insufficiency of the personal needs allowance.

115. Services
Use for complaints about the quality or quantity of services covered by Medicaid or difficulty in obtaining services. (Use 113 for non-covered services.)

116. Not Used

P. SYSTEM/OTHERS

*Use appropriate categories in this section to document the range of complaints against or involving individuals who are not managers/staff of facilities * or of the State=s licensing and certification or Medicaid agency. (*except for 119, as specified)*

117. Abuse/neglect/abandonment by family member/friend/guardian or, while on visit out of facility, any other person
Use for abuse/abandonment by individuals other than facility staff, when the facility could not reasonably have been expected to observe the acts. Use A.1 or other A categories when the facility should have overseen and acted.

118. Bed shortage - placement
Use when resident is unable to find a facility placement, or for a bed shortage.

119. Facilities operating without a license
Use for complaints about facilities providing services to residents which should only be offered in a regulated environment.

120. Family conflict; interference
Use when a family conflict interferes with resident's care. Use only if the conflict or problem affects the resident's care or well being.

121. Financial exploitation or neglect by family or other not affiliated with facility
Use for cases of financial exploitation or financial neglect of a resident by individuals whose actions the facility could not reasonably be expected to oversee or be responsible.

122. Legal - guardianship, conservatorship, power of attorney, wills
Use if the complaint involves any of the above legal issues.

123. Medicare
Use if resident has complaint related to Medicare coverage.

124. Mental health, developmental disabilities, including PASRR
Use for problems with access to services for persons with mental illness or developmental disabilities or for problems involving implementation of the Pre-Admission Screening and Resident Review (PASRR) requirements of the Nursing Home Reform Act related to individuals with mental illness, mental retardation, or a developmental disability living/making application to live in a Medicaid-certified nursing home.

125. Problems with resident's physician/assistant
Use if the resident's physician or assistant fails to provide information, services, is not available, or makes inappropriate or fraudulent charges. (Use F.46 if facility fails to arrange for physician service and P.48 if facility fails to attend to medical symptoms or notify family of change in resident's condition.)

126. Protective Service agency
Use for complaints involving the agency in the State charged with investigating reports of adult abuse or exploitation and providing protective services for victims of abuse and exploitation.

127. SSA, SSI, VA, other benefits/agencies
Use for complaints for these non-Medicaid and non-Medicare benefits and the agencies which administer them.

128. Request for less restrictive placement
Use for a complaint against any other agency or individual, but not facility staff or licensing agency staff. Use for resident requests for assistance in moving out of the facility and/or ombudsman initiative to help resident find less restrictive placement. Includes work to implement the Supreme Court's Olmstead decision.

Q. COMPLAINTS ABOUT SERVICES IN SETTINGS OTHER THAN LONG-TERM CARE FACILITIES OR BY OUTSIDE PROVIDER

Use categories in this section to document any complaints accepted and acted upon by the ombudsman involving individuals living in private residences, hospitals or in hospice care, and congregate and/or shared housing not providing personal care. Also use for services in a facility provided by an outside provider.

129. Home care
Use if complaint is made by or on behalf of an individual living in a private residence.

130. Hospital or hospice
Use for complaint involving hospital or hospice care, service, or administration.

131. Public or other congregate housing not providing personal care
Use for complaint made by or on behalf of individual living in public or private congregate housing unit where personal care is not included in the rental contract.

132. Services from outside provider
Use for services from an outside provider which are not included in other categories for which the facility makes arrangements; for example, personal and homemaking services in an assisted living facility, therapies, non-Medicaid transportation, psychosocial service. (Use P.125 for outside physician services.)

133. Not Used

Supplement B-8a: Long-term Care Ombudsman Activity Report DADS Form 8620

.

Supplement C-8a: Report Instructions

Form 8620 Instructions
08-2010

Long-Term Care Ombudsman Activity Report

Certified volunteer ombudsmen are required to submit DADS Form 8620, Activity Report, each month. The report can be submitted electronically or as a paper copy. Submit the report by the due date set by the local long-term care ombudsman program. Staff ombudsmen may use Form 8620 and then enter in OmbudsManager.

INSTRUCTIONS

Enter your name, assigned facility, and the report month and year.

Visits

Required: Enter dates and time spent on site.
Your local program decides whether you are required to track number of contacts, travel time and mileage.

- Date – Enter each date you visited.
- No. of Contacts – Enter the number of separate contacts for resident, family/other (non-relative visitors) and staff. A contact consists of meaningful interaction and can be done by phone, e-mail, letter, or in person.
- Time On Site – Enter time spent in the facility and/or resolving complaints.
- Travel – Enter time spent traveling to and from the facility.
- Mileage – Enter miles traveled to and from the facility.

Note to the managing local ombudsman – Determine whether certified ombudsmen will report on the items listed above. When reporting donated hours of service, count time on site, travel time and mileage (if the volunteer is not reimbursed).

Activities

Enter a date you participated in an activity during the month or if you attended more than one, enter a number attended for each type of activity, as appropriate.

- Care plan meeting – Attendance at the invitation of a resident or legally authorized representative.
- Family council – Attendance at the invitation of a family council member.
- Resident council – Attendance at the invitation of a resident council member.
- Survey – Participation in any part of a DADS Regulatory Services annual survey or complaint investigation; count only once per survey.

Notes

This section is optional. Enter information about other activities or, information such as referrals to legal services; facility staff changes; changes in overall quality; and requests for information and assistance or consultations you provided.

Cases and Complaints

- Date Opened – Enter the date you received or identified the first complaint within a case.
- Resident/Complainant – Complainant roles include:
  1 resident
  2 relative/friend of resident
  3 guardian/legal representative
  4 ombudsman
  5 facility staff or former staff
  6 medical physician/staff
  7 social/health agency representative
  8 unknown/anonymous
  9 bankers, clergy, law enforcement, public officials, etc.
- Consent – To show resident or complainant consent, mark Yes or No. With consent, work to resolve complaint(s). Without consent, seek guidance from supervising staff ombudsman or managing local ombudsman.
- Complaints (Codes 1-132) – Enter the code that best matches the complaint and/or enter information about the complaint in the Notes field. Your local long-term care ombudsman program can provide a list of the complaint codes.
- Verified – After investigation, mark Yes if you verified the complaint (found it to be generally accurate). If not, mark No. A certified ombudsman may work to resolve a complaint regardless of verification.
- Disposition – For each complaint, choose a disposition that best describes the outcome after you have done all you can to seek resolution. If you refer a complaint to an agency that reports the outcome to you, code with the appropriate disposition. If the agency did not notify you of the disposition, choose d1, d2 or d3. Dispositions include:
  a government/legislative (policy, regulatory change or legislative action is required)
  b not resolved
  c withdrawn
  d1 referred: disposition not obtained
  d2 referred: failed to act on complaint
  d3 referred: complaint not substantiated
  e no action needed
  f partially resolved (some problem remained)
  g resolved
- Date Closed – Enter the date you closed the case because complaints required no further action.

Ombudsman Certification Training

SUBCHAPTER 8b

Resident Records

--This page intentionally left blank--

Resident Records

Subchapter 6b is about ombudsman program authority to access resident records and other confidential information. Ombudsmen must get resident consent before accessing their records and then must keep all information confidential.

Learning Objectives

- Know which facility records ombudsmen can access
- Understand the requirement to get resident consent
- Distinguish whether reviewing resident records is necessary
- Identify elements of medical records

Contents

Ombudsman Access
Medical Records

Supplement A-8b: Common Medical Chart Abbreviations
Supplement B-8b: Consent to Release Records to the Certified Ombudsman DADS Form 8624-O (oral)
Supplement C-8b Consent to Release Records to the Certified Ombudsman DADS Form 8624-W (written)

Ombudsman Access

The Older Americans Act requires each state to ensure ombudsmen have access to facilities, residents, and medical and social records of residents. Ombudsman *interns* have access to facilities and residents, but *do not have access* to a resident's record or its contents.

In Texas, laws and rules require nursing homes and assisted living facilities to allow ombudsman entry and private visits with residents. All Information documented in a resident's records or shared orally by a caregiver, resident, or physician is confidential. Laws and rules require ombudsmen to protect resident confidentiality. Never share information about a resident without the resident's consent.

Residents or legal representatives have the right to access the residents' records, and facilities must comply with

- Nursing facility requirement §19.403(f)
- Assisted living facility standard §92.125(a)(3)(m)

Residents have the right to review all medical and financial records pertaining to them. True or False

---

Types of Resident Records

To access a resident's medical, incident, financial, and other records, an ombudsman must get consent from the resident or his or her legal representative.

- Medical: See pages 5-9 for more details on medical records.
- Incident: DADS requires staff to report incidents that are abnormal events, including accidents or injury to staff or residents. A facility may keep incident reports in one location rather than in an individual resident record.
- Financial: Residents have the right to manage their financial affairs. However, DADS requires nursing homes to protect resident funds with some distinction between licensed-only and Medicaid-certified facilities.
- Other records: Facilities keep records such as:
  - Bathing schedules
  - Care notes
  - Care plans
  - Dietary orders
  - Grievance reports
  - Medication administration records

Residents or guardians, family members or powers of attorney, the State Long-term Care Ombudsman, or your supervising staff ombudsman may ask you to review a record. In every case, follow ombudsman procedures.

- When residents ask you to look at their records, you may assist immediately and involve them in the request to facility staff.
- If you decide that review of a record is necessary to investigate a complaint or if you plan to attend a care plan meeting at which you will see and hear information, consult with your supervising staff ombudsman before proceeding.
- Always get written or oral consent from the resident or legal representative.
- Always document that the resident or legal representative gave consent and provide documentation to your ombudsman office.

Consider the following questions before consulting your supervising staff ombudsman:

1. What is the issue or concern?
2. What actions have the resident or ombudsman already taken to resolve the situation?
3. Does the resident have a legally authorized representative?
4. Does the resident know he or she has the right to review personal records?
5. What factors make review of a record necessary?
6. With consent, could you get reliable information by asking a facility staff person?
7. Does the resident understand a request for records will identify him or her?
8. What specific facts are you looking for?

Based on the answers, you may need to access a resident record. The next step is to consult with your supervising staff ombudsman to seek agreement that review of a medical record is necessary. Under some circumstances, a staff ombudsman must also consult with the state ombudsman. If all parties agree, proceed with seeking consent from the resident; if parties do not agree, stop.

Consent

In all cases, obtain resident consent to access a confidential record and document it. If the resident declines, stop the process. Other situations may include:

- If the complainant is not the resident, get resident consent before proceeding.
- If the resident has a Legally Authorized Representative (LAR), get the LAR's consent if he or she has authority to consent through an advance directive or legal guardianship.

When a resident is unable to consent and you want to review records, consult with your supervisor who then consults with the state ombudsman. Certified staff ombudsmen (including Managing Local Ombudsmen) who want to review a record of a resident who cannot consent must consult with the state ombudsman before accessing the record.

Obtain resident consent to access a _______________ record.

Request, Review and Use of a Record

After a resident grants consent, request only the records necessary to investigate. Request a record at the nurse's station or administrative office. If facility staff asks for proof of consent, present documentation, or if the resident consented orally, staff may confirm the request with the resident.

Records that facilities are not required to provide to ombudsmen include:

- Personnel
- Facility budget and accounting
- Quality assurance committee documentation

To review a record, find a private location. Review only records pertinent to the concern or inquiry and use the findings appropriately. If possible, involve the resident in the review.

Inform the resident, or legally authorized representative if appropriate, of findings on an ongoing basis. Present information to facility staff only according to resident wishes.

Document

Ombudsmen document consent in case notes, the Long-term Care Ombudsman Activity Report, Consent to Release Records to the Certified Ombudsman DADS Form 8624-W (written), or Consent to Release Records to the Certified Ombudsman DADS Form 8624-O (oral).

Before closing a case, transfer temporary notes to a reporting form and submit documentation to the local ombudsman program, who must keep it secure.

Medical Records

Ombudsmen do not need to be experts on clinical records. However, records can be an important source for information during investigation of a complaint. Do not make medical assumptions, interpretations, or provide medical advice. As an advocate, ask questions and stay grounded in resident rights.

To provide quality care, members of the health care team must communicate. Medical records facilitate communication among all team members who are involved.

Medical offices, hospitals, and care facilities keep medical records. Records may be paper, electronic, or a combination. All entities must comply with privacy laws:

- State: Health and Safety Code Chapter 181 Medical Records Privacy
- Federal: Public Law 104-191 Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Staff organizes content in a resident medical chart by sections that often include the following:

- Administration
- History and Physical
- Vital Signs
- Progress Notes
- Physician Orders
- Nurses Notes
- Labs
- Imaging
- Therapy
- Case Management

Administration

Find documents related to advance care planning such as Directive to Physician, Medical Power of Attorney, Out-of-Hospital Do Not Resuscitate, and Guardianship

History and Physical

- Latest comprehensive medical history and physical exam done by the physician
- Sometimes includes a discharge summary from a recent hospitalization
- Medical overview of the patient

Vital Signs

- Temperature
- Blood pressure
- Heart rate
- Respiratory rate
- Pain assessment
- Other measurements
- I/Os (input and outputs), such as fluid intake or a bowel movement log

Progress Notes

- Dated “SOAP” notes
    - S = Subjective: what the patient states or is reported
    - O = Objective: what the physician can measure or evaluate by a physical examination
    - A = Assessment: summary of the current situation and working diagnoses
    - P = Plan: what the physician plans to do next
- Physicians must sign their notes.

Physician Orders

Instructions to support personnel for any service to be done for the resident

- Medication
- Lab test or x-ray
- Therapy: speech, physical, occupational
- Activity level

Nurses Notes

Reports on what happened during each shift

Labs

Reports of laboratory results

- Blood chemistry
- Urine cultures
- Sputum cultures
- Feces test

Imaging

Reports of any imaging study

- X-rays
- CT scans (computed tomography)
- MRIs (magnetic resonance imaging)
- Others

Therapy

- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy (ST)

Case Management

- Transfer or discharge plan: which location and when
- Social service notes

Information that may not be stored in an individual medical record:

- Medication Administration Record (MAR). This is the list of all medication given; usually found in or near the medication room or nurses’ desk
- Social services & activity notes may be stored in individual charts or in a separate folder
- Incident reports

If you cannot find information, ask a charge nurse for help. Many care providers use electronic records and an ombudsman has access to the same information in them as a written medical record.

Exercise: Name the Medical Record Section

In which section of the medical record would you find the following?

1. What care does the morning shift need to give following the night shift?

   ____

2. Who did the resident name as her Medical Power of Attorney?

   ____

3. What kind of rehab does the resident need and how often?

   ____

4. When was the last x-ray to check whether the hip healed?

   ____

5. When did the resident return from the hospital?

   ____

6. What is the resident's working diagnosis?

   ____

7. Did the physician prescribe Ativan?

   ____

8. When does the facility plan to discharge the resident?

   ____

Supplement A-8b: Common Medical Chart Abbreviations

AB	Antibody
ABD, ABDOM	Abdomen
ABN	Abnormal
ADENOCA	Adenocarcinoma
ADM	Admission
ADR	Adverse drug reaction
AK(A)	Above knee (amputation)
AKA	Also known as
BCC	Basal cell carcinoma
BE	Barium enema
B/F	Black female
BIL	Bilateral
BK(A)	Below knee (amputation)
BM	Bone marrow
BM	Bowel movement
B/M	Black male
BP	Blood pressure
BX	Biopsy
CC	Chief complaint
CHF	Congestive heart failure
CIS	Carcinoma-in situ
CRF	Chronic renal failure
CT SC	Computerized tomography scan
CVA	Cerebrovascular accident
CVA	Costovertebral angle
CXR	Chest x-ray
DC	Discharge
DC	Discontinued
DNR	Do not resuscitate
DO	Doctor of Osteopathic Medicine
DTR	Deep tendon reflex
DX	Diagnosis

ECF	Extended care facility
ECG, EKG	Electrocardiogram
EEG	Electroencephalogram
EENT	Eyes, ears, nose, & throat
EGD	Esophagogastroduodenoscopy
EMG	Electromyogram
ENL	Enlarged
ENT	Ear, nose & throat
FBS	Fasting blood sugar
FU	Follow up
FUO	Fever unknown origin
FX	Fracture
GB	Gallbladder
GI	Gastrointestinal
HB	Hemoglobin
HEENT	Head, eyes, ears, nose, throat
HGB	Hemoglobin
H&P	History and physical
IM	Intramuscular
IV	Intravenous
K	Potassium
L1-L5	Lumbar vertebrae
LE	Lower extremity
LFT	Liver function test
LLE	Left lower extremity
LLL	Left lower lobe (lung)
LLQ	Left lower quadrant (abdomen)
L-SPINE	Lumbar spine
LUE	Left upper extremity
LUL	Left upper lobe (lung)
LUQ	Left upper quadrant (abdomen)
MD	Doctor of Allopathic Medicine
MI	Myocardial infarction

MRI	Magnetic resonance imaging
NEURO	Neurology
N&V	Nausea and vomiting
OP	Operation
OP	Outpatient
OPHTH	Ophthalmology
OR	Operating room
OSTEO	Osteomyelitis
OT	Occupational therapy
OV	Office visit
PA	Posteroanterior
PA	Pulmonary artery
PA	Physician assistant
PALP	Palpable, palpated, palpation
PATH	Pathology
PDR	Physician's Desk Reference
PE	Physical examination
PEG	Percutaneous gastrostomy tube
PMD	Personal (primary) medical doctor
PMH	Past medical history
PND	Postnasal drip
POD	Postoperative day
PT	Patient
PT	Physiotherapy
Q	Quadrant
q	every
QID	Four times a day
qd	Every day
RLE	Right lower extremity
RLL	Right lower lobe (lung)
RLQ	Right lower quadrant
RML	Right middle lobe (lung)
RO, R/O	Rule out
ROM	Range of motions
RT	Right

RUE	Right upper extremity
RUL	Right upper lobe
RUQ	Right upper quadrant
RX	Treatment
SCC	Squamous cell carcinoma
SNF	Skilled nursing facility
SOB	Shortness of breath
STAPH	Staphylococus
STAT	Immediately (statim)
STREP	Streptococcus
SUB-Q, SUBQ	Subcutaneous
SX	Symptoms
T1-T2	Thoracic vertebra
TID	Three times a day
T-SPINE	Thoracic spine
UE	Upper extremity
UGI	Upper gastrointestinal
URI	Upper respiratory infection
UROL	Urology
UTI	Urinary tract infection
VS	Vital signs
W/	With
W/F	White female
WNL	Within normal limits
W/O	Without
WT	Weight
W/U	Work-up
XR	X-ray

Differential Diagnosis: The process of weighing the probability of one disease versus that of other diseases possibly accounting for a patient's illness. For example, the differential diagnosis of rhinitis (a runny nose) includes allergic rhinitis (hay fever), the abuse of nasal decongestants, and the common cold.

Supplement B-8b: Consent to Release Records to the Certified Ombudsman DADS Form 8624-O (oral)

Supplement C-8b: Consent to Release Records to the Certified Ombudsman DADS Form 8624-W (written)

Ombudsman Certification Training

CHAPTER 9

Regulators and Resources

--This page intentionally left blank—

Regulators and Resources

Chapter 9 is about federal and state agencies that license and certify nursing homes and that license assisted living facilities and programs within state agencies that can impact residents.

Learning Objectives

- Become familiar with federal and state agencies that regulate nursing homes and assisted living facilities
- Know the basic roles of each agency
- Learn the enforcement options available to regulatory to bring operators into regulatory compliance

Contents

Regulatory Agencies
Surveys and Licensures
Enforcement
Credentialing
Resources
    Department of Aging and Disability Services (DADS)
    Department of Family and Protective Services (DFPS)
    Health and Human Services Commission (HHSC)
Ombudsman Role

Supplement A-9: Program Agreement between DADS Long-term Care Ombudsman Program and Regulatory Services
Supplement B-9: Memorandum of Understanding between DFPS Adult Protective Services and DADS Long-term Care Ombudsman Program

Regulatory Agencies

Agencies in our federal and state governments have responsibilities to oversee health care facilities on behalf of residents as consumers, beneficiaries, and citizens. Responsibilities belong to:

- Federal - Centers for Medicare and Medicaid Services (CMS)
- State - Texas Department of Aging and Disability Services (DADS)

Centers for Medicare and Medicaid Services (CMS)

The Centers for Medicare and Medicaid Services mission states, “We assure health care security for beneficiaries.” One main goal is to “protect and improve beneficiary health and satisfaction.” The agency has program and operational objectives. Program objectives are:

- give access to quality care by protecting beneficiaries from substandard or unnecessary care; and
- provide services to beneficiaries by improving beneficiary satisfaction with programs, services, and care.

Ombudsmen do not often interact with CMS surveyors and other staff. The CMS surveyor role is to monitor state surveyors for compliance with federal policy and procedures in the survey process; thus ensuring federal requirements are consistently applied across state survey agencies.

Because assisted living has no federal definition or requirements, CMS has no role in regulating assisted living facilities.

Texas Department of Aging and Disability Services (DADS)

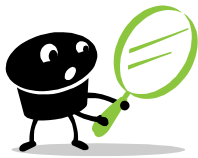
DADS Regulatory Services main responsibilities are licensure and certification of facilities. This is accomplished through inspections of a number of facility types and services related to long-term supports and services. DADS monitors facilities for compliance with the Nursing Facility Requirements and Licensing Standards for Assisted Living Facilities. Another major responsibility is to conduct investigations of complaints and incidents.

DADS Regulatory Services staff who conduct inspections are commonly referred to as “surveyors.”

DADS Regulatory Services staff:

- determines that regulated facilities comply with federal and state rules;
- determines if providers are meeting the minimum standards and requirements for service, determines conditions that may jeopardize client health and/or safety, and identifies deficient practice areas;
- monitors providers' plans of correction to ensure that areas of inadequate care are corrected and comply with state and federal requirements; and
- takes enforcement actions if facilities are not in compliance with requirements.

By federal and state laws, both Regulatory Services and the Long-term Care Ombudsman Program within DADS have mandates to receive and investigate complaints. To expedite investigations, a DADS Program Agreement explains their joint and individual responsibilities.



In DADS, Regulatory Services and the Long-term Care Ombudsman Program are mandated to investigate complaints. To expedite investigations, a DADS Program Agreement explains our joint and individual responsibilities.

Important: the Texas Long-term Care Ombudsman Program does not investigate allegations of abuse, neglect, or exploitation. Regulatory Services investigates abuse, neglect, and exploitation alleged to have occurred in a facility.

Surveys and Licensures

Initial Licensure

Background checks are conducted on the individuals and corporations responsible for resident health and safety in nursing homes and assisted living facilities. Checks are made to ensure the responsible parties have a good history of operating long-term care facilities. If new owners and operators are added to a license, these individuals' backgrounds are also checked and must be approved in order for a license to remain valid.

For a facility to retain its license, the results of any inspection, follow-up visit, complaint investigation, and incident investigation must show the facility complies with current state licensure laws and rules.

Nursing Homes

To become a provider, a nursing home operator submits a license application to DADS, pays an annual fee, and the facility passes a health and life safety code inspection. Facilities choose to be private pay (licensed only), Medicaid-

or Medicare-certified, or dually certified to be reimbursed for Medicaid and Medicare services.

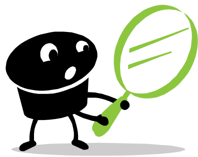
Assisted Living Facilities

To become licensed, an applicant submits an application, completes an Assisted Living Facility Pre-licensure computer-based training, pays an annual fee, and the facility passes a health and life safety code inspection.

DADS Regulatory Services conducts surveys and licensing inspections of nursing facilities. The licensing inspection is usually conducted in conjunction with the annual recertification survey. These visits:

- are unannounced;
- may take place on any day of the week at any time of day;
- have results that are available to the public; and
- are resident-directed and outcome-oriented.

For assisted living facilities, DADS Regulatory Services conducts similar licensure inspections, on average once every year, to determine if the facility is in compliance with licensing standards. These standards are less rigorous than requirements of nursing homes.



Just like ombudsman visits, surveyor visits to facilities are unannounced.

Purposes of a Survey

1. To monitor whether nursing homes provide care and services to residents that meet licensing standards. In certified facilities, surveys also determine if the facility meets standards for participation in Medicare or Medicaid. Inspections are resident-centered, outcome-oriented inspections that rely on a case-mix sample of residents to gather information about facility compliance with participation requirements. Outcomes include both actual and potential negative outcomes, as well as failure of a facility to help residents achieve their highest practicable level of well-being.

2. To monitor whether assisted living facilities provide services and care to residents that meet licensing standards. Inspections are resident-centered, outcome-oriented inspections.

Within two hours of entering a facility, surveyors are instructed to contact the ombudsman office to request information about any concerns. With resident and complainant permission, ombudsmen provide resident names to include in the survey sample, residents for closed record review, and family members for interviews. Ombudsmen also describe systemic or serious concerns they have not been able to resolve. Generally, ombudsmen do not report complaints they are currently working to resolve as it may trigger the surveyors to investigate the issue.

Survey inspection reports and copies of other inspection reports are to be made available to the ombudsman upon request.

Surveyors must complete 7 tasks during a standard survey.

1. Offsite preparation. Surveyors review the facility's history and identify any existing concerns. They may pre-select potential residents for the sample. They determine if any features of the facility require specialty surveyors, such as pharmacists and dieticians, to join the survey team. These surveyors may be onsite only for the portion of the survey relevant to their expertise.

2. Entrance conference/onsite preparatory activities. At the entrance conference, the team leader informs the administrator of the survey and introduces the team members. While the team leader requests additional information from the administrator, the other team members may begin task 3, the initial tour.

3. Initial tour. Surveyors review the facility, staff, and residents, obtain an initial evaluation of the environment including the kitchen, and confirm or invalidate any pre-selected concerns and add concerns discovered during the tour.

4. Sample selection. Surveyors select a case-mix stratified sample of residents based on quality indicators (know as QIs) and other offsite and onsite sources of information in order to assess compliance with the resident-centered long-term care requirements.

5. Information gathering. Surveyors make observations of the facility, kitchen, residents, quality of life assessments, medication passes, quality assessment and assurance review, and abuse prohibition review.

6. Information analysis for deficiency determination. Surveyors review the collected information and determine whether or not the facility failed to meet one or more of the regulatory requirements**.**

7. Exit conference. Surveyors inform the facility of their observations and the preliminary findings.

The purpose of a survey is to ___________________ whether facilities meet licensing standards and whether ____________ meet standards for participation in Medicare or Medicaid.

Throughout the survey, the team discusses observations and information obtained. Surveyors can extend a survey beyond the typical four days in a nursing home and one day in an assisted living facility.

If the facility is out of compliance with any regulations, they send an official statement of deficiencies to the facility within 10 working days after the end of a survey. The facility must respond within 10 calendar days with a plan of correction for each item of noncompliance and establish a timeframe for correcting the problem. Regulatory Services will then conduct a follow-up visit, or conduct a desk review, to determine if the proposed corrections were made.

Complaint Investigations

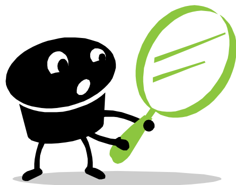
A survey team may also conduct an abbreviated survey to investigate a complaint and determine if the facility violated any requirements. If a complaint specifies conditions on a certain day, such as on weekends, or during a particular shift, then the survey team should investigate on that day or during that time frame.

Substandard Quality of Care (SQC)

Substandard Quality of Care (SQC) indicates a systemic deficiency in quality of care and quality of life within a nursing home. For this designation, citations relate to the quality of resident care such as skin wound care. In addition, for this designation, the deficiency must be severe and/or impact several residents. An SQC finding indicates Regulatory Services found the nursing home to have had a significant deficiency (or deficiencies), which the home must address and correct quickly to protect the health and safety of residents.

Immediate Jeopardy (IJ)

Immediate jeopardy is a situation in which the provider's noncompliance has caused, or is likely to cause, serious injury, harm, impairment or death to a resident or several residents. If surveyors identify an immediate jeopardy to residents' health and safety, they notify the administration with specific details, including the individuals at risk, before the survey team leaves the facility. The facility must immediately implement corrective measures and faces daily fines until the problem is corrected. Only onsite confirmation by surveyors of the facility's corrective actions can remove immediate jeopardy status.



Nursing Facility Requirements §19.409, Examination of Survey Results.

- Residents have the right to examine the results of the survey of the facility conducted by federal or state surveyors and any plan of correction.
- The facility must make the results available for examination in a place readily accessible to residents, and must post notice of their availability.

Enforcement

DADS Regulatory Services, Enforcement Section may impose remedies on all licensed facilities and Medicaid-certified facilities. When surveyors determine a facility is out of compliance with licensure rules, they may send a warning letter to the facility. The letter notifies the facility that the violations of licensing rules must be corrected. The Enforcement Section may take one of several possible actions against an operator's license, and may take several actions simultaneously, including:

- suspension of a license;
- revocations of a license;
- emergency suspension and closing order;
- referral to the Attorney General;
- suspension of admissions; and
- administrative penalties, which range from $100 to $10,000 based on severity.

If a facility is Medicaid-certified, additional compliance remedy options exist. Enforcement actions in a Medicaid-certified facility are recommended by DADS to CMS and have slightly different means of correction and appeal for the provider. Appeal options include informal dispute resolution through the Texas Department of Health and

Human Services, arbitration, and appeal through CMS. Nursing facility Medicaid enforcement actions include:

- imposition of civil money penalties; and
- termination of the provider agreement (loss of Medicaid contract).

Administrative Penalties

Most administrative penalties allow a facility to correct the problem and remove the penalty. Some violations are not eligible for the right to correct, including:

1. a violation that DADS determines:
    a. results in serious harm or death to a resident,
    b. are a serious threat to the health or safety of a resident, or
    c. substantially limits the facility's capacity to provide care;
2. specific portions of the criteria for denying a license; or
3. a violation of a resident right.

Ask the Trainer: Enforcement

Which enforcement action is the most common?

____

Amelioration

Amelioration is a term used in enforcement to describe the option to make facility improvements with money imposed as a penalty. Amelioration allows a facility to submit a plan to DADS Commissioner. The plan must propose how part of the administrative penalty will be used to improve services in a nursing home or assisted living facility. Rules apply and the Commissioner must approve the plan.

Trustee Appointment

With assistance from the Office of the Attorney General, DADS may petition a Travis County court for the involuntary appointment of a trustee. This enforcement action is rare as it is costly and likely results in the forced closure of the facility and relocation of all residents. DADS argues its case to the court and the facility has an opportunity to make counter arguments. If a trustee is appointed, the trustee controls all facility operations and serves as an officer of the court until dismissed by the court.

Another option of a trustee placement is by agreement between DADS and the facility operator. In the case of a trustee by agreement, the operator pays all costs for the trustee. In practice, operators are more likely to hire a consultant to serve this function and not formally agree to a trustee.

Credentialing

Many types of personnel work in nursing homes and assisted living facilities. Professional boards license physicians, nurses, pharmacists, social workers, and others are regulated outside of DADS. DADS regulates certain classifications.

Nursing Facility Administrator (NFA) Licensing and Investigations Program

- Issuance, renewal, revocation of a license, as well as continuing education
- Investigate complaints or referrals resulting from findings of substandard quality of care and violations of the NFA standards of conduct
- Impose and monitor sanctions
- Provide quarterly training for administrators in training

Nurse Aide Registry

- Maintain a registry of all nurse aides who are certified. Certified Nurse Aides are required to have:
    - participated in a state-approved nurse aide training and competency evaluation program: 51 classroom hours; 24 hours clinical training; and
    - passed both skills and written portions of the competency evaluation program test.
- Review and investigate allegations of abuse, neglect, or misappropriation of resident property by nurse aides

Medication Aide Program

- Issue and renew Medication Aide permits and review continuing education
- Impose sanctions
- Approve and monitor medication aide training programs
- Develop educational, training, and testing curricula
- Coordinate and administer tests

All DADS-regulated facilities must check both Nurse Aide Registry and Employee Misconduct Registry at 800-452-3934 or on the DADS website before hiring a person to determine if he or she:

- is listed as having committed an act of abuse, neglect, exploitation, misappropriation, or misconduct against a resident or consumer; and
- is therefore, unemployable.

All nursing homes and assisted living facility employees must be determined employable. Operators must check what two registries?

- ____
- ____

Resources

Within state government, agencies hold authorities and responsibilities that may impact people who live and work in nursing homes and assisted living facilities. Long-term care ombudsmen interact with agency staff on various levels. Ombudsmen most often work with staff in divisions of the following agencies:

- Department of Aging and Disability Services (DADS)
- Department of Family and Protective Services (DFPS)
- Health and Human Services Commission (HHSC)

DADS Center for Policy and Innovation
Quality Monitoring Program

The Quality Monitoring Program (QMP) provides an educational, rather than regulatory, approach to quality improvement at nursing homes. The program increases positive outcomes and improves the quality of services for people who live in nursing homes.

QMP helps providers improve services and supports, so the right thing is done for the right person for the right reason at the right time. To promote the highest quality services and supports, the program distributes best practices for specific focus areas such as pain management, managing fall risk, and medication review.

QMP is not a regulatory program. Quality monitors do not cite nursing homes for deficient practices. Staff includes nurses, dietitians, pharmacists, psychologists, and social workers. Located across Texas, they work together with providers to implement best practices. Through positive partnerships, providers and monitors assess and strengthen systems to improve resident outcomes.

This educational approach has increased acceptance of quality monitors within facilities and is evidenced by an overall improvement in statewide scores of quality indicators such as restraint use, falls, depression, pressure sores, nutrition, cognitive behavior, medication use, behavior problems, and pain. Scores are calculated for chronic (considered as long-term) and short (often for rehabilitation) stay samples.

DADS Contract Oversight and Support

Client Trust Fund

Residents have the right to manage their financial affairs or designate other people to do so. Some residents deposit personal funds with the nursing home. Families and guardians often want facilities to assume this responsibility. If residents deposit their funds, staff manages resident funds but must keep them separate from facility funds.

To safeguard Medicaid-eligible residents' money, nursing homes use an accounting system for their incomes and expenses. DADS trust fund staff monitors facility systems that include:

- A collective bank account for all participating residents,
- Individual resident files showing all deposits and withdrawals,
- A petty cash fund to provide small amounts of money (generally $5 or less), and
- Receipt files for each resident of all purchases and payments made by and for that resident.

When a resident dies or moves, the nursing home closes the resident's trust fund account. Within 30 days of death, the facility must convey the resident's funds to the individual or probate jurisdiction managing the estate. If the resident moves, the facility conveys the funds within five days. Details about trust funds are in Protection of Personal Funds NFR §19.404.

DADS Promoting Independence

Money Follows the Person

Money Follows the Person (MFP) is a significant policy in DADS Promoting Independence Initiative. MFP allows residents to move out of nursing homes to receive services in the community. They bypass the interest list and do not use a community "slot" to access services.

DADS enters into contracts with relocation contractors that hire relocation specialists. Specialists work with residents to explore interest in MFP. Residents must have the opportunity to interact with relocation specialists to get information about moving back to the community. But, they are not obligated to speak to relocation specialists.

Specialists educate residents and identify those who want to access community services through MFP. They can help facilitate and coordinate transition activities.

DADS expects administrators and staff to support and help all MFP activities, including relocation specialists, specialists activities, and transitional services. Facilities should grant specialists visits with residents, along with family and others with the resident's approval, and access to clinical records and other documentation.

Department of Family and Protective Services (DFPS)
Adult Protective Services

Adult Protective Services (APS) investigates abuse, neglect, and exploitation of adults who are aged 65 or older or, if age 18-64, they have a disability. They may live in private homes, adult foster care homes, and unlicensed board and care homes.

APS caseworkers investigate reported abuse, neglect, or exploitation to determine if the reported situation exists and to what extent it adversely affects the elder or adult with disabilities. They must initiate an investigation within 24 hours of receipt of the report by DFPS. Initiation allows the workers to learn more about the situation and whether to intervene immediately. Through assessments, they determine the alleged victims' situations and needs as well as identify and address root causes.
To lessen or prevent further mistreatment, caseworkers provide or arrange for services such as financial help for rent and utilities, social and health services, and referrals to DADS Guardianship Program. Caseworkers may provide direct services, arrange services by others, or purchase services on a short term, emergency basis.

For people who live in nursing homes, assisted living facilities, and other institutions, APS investigates financial exploitation if the alleged perpetrator lives in the community. If abuse, neglect, and exploitation happen within a facility by staff or others, DADS Regulatory Services staff investigates.

Health and Human Services Commission (HHSC)
Fair and Fraud Hearings

The Fair and Fraud Hearings section of the HHSC Appeals Division receives appeal requests from applicants and clients to contest actions taken regarding benefits and services. The programs include all Medicaid-funded services, the Supplemental Nutrition Assistance Program (formerly known as the Food Stamp Program), and other agency programs required by law or rule to provide the right to a fair hearing.

Fair and Fraud Hearings provide accessible, neutral forums to conduct administrative hearings while issuing just and impartial decisions with respect for the dignity of individuals and their due process rights. Hearings officers conduct the hearings, consider evidence, and issue decisions in accordance with rules, regulations, and laws.

State and federal laws require hearings officers to be impartial and to not have prior knowledge of any case. They may only consider evidence and testimony provided at the hearing to make a decision on a case.

Most hearings are held by phone but may be face-to-face if requested. The date, time, and call-in number are in the appointment notice. Once everyone is in attendance, the hearings officer explains what will happen and swears in everyone. The agency representative explains the action they took. Then appellants ask questions and explain whey they disagree with the agency's action or inaction.

Hearings officers must issue a decision no longer than 90 days from the date of the appeal request. Some circumstances could extend the time. Appellants have 30 days from the date on the decision to ask the hearings officer to reopen an appeal.

Health and Human Services Commission (HHSC)
Office of Eligibility Services

Staff who determine Medicaid eligibility are called eligibility workers and are often responsible for handling other benefit applications. Duties of these workers include interviewing applicants and verifying application information, as well as helping clients to obtain necessary documentation. Authorizing approval for benefits, maintaining records, and investigating possible fraud are other required activities.

Residents interact with Medicaid eligibility (ME) workers if and when they apply for the Medicaid program or if they want to appeal a discharge from the nursing home. ME workers almost always provide assistance over the telephone because they assist clients all over the state. Some ME workers are called out-stationed workers with an office inside of a nursing home or hospital. Out-stationed workers are state employees who follow the same procedures as other ME workers. Ombudsmen may contact ME workers to assist in overcoming any barriers to services for a resident, to get information about eligibility or the application process, and to initiate an appeal request on behalf of a resident.

A list of ME workers and their assigned nursing homes is maintained by HHSC. The Office of the State Long-term Care Ombudsman has access to the information and provides it upon request. Nursing homes also have contact information for their assigned ME worker.

Exercise: Help! – Identify the Right Resource

Write the program or the best person to help solve each problem. To take action on a resident's behalf, you always need resident consent. For this exercise, assume you obtained consent from the resident.

1. Mrs. Cash moved to a new nursing home. She asks for her personal funds deposited with the home and is told no money is available.

   ____

2. When Mr. Rich moved in, he was private pay. Now he has spent down to a total of $2,000 in his accounts. Where does he apply for Medicaid?

   ____

3. You notice numerous residents are restrained. Facility staff says they use physical restraints to prevent falls, but they want to learn best clinical practices to keep residents safe.

   ____

4. Mr. Brown's bill hasn't been paid for the past three months. His dementia got worse and his son started paying. The business office manager believes the son is paying his own house payments out of his dad's money.

   ____

5. Each time you visit Julie Morrow, she talks about moving out of the nursing home because everyone is old and she believes she could live in an apartment.

   ____

6. The nursing home sent Alex Chang a 30-day discharge notice that they cannot meet his needs. He doesn't understand because other residents are in the same condition. He wants to stay.

   ____

Ombudsman Role

With regulators and other agency resources, ombudsmen communicate professionally as advocates and work on behalf of residents with their consent. They maintain resident and complainant confidentiality.

DADS survey team is to contact the local ombudsman program within two hours of entering a facility to ask about concerns and to say when the resident group interview and exit conference will be. Ombudsmen can suggest residents to review and families to interview, attend the resident group meeting if invited by residents, attend the exit interview, and participate in other activities as agreed upon.

If you arrive at a nursing home or assisted living facility while DADS is conducting a survey, introduce yourself to the lead surveyor, provide relevant information about the facility, and exit the building. Your absence emphasizes to residents and facility staff that surveyors are regulators and ombudsmen are advocates.

While educating, advocating, or solving problems, ombudsmen may consider supports and services at agencies and programs. Before using outside resources, discuss the situation with your supervising staff ombudsman. By contacting these resources or referring others to them, staff with in-depth knowledge of their agency programs provide answers in the most effective and efficient manner. With consent from residents and complainants, provide detailed information to help reach resolution appropriately and timely.

If you make referrals, follow up with the residents to see if they received answers to their questions, information about their issues, or resolution to their problems. If not, ask whether they want you to take further action or pursue a different approach.

Supplement A-9: Program Agreement between DADS Long-term Care Ombudsman Program and Regulatory Services

Supplement B-9: Memorandum of Understanding between DFPS Adult Protective Services and DADS Long-term Care Ombudsman Program

Ombudsman Certification Training

CHAPTER 10

Resident-directed Care

--This page intentionally left blank—

Resident-directed Care

Chapter 10 is about nursing homes providing care based on what each individual resident wants and needs and involving residents, family members, staff, and management. "Resident-directed care" is the goal and "culture change" is the action needed to attain that goal.

Learning Objectives

- Increase knowledge of individualized care as directed by the resident
- Be aware of reasons why facilities are changing
- Know major components of resident-directed care
- Distinguish between resident-directed and traditional practices

Contents

Resident-directed Care and Culture Change
Reconciling Regulatory Compliance with Resident-directed Care

Supplement A-10: Language of Culture Change

Resident-directed Care and Culture Change

A nursing home must "care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident" as required by the Texas Department of Aging and Disability Services (DADS). Based on the Nursing Home Reform Law of 1987, this requirement emphasizes dignity, choice, and self-determination for the people who live in nursing homes.

Even with laws emphasizing the need to focus on each resident, many nursing homes continue to provide institutionalized care based on a medical model. Since the 1990s, advocates, regulators, and providers have been working to more effectively blend a medical model with a social model. This transformation movement is known as culture change.

Like a nursing home, an assisted living facility (ALF) is responsible for all care provided to residents. Residents should receive the kind and amount of supervision and care they require to meet their basic needs. No federal regulations exist for assisted living facilities, but in Texas, facilities must comply with DADS Licensing Standards for Assisted Living Facilities.

While residents who live in ALFs are more independent, the facilities also risk becoming institutionalized. Culture change principles can transform assisted living facilities the same as nursing homes.

Culture Change

- Culture - a pattern of shared basic assumptions learned by members of a group. Assumptions stem from people's experience, as they repeatedly conduct their business. Cultural assumptions provide meaning to daily events for people inside a group; life is predictable and anxiety is reduced.
- Change - transformation or transition from one state, condition, or phase to another
- Culture change - a movement working to radically transform nursing home care and help facilities transition from institutions to homes
- Person-directed care - residents make decisions about individual routines of daily life and directly influence how their home operates

Culture change is a philosophy that focuses on fostering a person-centered, and ideally a person-directed, care system. Person-directed care means the resident actively determines the course of their life in daily activities, care, and choices. When a resident cannot fully direct their care, because of physical or cognitive disabilities, caregivers and advocates look to the person's expressed wishes for clues to provide resident-centered care.

Clues can come from advance care planning documents, known or previously expressed wishes, lifelong preferences, and input from family and friends. Person-centered and person-directed care requires regular communication with the resident to learn the resident's wishes and to create opportunity for the person to exercise choice and control over their life. Ombudsmen are trained to follow this same principle as we work to protect resident rights and resolve complaints.

Nursing home providers report that a commitment to culture change improves the quality of care and life for residents and the quality of work experience for staff.

Continuum of Resident-directed Culture

Sue Misiorski and Joanne Rader developed this continuum of direction to illustrate to the Pioneer Network the differences between staff-directed and person-directed culture.

Provider directed

Management makes most decisions with little conscious consideration of the impact on residents or staff.
Residents accommodate staff preferences and are expected to follow existing routines.

Staff centered

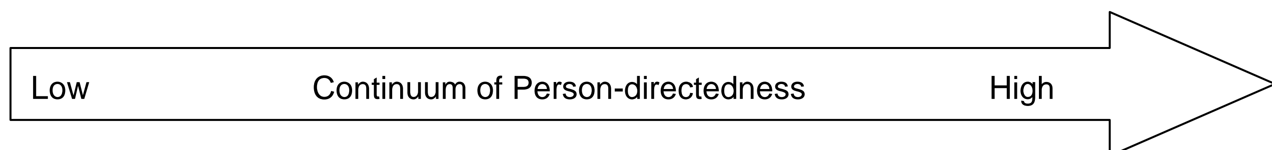
Staff consults residents or puts themselves in the residents' place while making the decisions.
Residents accommodate staff much of the time but have some choices within existing routines and options.

Resident centered

Resident preferences or past patterns form the basis of decision making about some routines.
Staff begins to organize routines to accommodate expressed or observed resident preferences.

Resident directed

Residents make daily decisions about individual routine. When not capable of stating needs, staff honor habits and observed preferences.
Staff organizes their hours, patterns, and assignments to meet resident preferences.



Words can affect our ability and willingness to change by coloring how we see the people and places around us. Words can make a difference, such as calling a child difficult rather than high-spirited, or the grocery store clerk slow instead of careful. Changing our language can lead to changing our perspective on the places residents call home.

Exercise: Suggest how traditional words could be replaced with words that emphasize the person.

1. Nursing facility ______________________________________
2. Staff ______________________________________
3. Resident ______________________________________
4. Hallway/unit______________________________________
5. Nourishment ______________________________________
6. Pet therapy ______________________________________
7. Activities room ______________________________________
8. Resident council ______________________________________
9. Therapy room ______________________________________
10. Meal tray ______________________________________

Traditional Care Practices

Traditional practices focus on the efficiency of business. Many nursing homes are large physical buildings based on efficiency principles to maximize economies of scale and get things done quickly, smoothly, and routinely. Power is held by managers and corporate staff.

For efficiency, management tightly controlled staff life. Direct care staff voiced concerns including:

- Lack of respect
- Not being valued by the organization
- Lack of good leadership role models
- Stress of working short staffed
- Lack of empowerment or adequate training
- Limited opportunities for growth

Facility practices encouraged absenteeism:

- Incentives to waive benefits
- Denial of pay for absences less than two days
- Use-it-or-lose-it sick pay
- Rotating staff assignments; not having consistent caregivers inhibits relationships between residents and caregivers

Person-directed Practices

The person-directed care model involves three interconnected areas: environment, care, and work. Changes can range from simple and inexpensive to complex and costly.

Environmental

- Create a home with a sense of community and safety for residents and staff
- Demonstrate affection, validation, and support
- Shift toward neighborhoods and communities within a building
- Reduce noise from overhead paging with pagers or wireless phones
- Change centralized nursing stations to several nursing areas
- Exchange medication carts for locked medication storage in resident rooms
- Remove institutional signage
- Serve meals from a buffet or use table service rather than using trays
- Construct private rooms and private baths
- Build smaller houses where 10-12 residents live together with a caregiver

Care

- Use creative care solutions based on resident preferences
- Be flexible about waking and sleeping times
- Make dining more personal and pleasant
- Accommodate resident bathing preferences
- Create and honor rituals and celebrations
- Design social activities based on individual and group preferences
- Staff promotes individuality and normalcy and gives residents as much choice and control as possible

Workplace

- Establish relationships as the # 1 organizational priority
- Promote high quality leadership
- Value and respect caregivers and their needs
- Develop leadership opportunities for direct care staff
- Assign direct care staff consistently to the same residents

---

List two differences between traditional care practices and person-directed care practices.

1. Traditional

   ____

   Person-directed

   ____

2. Traditional

   ____

   Person-directed

   ____

Comparing Models of Care

Model	Description
Traditional	Staff provides standardized treatments based on medical diagnosis
Person-directed	Staff bases care on individualized care needs and personal wishes
Traditional	Facility designs schedules and routines; staff and residents comply
Person-directed	Flexible schedules and routines match resident needs and wishes
Traditional	Task-oriented work; staff rotates assignments and knows how to perform tasks on any resident
Person-directed	Relationship-centered work; consistent staff assignments brings personal knowledge of residents into caregiving
Traditional	Management makes all decisions
Person-directed	Residents and those close to them make decisions
Traditional	Facility is staff's workplace
Person-directed	Facility is resident's home
Traditional	Isolation, loneliness, and feeling of homelessness are common
Person-directed	Residents and staff share a feeling of community and belonging
Traditional	Resident adapts to facility
Person-directed	Facility adapts to the resident. Residents make decisions about their daily routines such as waking, sleeping, dining, bathing, and participating in activities
Traditional	Medical model focus
Person-directed	Staff supports quality of life with quality of care by considering the resident's spiritual, mental, and physical well-being in all decisions

Traditional	Impersonal work practice
Person-directed	Facility involves employees, residents, and family to support relationships; invests in staff through time, education, and commitment

Traditional	Authoritarian process
Person-directed	Facility creates opportunities where individuals make decisions and take greater responsibility to better the home and their lives and implements a team-driven change process

Traditional	Resident sees the nursing home as a place to die
Person-directed	Rituals and celebrations acknowledge life and establish an environment where everyone thrives and grows • noting large and small accomplishments • celebrating the lives of residents and employees • supporting life and growth through daily activities • providing purpose, diversity, and spontaneity

---

How can person-directed care improve quality of life in nursing homes and assisted living facilities?

____

____

____

____

____

____

____

Activity: Mystery Game

Find clues to person-directed care.

This game introduces thinking person-directed through three objectives:

1. Recognize how current circumstances and culture inadvertently create problems.
2. Apply person-directed thinking to develop solutions for the resident.
3. Understand that changing to more person-directed practices requires changes in the entire facility system and all departments.

Starting with a set of 42 clues, hand out the clues, facedown, as if dealing a deck of cards. Everyone at the table will have several clues. Game time is about 20 minutes.

Each card contains pieces of information about Thomas McNally who lives in a nursing home. Information is clinical and personal. All the information is necessary to solve the mystery.

After all clues are handed out, everyone shares their clues with each other to solve the mystery. The facilitator can document answers on a board or chart.

The group answers the following:

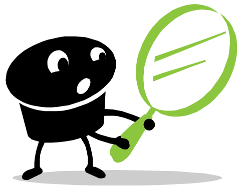
1. How are facility routines contributing to Mr. McNally's decline?
2. What clues do you have about his strengths and interests?
3. How can staff use his strengths and interests to start a person-directed approach that may reverse his decline?
4. What changes in his routine need to be put in place? What changes in facility routine need to happen so his personal routines can be restored?
5. What additional information is needed?
6. Who else needs to be involved in the discussion?

Additional Discussion

Learn the word "i-atro-gen-e-sis," which is Greek for "we caused it." A formal definition is "inadvertent and preventable induction of disease or complications by the medical treatment or procedures of a physician." This term describes a clinical problem caused by clinical treatment. Draw a parallel to using restraints: while used for safety, they unintentionally cause harm.

Other facility routines meant to provide care for residents inadvertently harm them. Centering care around a person's routines, instead of facility routines, can reverse this harm and help people thrive.

Question: How can an ombudsman support a facility to expand their care-planning activities to get the information needed to be person-directed?



Through its Culture Change Initiative, DADS supports moving nursing homes away from institutional models to person-directed models. The initiative expands the focus of care to include not only clinical and safety concerns but also residents' quality of life, relationships, and respect for individual needs and wishes. State and local long-term care ombudsmen are members of the initiative.

Reconciling Regulatory Compliance with Resident-directed Care

Facility staff may find it challenging to connect culture change principles and regulatory compliance. The Centers for Medicare and Medicaid (CMS) State Operations Manual provides interpretive guidelines on how to conduct nursing home surveys and determine compliance. The manual is routinely updated and many culture change principles are incorporated.

This section reviews several DADS Nursing Facility Requirements and federal State Operations Manual F-tags (CMS federal citation codes). It is adapted from training designed for providers and surveyors to understand and support culture change in Texas nursing homes.

Since federal regulations for assisted living facilities do not exist, CMS has no interpretive guidelines. To conduct surveys and determine compliance, Regulatory staff uses DADS Licensing Standards for Assisted Living Facilities. Management of assisted living facilities risk falling into institutional patterns. While F-tags do not apply in these facilities, the principles do.

In light of the culture change principles of respect, choice, empowerment, relationships, and community, ombudsmen help influence how facilities can change. When reviewing the following pages, think about how assisted living facilities and nursing homes can comply with regulations and be resident-directed.

§19.401 Introduction F-150

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. A facility must protect and promote the rights of each resident.

List some practices a facility can do to promote dignity and choice?

- Build relationships with residents, families, and physicians to understand residents as individuals and provide care according to resident preferences.
- Enable residents to self-administer medications if they want to and it is safe.
- ____
- ____

§19.403 Notice of Rights and Services F-154

(h) The resident has the right to refuse treatment, to formulate an advance directive, and to refuse to participate in experimental research.

How can a care provider support resident-directed care, including the right to refuse care?

- Learn the person's cultural and spiritual practices and how they may affect treatment decisions.
- Determine exactly what service a resident is refusing and why.
- ____
- ____

§19.408 Grievances F-165

A resident has the right to voice grievances without discrimination or reprisal.

How can the right to complain be assured?

- Empower residents to feel comfortable voicing complaints to the ombudsman, facility staff, and family members to find a solution to their complaints.
- Empower resident and family groups to help resolve conflicts, grievances, and complaints, thus keeping problems close to their source.
- ______________________________
- ______________________________

§19.407 Privacy and Confidentiality F-164

The resident has the right to personal privacy and confidentiality of his personal and clinical records.

(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

(2) The resident may approve or refuse the release of personal and clinical records to any individual outside of the facility.

(3) The resident's right does not apply when transferred to another health care institution; record release is required by law; or during surveys.

How can privacy be respected and allow residents to thrive?

- Teach staff that only persons directly involved in providing treatments, delivering care, or to whom the resident has given consent can be present during care.
- Ensure privacy when residents go to the bathroom and receive other hygiene care.
- ______________________________
- ______________________________

Certified ombudsmen have access to residents and their clinical records.

- Nursing homes §19.413 Access and Visitation Rights F-172
  (a) A resident has the right to have access to, and the facility must provide immediate access to a resident to, the following:
    (4) a representative of the Office of the State Long Term Care Ombudsman.

- Assisted living facilities §92.801 Access to Residents and Records by the Long-term Care Ombudsman Program
  (a) A resident has the right to be visited by, and a facility must provide immediate access to any resident to:
    (1) a staff person of the Office of the State Long-term Care Ombudsman (the Office) employed by DADS;
    (2) a certified ombudsman; and
    (3) an ombudsman intern.

How can ombudsmen respect residents' privacy?

- In rooms:

  ____

- Visiting a resident with a complaint:

  ____

- Investigating a complaint:

  ____

- Accessing resident's medical records:

  ____

---

§19.701 Quality of Life F-240

A facility must care for its residents in a manner and environment that promotes maintenance or enhancement of each resident's quality of life.

Suggest some changes in facility environments to enhance quality of life.

- Furnish the home with personal items, such as pictures and furnishings that belong to the residents.
- Offer parties, dinners, and celebrations.
- Provide a variety of spiritual opportunities, such as speakers, services, and music.
- ____
- ____

§19.701(1) Dignity F-241

The facility must promote care in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of individuality.

How can resident dignity, respect, and individuality be enhanced?

- Get resident input before choosing a radio or television station.
- Offer choice of paint colors to decorate rooms.
- ____
- ____

§19.702 Activities F-248

The facility must provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, interest, and the physical, mental, and psychosocial well-being of each resident.

How can a home provide meaningful activities that offer interesting activity for all?

- Incorporate lifelong interests into activity options.
- Consider male and female, all ages, and various cultures and religions.
- ____
- ____

§19.901 Quality of Care F-309

Each resident must receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

How can care practices help a person attain physical and mental well-being?

- Ensure direct care staff recognize and know how to report changes in a resident's condition.
- Develop a staff training program with opportunities for interactive learning and resident participation.
- ______________________________
- ______________________________

§19.901(3) Pressure sores F-314

The facility must ensure a resident who enters the facility without pressure sores does not develop pressure sores unless his clinical condition demonstrates they are unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores.

What are some person-directed ways to prevent pressure sores?

- Offer and provide pain medication before dressing changes and wound care.
- Offer emotional support to residents with pressure sores, as changes in body integrity can influence self-esteem.
- ______________________________
- ______________________________

§19.901(4) Urinary Incontinence F-315

The facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless his clinical condition demonstrates catheterization is necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

How can a resident's bladder continence be maintained?

- All staff responds to call lights and routinely offer to help residents at risk of incontinent episodes to go to the bathroom.
- Create privacy covers for catheters and portable urinals to prevent decline in self-esteem.
- ____
- ____

§19.901 (10) Hydration F-327

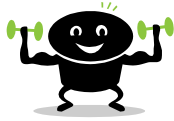
The facility must ensure the resident is provided with sufficient fluid intake to maintain proper hydration and health.

How can hydration be promoted?

- Provide mobile beverage and healthy food stations.
- Document and honor residents' fluid preferences and routines.
- ____
- ____

§19.1108 Food F-364

Each resident must receive and the facility must provide food prepared by methods that conserve nutritive value, flavor, and appearance and food that is palatable, attractive, and proper temperature.



How can food taste and appear better to residents?

- Kitchen staff can be trained on cooking methods that enhance tastiness.
- During meals, observe whether food is attractive and eaten.
- Routinely survey all residents about their opinions of food served.
- Make fresh fruits and vegetables readily available.
- ____
- ____

§19.1110 Frequency of Meals F-368

(a) Each resident receives and the facility provides three meals daily, at regular times.
(b) There must not be more than 14 hours between a substantial evening meal and breakfast the following day.
(c) The facility must offer snacks at bedtime daily.
(d) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast.

What are some ways for residents to direct meal times?

- Use neighborhood meetings (resident councils) to identify the best meal times.
- Accommodate individual preferences regarding waking and sleeping.
- ____
- ____

Supplement A-10: Language of Culture Change

Karen Schoeneman, Senior Policy Analyst
Centers for Medicare and Medicaid Services
Opinions expressed below are those of the author, not necessarily shared by CMS.

The language of long-term care belongs to all of us. The most urgent task may be agreeing which old words to throw away. Finding new ones should be easier. It's a matter of choosing accurate and respectful words.

PEOPLE	OLD WORDS	NEW WORDS
	grandma, mommy, sweetie, kid, honey, girls, old timer	resident's name, Mr./ Mrs./ Ms.
	wheelchairs/walkers	people who use a wheelchair/walker
	the elderly	elders, older adults
	patient	resident, client, neighbor, friend
	residents known by diagnosis	their name -- learn it!
	wanderers	people who like to walk
	disabled, diabetic, , quad, , CVA	a person who has (whatever condition)
	toilet resident	needs help in the bathroom
	activity director	community life coordinator
	non-nursing/ancillary staff	(name) from (department)
	new admit	someone at a home here, new neighbor
	feeder, feeder table	person needing help to eat, dining table
	dementia/demented	person with cognitive losses
	girl, guy (CNA)	their name, my friend
	I	We, the team
	nurse aide, CNA, nursing assistant, front line staff	resident assistant, certified resident assistant
	food service worker, hey you	their name
	problem resident, behavior problem	person with behavioral symptoms
PLACES	OLD WORDS	NEW WORDS
	facility, institution, nursing home	home, life center, living center
	agency	supplemental staffing
	lobby, common area	living room, parlor, foyer
	ward, unit	Village, neighborhood
	nurses' station	work area, den, support room, desk
	tray line	fine dining
	100-bed facility	100 people live in this home

THINGS	OLD WORDS	NEW WORDS
	activities	meaningful things to do
	mechanical soft food	chopped food
	nourishment	snack
	bibs	napkin, clothing protector
	diapers, pampers, pull-ups	briefs, panties, attends, brand names
	dietary services, food service	dining services
ACTIONS	**OLD WORDS**	**NEW WORDS**
	admit, place	move in
	discharge	move out
	transport	assist to…
	ambulation, wandering	walking
	eloped, escaped, elopement	left the building, unescorted exiting
	toileting	using the bathroom
	baby-sit	resident interaction
	allow	help, facilitate, encourage, welcome
	claims	states, says
ATTITUDES	**OLD WORDS**	**NEW WORDS**
	care plan problem	resident strength
	"I didn't know she could do that."	"I love it when she does that!"
	problem	challenge, opportunity
	"You need to…"	"Would you like to...?"
	"Sit down, you'll fall."	"Let's walk!"
	"Trays are here."	"Dinner is served."; "It is dinnertime!"
	"He's on the pot."	"He's not available right now."
	long-term care industry	long-term care community
	a two-assist	requires two helpers
	"We're already doing that."	"We need to really do that."
	"We tried that."	"Let's try again."
	"That's not my job."	"I'll take care of that."
	14-hour rule	freedom of choice
	old ways	change in order
	can't escape	would like to go outside
CONDITIONS	**OLD WORDS**	**NEW WORDS**
	short-staffed	adequate staffing
	confined to wheelchair	uses a wheelchair
	"victim of..." or "suffering from..."	person "has..." or "with..."
	agitated	active, communicating distress

SOURCE: Culture Change Language, Pioneer Network

Ombudsman Certification Training

CHAPTER 11

Systems Advocacy

--This page intentionally left blank—

Systems Advocacy

Chapter 11 describes how influencing and changing a system benefits people who live in nursing homes and assisted living facilities. Long-term care ombudsmen can encourage changes to laws, regulations, policies, facility practices, and community attitudes.

Learning Objectives

- Distinguish between individual and systems advocacy
- Be aware of relevant statutory language in the Older Americans Act
- Understand the ombudsman role in systems change

Contents

What is Systems Advocacy?
The Older Americans Act and Systems Advocacy
Distinguishing Systems and Individual Change
Systems Advocacy Activities in Texas

What is Systems Advocacy?

Ombudsmen can advocate to change systems as well as to solve individual problems. Changing a system can impact a single facility, all facilities operated by a provider, or all facilities in the U.S. This level of advocacy requires ombudsmen to identify broad trends across the long-term care system and to expand individual advocacy goals.

In assisted living facilities and nursing homes, systems may need to change in order to improve the quality of life and care of the people who live there. Systems may also improve the work setting of facility staff. Chapter 10 described person-directed care and culture change, which are systems change efforts.

The Older Americans Act and Systems Advocacy

The federal Older Americans Act established the long-term care ombudsman program and ombudsman mandates. Ombudsman representatives at the state and local programs fulfill several duties. The following references from the Older Americans Act are most directed toward systems advocacy:

- Represent the interests of residents before government agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents;
- Review, comment on existing and proposed laws, regulations, and other government policies and actions, pertaining to resident well-being and rights;
- Facilitate the public's ability to comment on laws, regulations, policies, and actions;
- Support development of resident and family councils; and
- Carry out other activities the ombudsman determines to be appropriate.

To assure resident interests are represented to the public and lawmakers, ombudsmen:

- Educate advocacy groups, governmental agencies, and policy-makers regarding the impact of laws, policies, or practices on residents;
- Seek modification of laws, regulations, policies, and actions pertaining to the right and well-being of residents;
- Facilitate the ability of residents, resident and family councils, and the public to comment on laws, regulations, policies, and actions;
- Develop or participating in work groups to study an issue;
- Participate in public hearings and forums;
- Provide community education or information; and
- Educate other aging services providers, advocacy groups, and the public on long-term care issues.

For effective coordination, state and local ombudsmen need to exchange information on systems advocacy issues and activities. Good communication and coordination synchronizes messages and creates a broader impact to align systems with residents' interests.

Distinguishing Individual and Systems Change

Making changes can help one person, several individuals, or thousands.

Issues vary. Common complaints ombudsmen investigate have different root causes, such as unanswered call lights (out of resident reach, electrical malfunctioning, short staffing), dental care (neglect, access to dentists, lack of social and health services, lack of information about benefits), or physical restraints (family fears a fall and injury, resident wants to assume certain risks, facility policies). Solving any one of these problems for one person is an example of individual change. If an ombudsman works to change the problem's root cause and takes into account how the same problem can be avoided in the future, an ombudsman can help develop a systemic solution to impact many residents.

Outcome for both individual and systems change may appear the same, but difference is apparent over time - when systems change will show a more lasting impact on the problem.

U.S. citizens have the right to vote in local, state, and national elections. Individual and systemic approaches can help ensure this right.

- Individual - arranging transportation for one resident to travel to the voting precinct on Election Day.

- System - arranging for residents in a nursing home to vote via absentee ballots, establishing the nursing home as a precinct voting site, supporting the resident council's efforts to invite candidates to the home for a debate, and arranging transportation to a voting location on Election Day.

These activities are not directly arranged by an ombudsman, but ensuring the facility fulfills its obligation is action the ombudsman can take to provide individual and systems advocacy regarding voting rights.

A resident council discusses their home's cutting back van travel on weekends. Identify one individual and one systems advocacy approach to resolve this problem.

- Individual - ____

  ____
- Systems - ____

  ____

Moving out of a Nursing Home

Another activity that demonstrates the difference between individual and systems change is the process of a person moving out of a nursing home. This example also shows how individual advocacy may depend first on systems change.

Systems Change

1. A guardian ad litem for two individuals with mental and cognitive disabilities who live in a state institution files a lawsuit for their right for care in an integrated setting. The lawsuit is based on the Americans with Disabilities Act.
2. The U.S. Supreme Court rules in Olmstead v. Zimring that states must provide community-based services for persons with disabilities who would be entitled to institutional services.
3. Governor George W. Bush issues an Executive Order requiring the state of Texas to offer community-based alternatives for persons with disabilities.
4. The Texas Health and Human Services Commission develops the Texas Promoting Independence Plan with an initiative allowing an individual with a disability to live in the most integrated care setting available.
5. Governor Rick Perry signs Executive Order RP 13, also relating to community-based alternatives for people with disabilities.
6. The Money Follows the Person (MFP) initiative helps people who receive long-term services and supports in a nursing home or state supported living center return to the community to receive their services without waiting. One of 30 states, Texas receives federal funds to help older adults and people with disabilities out of institutional settings. Ombudsmen help statewide by identifying residents who wish to move and supporting residents with resolving complaints associated with relocation.

7. By 2011, more than 20,300 Texans have moved to community-based settings with long-term services and supports.
8. The Minimum Data Set (MDS) version 3.0, Section Q begins implementation in September 2010. The assessment tool now asks every nursing home resident in Texas about their wishes to live in a community-based setting and requires the nursing home to act upon those wishes. Ombudsmen helped shape the MDS 3.0 assessment tool, trained facility staff, and will monitor for interference with resident rights.

Individual Change

1. A resident sits in a wheelchair in the front lobby. She tells everyone who walks by that she would like to go home.
2. During a visit, the ombudsman speaks with the woman about what she would like to do and where she would like to live.
3. She has lived in the nursing home for 14 months, is Medicaid-eligible, and owns her home.
4. Explaining MFP policy, the ombudsman asks if the resident would like to speak with the local relocation contractor.
5. The resident asks the ombudsman to start the process on her behalf. The ombudsman contacts the local relocation specialist.
6. A relocation specialist visits the resident and explains the process of moving out of the home using MFP. The resident works with agencies to prepare for her move. The ombudsman follows up to monitor progress and respond to the resident's concerns about the process.
7. The relocation specialist works with nursing home staff regarding the resident's needs and with community providers for the necessary long-term services and supports. The specialist makes arrangements regarding housing, furnishings, Medicaid-waiver services, and other needs.
8. The resident moves back to her home to receive care. She knows who to call if problems arise and has a network in place to support her. The relocation specialist follows up with her for six months after her return home.

How does the successful relocation of the person described above depend on a systems change?

____

Find two system advocacy activities in the example above in which ombudsmen can participate in:

1. ____
2. ____

Systems Advocacy Activities in Texas

The long-term care ombudsman program in Texas has been active in systems change since the mid-1980s. Some activities have succeeded such as an increase above the $30 federal personal needs allowance and others with limited success such as improving consumer protections for assisted living residents.

Systems within the industry, regulatory services, funding sources, advocacy groups, legal resources, and others may be involved. The needed change will determine which stakeholders must work together to achieve the best outcome.

Long-term care ombudsmen have been and continue to be active in systems advocacy issues. When systems change, ombudsmen watch to assure the change is implemented as intended and resident quality of care and life are improved. The following examples demonstrate the:

- stakeholders involved;
- change accomplished; and
- future advocacy needed to resolve the systemic problem.

Example 1: Personal Needs Allowance Increase

Medicaid-eligible individuals who live in nursing homes and assisted living facilities keep some of their income. This is called Personal Needs Allowance (PNA) and they use the money as they choose. The remainder of their income is paid to the facility for their care, known as applied income.

Federal law established PNA to provide funds for Medicaid residents in nursing homes to purchase goods and services. The federal minimum PNA is $30 a month. State legislatures can appropriate additional funds. On September 1, 1999, Texas increased PNA to $45. Since then, it has been $60, back to $45, and as of 2011, is $60.

- Stakeholders
  - Residents and family members
  - Citizen advocacy groups
  - Health and Human Services Commission Office of Medicaid Eligibility
  - DADS Regulatory Services, LTC Ombudsman Program, Financial Office
  - Nursing home and ICF-MR providers

- Changes
  - The Texas Legislature enacts laws within the Texas Human Resources Code (HRC) Chapter 32 – Medical Assistance Program; this chapter enables Texas to provide medical assistance on behalf of needy individuals (Medicaid) and to obtain all benefits for persons authorized under the Social Security Act or any other federal act
  - HHSC established rules to implement the law. Since January 1, 2006, PNA is $60
  - Policy interpretation is released to clarify PNA for veterans and others
    - For Supplemental Security Income (SSI) recipients who receive the $30 reduced federal benefit, the state pays the person the remaining $30 to reach the minimum PNA level set by HHSC
    - If a veteran without a spouse or child or a surviving spouse without a child is covered by Medicaid for nursing home services, the Veterans Administration pays $90 to the veteran or surviving spouse in addition to the PNA amount

- Future advocacy
  - Change laws impacting PNA to include a cost of living adjustment to avoid needing to routinely seek statutory change.
  - Monitor for residents who are restricted from using their PNA as they wish and identify policy changes that may be necessary.
  - Monitor for issues of possible financial exploitation related to PNA and continuously educate facility staff of their requirement to report suspected financial exploitation. Ombudsmen will need to continue to educate Adult Protective Services about their role in financial exploitation alleged to have occurred by family or others not associated with the nursing home.

Example 2: Physical Restraint Reduction

A physical restraint is anything that keeps residents from moving around or getting to a part of the body. Residents have the right to be free from physical restraints imposed for discipline or convenience and not required to treat the resident's medical symptoms. Family members and facility staff may believe restraints keep people safer.

If used inappropriately, restraints can be harmful. Residents who have been restrained for long periods can have poor circulation, constipation, incontinence, weak muscles and bones, pressure sores, poor appetite, and infections. Restraints can cause agitation, less ability to do daily activities, less social contact, withdrawal, depression, and poor sleep. Some residents have died from restraints.

- Stakeholders
  - Residents and family members
  - Citizen advocacy groups
  - DADS Quality Monitoring Program, Regulatory Services, and LTC Ombudsman Program
  - Nursing homes and assisted living facility providers

- Changes
  - In 2000, Texas ranked among the four states with the highest prevalence of restraint use. A statewide assessment indicated 19.5% of nursing home residents were physically restrained.
  - Nursing home providers and DADS divisions including Regulatory Services, Quality Monitoring, and LTC ombudsman programs concentrated education, policy, and practice on restraint reduction.
  - DADS held joint training, quality monitors advised facility staff, long-term care ombudsmen conducted education programs for families, facility staff revised policies and procedures, and residents and families discussed restraint use in care plan meetings.
  - In fall 2005, the Centers for Medicare and Medicaid Services reported restraint use in Texas at 6% - a 13.5% decrease.
  - Freeing residents from restraints and never using restraints continues.

- Future advocacy
  - Based on resident data, DADS estimates medically unavoidable restraints at 1-2%. Restraint reduction trials show restraint use can be decreased to 5% or less. Therefore, DADS goal is to help reduce the occurrence of restraint use to below 5%.
  - The Advancing Excellence in America's Nursing Homes campaign has eight goals. Goal 3 is "Restraints: residents are independent to the best of their ability and rarely experience daily physical restraints." Consumers, facility staff, and advocates use the campaign as an opportunity to influence reducing and eliminating restraints.
  - In some facilities, restraint use is on the rise. Use Office-provided training materials to train facility staff, residents, and family groups.

Example 3: Consumer Protection for Residents in Assisted Living Facilities

The people who live in assisted living facilities (ALFs) today would have lived in nursing homes 10 years ago. ALF residents may be on hospice, have complex medical needs, and many have cognitive impairments associated with dementia of the Alzheimer's type. While needs have increased, licensure standards do not require ample training of staff nor provide sufficient consumer protection from discharge or other adverse actions.

- Stakeholders
  - ALF residents and family members
  - Texas Association of Area Agencies on Aging (T4A), Texas Senior Advocacy Coalition (TSAC), and Texas Silver Haired Legislature (TSHL)
  - DADS Quality Monitoring Program, Regulatory Services, and LTC Ombudsman Program
  - Assisted living facility providers
  - Physicians, physician assistants, nurse practitioners, nurses, and unlicensed caregivers

- Changes
  - DADS identified issues related to medications in assisted living facilities, began to revise rules with input from the State Long-term Care Ombudsman, and invited stakeholders including local long-term care ombudsmen to form a medication administration work group. All parties agreed on rule revisions for greater clarity.
  - After unanimous support from T4A, TSAC, and TSHL, funding for assisted living long-term care ombudsmen was incorporated in the 2012-2013 DADS legislative appropriations request. This effort failed due to state budget constraints, but will serve as the foundation for future requests

- Future advocacy – ombudsmen can
  - Use the 2010 Long-term Care Ombudsman Annual Report recommendations to keep the needs of assisted living residents on the minds of DADS stakeholders, DADS, and lawmakers. In 2012, DADS will develop the next Legislative Appropriations Request. Stakeholders can support funding in the 2014-2015 DADS budget for assisted living long-term care ombudsmen.
  - Tell the public and lawmakers about the benefits of applying the ALF Alzheimer's licensure standards for manager and staff training, staffing, and activities to all Type B ALFs. Review the standards in chapter 92 of the Texas Administrative Code.
  - Support the need to require assisted living facility employees who provide direct care to be Certified Nurse Aides (CNAs). Inform the public and stakeholders about the benefits of trained and certified caregivers on the quality of life and care for ALF residents.
  - Advocate for the need to provide a fair hearing appeal for assisted living residents facing discharge to give ALF consumers protection from illegal eviction.

List two ways you can help the public and lawmakers understand the needs of people who live in assisted living facilities.

1. ____

2. ____

Example 4: Culture Change

Chapter 10 described person-directed care and culture change. Resident-directed care requires many people changing attitudes about nursing homes from institutions of efficiency to places where individuals live, thrive, and exercise choice and control. Culture change transformation describes changes in organization practices, physical environments, relationships at all levels, and workforce models. To change the culture from institutional to individual does not require radical physical changes and expensive remodeling. In fact, it does not have to cost anything, but must be supported by direct care providers and management.

Ombudsmen can play an important role in a home's decision to implement person-directed care and to change their culture from an institution to a place to thrive.

- Stakeholders
  - Residents and family members
  - Citizen advocacy groups such as Texas Advocates for Nursing Home Reform
  - DADS Quality Monitoring Program, Regulatory Services, and LTC Ombudsman Program
  - Nursing home and assisted living facility providers

- Changes
  - Several early models of this change were presented at the 1995 Consumer Voice conference. One outcome was the Pioneer Network.
  - At the invitation of the Texas State Long-term Care Ombudsman, the Pioneer Network Board of Directors conducted training for providers and ombudsmen in San Antonio in 2002.
  - In 2006, the Centers for Medicare and Medicaid Services provided national guidance to support facility implementation of culture change. The federal State Operations Manual includes guidance that encourages person-directed care and other elements of culture change.
  - DADS routinely conducts regional joint training on culture change for providers, regulatory services staff, and long-term care ombudsmen at no charge.

- In 2010, DADS staff interested in moving nursing homes from an institutional model to a person-directed one created a Culture Change Initiative. It expands the major focus of care to include not only clinical and safety concerns but also residents' quality of life, relationships, and respect for individual needs and wishes. The Texas Long-term Care Ombudsman is a member as well as DADS Regulatory Services and the Quality Monitoring Program.
- In July 2010, the Texas Culture Change Coalition (TxCCC) was formed. The statewide membership of consumers, providers, advocates, agencies, and organizations is dedicated to culture change in a variety of aging and disability service provider types, including nursing homes and ALFs.

Exercise: Future Advocacy

Promote resident-directed care. Brainstorm ideas for systemic culture change in your assigned facility. Consider the following areas:

- Meal service: ____
- Bathing and hygienic experiences: ______________________________
- Social activities: ____
- Intimacy: ____

In general, what is one change that could provide all residents with an opportunity to exercise more choice and control?

____

____

Ombudsman Certification Training

Ombudsman

Policies and Procedures

Ombudsman Policies and Procedures

100 Introduction

200 Roles and Responsibilities

300 Conflict of Interest

400 Consent

500 Access

600 Consultations and Cases

700 Reporting

800 Records

900 Disclosure of Confidential Information

1000 Legal Counsel and Resources

1100 Volunteer Management

1200 Other Required Documents

Getting Acquainted with
Ombudsman Policies and Procedures

Open the Ombudsman Policies and Procedures to answer the following items.

Section 100 Introduction

1. According to Section 101, what gives the Long-term Care Ombudsman Program legal authority?

   ____

2. Section 103 describes the line of communication for the ombudsman program. To whom should a volunteer ombudsman take consultations, grievances, and escalation of complaints?

   ____

Section 200 Roles and Responsibilities

1. Section 201.2 describes staff responsibilities, some required by a Managing Local Ombudsman and others that may be executed by any certified staff ombudsman. To access confidential program information, what happens first?

   ____

2. In Section 202, what is one capacity in which an ombudsman may not serve a resident because it is a conflict of interest?

   ____

3. According to Section 204, what must an ombudsman do if participating on behalf of the ombudsman program in local activities pertaining to policy or legislation?

   ____

4. Section 206.3 describes interaction between Regulatory Services and Ombudsman Program. Name two reasons an ombudsman would contact Regulatory Services.

   ____

   ____

5. In Sections 207.1-2 and 207.2, what are suggested topics for an ombudsman to present to residents and families and facilities?

   ____

   ____

Section 300 Conflict of Interest

1. Section 301 states it is best to __________ rather than ___________ conflicts.

2. In Section 301.1, what form does the ombudsman sign to acknowledge he or she will support a strict conflict of interest standard that prohibits conflicts such as financial gain, promoting management over residents, or serving in a facility where a family member is a resident? ____

3. According to Section 302, an ombudsman may not accept ___________________, _____________, or ___________ _________________ from a LTC facility, resident, or anyone other than the local LTCOP for performing ombudsman services.

Section 400 Consent

1. Ombudsmen are required to obtain resident consent to __________ ___________.

2. According to Section 400, consent applies only to the ____________________ case and does not extend to ___________ work.

3. Section 401 states if a complainant is not a resident, the ombudsman seeks agreement from the resident to work on an issue. What happens if the resident does not give consent?

   ____

4. In Section 402, an ombudsman is required to protect the identity of _____________ complainants the same as residents.

5. According to Section 403, an ombudsman should be prepared with applicable _______ and _________ and if facility staff denies access, consult with _________.

Section 500 Access

1. Section 501 says ombudsman visits to a facility should be _________________.

2. In Section 501.1, ombudsmen visit during regular visiting hours when residents are awake. Why would an ombudsman visit at other times and who would he or she consult first?

   ____

3. Section 501.2 states review of facility policies may be relevant if staff refer to policy as a reason for a decision or action. When should an ombudsman consult with facility staff and the MLO regarding a policy?

   ____

4. Section 503.1 introduces the term responsible party. Why should an ombudsman be careful when the facility uses this term?

   ____

5. Section 503.4 discusses resident and family groups. An ombudsman attends a resident or family council meeting by ____________________ only.

Section 600 Consultations and Cases

1. Section 602.1 states some complaints are inappropriate for ombudsman activity. What are examples of complaints an ombudsman should not investigate?

   ____

   ____

2. In Section 602.2, what does it say an ombudsman should explain to a complainant who wishes to remain anonymous?

   ____

   ____

3. Section 602.3 explains an ombudsman should respond to a complaint within two business days or sooner if circumstances appear urgent. What complaints take priority over others?

   ____

   ____

4. According to Section 602.4, what should the ombudsman discuss with the resident?

____

____

5. Section 603 describes the investigative process. What questions should an ombudsman ask to determine facts about the issue?

____

____

6. Section 604 describes actions an ombudsman can take toward the resolution of a complaint. What is the first action?

____

____

Section 700 Reporting

1. In Section 700, what are some purposes of reporting?

____

____

2. In Section 700, what form is used to collect information from volunteers?

____

3. According to Section 701.2, to be considered active in a quarter, what criteria must an ombudsman meet?

____

Section 800 Records

1. According to Section 802, three signed forms must be included in all certified ombudsman records. What are they?

   - ____
   - ____
   - ____

2. Section 802 describes what must be in a certified ombudsman file to document continuing education (CE). What should CE documentation include?

   ____

   ____

3. According to Section 802.2, what notes are included in ombudsman case records?

   ____

   ____

Section 900 Disclosure of Confidential Information

1. According to Section 902, what does confidential information include and not include?

   ____

   ____

2. In Section 903, it states confidential information may only be disclosed according to the Older Americans Act. Why is it important for an ombudsman to keep information confidential?

   ____

   ____

3. According to Section 904, what are some situations in which an ombudsman might need to orally disclose confidential information?

   ____

   ____

4. Section 905.2 describes the disclosure process when a complaint is filed on behalf of a resident who does not have a Power of Attorney. What should ombudsmen do once they determine it is necessary to disclose confidential information?

   ____

   ____

5. According to Section 905.3, when responding to a request for information about a resident's health condition, what procedure should an ombudsman follow?

   ____

   ____

Section 1000 Legal Counsel

1. Certified ombudsmen and ombudsman interns are provided legal counsel, free of ___________________ of interest, for legal representation and consultation in the performance of their official ____________.

2. Section 1001.2 describes under what circumstances an ombudsman consults with the SLTCO regarding legal matters. What are these circumstances?

   ____

   ____

3. Give two examples of appropriate legal resources to provide a resident or their legal representative.

   ____

   ____

4. Give one example of a legal resource a CO should never provide to a resident.

   ____

Section 1100 Volunteer Management

1. According to Section 1101.1, what is the definition of an ombudsman volunteer?

    ____

    ____

2. Section 1102.2 describes actions for which a CVO must get approval from the MLO. What are some examples of these actions?

    ____

    ____

3. In Section 1103.1, a volunteer who does not wish to investigate complaints may do what?

    ____

4. In Section 1103.3, what does a CO agree to by signing the CO application?

    ____

    ____

5. According to Section 1104.3, a CO can request alternate CE. What must happen prior to using these resources for CE credit?

    ____

    ____

6. Section 1105.1 describes the certification process upon completion of certification training. What are the steps for certification after the MLO recommends the volunteer to the SLTCO?

    ____

    ____

7. According to Section 1105.2, the LTCOP may recommend decertification if a CO does what?

    ____

    ____

8. Section 1106.3 describes the evaluation process for each CVO. What is one purpose of the annual evaluation?

____

9. In Section 1108, what are two possible grounds for decertification of a CVO?

____

____

Section 1200 Other Required Documents

- Program Agreement between the LTC Ombudsman Program and Regulatory Services – Signed
- Memorandum of Understanding with DFPS Adult Protective Services – Signed