



Annual Report

State Fiscal Year 2023

**State Long-Term Care
Ombudsman Program**

November 2023

Overview

The Office of the State Long-Term Care Ombudsman is independent within the Texas Health and Human Services (HHS) to ensure the office fulfills its advocacy function for residents of nursing facilities and assisted living facilities (ALFs). This report is required by Section 101A.262 of Title 6 of the Texas Human Resources Code, [Chapter 101A](#), Subchapter F.¹ It is due on November 1 of each even-numbered year to inform the public of the work of the State Long-Term Care Ombudsman Program (Ombudsman Program) on behalf of residents. The report includes information and findings relating to the problems and concerns of residents and recommendations to solve the problems, resolve the concerns, and improve the quality of the residents' care and lives.

Federal law and regulation also require an annual report by the Ombudsman Program. Title 45 of the Code of Federal Regulations, Section 1324.13(g) requires that the report describe program activities and analyze program data; evaluate resident problems and complaints; identify problems or barriers to resolving complaints; make policy, regulatory, and legislative recommendations; analyze the success of the program; and describe barriers that prevent the optimal operation of the program.²

Mission

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

Functions

The purpose of the Ombudsman Program is to protect the health, safety, welfare, and rights of residents. Ombudsmen:

¹ [Ombudsman Program State Statute](https://statutes.capitol.texas.gov/Docs/HR/htm/HR.101A.htm)
(<https://statutes.capitol.texas.gov/Docs/HR/htm/HR.101A.htm>)

² [Ombudsman Program Federal Regulation on Annual Report](https://www.ecfr.gov/current/title-45/part-1324#p-1324.13(g))
([https://www.ecfr.gov/current/title-45/part-1324#p-1324.13\(g\)](https://www.ecfr.gov/current/title-45/part-1324#p-1324.13(g)))

- 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, and rights of residents;
- Provide services to protect the health, safety, welfare, and rights of residents;
- Provide residents with information about the Ombudsman Program, their benefits, rights, and services;
- Make regular visits to residents in facilities and respond to requests received in person, and by telephone, mail, and email;
- Represent the interests of residents before governmental agencies, and pursue administrative, legal, and other remedies to protect residents;
- Advocate for system improvements to the media and state and federal decision-makers; and
- Coordinate with and promote citizen organizations and councils.

Staff and Volunteer Ombudsmen

Staff and volunteer ombudsmen must complete 36 hours of initial certification training and 18 hours of annual continuing education.

Staff

The Ombudsman Program is staffed with 112 ombudsmen, some of whom work part-time. On average, one staff ombudsman is assigned 37 facilities to visit, respond to requests for assistance, and investigate and resolve complaints. A 1995 Institute of Medicine study recommended one full-time equivalent (FTE) staff per 2,000 licensed facility beds.³ With 87 FTEs in local offices responsible for 3,205 facilities statewide, on average, one staff ombudsman is responsible for over 2,500 licensed beds and more when staff vacancies exist.

Volunteers

In 2023, volunteer ombudsmen donated 8,853 hours. Using the Independent Sector's value of a volunteer hour in Texas of \$29.86, that equals \$264,351 in donated time.⁴ The number of volunteers at year end are shown in the table below.

Year End	Number of Active Volunteers
2019	386
2020	347
2021	268
2022	290
2023	290

³ Institute of Medicine. 1995. [Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act](#). Washington, DC: The National Academies Press (<https://doi.org/10.17226/9059>)

⁴ [Value of Volunteer Time Report | Independent Sector Resources](#)

Visits by an Ombudsman

The purpose of an ombudsman visit is to monitor residents' health, safety, welfare, and rights; communicate with residents, which may involve receiving, investigating, and resolving a complaint; and observe conditions of the facility. When conducting a visit, volunteer and staff ombudsmen must comply with facility requirements related to infection control.

Visits are typically unannounced to the facility staff. Conversations between an ombudsman and a resident or complainant are confidential. While onsite, ombudsmen may attend care plan meetings when invited by a resident, attend resident and family council meetings when invited by a council, and train facility staff upon request of a facility. Numbers of visits by facility setting are provided in the table below.

Type of Facility	Number of Licensed Facilities ⁵	Number of Ombudsman Visits
Type A and C ALF	406	2,289
Type B ALF	1,610	9,222
Nursing Facility	1,189	14,283

Information and Assistance

Ombudsmen provide information and assistance (I&A) to residents and others who seek information about the Ombudsman Program, residents' rights, and facility requirements. In 2023, ombudsmen reported over 28,000 instances of I&A to residents and family members of residents, and over 4,000 instances of I&A to facilities.

Meetings, Hearings, Training, and Survey Participation

In 2023, ombudsmen:

- Attended almost 900 care and service plan meetings for residents.
- Attended over 600 resident council meetings and 20 family council meetings.

⁵ Data as of Sept. 2023 from [Long-Term Care Regulation](#)

- Participated in 165 fair hearings for appeal of a resident discharge or Medicaid denial.
- Trained 84 facilities.
- Participated in over 1,200 Long-Term Care Regulation facility surveys.

Complaints

In 2023, ombudsmen investigated 1,393 complaints regarding ALFs and 7,196 complaints regarding nursing facilities. An ombudsman complaint investigation and resolution is typically completed within two months.

Who Makes Complaints

Anyone may make a complaint to an ombudsman if it relates to the health, safety, welfare, or rights of a resident. More than half of complaints received are voiced by a resident. A family member, guardian, or friend is the next most likely source of a complaint, followed by an ombudsman. The table below shows the type of complainant and the percent of complaints made by them.

Percent of Complainants by Type

Rank	Complainant	Percent
1	Resident	64%
2	Family, Guardian, or Friend	19%
3	Ombudsman	10%
4	Facility Staff	3%
5	Concerned Person or Group	2%
6	Unknown	2%

Assisted Living Facilities

Ombudsmen verified 93% of all complaints received and resolved 85% to the satisfaction of the complainant.⁶ The table below explains the five most common complaints received about an ALF.

⁶ Verified means that after observation, interview, and record review, the ombudsman determines that circumstances described in the complaint are generally accurate.

2023 ALF Complaints

Rank	Complaint Description	Number Received	Percent Verified	Percent Resolved
1	Food Services	105	96%	87%
2	Problems with Medications	103	83%	87%
3	Housekeeping, Laundry, Pest Control, and Infection Control	101	99%	89%
4	Involuntary Discharge	82	100%	82%
5	Unmet Requests for Help	65	86%	86%

Issue: Indoor Air Temperatures Affect Health and Safety

The temperature inside an ALF is closely related to residents' health and safety, whether outdoor temperatures are extremely hot or cold. If a facility has inadequate air conditioning (AC) or heating, it may affect residents' activity and socialization and can have serious health effects. An example is described below.

In a large Type A facility, recurring and prolonged AC problems were affecting residents' health and quality of life. Residents say the current problem was ongoing for three months. Small ACs are installed in resident rooms but the AC doesn't work in the public areas of the building where they dine and socialize. One resident goes to the library most days to seek a cool environment and be around other people. Another resident said she couldn't enjoy activities any longer because of the heat. After a meal, residents return to their room in clothes and undergarments that are wet with sweat. Another resident went to the emergency room for blood pressure changes and shortness of breath exacerbated by the heat. Residents can't walk far in the hallways due to the heat. Indoor air temperatures were measured in the mid and upper 80s.

Issue: Immediate Threats to Health and Safety

Our office is concerned about serious violations occurring in ALFs. We are aware of over 100 violations that occurred in ALFs in 2023 involving an immediate threat to health and safety of residents, including violations involving staffing and supervision of residents and violations involving abuse.

Examples of these situations are described below, and a recommendation related to immediate threats is made on page 26.

Example: Locking Residents in Rooms

A large Alzheimer’s certified ALF had more than 20 residents. Facility staff reported they lock each resident’s door at night to prevent the residents from wandering into other residents’ rooms. Only one staff member had the room keys. Two residents could not independently exit their rooms in the event of an emergency. The facility staff did not have access to a key or the means to communicate with the facility staff person with a key to observe residents and determine they were safe.

Example: Insufficient Nighttime Staffing

A two-story Type B ALF routinely had just two staff available at night though several residents living on the second floor use a wheelchair and would need help using stairs to evacuate in an emergency. The facility had a device to manually evacuate via stairs using a chair, but staff weren’t aware of it and didn’t know how to use it. Several residents on the first floor required a two- or three-person assist to get out of bed.

Example: Insufficient Staffing in Alzheimer’s Care Unit

For approximately two hours, a resident with dementia was not monitored in the facility’s interior courtyard when outside temperatures were over 100 degrees. The resident was found lying in the grass, vomiting.

Nursing Facilities

Ombudsmen verified 94% of all complaints received and resolved 88% to the satisfaction of the complainant. The table below explains the 10 most common complaints received about a nursing facility.

2023 Nursing Facility Complaints

Rank	Complaint Description	Number Received	Percent Verified	Percent Resolved
1	Unmet Requests for Help	624	96%	89%
2	Involuntary Discharge	584	97%	83%
3	Food Services	477	94%	89%
4	Problems with Medications	370	92%	89%
5	Assistance with Personal Hygiene	353	94%	89%
6	Dignity and Respect	348	95%	87%
7	Personal Property Lost, Damaged, or Stolen	337	90%	84%
8	Housekeeping, Laundry, Pest Abatement, and Infection Control	313	94%	91%
9	Assistive Devices and Equipment	280	96%	89%
10	Other Rights and Preferences, Including Choice, Religion, and Voting	261	96%	91%

Staffing Is the Underlying Cause of Many Complaints

Of the 10 most frequent complaints received, complaints about unmet requests for help, personal hygiene, food services, dignity and respect, housekeeping and infection control, and medications relate to an insufficient number of staff.

Understaffing also leads to residents having more unmet behavioral health needs, which a facility may try to solve with discharge rather than meet its requirements.

Example: Listening to the Resident's Experience Identifies and Solves Problems

A resident told her ombudsman that when she pulls her call light in the evening, staff will come in and turn it off, telling her they will be right back but do not return. This results in the resident going to the bathroom on herself. The resident was nervous about using her name with the complaint and gave the ombudsman permission to

speak to the facility administrator about her concern without identifying her. The ombudsman shared the problem with the administrator, who took action by giving training to all staff on the expectations for all staff to respond to call lights. The administrator intensely monitored the situation for several weeks. On our next facility visit, the resident said the administrator had been visible and asking about staff response times to call lights. The resident reported that wait times were much improved and she felt relief that her concern was recognized and addressed.

Representing Residents in a Discharge Appeal

Many residents rely on an ombudsman to help when a facility notifies them of its plan to discharge the resident. Ombudsmen can represent residents in their discharge appeal, helping a resident explain how their needs can be met at the facility or how the facility failed to meet its legal requirements. Because discharge continues to be a top complaint, we recommend three actions to address the issue on page 19.

Councils Can Solve Important Problems

The resident council president of a facility asked their ombudsman for information about residents' rights and facility responsibilities related to food and dining. The president explained there were problems with the food quality and service and that the council planned to request a meeting with the facility's new dietary manager. The president asked the ombudsman to join them.

The resident council president, vice president, and secretary, ombudsman, and the facility's dietary manager sat down to discuss the issues. The ombudsman reviewed rules related to food and dining. Council leaders described the specific meals that were universally disliked by residents. Council leadership also described problems with the kitchen staff serving the wrong items, like dislikes and allergies, which are listed as each resident's needs and preferences.

The dietary manager committed to speaking with staff about adhering to each resident's diet plans and replacing meals that were not liked by residents. Council leaders and the dietary manager reviewed the seasonal rotating menu and changed meals that were

not liked by residents. They agreed to meet every three months to check on progress.

Residents reported improvement in the quality of the meals and say that kitchen staff are following residents' dietary needs and preferences. The residents are now meeting weekly with the dietary manager to talk about the quality of meals provided and keep the lines of communication open.

Critical Thinking and the Root Cause of a Problem

Ombudsmen must identify a complaint and assign it a code based on the problem that is described by a complainant. During investigation and resolution steps, thinking critically about information received and seeking to understand *why* something is happening is essential to finding a solution that works.

Example: Not Getting a Shower

A resident had lived in a nursing facility for one week when he met his ombudsman. He reported that in one week he'd only had one shower. As she investigated, the ombudsman learned the facility had offered showers and the resident refused them. Facility staff said they documented his refusal of showers in his medical record, but the ombudsman found no evidence that facility staff sought information about why he had declined. So, the ombudsman spoke with the resident, asking him why he'd declined showers when they were offered. He explained that he did not feel comfortable with the young woman who offered help because the resident was a similar age. He asked instead for a male aide or older female to assist him. The Director of Nurses updated the resident's care plan and he immediately received help according to his stated preferences.

Personal Needs Allowance Increased to \$75 for Nursing Facility Residents

For the majority of residents who pay for their care with Medicaid, residents say their personal needs allowance, or PNA, is important to their quality of life. Residents, ombudsmen, other advocates, and nursing facility activities staff worked during the 88th regular session to elevate residents' voices about a needed increase in PNA. Residents wrote and dictated letters for ombudsmen to send to their legislators and provided testimony in support of a raise.

Residents spend their money on things the facility doesn't provide, including cell phone minutes, haircuts, favorite drinks, a meal out, and personal care products. For example, because many facilities only provide all-in-one soap and other institutional products, residents buy shampoos and lotions. Residents also buy their own pullup-style adult briefs for dignity and independence because some facilities won't buy them or frequently run out of supplies. And, residents must buy their own clothes and shoes, which are destroyed quickly by industrial washing and lost in the laundry.

Residents and their supporters are excited that the 88th Texas Legislature passed HB 54, which increases the PNA from \$60 to \$75 each month, effective Sept. 1, 2023. HHS reports that in January 2024, it expects to have the increase implemented through its State Medicaid Plan, meaning residents will see the increase take effect on Jan. 1, 2024. The Ombudsman Program is tracking HHS' progress towards implementation to keep residents informed and advocate as needed.

Ombudsmen learned helpful lessons from our advocacy to support a PNA increase, but most important among them is to not underestimate residents and their ability to engage on issues that matter to them.

Comments on the Long-Term Care Landscape

This section includes comments related to the long-term care landscape. These conditions inform our work and relate to recommendations in the report.

COVID-19 Continued Effects

COVID-19 has become a way of life in long-term care facilities. Some restrictive policies implemented in the first years of COVID-19 have diminished and others are incorporated into facilities' infection and prevention and control policies.

Locked Exterior Doors

One notable facility practice is locking its exterior doors, which either requires a code to enter and exit or a staff person to monitor and permit entrance and exit by staff, visitors, and residents. We recognize that security at the entrance and exit of a facility can be an important safety feature. When wait times are longer than a couple of minutes, ombudsmen view this delay as limiting a resident's right to leave the facility and may violate other requirements such as an ombudsman's immediate access to the facility and a resident's right to visitation and self-determination.

Long COVID

Long-term effects from a COVID-19 infection are commonly known as Long COVID. Symptoms vary and may include general fatigue, respiratory and heart problems, neurological symptoms, and digestive problems. Experts recommend that older adults and adults with disabilities who had a COVID-19 infection are screened for Long COVID, which means that most residents of nursing facilities and ALFs should be screened for the condition. To prepare for a Long COVID evaluation, the Centers for Disease Control and Prevention (CDC) recommends that the patient summarize their experience with COVID-19 and any symptoms they experienced after their initial infection. After diagnosis of Long COVID, the CDC recommends keeping a dated journal of symptoms and treatments.⁷

We recommend that nursing facility and ALF residents are screened for Long COVID at admission, four weeks after infection, upon a change in condition after infection, and once a year.

⁷ [CDC Long COVID](https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html) (https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html)

Long-Term Care Regulation Surveyors

We described in the FY21-22 report concerns about the lack of survey positions funded to investigate complaints and conduct licensing inspections for more than 2,000 ALFs statewide. The 88th Texas Legislature appropriated new funds in Strategy 8.1.1 of the HHS 2024-25 legislative appropriations request, which funds more surveyors to conduct surveys and complaint investigations in licensed-only facilities like ALFs and day activity health services. We thank legislators and the Office of the Governor for its support of this critical service to protect ALF residents.

Nursing Facility Enforcement

Texas has the most nursing facilities in the U.S.⁸ In total numbers of serious deficiencies and total numbers of civil money penalties imposed, Texas ranks 1st and 2nd in the U.S.

The Kaiser Family Foundation, or KFF, reports on CMS data related to nursing facilities and states' enforcement of federal regulations.⁹ It analyzes enforcement and other data and presents it by facility as a way to compare and rank states. In that context, Texas ranks 26th for its percent of facilities with serious deficiencies causing actual harm. It ties for 19th with five other states in the percent of facilities with any deficiency cited and ties for 25th with seven other states for the percent of facilities with no deficiency cited. Texas ranks 13th in the percent of facilities with a federal civil money penalty imposed and 37th in the average number of deficiencies cited per facility. These data indicate that Texas is about average in its regulatory enforcement actions when compared with other states.

Behavioral Health of Nursing Facility Residents

A national Center of Excellence for Behavioral Health is now in place to support nursing facilities with specialized training and a direct consultation phone line. This is a promising service funded by the federal government. It focuses on residents with serious mental illness, substance use disorder, and co-occurring disorders. Ombudsmen are working to build awareness of the new Center for Excellence and encourage nursing facilities to use the free services to support residents with behavioral health needs.

⁸ [CMS QCOR Survey Data](#)

⁹ [State Health Facts - Nursing Facilities | KFF](#) Data as of Oct. 27, 2023

Unfortunately, this service is not intended for residents with a primary diagnosis of dementia. On page 25, we recommend action that the Texas legislature could take to address this unmet need.

Low Nursing Facility Occupancy

With over 83,000 residents, Texas has the 3rd highest number of nursing facility residents in the country, behind California and New York.¹⁰ Based on data from the Centers for Medicare and Medicaid Services (CMS) and reported on by KFF, the average occupancy rate in the U.S. is 75%.¹¹ Texas facilities have some of the lowest occupancy rates in the U.S. with an occupancy rate of 64%.

Long-Term Care Workforce

In 2023, the 88th Texas Legislature passed legislation and funding to implement loan repayment for nurses. Senate Bill 25 (88th regular legislative session) supports loan repayment for nurses and nurse faculty and grants to nurse education programs. Funding nurse education is expected to increase the number of nurses prepared to work in Texas and improve nurse staffing in a variety of clinical settings. We thank legislators and the Office of the Governor for its support of this bill.

¹⁰ [The Payroll Based Journal \(PBJ\) Nurse Staffing and Non-Nurse Staffing Datasets](#) at data.cms.gov and [Long Term Care Community Coalition Analysis of Nursing Home Staffing Data](#)

¹¹ [State Health Facts - Nursing Facilities | KFF](#) Data as of Oct. 27, 2023

A Resident's View of Staffing

Cindy N. is a nursing facility resident from Mesquite who contacted the State Long-Term Care Ombudsman with concerns about the lack of staff in nursing facilities. She gave permission for the content that follows to be shared in this report.

I'd like to share with you what it's like to be a resident in a nursing home and experience a lack of staff. Decades ago, my daughter and I were diagnosed with multiple sclerosis. We were cared for by my husband until his sudden death in 2017. We hired part-time help to care for us at home, but because of the cost and lack of accessibility of our home, we entered long-term care.

My current nursing home houses 130 people. I live on a hall with 37 other residents and each room has two residents that share a common bathroom and shower. During our monthly resident council meetings, the number one concern of residents is staff shortages.

The most important department is our nursing care, especially certified nurse aides (CNAs). We rely on our CNAs to provide total care for us 24 hours a day, which means they clean, dress, change, shower, and lift us from bed to wheelchair. Our facility is hiring aides who have little or no training. During staff shortages, showers are cancelled, diapers remain dirty and we have to stay in our beds, which is unhealthy and depressing. Some days I wait two hours for an aide to answer the call light and change me. If we're lucky enough to have the same aide daily, they learn our routine and we don't have to constantly explain our needs. Most of these aides are trying to do their best to get the job done, but because they have so many to care for, they feel defeated and overwhelmed and leave our facility.

A medication aide is responsible for 60 residents and a nurse cares for 38 residents. If they don't show up for work, there is a wait for a replacement and medications and nursing duties are delayed.

An example of the effects of short staffing of nurses happened this winter when my facility experienced an outbreak of a stomach virus. One night I got that funny feeling in my throat and stomach. I turned on the call light, waited 15 minutes, had my daughter call

the nurses station to ask for help, and another 15 minutes went by and I vomited on myself three times. Finally, an aide came in and spent 30 minutes cleaning me and my bed. If there was a staffing standard, my light would have been promptly answered, a receptacle given, and we could have avoided the messy clean up.

I've seen and heard residents who are in bed or a wheelchair and need help, try to get the attention of a staff member, and with no response, they try to do it themselves and fall and get hurt. X-rays, constant monitoring, and a trip to the hospital require more work for staff and more costs to the system. A staffing standard will reduce accidents and save money.

When my facility is short-staffed in dining services, the meal is delayed and our meal ticket may not get checked for food consistency, allergies, and supplements. Staff may not be available to help feed and supervise residents, especially on weekends.

When my facility is short-staffed in housekeeping, I have to wait for towels and bed linen to arrive before receiving my shower and if nothing arrives, my shower is cancelled. Short staffing in the kitchen means my meal will arrive late, cold and plated on a paper plate with plastic utensils.

So many residents do not have anyone to help them maneuver through this stage of life, and they totally depend on their caregivers for physical, emotional, and spiritual support. A strong minimum staffing standard will improve the lives of nursing staff working in all facilities, dramatically improve the lives of residents, and lower the costs caused by staff shortages.

Cindy N.

Recommendations

Problem: More Staff Ombudsmen Are Needed

Long-term care ombudsman services are delivered through contracts between HHS and agencies housing area agencies on aging (AAAs). Ombudsmen and the agencies that employ them report insufficient funding to operate at an optimal level. Since 2018, \$1.8 million in state revenue has been allocated for Ombudsman Program operations. The program receives less than \$1.5 million in federal funds for the exclusive use on ombudsman services. This results in AAAs dedicating an additional \$2.6 million in other federal funding meant for serving older Texans in a variety of important ways. As described on page 3, the ratio of staff ombudsmen to licensed bed capacity exceeds by 500 beds the recommended level of one staff ombudsman for every 2,000 licensed beds. This means ombudsmen spend less time with residents than needed to resolve problems.

Solution: Increase state funding for the Long-Term Care Ombudsman Program

Additional general revenue is needed to sustain high-quality ombudsman services. Estimating the cost of salaries and travel expenses at \$100,000 per full-time employee, an additional \$2.8 million in general revenue would allow AAAs to hire additional ombudsmen and increase hours of part-time ombudsmen at the equivalent of 28 full-time positions. These changes would mean more staff ombudsman eyes and ears in facilities, observing conditions, investigating complaints, and working to resolve complaints in lieu of regulatory action.

Problem: Nursing Facilities Continue to Not Comply With Discharge Rules

Involuntary discharge from a nursing facility continues to be a top complaint received in the Ombudsman Program. With federal funds available through Sept. 2025, we established a Discharge Rights Ombudsman position within the Office of the State Long-Term Care Ombudsman. Analysis by the Discharge Rights Ombudsman finds that facilities are inconsistently sending notices to ombudsman office locations and use facility notice templates with errors. This means that residents are not receiving proper notice of their discharge and appeal rights.

A 2021 U.S. Office of Inspector General report about nursing facility-initiated discharges includes recommendations to CMS and state long-term care ombudsman

programs to better understand the problem and address it.¹² Available national data show that discharge is the top national complaint received by state long-term care ombudsman programs for the past 11 years.

Facilities are willing to “take the hit,” meaning accept the costs of a citation from HHS, for a violation of discharge requirements. A reason enforcement doesn’t work is the violation often doesn’t come with administrative penalties or other effective deterrents.

Solution 1: Authorize an HHS portal where discharge notices must be filed.

In response to the prevalence of nursing facility discharge complaints in other states, state agencies developed a portal for facilities to upload or generate a discharge notice. Access to the portal is available to the Office of the State Long-Term Care Ombudsman, State Survey Agency, and Office of Fair Hearings to efficiently respond to the notice or take action such as processing a fair hearing request. A portal implemented in Texas would help facilities provide accurate and standard notice to a resident, meet notice requirements to the ombudsman, and efficiently initiate a fair hearing request on behalf of a resident.

Solution 2: Fund a Discharge Rights Ombudsman to help ombudsmen respond to discharge complaints.

We request that the Texas legislature authorize one full-time position and funding for an Ombudsman IV classification within the Office of the State Long-Term Care Ombudsman. With ongoing funding, we can leverage the work accomplished by this specialized ombudsman and continue our analysis, training, and direct advocacy by the Discharge Rights Ombudsman.

Solution 3: Increase the penalty for discharge violations.

Modify Health and Safety Code §242.066 to establish a minimum daily fine for a discharge violation. If Long-Term Care Regulation determines that a violation of the discharge requirements occurred that resulted in the improper expulsion of a resident from the facility, require HHS to impose a minimum penalty of \$5,000 per day that the resident is denied return to the facility.

¹² U.S. Office of Inspector General, “[Facility-Initiated Discharges in Nursing Homes Require Further Attention](https://oig.hhs.gov/oei/reports/OEI-01-18-00250.asp)”, Nov. 2021, OEI-01-18-00250, <https://oig.hhs.gov/oei/reports/OEI-01-18-00250.asp>

Problem: Understaffing of Nursing Facilities

Staffing is an essential element of quality care. Research and reporting show that facilities will understaff to increase profits, which results in residents going without needed care.¹³ A 2023 study on nursing facility staffing found a strong relationship to quality and safety when nursing facilities are staffed with CNAs for 2.44 hours per resident day (HPRD) or higher. The report also found that nursing facilities with higher staffing perform better on facility-reported quality and safety measures and Registered Nurse (RN) staffing had the strongest effect of quality and safety.¹⁴ A 2016 study found that to avoid omitted care that exceeds 10% daily, CNAs should be staffed at 2.8 HPRD for residents with lower care needs and 3.6 HPRD for residents with high care needs.¹⁵

State policies that pay the same for poorly staffed facilities as well-staffed facilities encourages understaffing. On average, nursing facilities with lower staffing levels have lower costs because the facilities spend less on staff.¹⁶ Texas has among the lowest nursing facility staffing rates in the country, according to facility-reported payroll data to CMS.¹⁷ The CMS Care Compare site lists Texas's average total nurse staffing hours, which includes RNs, Licensed Vocational Nurses, and CNAs, is 3.32 HPRD, with between 85 and 87% of facilities rated as one- or two-stars.¹⁸ In a 2022 issue brief, analysis of state staffing policies and reimbursement rates by MACPAC concluded that, "Even if a facility receives adequate overall payment from the state, it may not allocate that revenue to direct care staff if it does not have an incentive to do so. To counteract these incentives, several states have adopted minimum

¹³ Harrington C, Schnelle JF, McGregor M, Simmons SF. [The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes](#). Health Serv Insights 2016; Rau, Jordan, [Care Suffers as More Nursing Homes Feed Money into Corporate Webs](#) December 31, 2017; and [Private Investment Homes Sometimes Differed from Others in Deficiencies, Staffing, and Financial Performance](#). Government Accountability Office (GAO-11-571): July 15, 2011.

¹⁴ [Abt Associates Nursing Home Staffing Study](#) June 2023

¹⁵ Schnelle, et al. [Determining nurse aide staffing requirements to provide care based on resident workload: A discrete event simulation model](#). J. American Medical Directors Association November 2016.

¹⁶ [MACPAC Issue Brief: Estimates of Medicaid Nursing Facility Payments Relative to Costs](#). January 2023 and [MACPAC Report to Congress on Medicaid and CHIP, Principles for Assessing Medicaid Nursing Facility Payment Policies](#). March 2023.

¹⁷ [The Payroll Based Journal \(PBJ\) Nurse Staffing and Non-Nurse Staffing Datasets](#) at data.cms.gov and [Long Term Care Community Coalition Analysis of Nursing Home Staffing Data](#)

¹⁸ [CMS Nursing Home Care Compare](#) retrieved October 2023

staffing standards that exceed the federal requirements and have designed Medicaid payment methods to incentivize greater spending on staffing.”¹⁹

According to 2023 facility-reported payroll data to CMS, 25.6% of nursing facilities in the U.S., and 10.4% in Texas, are currently meeting or exceeding 4.1 hours of daily direct care staff time to each resident. Texas nurse staffing ranks 50th out of 52 states, DC, and Puerto Rico. Only Illinois and Missouri rank below us.²⁰

Solution 1: Require a percentage of nursing facility Medicaid reimbursements to pay for direct care staff.

For nursing facilities that participate in the Texas direct care staff enhancement program, 85% of its add-on reimbursement must be spent on direct care staffing. We recommend that a comparable percentage is applied to the Medicaid daily rate reimbursements that all Medicaid-certified facilities receive, using the enhancement program definition of direct care staff. Outcomes should be measured by analysis of the CMS payroll-based journal dataset.

Solution 2: Set a minimum direct care staffing ratio in nursing facilities.

We recommend a minimum of 4.1 hours of direct care staff time is given to each resident, seven days a week. A 2001 study by CMS found that this is the minimum amount of staff time to prevent adverse outcomes for residents.²¹

Problem: ALF Alzheimer’s Care Has Weak Staffing Standards

Because only 33 nursing facilities are Alzheimer’s certified, ALFs serve as the primary setting offering Alzheimer’s certified care in Texas. A total of 712 ALFs are Alzheimer’s certified.²² The only minimum staffing requirement in an Alzheimer’s certified ALF requires two staff immediately available for a facility with 17 or more

¹⁹ [MACPAC Issue Brief: State Policy Levers to Address Nursing Facility Staffing Issues](#). March 2022

²⁰ [Long Term Care Community Coalition Analysis of Nursing Home Staffing](#) retrieved October 2023

²¹ Centers for Medicare & Medicaid Services, Abt Associates Inc. Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes. Report to Congress: Phase II Final. Volumes I–III. Baltimore, MD: CMS, 2001.

²² Data as of Sept. 2023 from [Long-Term Care Regulation](#)

residents.²³ Licensed capacity of these facilities range from four to 96 beds with an average of 30 beds per facility.

Residents with Alzheimer's disease and related dementias experience a variety of symptoms and require individualized interventions. Common care needs that are staff-intensive for residents with Alzheimer's disease include:

- supervision to avoid elopement or injury
- reminders to use a toilet
- encouragement or help eating
- frequent and personalized activities to avoid boredom
- redirecting distressing or negative behavior

Solution: Set a minimum direct care staffing ratio in Alzheimer's certified ALFs

Appropriate minimum staffing ratios provide residents the supervision, quality activities, and health care services they need. An Alzheimer's certified nursing facility must have one staff for every six residents during the daytime, one staff for every 10 residents in the afternoon to evening, and one staff for every 18 residents overnight. A staffing standard for Alzheimer's certified ALFs that is comparable to an Alzheimer's certified nursing facility would protect residents and ensure they get quality care and adequate supervision.²⁴

Problem: Emergency Response Plans Are Not Reviewed and Plans Are Not Known to the Public

Long-term care facilities regularly experience natural disasters like hurricanes, wildfires, and flooding and other emergencies like infectious disease outbreaks and active shooters. All ALFs and nursing facilities are required to maintain an all-hazards emergency preparedness and response plan. These plans may be reviewed by HHS when a surveyor is onsite, but a comprehensive review of emergency preparedness plans by HHS is not routinely conducted. The only way for the public to know what a facility's emergency plan includes is to request it from the facility.

²³ Title 26 Texas Administrative Code, Chapter 553, Section 553.305

²⁴ Title 26 Texas Administrative Code, Chapter 554, Subchapter W, Section 554.2208

Solution 1: Require ALFs and nursing facilities to annually submit emergency plans to HHS.

Providers are accustomed to submitting reports to HHS as a condition of licensure. Facilities should be required by statute to annually submit an emergency response plan to HHS for review. Having the plans at HHS will be useful for state emergency planning and response.

Solution 2: Require HHS Long-Term Care Regulation to annually review facility emergency plans and publish results.

With a modest allocation of positions, HHS could hire staff to review all emergency plans and publish key details from each plan on the HHS website. Public information should include which facilities have an onsite generator and what systems the generator is capable of powering.

Problem: Many Facilities Do Not Have Generators

Natural disasters and other emergencies present great risk to long-term care residents. The ability to heat or cool a facility during an emergency saves lives in long-term care facilities. In August 2022, HHS released a report on generator availability and usage in ALFs and nursing facilities.²⁵ Based on a survey of providers, 99% of nursing facilities and 47% of ALFs reported having an onsite generator. Over half of nursing facilities reported the system could power air conditioning and heating. For ALFs with a generator, 63% reported the system could power air conditioning and 67% reported the system could power heating. Only 38% of small ALFs, which are licensed for fewer than 17 beds, reported having a generator.

Solution 1: Require large ALFs and all nursing facilities to maintain safe temperatures during an emergency with backup power.

ALFs with a licensed capacity of 17 or greater and all nursing facilities should be required to maintain safe temperatures, as defined by rule, when power is lost. We recommend that these facilities have onsite capabilities to generate emergency power by:

- having enough fuel, or an alternative power source with sufficient capacity to operate, for 72 hours;
- maintain safe temperatures in an area in the facility of sufficient size to maintain residents safely at all times; and
- for a facility that maintains a separate area in the facility with a locking device as defined by commission rule to restrict a resident's ability to exit the facility, maintain a separately powered area within the locked area.

Solution 2: Issue grants to facilities to pay for generators.

We recommend that the Texas legislature establish a grant program for facilities in need of a first-time or replacement generator. We encourage the legislature to consider factors such as whether residents of the building pay for their care using SSI and SSDI benefits, whether the facility participates in the STAR+PLUS waiver program, and other factors that demonstrate the greatest financial need. We encourage the legislature to seek input from stakeholders, including the Texas Governor's Committee on People with Disabilities, with an interest in the issue.

²⁵ [Generator Availability in Nursing Facilities and Assisted Living Facilities](https://www.hhs.texas.gov/regulations/reports-presentations) Aug. 2022, <https://www.hhs.texas.gov/regulations/reports-presentations>

Problem: Behavioral Health Needs of Nursing Facility Residents With Dementia Are Not Met

When a facility admits a resident into their care, the facility agrees to meet the person's needs. Behavioral health needs too often go unmet with facility staff not giving personalized care and not knowing how to respond to a person's symptoms of dementia. If common and predictable behavioral symptoms associated with dementia are not managed by facility staff, they escalate. As the problem goes unaddressed, a resident's unmet needs can trigger a revolving door of discharge from facilities and transfers in and out of hospitals. A resident's family supports and cognitive strengths tend to decline as multiple discharges and transfers happen.

Nursing facility rules and regulations already require a facility to plan and provide individualized and trauma-informed care. In our experience, enforcement of these requirements is not effective at curtailing the problem and happen too late to prevent harm.

Providing good care to a person with dementia requires ample staffing for supervision, activities, and healthcare delivery. Residents with dementia benefit from individualized care given by the same caregivers. Meeting the staffing requirements for Alzheimer's certification in rule has costs that providers say are not covered by standard Medicaid reimbursement because many residents with dementia are otherwise relatively healthy. Staffing requirements in the Alzheimer's certification rules ensure competent and sufficient numbers of staff deliver care but only 33 nursing facilities are Alzheimer's certified.

Solution: Implement a rate enhancement for nursing facilities with Alzheimer's certification

We recommend that the Texas legislature authorize and fund a rate enhancement to incentivize more nursing facilities to achieve Alzheimer's certification. An enhanced reimbursement rate for Alzheimer's certified care will get more nursing facilities certified and require compliance with the staffing and training standards within these settings.

Problem: The Public Is Not Aware of Serious Violations Cited by HHS Long-Term Care Regulation

Existing nursing facility report

Certain serious violations that are cited in a nursing facility are classified as immediate jeopardy, or IJ, which means a situation where noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. Every three months, HHS publishes an IJ report on its website called the Quarterly IJ Summary Report. The report is in PDF format that includes a list of violations cited, the frequency of each citation, and whether the violation was identified from a complaint, incident, or survey. It identifies the region where the facility is located, date, purpose of visit, and describes the citation, situation, and deficient practice.

The Quarterly IJ Summary Report is limited in its use because it does not identify the name of the nursing facility associated with the citation. This means the public cannot use this report to identify a problem at a specific location or evaluate care concerns with several facilities. Because each report is published as a PDF, analysis across time or by deficiency requires significant effort.

No comparable ALF report

The most serious violations in an ALF are called an immediate threat, or IT, which means a situation that causes, or is likely to cause, serious injury, harm, or impairment to or the death of a resident. ITs are cited by LTC Regulation, but the only way to view this public information is by knowing where a problem occurred or searching each facility on the HHS website. Violations that are published on the HHS site are difficult to find and lack detail. An ALF IT Summary Report would give the public important information about facilities where serious problems occur, like those described on page 8.

Solution 1: Revise the nursing facility Quarterly IJ Summary Report.

HHS should revise its existing report to be useful for a larger segment of the public. We recommend the report is published in Excel format, sorted by year, and updated every three months. We recommend that the facility name, address, and bed capacity is included on the report and that the report is available for download.

Solution 2: Publish a quarterly report on ALF immediate threats.

We recommend that the Texas Legislature direct HHS Long-Term Care Regulation to publish an ALF Immediate Threat report with the requirements that follow.

- Publish in an Excel format on the HHS website.
- Publish every three months and sort by year.
- Identify the name and address of the facility.
- Include the facility type, licensed bed capacity, and whether the facility is Alzheimer's certified.
- Include details about the IT that are similar to those provided in the nursing facility Quarterly IJ Summary Report.
- Allow the document to be downloaded, similar to the facility list published on the HHS website.

Problem: ALF Policies Can Undermine Residents' Rights

ALF rules require a facility to set and follow its own policies. When there is a complaint about an ALF policy filed to HHS, HHS usually finds the ALF to be in compliance if the ALF has a policy and follows it. However, ALF policies can be at the detriment of free choice and other rights. For example, a resident who uses a motorized wheelchair can be charged significant non-refundable fees to use the wheelchair in the facility. Policies have also limited when a person is allowed visitors or use a telephone and set unreasonable notice requirements on a resident who wants to move out.

Solution: Prohibit ALF policies that limit a resident's right.

HHS should implement rule changes that prohibit facility policies from conflicting with a resident right. Rules should require that any limit placed on a resident right must be time-limited and determined necessary to protect the health and safety of the resident.

Problem: It Is Difficult to Know Who Owns Facilities

Knowing who owns and operates a facility licensed by the State should be easily accessible to residents, regulators, and others. Some ownership detail is collected on facility cost reporting, facility licensure applications, and change of ownership applications but HHS does not make the information available to the public. The information published on facility ownership does not show common ownership or

provide the public with information about quality care provided by a particular owner.

When facility revenues are made up of mostly tax dollars, the information should be available to the public. Management services, rent, and related businesses like a staffing agency can be subsidiaries of the same parent company, each collecting fees. These investment strategies warrant greater attention to ensure government funding goes to resident care.

Solution 1: Publish key elements of Medicaid cost reports.

Financial information reported to HHS about each Medicaid-certified nursing facility should be available to the public. HHS should analyze and report on its website key measures of financial health as part of the cost reporting process.

Solution 2: Publish clear information on corporate ownership and quality.

HHS should publish more ownership information on nursing facilities and ALFs that includes the parent company, all related companies, and any management company associated with the business. Further, it should publish quality data by common ownership and management companies on the Long-Term Care Provider Search webpage.²⁶

²⁶ [HHS provider search](#)

Major Program Activities Planned in 2024

The following Ombudsman Program activities are planned for implementation in 2024.

Revise Program Rules

We are revising program rules for the Ombudsman Program in Title 26 of the Texas Administrative Code, Chapter 88. When rules are final, revisions to the Ombudsman Policies and Procedures Manual will be made.

Training and Education

We plan to implement an updated certification training manual for new ombudsmen in training. The revised curriculum adds:

- references to Code of Federal Regulations and Texas Administrative Code, when applicable to training content, to help trainees connect ombudsman practice with facility requirements;
- iCARE infection control and prevention training, developed by the University of North Texas Health Science Center, for long-term care ombudsmen;²⁷ and
- content on person-centered care and trauma-informed care.

State ALF proposed and final rules are anticipated in 2024. When final, we will update our educational materials for residents, ombudsmen, and others.

The comment period on a proposed federal rule on nursing facility staffing requirements ends on Nov. 6, 2023. CMS is expected to issue a final rule on staffing requirements in 2024. Once final, ombudsmen will take part in educating residents and others on the requirements.

²⁷ [UNTHSC Center for Geriatrics ICARE for Ombudsmen](#)

Contact Information

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Facebook: www.facebook.com/texasltcombudsman/

Website: www.texashhs.org/lcombudsman