TRAINER GUIDE
Initial Certification Training Curriculum for Long-Term Care Ombudsman Programs

January 2022
MODULE ONE

The State Long-Term Care Ombudsman Program: Roles, Responsibilities, and Authorities

TRAINER GUIDE
Table of Contents
Module 1 State-Specific Information.................................................................2
Section 1: Welcome and Introduction...............................................................3
Section 2: An Overview & History of the Long-Term Care Ombudsman Program ....11
Section 3: Long-Term Care Ombudsman Program Requirements and Management...17
Section 4: State Long-Term Care Ombudsman Program......................................22
Section 5: Long-Term Care Ombudsman Program Role and Responsibilities..........26
Section 6: Conflicts of Interest........................................................................39
Section 7: Long-Term Care Ombudsman Program Ethics....................................47
Section 8: Conclusion.......................................................................................55

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Module 1 State-Specific Information

The list below outlines state-specific information for trainers to discuss, provide a link, or add directly to the Trainer Guide, Trainee Manual, and/or PowerPoints. When you get to the point in the training where you need to discuss, include a link, or add state-specific information, you will see a **bold, blue arrow (→)** and a brief description of what to include.

→ **State-Specific Information**

**Section 1 Welcome and Introduction**
- Explain training requirements in your state if they exceed federal requirements.

**Section 2 An Overview & History of the Long-Term Care Ombudsman Program**
- Describe additional qualifications for designation of a representative of the Office if they exceed federal requirements (optional).
- Share information relevant to the history of the Long-Term Care Ombudsman program (LTCOP) in your state.

**Section 3 Long-Term Care Ombudsman Program Requirements and Management**
- Include information about your State Long-Term Care Ombudsman program requirements.
- If your state has local Ombudsman entities, explain how many, where they are located, and include a program map, program contact list, or name a few for reference.

**Section 5 Long-Term Care Ombudsman Program Role and Responsibilities**
- Compare your state to the Figure 4 chart *Functions, Responsibilities, and/or Duties*. Indicate where state responsibilities of the Ombudsman and representatives of the Office are the same and different (e.g., where there might be additional policies and procedures, such as representatives’ role in systems advocacy). When applicable, add another column for others who may have a role within the program (e.g., interns).

**Section 6 Conflicts of Interest**
- If applicable, include state-specific conflicts of interest not mentioned in the LTCOP Rule.
- Explain your state’s process for identifying and remedying or removing individual conflicts of interest, including any required paperwork.
Section 1:

Welcome and Introduction
Welcome

**Trainer’s Note:** Allow at least 30 minutes to go over Section 1.

Begin the session by welcoming the trainees and thanking them for their interest in the program. Introduce yourself by answering the questions below and include your experience with the program. Explain the “aha” moment that led you to become a representative. Ask the trainees the questions below. When asking about the “aha” moment you can also say, “or what was the moment you decided you wanted to join the Long-Term Care Ombudsman program?”

Make sure everyone introduces themselves – even if they come late.

To begin, please share:
- Your name
- Where you are from
- The “aha” moment that brought you here today
- What you hope to gain from this training

After introductions, thank the trainees for sharing their information and explain any housekeeping items that need to be addressed including the timeframe of the training day, breaks, location of restrooms, refreshments, etc. Ask the trainees to speak up if they have any questions throughout the training.

Explain that the intent of the training is to gain the knowledge and tools to become a successful advocate for individuals who live in nursing facilities and other types of long-term care settings.

Welcome to Module 1 of certification training *The State Long-Term Care Ombudsman Program: Role, Responsibilities, and Authorities*. This curriculum is designed to prepare you for your work as an advocate for residents. Thank you for investing your time and having an interest in the lives of individuals living in long-term care settings.

**The Initial Certification Training Curriculum for Long-Term Care Ombudsman Programs**

**Trainer’s Note:** Tell trainees that their manual is a resource to use during the certification process and during their time as a representative of the Office if/when they become designated. It is theirs to keep and to take notes. The trainee is expected to read through the materials on their own time. Refer the trainees to the Resource Section in the back of the Module.
This is the *Initial Certification Training Curriculum for Long-Term Care Ombudsman Programs*, developed by the National Long-Term Care Ombudsman Resource Center (NORC). The curriculum has ten Modules, each with a specific topic(s). The manual is yours to keep. Feel free to take notes as you go along and be sure to ask questions about any information discussed. If at any time a term or an abbreviation is used that has not yet been explained, please ask for clarification.

Included in each Module are:

- **Table of Contents** with topics and corresponding page numbers.
- **Key Words and Terms** specific to the Module.
- **Learning Objectives** to indicate what you can expect to learn from each Module.
- **Footnotes** which include citations for the source material and/or links for additional information.
- **Module Questions** specific to each Module intended to be discussed at the end of the training session.
- **Additional Resources** for supplemental information.

**Certification Training Learning Outcomes**

Based on the Administration for Community Living (ACL) Training Standards, during certification training, trainees will learn:

1. The Ombudsman program serves a vital purpose at the individual and systems level.
2. The representative of the Office is part of a statewide program under the direction of the Office of the State Ombudsman and carries specific responsibilities and duties to the resident and the program.
3. The program serves as a resource to residents, their families, and facility staff with the goal to promote and protect the health, safety, welfare, and rights of residents.
4. Resident rights and choice are paramount. The program is resident-directed and promotes empowerment.
5. Relevant laws, along with where to find information on these laws, i.e., how to use the training manual, links to websites, who to call for technical assistance and support.
6. Basic information about different communication styles and strategies to improve communication.

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7. The importance of, and responsibility to maintain confidentiality of all communications, records, and other information concerning residents, complainants, and others.
8. Steps to take when investigating a complaint and purpose of resolving the complaint to the resident’s satisfaction and of protecting the health, welfare, and rights of the resident.
9. Programmatic requirements.

Module 1 Agenda

**Trainer’s Note:** The timeframes for each Section are approximate. Allow at least 3.5 hours for Module 1. If you think additional time is needed, ask the trainees to read about the history of the LTCOP prior to attending the training session or on their own time (in Section 2).

Section 1: Welcome and Introduction (30 minutes)
Section 2: Overview & History of the Long-Term Care Ombudsman Program (15 Minutes)
Section 3: Long-Term Care Ombudsman Program Requirements and Management (15 Minutes)
Section 4: The State Long-Term Care Ombudsman Program (30 Minutes)
BREAK (10-15 Minutes)
Section 5: The Long-Term Care Ombudsman Program Role and Responsibilities (60 Minutes)
Section 6: Conflicts of Interest (10 Minutes)
Section 7: Long-Term Care Ombudsman Program Ethics (30 Minutes)
Section 8: Conclusion (15 Minutes)

Module 1 Learning Objectives

**Trainer’s Note:** Review Module 1 learning objectives with trainees.

After completing Module 1 you will understand:

- The history of the program
- Laws and regulations pertaining to the Long-Term Care Ombudsman program (LTCOP)
- Program structure
- Training requirements
- Functions and responsibilities of the State Long-Term Care Ombudsman
- Duties of the representatives of the Office of the State Long-Term Care Ombudsman
- The difference between individual advocacy and systems advocacy
Training Requirements

Certification training is required as part of the process to become a representative of the Office of the State Long-Term Care Ombudsman. A representative of the Office of the State Long-Term Care Ombudsman (representative) is an individual (employee or volunteer) designated by the State Long-Term Care Ombudsman (Ombudsman) to fulfill the duties as defined in federal law and regulations. States may use the term “ombudsman” more broadly in reference to a representative.

→ Explain training requirements in your state if they exceed federal requirements.

Each state is required to provide a minimum of 36 hours of initial certification training that includes:

- Up to 7 hours of independent study
- At least 10 hours in the field
- 16-20 hours of classroom style training

Once designated, at least 18 hours of in-service training (also known as “continuing education training”) is required annually.

Module 1 Key Words and Terms

Trainer’s Note: Reference the following key words and terms and let the trainees know each of these will be covered in more detail during Module 1 and throughout the training. Point out the specific key words as listed in the PowerPoint slides.

States can add state-specific key words and terms to this list. Make sure the terms and words defined are used in this Module.

The following key words and terms are defined relative to Ombudsman program practices and are found throughout this Module. Take a moment to familiarize yourself with this important information.

Administration on Aging (AoA) – An operating agency within the federal Department of Health and Human Services (HHS) that provides assistance in the development of new or improved programs to help older persons. It provides grants to the States for community planning and support services and for training, through research, development, or training project grants.²

Advocate – An individual who works on behalf of another individual or group of individuals or an action taken on behalf of an individual or a group of individuals. An advocate does not represent their own views but amplifies those of the person or persons they are supporting.

Area Agency on Aging (AAA) – An agency designated by the state to address the needs of older individuals within a specific region or geographical area known as a planning and service area (PSA).

Certification – The process of satisfying the training and other program requirements to become a representative of the Office.

Client – The resident whom the Long-Term Care Ombudsman program represents.

Confidentiality – Federal and state laws mandate that the Long-Term Care Ombudsman program keep all identifying information about a resident and a complainant private within the program.

Designation – The authority given to the State Ombudsman to appoint or select (i.e., designate), and refuse, suspend, or remove designation of local Ombudsman entities and representatives of the Office pursuant to section 712(a)(5) of the Older Americans Act set forth in §1324.11(e)(6) of the State Long-Term Care Ombudsman Programs Rule.

Empowerment – This is a primary role of the Long-Term Care Ombudsman program in which representatives provide the tools (e.g., information about residents’ rights, facility responsibilities), encouragement, and assistance to promote resident self-advocacy.

Immediate Family – As pertaining to conflicts of interest, is a member of the household or a relative of the representative of the Office with whom there is a close personal or significant financial relationship. Such relationships could impair the judgment or give the appearance of bias on the part of a representative of the Office.

Local Ombudsman Entity (LOE) – Public agencies or nonprofit organizations, designated by the State Ombudsman, responsible for hosting local or regional Ombudsman programs to carry out the activities of the program.

National Ombudsman Reporting System (NORS) – The uniform data collection and reporting system required for use by all State Long-Term Care Ombudsman programs.

Office of the State Long-Term Care Ombudsman (Office, OSLTCO) – As used in sections 711 and 712 of the Act, means the organizational unit in a State or territory which is headed by a State Long-Term Care Ombudsman.

3 45 CFR Part 1324 Subpart A §1324.1 Definitions
4 45 CFR Part 1324 Subpart A §1324.1 Definitions
Older Americans Act (the Act, OAA) – Federal law enacted in 1965 that provides for comprehensive services for older adults. The OAA created a National Aging Network comprised of federal, state, and local supports and services for individuals ages 60 and older. The OAA established the Long-Term Care Ombudsman program. This law is reauthorized (revised) by Congress every five years and signed into law by the President.

Ombudsman – A Swedish word meaning agent, representative, or someone who speaks on behalf of another. For the purposes of this manual, the word “Ombudsman” means the State Long-Term Care Ombudsman.

Representatives of the Office of the State Long-Term Care Ombudsman (Representatives) – As used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in §1324.19(a), whether personnel supervision is provided by the Ombudsman or his or her designees, or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.

Resident – An individual of any age who resides in a long-term care facility.

Resident-Directed – The core of the Ombudsman program’s foundation is to follow the direction of the resident to the fullest extent possible. For example, the Ombudsman program does not make decisions for the resident but does support and advocate on behalf of the resident’s wishes.

Skilled Nursing Facility or Nursing Facility – Also known as a “nursing home,” is a certified facility that provides skilled nursing care for residents who require medical or nursing care rehabilitation or provides health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities. For the purposes of this training and to be consistent with the National Ombudsman Reporting System (NORS), we use the term “nursing facility” for both skilled nursing facilities and nursing facilities.

5 https://acl.gov/about-acl/authorizing-statutes/older-americans-act
6 45 CFR Part 1324 Subpart A §1324.1 Definitions
8 This definition is a combination of Requirements for, and assuring Quality of Care in, Skilled Nursing Facilities, Section 1819(a) of the Social Security Act [42 U.S.C. 1396r–3(a)]
9 NORS Table 1 https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
**State Agency/State Unit on Aging (SUA)** – The designated state agency responsible for developing and administering programs that provide assistance to older individuals, their family members, and in many states, for adults with disabilities.

**State Long-Term Care Ombudsman (Ombudsman, State Ombudsman)** – As used in sections 711 and 712 of the Act, means the individual who heads the Office and is responsible personally, or through representatives of the Office, to fulfill the functions, responsibilities, and duties set forth in §1324.13 and §1324.19.10

**State Long-Term Care Ombudsman program (Ombudsman program, the program, LTCOP)** – As used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.11

**State Long-Term Care Ombudsman Programs Rule (LTCOP Rule)** – The Federal Rule that governs the Long-Term Care Ombudsman program (45 CFR Part 1324).12

**Subsection Symbol (§)** – The subsection symbol is used to denote an individual numeric statute or regulation (rule).

**U.S. Department of Health and Human Services (HHS)** – The principal agency for protecting the health of all Americans and providing essential human services, especially for those who are least able to help themselves.13

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10 45 CFR Part 1324 Subpart A §1324.1 Definitions
11 45 CFR Part 1324 Subpart A §1324.1 Definitions
13 https://www.hhs.gov/about/strategic-plan/introduction/index.html
Section 2:
Overview and History of the Long-Term Care Ombudsman Program
What is an Ombudsman?

*Trainer’s Note: Allow at least 20 minutes to cover Section 2.*

Ombudsman is a Swedish word meaning agent, representative, or someone who speaks on behalf of another. There are many different types of ombudsmen which may lead to some confusion with people understanding what type of ombudsman is working within the Long-Term Care Ombudsman program.

The Long-Term Care Ombudsman program (LTCOP) serves as an *advocate ombudsman*. The LTCOP is impartial while investigating to determine the facts relevant to a case. Once the facts are determined, the LTCOP advocates, seeking a resolution the resident wants. An advocate ombudsman does not represent their own views but amplifies those of the person they are supporting. The goal is resolution to the satisfaction of the resident.

*Trainer’s Note: Show the video below or show your state promotional video to provide a brief introduction to the Long-Term Care Ombudsman program. Clarify that when the video refers to “ombudsmen,” it is referring to representatives of the Office.*

After you show the video, ask the trainees if anything surprises them and if they have any questions.

Watch the video: *What is a Long-Term Care Ombudsman?*[^14] The video provides a brief introduction to the program.

The State Long-Term Care Ombudsman

*Trainer’s Note: This is an introduction to the Ombudsman. The functions and responsibilities are discussed in more detail later in this Module.*

The Ombudsman is the head of the Office of the State Long-Term Care Ombudsman program (the Office) and is responsible personally, or through representatives of the Office, to carry out a variety of functions and responsibilities about which you will learn in this Module. In general, the Ombudsman is responsible for:

- Ensuring that residents have access to the program
- Responding to and resolving complaints
- Representing the interests of residents before governmental agencies
- Ensuring all program requirements are fulfilled
- Ensuring representatives of the Office fulfill their duties
- Designating representatives of the Office and local Ombudsman entities

[^14]: This video series was developed by the Texas Department of Aging and Disability Services in coordination with the Texas Long-Term Care Ombudsman Program. [https://www.youtube.com/watch?v=6VRmetXQVEY](https://www.youtube.com/watch?v=6VRmetXQVEY)
The Ombudsman’s responsibilities are covered in greater detail later in the training.

The State Long-Term Care Ombudsman is also known as the State Ombudsman, the Ombudsman, and SLTCO. Since the term “Ombudsman” (always capitalized) is used in federal references to differentiate the State Ombudsman from representatives of the Office, it is also used as such in the training materials.

Representatives of the Office

→ Describe additional qualifications for designation of a representative of the Office if they exceed federal requirements (optional).

Representatives of the Office of the State Long-Term Care Ombudsman (representatives) are employees or volunteers designated by the Ombudsman to fulfill the duties of the Long-Term Care Ombudsman program set forth in the Older Americans Act and §1324.19 of the LTCOP Rule.

The State Ombudsman is responsible for designating representatives of the Office. Individuals so designated are responsible for carrying out the duties of the Office. To be considered for designation, individuals are required to:

- Meet the screening criteria for certification and/or designation under your state’s LTCOP policies and procedures
- Identify, remove, or remedy all conflicts of interest as specified in the Older Americans Act (OAA), State Long-Term Care Ombudsman Programs Rule (LTCOP Rule), and in your state program policies and procedures
- Complete certification training

History of the Long-Term Care Ombudsman Program

→ Share information relevant to the history of the LTCOP in your state.

Optional Prework: You may choose to ask trainees to review the history on their own time (before or after training). If you cover this information in class, do not go over every decade in detail. Instead, highlight the main points as demonstrated in the PowerPoint.

To fully understand the unique and essential roles of the Ombudsman and representatives of the Office, it is important to understand the history of the Long-Term Care Ombudsman program (LTCOP).
The idea for the LTCOP was developed by Dr. Arthur Flemming, Commissioner on Aging to President Nixon. Dr. Flemming envisioned the program as an advocacy program for residents; and he personally wrote the first guidelines.15

The program officially began in 1972 with implementation of President Nixon’s 1971 Eight Point Initiative to improve nursing facility care. The Health Care 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.”

The following is from the State Long-Term Care Ombudsman Program 2019 Revised Primer for State Agencies:16

1970s
The Nursing Home Ombudsman program was created as part of President Nixon’s initiative to improve conditions and respond to widespread reports of resident abuse in the nation’s nursing facilities. The initiative started as a demonstration program to test its effectiveness, and by the late 1970s, all states were required to have an Ombudsman program as a requirement of the Older Americans Act (OAA).

1980s
The program expanded in the 1980s to include board and care as well as other similar adult care facilities. Clarifying language was added to the OAA in the late 1980s to ensure the program’s access to long-term care facilities and residents, as well as access to resident and facility records. The amendments also provided immunity from liability to the Ombudsman and representatives of the Office who were acting in “good faith” in the performance of their duties. The program was also renamed the Long-Term Care Ombudsman program (LTCOP) to reflect its expanded scope.

1990s
Title VII, the Vulnerable Elder Rights Protection Program, was created by Congress in the 1992 amendments to the OAA. Title VII focused renewed attention on the individual and collective advocacy functions of the aging network and recognized the unique role played by each of the four advocacy programs -- Ombudsman, elder abuse prevention, legal assistance, and benefits counseling. Title VII emphasized the benefit of a coordinated

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15 Statement by Elma Holder, Founder, National Citizens’ Coalition for Nursing Home Reform (now the National Consumer Voice for Quality Long-Term Care), in a presentation, “Tapping and Nurturing Grassroots Support,” for State Long-Term Care Ombudsman Representatives, Rhode Island, April 2000.
advocacy approach to address older persons’ understanding and exercising of their rights as well as access to assistance with problems they encounter. The 1992 amendments included the creation of an Office of the State Long-Term Care Ombudsman (the State Ombudsman Office) and some clarification of conflicts of interest.

2000s
The 2000 OAA amendments included specific language that prohibited Ombudsmen entities and representatives of the Office from financial gain through an action or potential action brought on behalf of individuals they served. It also required coordination of the program with state and local law enforcement agencies. The OAA amendments retained and updated Ombudsman provisions in Titles II, III, and VII, including specific conflict of interest provisions.

2006
Reauthorization added “Assisted Living Facilities” to the definition of “Long-term Care Facility” thereby clarifying that the program provides services to residents of Assisted Living Facilities.

2015
The State Long-Term Care Ombudsman Programs Rule was published in February 2015 with an effective date of July 1, 2016. The LTCOP Rule adds clarity to many of the program responsibilities and provisions in the OAA.

2016
The 2016 OAA amendments added clarity and additional authority to the program in several areas.

Pertinent amendments to the LTCOP included:

- Authorizing the program to serve all long-term care facility residents regardless of their age
- Serving residents transitioning from a long-term care facility to a home-care setting, when feasible
- Clarifying that the program may work to resolve complaints on behalf of residents unable to communicate their wishes, including those lacking an authorized representative (e.g., guardian, power of attorney)
- Requiring programs to actively encourage and assist in the development of resident and family councils
- Confirming that the program is considered a “health oversight agency” for the purposes of the Health Insurance Portability and Accountability Act (HIPAA)
2020

*Trainer's Note:* Be prepared to explain your program's policy on volunteer reimbursement if applicable, especially if reauthorization has changed the program policies and procedures with regards to reimbursement or recognition.

The 2020 OAA reauthorization clarified that the LTCOP is allowed to provide, and financially support, recognition for individuals designated as volunteer representatives. The LTCOP may reimburse or otherwise provide financial support for any costs, such as transportation costs, incurred by representatives of the program.

Learn more about the history of the program [here](https://ltcombudsman.org/uploads/files/about/ltcop-milestones-to-2016.pdf)."
Section 3:

Long-Term Care Ombudsman Program Requirements and Management
Federal Requirements

*Trainer's Note: Allow at least 20 minutes to cover Section 3.*

The Long-Term Care Ombudsman program has federal and state requirements that direct the structure, role, and responsibilities of the program. It is important for representatives to understand the federal and state laws as well as program policies and procedures. The following are federal requirements for the LTCOP.

**The Older Americans Act (OAA)**

The Older Americans Act (OAA) of 1965 created a National Aging Network comprised of federal, state, and local supports and services for individuals ages 60 and older. In addition to providing comprehensive services for older adults, the OAA established the Long-Term Care Ombudsman program.

The OAA also authorizes the State Units on Aging and the Area Agencies on Aging. The OAA is the legal basis for services and funding in every state to support the dignity and welfare of individuals who are 60 years of age and older.

These services include but are not limited to:

*Trainer's Note: Be prepared to talk about the services provided by your state. For example, name the senior transportation system in your area, or your home-delivered meal provider.*

- Home and community-based services
- Nutritional programs
- Health promotion and disease prevention activities for older adults
- Programs that protect vulnerable persons, such as the Long-Term Care Ombudsman program

The OAA is the foundation for the authority of the Ombudsman and the Long-Term Care Ombudsman program, and it is administered at the state level.18

While the OAA requires every state to have a Long-Term Care Ombudsman program, it also:

- Authorizes funding for the LTCOPs
- Authorizes the establishment of the Office
- Determines the functions and responsibilities of the Ombudsman
- Identifies the Ombudsman as the head of the State Long-Term Care Ombudsman program responsible for the management and fiscal management of the program

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- Authorizes the Ombudsman and representatives of the Office regular, timely, private, and unimpeded access to residents and access to residents’ records
- Requires that all potential individual and organizational conflicts of interest are identified and remedied

**The State Long-Term Care Ombudsman Programs Rule**

*Trainer’s Note: Section 5 goes into much greater detail about the bullet points below. Provide a brief overview for now.*

The Administration for Community Living (ACL) published the State Long-Term Care Ombudsman Programs (LTCOP) Rule (45 CFR Part 1324) in February 2015 and effective on July 1, 2016. The LTCOP Rule guides states in their operation of the LTCOP and clarifies program responsibilities and requirements of the Older Americans Act including but not limited to:

- Responsibilities of key figures in the system, including the Ombudsman and representatives of the Office
- Responsibilities of the entities in which LTCOPs are housed
- Criteria for establishing consistent, person-centered approaches to resolving complaints on behalf of residents
- The appropriate role of LTCOPs in resolving abuse complaints
- Conflicts of interest

Throughout this training, the “State Long-Term Care Ombudsman Programs Rule” is also referred to as the “LTCOP Rule.”

→ Include information about your State Long-Term Care Ombudsman program requirements.

**Long-Term Care Ombudsman Program Management**

Providing an effective Long-Term Care Ombudsman program requires coordination at the federal, state, and local levels.

**Federal**

At the federal level, the U.S. Department of Health and Human Services (HHS) improves the health and well-being of all Americans focusing on public health and social services.
Within HHS, the Administration for Community Living (ACL) believes that older adults and people of all ages with disabilities should be able to live where they choose, with the people they choose, and be able to participate fully in their communities.

The Administration on Aging (AoA) is the primary agency within ACL responsible for carrying out the requirements of the Older Americans Act. AoA oversees the Long-Term Care Ombudsman program (LTCOP) and offers support and assistance to State Units on Aging (SUAs) and State Long-Term Care Ombudsman programs.

State

*Trainer’s Note: Use the name of the State Unit on Aging in your state.*

A State Unit on Aging (SUA) is the designated state agency responsible for developing and administering programs that provide assistance to older individuals, their family members, and in many states, adults with disabilities. The SUA is responsible for ensuring that the Ombudsman program has sufficient authority, access to facilities and residents, and information and training needed to perform all the functions of the Office. The SUA determines the structure of the Long-Term Care Ombudsman program. The SUA is responsible for providing legal counsel to the Ombudsman program for consultation and representation as needed for the LTCOP to protect the health, safety, welfare, and rights of residents. All program responsibilities of the SUA are included in the LTCOP Rule, the OAA, and in other regulations governing Health and Human Services (HHS) grantees.

Local

*Area Agencies on Aging*

*Trainer’s Note: Not all states have an Area Agency on Aging (AAA) system. If your state does not use AAAs, then skip the information in this section. If your state has an AAA structure, share information about the role of AAAs in your state.*

Area Agencies on Aging (AAAs) were established by the Older Americans Act to provide options, supports, and services to individuals 60 years of age and older. An AAA is an agency designated by the state to address the needs of all older individuals within a specific region or geographical area known as a planning and service area (PSA).

*Local Ombudsman Entities (LOEs)*

→*If your state has local Ombudsman entities, explain how many, where they are located, and include a program map, program contact list, or name a few for reference.*

*Trainer’s Note: If your state does not have LOEs, skip to Section 4.*
The Ombudsman is responsible for designating local Ombudsman entities (LOEs). LOEs are public agencies or nonprofit organizations responsible for hosting local or regional Ombudsman programs to carry out the activities of the program. States that utilize other agencies or organizations to host the program have specific requirements. Some AAAs are designated by the State Ombudsman as host agencies of an LOE.

Local Ombudsman entities are required to:

- Refrain from having personnel policies or practices which prohibit representatives of the Office from performing the duties of the program or from adhering to Section 712 of the Older Americans Act
- Be responsible for the personnel management, but not the programmatic oversight, of representatives of the Office
- Coordinate with the State Ombudsman when hiring individuals to be considered as representatives of the Office
- Allow the State Ombudsman to monitor the performance of the representatives of the Office in carrying out the duties of the program
- Identify, remove, or remedy all conflicts of interest as specified in the LTCOP Rule and in your state’s policies and procedures
- Adhere to the Ombudsman’s federal and state confidentiality and disclosure requirements
Section 4:
State Long-Term Care Ombudsman Program
State Long-Term Care Ombudsman Program

_Trainer's Note:_ Allow at least 30 minutes to cover Section 4. Emphasize that the program is inclusive of the Office and local Ombudsman entities (if applicable).

The Long-Term Care Ombudsman program (LTCOP) consists of the Office, headed by a full-time State Long-Term Care Ombudsman; all representatives (both paid and volunteer); and local Ombudsman entities (when applicable).

The Ombudsman program addresses complaints and advocates on behalf of residents and responsibilities include:  

- Educating residents, their family, and facility staff about residents’ rights, good care practices, and similar long-term services and supports resources
- Ensuring residents have regular and timely access to Ombudsman services
- Providing technical support for the development of resident and family councils
- Advocating for changes to improve residents’ quality of life and care
- Providing information to the public regarding long-term care facilities and services, residents’ rights, and legislative and policy issues
- Representing resident interests before governmental agencies
- Seeking legal, administrative, and other remedies to protect residents

The LTCOP is unique in that it is required to provide **individual and systems advocacy** on behalf of residents in nursing facilities and other long-term care facilities.

**Individual advocacy** occurs when the representative takes direction from a resident and works to resolve their concern or concerns.

**Systems advocacy** occurs when the LTCOP recommends changes to a system (e.g., a long-term care facility, a government agency, an organization, a corporation, policies, regulations, and law) to benefit long-term care residents. Effective and credible systems advocacy is supported by data and complaint trends, but can also be in response to policy, regulatory, and legislative proposals that could negatively impact residents.

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19 National Ombudsman Resource Center. LTCOP What you Must Know  
Whether through individual or systems advocacy, the LTCOP works to resolve problems affecting residents’ health, safety, quality of care, quality of life, and rights. These responsibilities will be discussed in greater detail throughout the training.

The Office of the State Long-Term Care Ombudsman

*Trainer’s Note:* Explain where the Office is located within your state and who is employed within the Office.

The Office is required to be a distinct and separately identifiable entity and is charged with carrying out the functions and responsibilities set forth in the Older Americans Act and in the LTCOP Rule.

A “distinct and separately identifiable entity” means that the Office operates independently from the host agency and/or the State Unit on Aging and is understood to be a separate entity.

The Structure of the Long-Term Care Ombudsman Program

*Trainer’s Note:* Only explain the structure of your state. Skip or remove the information in the text and the PowerPoint slide that does not pertain to your state structure.

The Office may be located within or connected to the State Unit on Aging (SUA), or the SUA may designate a public or non-profit agency to host the Office of the State Long-Term Care Ombudsman program. LTCOPs have one of two structures: centralized or decentralized.

**Centralized**
In a centralized structure, the State Ombudsman and all representatives of the Office are housed within a single entity. This entity could be a State Unit on Aging, or an agency designated by the SUA.

**Decentralized**
In a decentralized structure, the State Ombudsman is an employee of the state, or designated agency, but the regional/district/local representatives of the Office are employed by other contracted entities referred to as local Ombudsman entities (LOEs). In this structure, the Ombudsman has programmatic oversight (e.g., designation and de-designation of representatives, training representatives, providing guidance regarding complaint processing and other activities), but not personnel oversight (e.g., hiring and...
firing) of the representatives of the Office. In some states, the local LTCOP is a stand-alone entity. Most states have a decentralized structure.

Learn more about program structure\textsuperscript{21} and for more information on program management, visit the NORC website\textsuperscript{22}.

\textsuperscript{21} Nguyen PhD, Kim and White MA, Emily, Protecting Rights and Preventing Abuse: Systems Advocacy and Long-Term Care Ombudsman Program Organizational Placement https://acl.gov/sites/default/files/programs/2020-10/NORC%20Research%20Brief_Systems%20Advocacy_508.pdf
Section 5:
Long-Term Care Ombudsman Program
Role and Responsibilities
Activity: Who Are We?

**Trainer’s Note:** Allow at least 60 minutes for Section 5.

This activity will be introduced now and then you will revisit with the answers at the end of this section. Do **NOT** discuss the answers for this activity until the end of this section.

**If presenting virtually,** conduct the activity within the PowerPoint presentation. Ask the trainees where each word should be placed in the columns and ask for a volunteer to keep track of where the group decides to place the word. Tell them this activity will be revisited at the end of this Section.

**If presenting in person,** write the 3 columns “Best Describes,” “May Describe,” and “Does Not Describe” on a white board (or something similar) and give each trainee sticky notes with one word from the list below on each, then ask them to come up and place them in the column they think is applicable. You can use any kind of a flat surface, preferably one that everyone can see. It is helpful to color code the words so you can easily see if the word has been placed in the correct or incorrect column.

The role of a representative of the Office is unique and one you may often find yourself having to explain. The word ombudsman is defined as “an agent, representative, or someone who speaks on behalf of another.” However, the definition does not fully describe the LTCOP’s role in resident-directed advocacy.

The following activity\(^\text{23}\) is designed to help clarify the role of a representative. Place the words in the category that you think **Best Describes, May Describe,** or **Does Not Describe** the role of a representative. This activity will be discussed at the end of the Section.

- Investigator
- Judge
- Neutral
- Open-minded
- Social Worker
- Friend
- Mediator
- Facilitator
- Advocate
- Educator

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<tr>
<th></th>
<th>Best Describes</th>
<th>May Describe</th>
<th>Does Not Describe</th>
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\(^{23}\) Adapted and revised from the Illinois State Long-Term Care Ombudsman Program Level 1 Trainer’s Manual
Activity: Fact or Fiction

Trainer’s Note: Allow approximately 15 minutes for this activity. The PowerPoint presentation asks the trainees to determine if each statement is fact or fiction. Before starting the activity, ask the trainees to close their manuals, so they do not see the answers. Use the Figure 1 chart to explain why the statements are fact or fiction and point out that the facts are based on the LTCOP Rule. Explain it is not expected that the trainees will know all the answers as information will be discussed further in this Module. Let the trainees know that the purpose of this activity is to introduce some of the challenges they may encounter when serving as a representative.

Federal and state requirements direct the LTCOP to identify, investigate, and resolve complaints made by or on behalf of residents when those complaints are related to an action, inaction, or decision that may adversely affect the health, safety, welfare, or rights of residents. However, many residents, family members, individuals working in long-term care settings, or state agencies do not fully understand the role of a representative. Below are some common myths about the program, followed by explanations of the facts, and where those facts are located in the LTCOP Rule.

THE LONG-TERM CARE OMBUDSMAN PROGRAM – FACT OR FICTION?  

Figure 1

<table>
<thead>
<tr>
<th>Fiction</th>
<th>Fact</th>
<th>Basis</th>
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<tr>
<td><em>The Long-Term Care Ombudsman Program...</em></td>
<td>Within the scope of the program, the representative follows the direction of the resident, even if that is not what others think is in the resident’s best interest.</td>
<td>The LTCOP rule directs the representative to support and maximize resident participation in the process of resolving the complaint and determine the wishes of the resident with respect to resolution of the complaint. The LTCOP’s top priority is to empower residents to...</td>
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Works in the best interest of the resident.

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 Adapted and revised from the Illinois State Long-Term Care Ombudsman Program Level 1 Trainer’s Manual
<table>
<thead>
<tr>
<th><strong>Shares resident information freely with family members, facility staff, and medical providers in an effort to resolve concerns.</strong></th>
<th>The representative needs permission from the resident to discuss the resident’s concerns with anyone, including facility staff and family.</th>
<th>The representative is bound by strict rules of confidentiality and may not disclose any identifying information about the resident or complainant without consent from the resident, complainant, or the State Ombudsman. §1324.11(e)(3)</th>
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<tr>
<td><strong>Does not investigate allegations of abuse.</strong></td>
<td>The LTCOP does investigate allegations of abuse but does so as directed by resident goals for complaint resolution. The LTCOP does not gather evidence to substantiate that abuse occurred or to determine if a law or regulation was violated to enforce a penalty.</td>
<td>The LTCOP investigates and resolves complaints that “relate to action, inaction or decisions that may adversely affect the health, safety, welfare, or rights of the residents” and that includes complaints about abuse, neglect, and exploitation. The LTCOP is designed to represent resident concerns and interests. The representative is unbiased while investigating a complaint and gathering information, but the information gained is to be used to advocate on behalf of residents. §1324.19(b)(2)</td>
</tr>
<tr>
<td><strong>Acts as a neutral third party.</strong></td>
<td>The representative is not neutral when advocating to resolve a complaint on behalf of a resident. The representative works to resolve concerns to the satisfaction of the resident, not other parties involved. The LTCOP may mediate when there is a conflict between parties of equal power (e.g., two residents).</td>
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**What Do We Do?**

*Trainer's Note: Allow at least 30 minutes to go over this portion of the training. Make sure to emphasize this section is inclusive of the State Ombudsman and representatives of the Office. Use the chart in Figure 2 to demonstrate the functions and responsibilities of the State Ombudsman and duties of representatives of the Office under the LTCOP Rule. For clarification, the term “functions and responsibilities” refers to the State Ombudsman and the term “duties” refers to representatives of the Office per the LTCOP Rule. Check in after each PowerPoint slide to see if the trainees understand and provide clarification as necessary.*

*Say to the trainees: “Remember a few slides or sections back when we went over the responsibilities of the LTCOP? The responsibilities we discussed are based on the responsibilities listed in these charts which are based in federal law. The chart breaks down who is responsible for each required task.”*

The Ombudsman and representatives of the Office have similar and different responsibilities under federal law.

One way to describe the relationship of the Ombudsman to the representatives of the Office is to think of the representatives as an extension of the Office. This means that...
every required activity conducted as a representative of the Office is a direct action from the Office. For example, the LTCOP Rule states that “functions” of the Ombudsman are to be carried out “personally or through representatives of the Office” [§1324.13(a)]. Therefore, it is important that all representatives have a clear understanding of the actions required by the Older Americans Act and the LTCOP Rule. The functions, responsibilities, and/or duties outlined in Figure 2 are exact language from the LTCOP Rule.

→ If different than the Figure 2 chart Functions, Responsibilities, and/or Duties, indicate where state responsibilities of the Ombudsman and representatives of the Office are the same and different (e.g., where there might be additional policies and procedures, such as representatives’ role in systems advocacy). When applicable, add another column for others who may have a role within the program (e.g., interns).

### FUNCTIONS, RESPONSIBILITIES, AND/OR DUTIES

<table>
<thead>
<tr>
<th>Functions, Responsibilities, and/or Duties</th>
<th>The Ombudsman §1324.13</th>
<th>Representatives of the Office §1324.19</th>
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<td>Establish or recommend policies, procedures, and standards for the administration of the LTCOP.</td>
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<td>Require representatives to fulfill the duties set forth in the LTCOP Rule and in accordance with state program policies.</td>
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<td>Determine designation, refusal, suspension, or removal of designation of LOEs and representatives.</td>
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<td>Monitor the performance of local Ombudsman entities (LOEs).</td>
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<td>Establish training requirements for representatives.</td>
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<td>Maintain sole authority to determine disclosure of files, records, and other information maintained by the Office.</td>
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<td>Determine the use of fiscal resources appropriated and available for the operation of the Office and determine that program budgets</td>
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</table>
and expenditures of the Office and LOEs are consistent with the laws, policies, and procedures governing the LTCOP.

Provide administrative and technical assistance to representatives of the Office and agencies hosting LOEs.

Coordinate with and promote the development of citizen organizations consistent with the interests of residents.

*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. *This language is specific to the Ombudsman per §1324.13(a)(7)(i)

Recommend any changes in laws, regulations, policies, and actions as the Office determines to be appropriate and facilitate public comment on the laws.

*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 facilitate the ability of the public to comment on the laws, regulations, policies, and actions. *This language is specific to representatives of the Office per §1324.19(a)(5)(i)

Identify, investigate, and resolve complaints made by or on behalf of residents and relate to action, inaction or decisions that may adversely affect the health, safety, welfare, or rights of residents.

Provide services to protect the health, safety, welfare, and rights of residents.

Inform residents about the ways to obtain LTCOP services.
Ensure that residents have regular and timely access to the services provided through the LTCOP and that residents and complainants receive timely responses from the representatives of the Office to their requests.

Represent the interest of residents before governmental agencies; assure that individual residents have access to, and pursue administrative, legal, and other remedies to protect the health, safety, welfare, and rights of residents.

Promote, provide technical support for the development of, and provide ongoing support as requested by the resident and family councils to protect the well-being and rights of residents.

### Fundamentals of the Long-Term Care Ombudsman Program

The fundamentals of the program provide an overall picture of the LTCOP. Each is discussed in detail throughout the training. These principles come from the Older Americans Act and the LTCOP Rule.

#### Empower

The primary role of the Long-Term Care Ombudsman program is **empowerment** in which representatives provide the tools (e.g., information about residents’ rights, facility responsibilities), encouragement, and assistance to promote resident self-advocacy. The Long-Term Care Ombudsman program has a responsibility to empower residents to advocate on their own behalf.

The LTCOP empowers residents by:

- Educating residents on their rights
- Educating residents on their options
- Discussing all possible outcomes
- Encouraging residents to do something about their concerns, needs, or wishes

#### Represent the Interests of Residents

The Long-Term Care Ombudsman program represents the interests of residents through individual and systems advocacy. The Ombudsman and representatives work with, and
on behalf of residents to ensure their voices are heard during complaint resolution, through legislation, and in the media.

**Provide Resident-Directed Advocacy**

The foundation of all Ombudsman program advocacy is to follow the direction of the resident to the fullest extent possible. The Ombudsman program cannot act without consent from the resident.

The LTCOP has a responsibility to:
- Determine the resident’s perception of the problem
- Explain potential solutions and outcomes
- Work with the resident to determine steps towards the resident’s goals

It is important to not let personal feelings or judgements interfere with resident-directed advocacy.

**Ensure Confidentiality**

Federal and state laws mandate that the Long-Term Care Ombudsman program keep all identifying information about a resident and a complainant private, within the program. There are strict federal requirements regarding disclosure of LTCOP information (e.g., resident and complainant identity, observations, complaint, and case documentation). Resident-identifying information cannot be shared with anyone without the permission of the resident, the resident’s representative, the State Ombudsman, or by court order. Confidentiality and disclosure of information are covered in more detail throughout the training.

**Educate**

The LTCOP is responsible for educating residents, family members, facility staff, state and local agencies, community members, and others about residents’ rights, good care practices, long-term services and supports, and the LTCOP.

**Comply with Federal and State Laws, Regulations, and Policies**

The Ombudsman and representatives of the Office are expected to follow both federal and state requirements while fulfilling the responsibilities of the LTCOP.

**Document**

The Ombudsman and representatives of the Office are responsible for accurately and appropriately documenting all activities conducted while performing the duties of the Office.
What Makes the Long-Term Care Ombudsman Program Unique?

Trainer’s Note: Thoroughly explain the key points below as they are often the hardest to comprehend. Make sure the trainees understand the uniqueness of the program before moving forward with the training.

Compared to other services and programs in the aging and disability networks, the Ombudsman program is unique in many ways. There is often misunderstanding, confusion, and even tension when representatives interact with others who do not understand the program. Therefore, it is important to have a clear understanding about the role and unique characteristics of the program.

The Long-Term Care Ombudsman Program is Resident-Directed

The resident is the “client” no matter where the complaint originates. Because it is a resident-directed program, the LTCOP is required to support and maximize resident participation in the process of resolving the complaint and follow their direction with respect to resolving the complaint.

When a complaint is initiated by someone other than the resident, the LTCOP first visits or contacts the resident to determine if the resident wishes the services of the LTCOP. If not, no further actions are taken. In addition, the LTCOP cannot report any information back to the person who filed the complaint without permission from the resident. An example of a common situation:

A daughter calls the LTCOP and says her mother, Olga, is getting terrible care and never gets her showers as scheduled. The representative visits Olga and Olga says that her daughter worries too much, and Olga has no concerns with her care. However, Olga complains the food is often cold and asks the representative to talk to the dietary manager about the problem.

As noted in this situation, the LTCOP’s focus is on the resident’s complaint, not the daughter’s complaint.

Trainer’s Note: If a trainee asks, “What if the resident has dementia or can’t talk or give permission?” Please respond with: “We’ll address that in a later module. For the time being, we’ll assume the resident can speak their mind.”

The Long-Term Care Ombudsman Program Does Not Work in the Best Interest of the Resident

Best interest is subjective and based on individual thoughts, experiences, morals, values, etc. It is a personal determination about what is beneficial for someone else. The program
does not determine what is best for residents, nor does it make decisions for the resident. Rather the **program supports and advocates on behalf of the resident’s wishes.**

This approach may conflict with the perspective of long-term care facility staff, medical professionals, family members, and others as they might feel that resident-directed advocacy is not in the best interest of the resident on specific issues. An example of a common situation:

*The facility refuses to honor Melissa’s choice in meals and snacks claiming it is in her best interest to follow a low-sugar diet since Melissa has a diagnosis of diabetes. However, Melissa understands the potential risks of not following a low-sugar diet and has the right to choose what to eat.*

**Long-Term Care Ombudsman Programs are Not Mandatory Reporters**

More specifically, representatives are **not allowed** to report suspected abuse, neglect, or exploitation of a resident without permission to do so. Permission can only be granted by the resident, the resident representative if the resident is unable to communicate informed consent, or the State Ombudsman under special circumstances.26

This mandate may cause tension between the LTCOP and others not familiar with the program. As a representative, it is important to talk to the resident about their situation and the consequences of reporting or not reporting the alleged abuse, including any fears of retaliation. Educating the resident allows for the resident to make an informed decision.

**The Long-Term Care Ombudsman Program Works Towards Resident Satisfaction**

The resident’s perception is used to determine whether the problem has been resolved.

The LTCOP determines resolution of the concern based on the resident’s satisfaction of the outcome. In some situations, reporting the complaint to the facility or to the state agency responsible for investigating long-term care facilities may not satisfactorily resolve the resident’s concern when the problem continues after the report has been made. An example of a common situation:

*Trainer’s Note:* This is a simple example to emphasize that the complaint is not resolved until the resident indicates satisfaction with the resolution, so focus on the main point instead of thinking about the variety of possible solutions.

26 Those circumstances are spelled out in 1324.19(b)(6)
The representative works with Tonya about concerns of staff and residents verbally abusing her because of her sexual orientation. The representative provides in-service training for the facility staff about rights and abuse. With the help of a representative, Tonya files a complaint with the state agency responsible for investigating long-term care facilities and the results show evidence of verbal abuse. While the verbal abuse stops, Tonya still feels uncomfortable around certain people. Because she is not satisfied with the outcome, the representative continues to work with Tonya towards her feeling more comfortable in the facility.

Activity: Who Are We?

*Trainer’s Note:* Go back to the first “Who Are We” activity and ask the trainees if they have changed their mind about their original answers and if so, what are the changes?

*If you are conducting the activity virtually,* ask the volunteer who agreed to keep track of the earlier responses to share what was added to the “best describes” column and ask if anyone has changed their mind – do this with each column.

*If you are conducting the activity in person,* go to the chart you made with the trainees’ responses and move the words to their new column. To summarize the activity, read the three paragraphs titled “Describes,” “May Describe,” and “Does not Describe” and move the words to the correct location.

*Read the three paragraphs to summarize the activity.*

At the beginning of this Section, there was an activity in which you were asked to categorize certain words that *describe, may describe,* or *do not describe* the role of representatives of the Office. Take another look at your answers and see if you have changed your mind about your responses.

**Describes**

First and foremost, the role of a representative is that of an *advocate* for residents. Representatives are *open-minded* and *investigate* every angle of the concern by researching the root cause of the concern and all potential remedies. Representatives serve as *facilitators* by requesting others to act in accordance with their roles and responsibilities. Representatives are trained in residents’ rights and are required to *educate* all parties about residents’ rights and Ombudsman services.
May Describe
While representatives would never mediate a resident’s rights away, there may be instances when mediation between individuals of equal power (e.g., two residents) occurs to obtain the best possible outcome for the resident(s).

The LTCOP is designed to represent resident concerns and interests and is not neutral with representation. However, representatives are neutral during an investigation and when gathering information. Information gained is used to advocate for the resident(s).

Does Not Describe
Representatives are resident advocates and attempt to foster trusting relationships, but not friendships with residents. A friendship is a reciprocal relationship and implies mutual support. Representatives don’t rely on residents for support or help. In addition, it is not the representative’s role to place their personal opinions or values on the decisions of residents. Representatives do not judge residents’ feelings, actions, or decisions. Representatives are sometimes confused with social workers, but they are not social workers. Representatives are advocates in the truest sense, meaning they advocate on behalf of residents, not in the best interest of residents.

Learn more about the Long-Term Care Ombudsman Program in Long-Term Care Ombudsman Program What You Must Know and in Long-Term Care Ombudsman FAQ.

Section 6:
Conflicts of Interest
Conflicts of Interest

“The ombudsman program has a mandate to focus on the individual resident. If the ombudsman finds him or herself in a conflict of interest situation (whether it is a conflict of loyalty, commitment, or control), the resident, even more than the program, may suffer. The resident’s problem may not be resolved, certain avenues of resolution may be foreclosed, the resident’s voice may not be heard by policymakers, and the resident’s interests will be inadequately represented or altogether absent from the table at which public policy is made.”

The following definitions of conflict of interest include insertions to illustrate how the definitions may apply to the Long-Term Care Ombudsman program.

- Situation where a party’s [representative’s] responsibility to a second party [employer or another program] limits its ability to discharge its responsibility to a third party [resident].

- a conflict between the private interests and the official responsibilities of a person [representative] in a position of trust

The Ombudsman program’s most important asset is its independence, which is crucial to the program’s success in advocating for residents. Key to this independence is freedom from conflicts of interest. An actual conflict of interest, or even the appearance of a conflict of interest, can seriously impact the effectiveness and credibility of the program as an independent advocate.

Three conflict-of-interest situations are described below to provide additional context to perceived or actual conflicts.

- **Conflicts of Loyalty:** These involve issues of judgment and objectivity and are typical situations almost everyone understands—financial and employment considerations. A representative’s ability to be fair and act as a resident advocate might be questioned if the representative also is a consultant to a facility, a board member of a facility or management company, or works as a case manager with responsibility for assisting individuals with moving into long-term care facilities.

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32 The following section describing conflicts of loyalty, commitment, and control are from the *Conflict of Interest and the Long-Term Care Ombudsman Program* (Hunt, S.) resource cited above.
Loyalty may also be an issue if the representative of the Office is assigned to a facility where the representative was previously employed.

- **Conflicts of Commitment**: These are issues of time and attention. Toward which goals or obligations does one direct one’s efforts—i.e., one’s time and energies? Concerns about the adequacy of resources come into play because pressures to do more occur when available resources are limited. In local Ombudsman entities, representatives who assume several other employment-related responsibilities in addition to their Ombudsman program responsibilities may experience conflicts of commitment.

- **Conflicts of Control**: These are issues of independence. Do other interests, priorities, or obligations of the agency that houses the program materially interfere with the advocacy of the Ombudsman and/or representative on behalf of residents? Do administrative or political forces materially interfere with the professional judgment of the Ombudsman or representative? Is the Ombudsman or representative able to act responsibly without fear of retaliation by superiors?

Learn more about [conflicts of interest and the Long-Term Care Ombudsman program](https://ltcombudsman.org/uploads/files/support/COI-July-09-paper-final.pdf).

There are two types of conflicts that are required to be addressed: *individual* and *organizational conflicts of interest*. Key requirements to handle both individual and organizational conflicts include the following:

- When possible, avoid the conflict of interest prior to designation.
- Require disclosure of conflicts and steps taken to remove/remedy them.
- Establish a process for periodic review/identification of conflicts.
- Establish criteria and processes for review and approval of steps taken to remedy or remove a conflict.

### Individual Conflicts of Interest

→ *If applicable, include state-specific conflicts of interest not mentioned in the LTCOP Rule.*

→ *Explain your state’s process for identifying and remedying or removing individual conflicts of interest, including any required paperwork.*

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Trainer’s Note: Allow approximately 15 minutes to go over both individual and organizational conflicts of interest. Review this NORC resource regarding individual conflicts of interest for additional information. ACL advises that your program address individual conflicts of interest with the trainees prior to certification training and the trainees complete all necessary conflict-of-interest paperwork.

It is important to point out here that if a new situation arises and there is a question about a conflict, the situation is required to be reported immediately. Explain your state’s process for disclosing potential or real conflicts.

The SUA and the Ombudsman are required to identify actual or potential conflicts of interest for the Ombudsman, representatives of the Office, and members of their immediate family. Your state may have policies and procedures that exceed the federal requirements listed below.

All representatives of the Office must disclose individual conflicts of interest including, but not limited to:

- Direct involvement of licensing or certification of a long-term care facility or a long-term care service provider

- Ownership, operational, or investment interest (represented by equity, debt, or other financial relationship) in an existing or proposed long-term care facility or a long-term care service provider

- Employment of an individual by, or participation in the management of, a long-term care facility in the service area or by the owner or operator of any long-term care facility in the service area

- Receipt of, or 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

- Accepting gifts or gratuities of significant value from a long-term care facility or its management, a resident, or a resident representative of a long-term care facility in which the Ombudsman or representative of the Office provides
services (except where there is a personal relationship with a resident, or resident representative which is separate from the individual’s role as Ombudsman or representative of the Office)

- Accepting money or any other consideration from anyone other than the Office, or an entity approved by the Ombudsman, for the performance of an act in the regular course of the duties of the Ombudsman or representatives of the Office without the Ombudsman’s approval

- Serving as guardian, conservator, or other fiduciary or surrogate decision-making capacity for a resident of a long-term care facility in which the Ombudsman or representative of the Office provides services

- Having management responsibility for, or operating under the supervision of an individual with management responsibility for, adult protective services

- Serving residents of a facility in which an immediate family member resides

Once identified, it is the responsibility of the Ombudsman to make the final determination if a conflict exists and if there are remedies. The representative of the Office does not make this decision. It is important to disclose all possible conflicts, even if it seems like it is not a conflict or that the potential conflict was in the past.

Examples of conflicts of interest:

“*My step-mother resides in the facility in which I am assigned, but we haven’t talked in years, so I don’t think it is a conflict of interest.*”

“I worked in the facility for only 2 months, and it was 2 years ago. I left on good terms, so I don’t see it as a conflict of interest to be assigned as a representative to this facility.”

These examples are potential conflicts and are to be disclosed as required by program policies and procedures. The Ombudsman will determine appropriate actions necessary to remove or remedy the conflicts of interest consistent with the program’s policies and procedures.

After a conflict is identified, it is required be removed or remedied. In the examples given above, a potential remedy would be to re-assign the representative of the Office to a different facility. Some conflicts of interest are not able to be removed or remedied. In these situations, the individual cannot be designated as a representative of the Office.
Examples of conflicts that cannot be removed or remedied:

“I own a licensed group home and would like to become a representative of the Office.”

“I license and inspect assisted living facilities but would like to volunteer as a representative of the Office in my spare time.”

Individuals cannot own or work for a facility, receive payment, or be involved with licensing or certifying long-term care facilities and be a representative of the Office. Additional disqualifications may include when an immediate family member has these conflicts.

When considering the employment or appointment of an individual as the State Ombudsman, the State agency or other employing or appointing entity cannot hire an individual who has been employed by or participated in the management of a long-term care facility within the previous twelve months. Many programs have similar requirements for representatives of the Office and the LTCOP Rule encourages programs to “make efforts to avoid appointing or employing an individual as a representative of the Office who has been employed by or participated in the management of a long-term care facility within the previous twelve months.”

Learn more about individual conflicts of interest.34

Organizational Conflicts of Interest
An organizational conflict of interest is a situation in which two entities have duties or responsibilities directly or indirectly influencing their vested interest. Organizational conflicts of interest are conflicts that may impact the effectiveness and credibility of the work of the Office of the State Long-Term Care Ombudsman (the Office). The State agency and the Ombudsman are required to:

- Avoid organizational conflicts prior to designating or renewing designation
- Consider organizational conflicts of interest that may impact the effectiveness and credibility of the program

The LTCOP Rule §1324.21 and the OAA identify specific organizational conflicts of interest for the Office and for entities hosting the Long-Term Care Ombudsman program.

Ensure that the program has policies and procedures in place to identify, remedy, or remove organizational conflicts of interest

The Ombudsman is required to report all organizational conflicts and remedies in the National Ombudsman Reporting System (NORS). If you have questions regarding an organizational conflict of interest about the agency hosting the LTCOP, contact your direct supervisor.

The LTCOP Rule and the OAA state that organizational conflicts of interest include, but are not limited to, placement of the Office, or requiring that an Ombudsman or representative of the Office perform conflicting activities, in an organization that:

- Is responsible for licensing, surveying, or certifying long-term care facilities
- Is an association (or an affiliate of such an association) of long-term care facilities, or of any other residential facilities for older individuals or individuals with disabilities
- Has any ownership or investment interest (represented by equity, debt, or other financial relationship) in, or receives grants or donations from, a long-term care facility
- Has governing board members with any ownership, investment, or employment interest in long-term care facilities
- Provides long-term care to residents of long-term care facilities, including the provision of personnel for long-term care facilities or the operation of programs which control access to or services for long-term care facilities
- Provides long-term care services, including programs carried out under a Medicaid waiver
- Provides long-term care coordination or case management for residents of long-term care facilities
- Sets reimbursement rates for long-term care facilities
- Sets rates for long-term care services
- Provides adult protective services
• Is responsible for eligibility determinations regarding Medicaid or other public benefits for residents of long-term care facilities
• Conducts preadmission screening for long-term care facility admission
• Makes decisions regarding admission or discharge of individuals to or from long-term care facilities
• Provides guardianship, conservatorship, or other fiduciary or surrogate decision-making services for residents of long-term care facilities

Here’s an example of an organizational conflict of interest:

“The agency hosting the LTCOP where I work has a nursing facility administrator on their Board of Directors and the administrator votes on our local Ombudsman budget.”

In this situation the representative, or host agency of the local Ombudsmen entity (LOE), would disclose this conflict to the Ombudsman. The Ombudsman would work with the LOE to remove or remedy the conflict.

Learn more about organizational conflicts of interest at the local and state levels.

Section 7:
Long-Term Care Ombudsman Program Ethics
Ethics

**Trainer’s Note:** Allow at least 30 minutes for Section 7.

Ethics are defined as:

- A set of moral principles: a theory or system of moral values
- The principles of conduct governing an individual or a group
- A guiding philosophy
- A consciousness of moral importance

Ethics are based on individual and social beliefs about what is or is not acceptable behavior. Sometimes individuals want to apply their personal ethics to their role as a representative of the Office, but when those ethics conflict with the goals of the program, it can cause the representative to feel uncomfortable and uncertain about how to handle certain situations.

*Like many other professions, the Ombudsman program has a code of ethics that provides the guiding philosophy and principles for the program’s work. Dilemmas sometimes arise regarding how to apply the ethical principles to a specific situation. Representatives need to able to work in situations where there may not be clearly “right” or “wrong” actions. Working through “gray” issues is typical for representatives. A key challenge is remaining sensitive to such issues by identifying the ethical dimensions of a situation and working through them with some thoughtfulness and consistent adherence to Ombudsman program principles.*

Keep in mind that the LTCOP is resident-directed, and the role of the representative is that of an advocate. In addition, the representative is often a facilitator, not the “doer” of the requested action as demonstrated in the following activity.


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**Activity: Ethical Dilemmas**

**Trainer’s Note:** Ask the trainees to close their manuals. This activity can be conducted as a role-play or as a large group activity. There are three scenarios, each involving one resident and one representative.

The point of this exercise is not complaint handling; it is to emphasize the importance of not acting outside the scope of duties while struggling with the personal, ethical dilemma of wanting to “help.”

**ROLE-PLAY**

If you are conducting the activity as a role-play, ask for six volunteers. If you don’t have enough trainees, someone can volunteer for more than one role. Three people will play the role of a resident and three people will play the role of the representative. There is no script, only a brief scenario for each situation.

If you are presenting in person, have the scenarios for June, Jack, and Billie printed out ahead of time to give to each person playing the resident or tell them to only look at the section in their manuals pertaining to the person they are role-playing.

Tell the trainees playing the representatives that this should be a quick role-play and to provide an initial response to the resident’s request.

Follow the directions on the PowerPoint slide to conduct the role-play activity and the remaining directions in the notes section in the PowerPoint presentation. Make sure to address the points following the questions.

**LARGE GROUP ACTIVITY**

To conduct this activity as a large group discussion, go over each scenario on the specific PowerPoint slide, and ask the attendees to respond to the questions after reviewing the scenario.

1. June asks you to pour her a glass of water because her throat is dry. The water pitcher and cup are on her bed-side table, but out of her reach.

   **What's the ethical dilemma?**
   Dilemma – The resident is thirsty, and you want to help but you are not able to give June the water.

   **What should you consider?**
Consider - Who is responsible for getting her water? Does she have fluid restrictions? Does she have difficulty swallowing?

**How would you respond?**
Response: “I’d be happy to ask a staff member to assist; is that okay with you?”

It is not the responsibility of a representative to give a resident drinks or food and it may even be dangerous to the resident. If the resident is hungry or thirsty, it is the job of the facility staff to see that food and drinks are delivered to the resident in the manner spelled out in the care plan. Residents may have a problem with swallowing, may be on water restrictions due to a serious medical condition, and/or staff may be required to document the resident's intake for medical purposes. The key is you don’t know, and it is not your role. Your role is to facilitate the request, not to personally provide the service.

**Trainer’s Note:** Reassure the trainees that while they cannot provide the water, they are still helping the resident by seeking out someone whose job it is to provide for the needs of the resident.

2. You are talking to Jack in a public area, but he wants to talk in private. Jack uses a wheelchair and cannot push himself down to his room. He asks you to do so.

**What’s the ethical dilemma?**
Dilemma – The resident wants you to talk with you in private and wants you to push him to his room. You want to help, but you are not allowed to push residents in their wheelchair.

**What should you consider?**
Consider – Who is responsible for taking Jack to his room?

**How would you respond?**
Response: “If you are okay with it, I’d be happy to ask a staff member to assist you; I am not allowed to push residents in their wheelchairs.”

Representatives cannot push a resident in their wheelchair, nor can they assist with any kind of ambulation in any way. It is not the role of the representative, but more importantly, providing assistance of any kind with ambulation could put the resident at risk of harm. For example, if you were to push a resident in a wheelchair and they put their feet on the ground, the resident could topple over and be seriously harmed.

3. During a visit in Billie’s room, she tells you she’s chilly and asks you to get her sweater out of her closet and help her put it on.

**What’s the ethical dilemma?**
Dilemma – The resident is uncomfortable, and you want to help but you are not sure if you can get her sweater from the closet or help her put it on.

**What should you consider?**
Consider - Who is responsible for assisting residents with their clothes? What is the perception of a representative going through a resident’s closet?

**How would you respond?**

Response: “I’d be happy to ask a caregiver to assist you; is that okay with you?”

While it may seem innocent enough to get a sweater out of a closet, the appearance of going through a resident’s belongings isn’t ideal. How would the resident get the sweater if you were not there? The answer is likely the direct care staff. More importantly, representatives cannot assist a resident with dressing or providing any personal care. Doing so is outside of the scope of duties and could potentially harm the resident. For example, you assist the resident with putting on her sweater and because she is so frail, you accidently hurt her arm while trying to get it into the sleeve.

**Trainer’s Note:** This is where you process the activity whether you are conducting it as a role-play or a large group discussion.

These are just a few of the many situations you will come across as a representative. It is possible to politely communicate that a request is something you cannot fulfill, but you can find someone who can.

When in doubt, take a step back, and consider the following:

1. Is the request within the scope of my duties as a representative of the Office (i.e., is it my job/role/responsibility to fulfill this request)?
2. Who else might be responsible for conducting the actions I am being asked to fulfill?
3. Is there potential harm that could be done to the resident if I personally act on the request?
4. What can I do to assist the resident without overstepping the boundaries of the program?

**Trainer’s Note:** Remind the trainees that part of their duties is to facilitate resolution and ensure facility staff are responding to residents’ needs and preferences. It is not the job of the representative to carry out the requested act when that request is someone else’s responsibility.

Advocacy work is a privilege and with that privilege comes the responsibility to demonstrate ethical behavior and decision-making. Actions taken by a representative of the Office can have a long-term impact on the credibility of the statewide Ombudsman program.
Ethical Situations
Representatives work in situations that are subjective, meaning they are not always clear or cut and dry. A key challenge is remaining sensitive to such issues by identifying the ethical challenges of a situation and working through them with some thoughtfulness.

Trainer’s Note: The point of this discussion is to get the trainees to start thinking about other ethical situations they may come across and how they may respond.

A few examples of such situations follow:

- A group of residents in a facility likes to congregate on Friday nights to order pizza and watch movies or listen to music. Other residents complain that the group gets too rowdy, and it interferes with residents trying to sleep or watch TV in their rooms. The group says they are exercising their choices and preferences. A resident asks you to represent those frustrated with the group of residents by talking to the administrator about banning the group’s gatherings. Who does the LTCOP represent?

  Answer: The LTCOP represents all residents and does not place value of one group of residents’ rights over another group, regardless of which group brought the complaint to the program.

- Stella complains that meals served in her room are cold and asks you to sample the food to see if you agree. What would you do?

  Answer: Politely decline tasting the food and explain to Stella that her opinion of the food temperature is all the information you need to assist her.

- Kai is at risk of choking but insists on eating all meals alone in his room. He is not comfortable eating in the dining room and doesn’t want a staff member in his room “babysitting” him. Kai asks you for help with convincing the staff to let him eat in his room. Are you comfortable advocating on behalf of the resident in this situation?

  Answers may include:
  - No, I wouldn’t want to help a resident if my helping could lead to potential harm.
  - No, I don’t think he should eat alone in his room. It is not safe.
  - Maybe, if I had direction from an experienced representative or the Office.
  - Yes, but I would need guidance and to find out more about his situation, where the concern is coming from, and if there are other options for him to consider.
  - Yes, he has a right to eat where he chooses.
**Trainer’s Note:** The most appropriate response for trainees is “Yes, but I would need guidance and to find out more about his situation, where the concern is coming from, and if there are other options for him to consider.” Explore those responses that are negative about helping the resident – why does this situation make the trainees feel uncomfortable? Are there other situations that may be presented to you by a resident that would make you feel uncomfortable?

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**Code of Ethics**

Many professional organizations have a code of ethics for individuals who work in that specific field. A code of ethics usually includes values, principles, and standards by which workers follow in their day-to-day work.

The National Association of State Long-Term Care Ombudsman Programs (NASOP) developed a Code of Ethics for Long-Term Care Ombudsmen. You will see that their Code of Ethics summarizes the information covered during this training session.

**Code of Ethics for Long-Term Care Ombudsmen**

*From: The National Association of State Long-Term Care Ombudsman Programs (NASOP)*

**Trainer’s Note:** There is also a National Association of Local Long-Term Care Ombudsmen called NALLTCO. NALLTCO has additional information related to the code of ethics that can be found in the link at the end of the list. Go over the Code of Ethics with the trainees or have them read it on their own. You can also ask for volunteers to read them.

The word “Ombudsman” in the Code of Ethics refers to the State Ombudsman and all representatives of the Office.

1. The Ombudsman provides services with respect for human dignity and the individuality of the client, unrestricted by considerations of age, social or economic status, personal characteristics, or lifestyle choices.

2. The Ombudsman respects and promotes the client’s right to self-determination.

3. The Ombudsman makes every reasonable effort to ascertain and act in accordance with the client’s wishes.

4. The Ombudsman acts to protect vulnerable individuals from abuse and neglect.

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40 In the Code of Ethics, *client* refers to the range of consumers served by LTCOP such as residents, their family members, and individuals who are seeking information about long-term care facilities.
5. The Ombudsman safeguards the client’s right to privacy by protecting confidential information.

6. The Ombudsman remains knowledgeable in areas relevant to the long-term care system, especially regulatory and legislative information, and long-term care service options.

7. The Ombudsman acts in accordance with the standards and practices of the Long-Term Care Ombudsman program, and with respect for the policies of the sponsoring organization.

8. The Ombudsman will provide professional advocacy services unrestricted by his/her personal belief or opinion.

9. The Ombudsman participates in efforts to promote a quality, long-term care system.

10. The Ombudsman participates in efforts to maintain and promote the integrity of the Long-Term Care Ombudsman program.

11. The Ombudsman supports a strict conflict of interest standard that prohibits any financial interest in the delivery or provision of nursing home, board and care services, or other long-term care services that are within their scope of involvement.

12. The Ombudsman shall conduct himself/herself in a manner that will strengthen the statewide and national Ombudsman network.

Learn more about LTCOP ethics: read this guide, visit this webpage, and National Association of Local Long-Term Care NALLTCO Code of Ethics for Ombudsmen.

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42 The National Long-Term Care Ombudsman Resource Center https://ltcombudsman.org/omb_support/pm/ethics
43 National Association of Local Long-Term Care Ombudsmen https://nalltco.weebly.com/code-of-ethics.html
Section 8: Conclusion
Module 1 Questions

Trainer's Note: Allow at least 20 minutes for Section 8. These questions are meant to determine if the trainees learned the fundamental learning objectives and may illicit discussion about the answers. The questions and answers are not meant to be rushed through.

Questions 1-6 True or False?

1. The authority of the LTCOP comes from the Older Americans Act.
   
   Answer: True. Authority was established in 1978 as a mandatory program of the Older Americans Act and has strengthened over the years due to several Amendments to the OAA.

2. Representatives of the Office are required to fulfill the duties set forth in the Older Americans Act, the LTCOP Rule, and the policies and procedures set forth by the Office and the State Unit on Aging.

   Answer: True. The LTCOP Rule specifies that once designated, representatives are required to carry out the duties of the program. Those duties are spelled out in the Older Americans Act and the LTCOP Rule. In addition, representatives are required to follow state policies and procedures specific to the LTCOP.

3. The Office of the State Long-Term Care Ombudsman is a distinct entity, separately identifiable from the State Unit on Aging or another hosting agency.

   Answer: True. The LTCOP Rule strengthened and clarified the independence of the program.

4. Only the State Ombudsman has the authority to designate, refuse to designate, or suspend or remove designation of a representative of the Office or a local Ombudsman entity, unless the State Unit on Aging overrules the Ombudsman's decision.

   Answer: False. Under the LTCOP Rule, the Ombudsman is responsible for making determinations surrounding designation; there is nothing in the LTCOP Rule that states a SUA can overrule the State Ombudsman’s decision on this matter.

5. My father just started working as a maintenance man in an assisted living facility. I don't visit that facility, so I don't need to report it as a conflict of interest.
**Answer:** False. You are required to report all potential and actual conflicts of interest. It is important to report all potential conflicts of interest because, in this case, it could be that the owners of the facility in which your father works also own one or more facilities in which you are assigned. The Ombudsman will determine if this conflict prohibits you from serving as a representative of the Office or if there are remedies to address the conflict.

6. The facility reached out to me and asked if I would volunteer to help take residents to activities every Tuesday. I noticed during my regular visits as a volunteer representative that residents miss activities because no one can take them to scheduled activities, so, I agreed to do so. It is not a conflict of interest because I volunteer as a representative on Fridays.

**Answer:** False. It is a conflict because the role of a facility volunteer and the role of a volunteer representative are quite different with opposing rules. It would be very confusing to staff and residents if one day it is okay to perform certain tasks, then the next day, they are not allowed.

7. Review the following situations to determine if the request to the LTCOP is appropriate or inappropriate. Explain why the representative would or would not have a role for each of the situations.

**Trainer’s Note:** Use these situations to bring about a discussion and allow ample time. In some cases, you may notice moral or ethical concerns that are brought up by the trainees. Make sure you recognize the trainee’s perspective, identify with the concern, and relate it to a situation when you may have had to advocate on behalf of a resident where you felt uncomfortable. Encourage the trainees to share their dilemmas with their direct supervisor.

A. Mr. Lopez has uncontrolled diabetes and is morbidly obese. Against the doctor’s recommended diet, he wants to eat the desserts that the other residents without diabetes are served. He asks you to talk to the dietary manager about getting the same desserts as everyone else.

**Answer:** Appropriate because the resident is seeking assistance from the LTCOP about his right to choose. The LTCOP often advocates on behalf of residents for dietary wishes and ensures that facility staff discuss the possible risks and benefits to going against doctor’s recommendations.

B. The facility social worker contacts the LTCOP and asks for help finding a facility for a resident who is causing “problems.”

**Answer:** Inappropriate because it is not the responsibility of the LTCOP to help facility staff find a new place for a resident to live. The LTCOP can visit the
resident and find out if the resident wants the assistance of the LTCOP and if so, then the LTCOP would follow the direction of the resident, not the facility staff.

C. Mrs. Thompson complains that she is lonely and asks you to stay longer to keep her company and look through her photo albums with her.

**Answer:** *Inappropriate because it is not the role of the LTCOP to be the friend of a resident or to help her pass the time. The LTCOP spends time with residents to explain their rights, explain the LTCOP, to empower them to advocate on their own behalf, and to hear concerns and complaints. However, this does not mean that the representative cannot take the time to get to know residents to understand their likes, dislikes, values, preferences, etc. In this example, it would be appropriate to ask the resident if she would like to talk to staff about other resources in the facility and the community.*

D. Mrs. Cohen tells the LTCOP she would like to go to Temple every week. Mrs. Cohen states that she heard “The Ride” program takes two fellow residents, but she needs assistance to fill out the application and submit it. With Mrs. Cohen’s permission, the LTCOP asks the social worker to help the resident complete the application.

**Answer:** *Appropriate because the representative is assisting the resident with facilitating a ride and has permission to talk with the social worker.*

E. Mr. Clark wants your help to convince the facility staff that he should be allowed to take a shower every morning. The facility says they are concerned they don’t have enough staff to allow for Mr. Clark or anyone else to shower daily and asked, “What would happen if all of the residents wanted to take a shower every morning?” The staff member asks you to talk Mr. Clark out of his request.

**Answer:** *This is an appropriate request from the resident, but an inappropriate request from the staff member. The LTCOP can assist a resident with the right to choose to shower daily. However, the LTCOP should not attempt to talk the resident out of something that is his right, as the staff member has requested.*
Module 1 Additional Resources

Federal Agencies and National Organizations

- Administration for Community Living https://acl.gov/programs/Protecting-Rights-and-Preventing-Abuse/Long-term-Care-Ombudsman-Program
- National Ombudsman Resource Center https://ltcombudsman.org/
  - NORC library of resources for the State Long-Term Care Ombudsman Programs Rule https://ltcombudsman.org/library/fed_laws/ltcop-final-rule
- The National Consumer Voice for Quality Long-Term Care https://theconsumervoice.org/home

Conflict of Interest

- See Conflict of Interest under Technical Assistance https://ltcombudsman.org/omb_support/ta
MODULE TWO

The Resident and the Resident Experience

TRAINER GUIDE

January 2022
## Table of Contents

Module 2 State-Specific Information.................................................................2  
Section 1: Welcome and Introduction...............................................................3  
Section 2: Who Lives in Long-Term Care Settings and Why?...............................9  
Section 3: The Resident Experience .................................................................23  
Section 4: Common Health Experiences............................................................31  
Section 5: Conclusion.........................................................................................46

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Module 2 State-Specific Information

The list below outlines state-specific information for trainers to discuss, provide a link to, or add directly to the Trainer Guide, Trainee Manual, and/or PowerPoints. When you get to the point in the training where you need to discuss, include a link to, or add state-specific information, you will see a bold, blue arrow (→) and a brief description of what to include.

→State-Specific Information

Section 2 Resident Demographics

- Share state-specific nursing facility demographics. The Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Frequency Report¹ summarizes information from the MDS for residents currently in nursing facilities. You can search for information by state and use it for demographics.

- Provide state-specific information for residential care communities:
  - Types of residential care communities
  - Any requirements for providing specific services for residents (e.g., dementia care)
  - Demographic data, if available, or from the 2016 National Study of Long-Term Care Providers²

- Review state-specific information about individuals with intellectual and developmental disabilities and where individuals with such disabilities live (e.g., in the community, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID), group homes, or personal care homes).

Section 1:
Welcome and Introduction
Welcome

_Trainer's Note:_ Allow at least 15 minutes for Section 1.

Begin the session by welcoming the trainees back to the training and thanking them for their continued interest in the program. Make sure everyone introduces themselves – even if they come late.

To begin, please share:
- Your name
- Where you are from
- One thing you learned from Module 1 - something that really stuck with you or surprised you
- What you hope to learn since the last module

After introductions, thank the trainees for their information and explain any housekeeping items that need to be addressed including the time frame of the training day, breaks, location of restrooms, refreshments, etc. Ask the trainees to speak up if they have any questions throughout the training.

Welcome to Module 2, _The Resident and the Resident Experience_. Thank you for being here to learn more about the Long-Term Care Ombudsman program and the certification process. Since this Module focuses on the resident and the resident experience, you will see several quotes from residents throughout the manual. The quotes are from actual residents, but the names have been changed for purposes of confidentiality. To amplify the voices of the residents, other than for length, the quotes have not been edited.

Module 2 Agenda

_Trainer’s Note:_ The timeframes for each Section are approximate. Allow at least 3.25 hours for this session.

Section 1: Welcome and Introduction (15 minutes)
Section 2: Resident Demographics (45 Minutes)
Section 3: The Resident Experience (45 Minutes)
BREAK (10-15 Minutes)
Section 4: Common Health Experiences (60 Minutes)
Section 5: Conclusion (15 Minutes)
Module 2 Learning Objectives

Trainer’s Note: Be mindful of the sensitive topics discussed in this Module. The discussion could trigger unexpected emotions from the trainees due to a personal experience. Sometimes when this happens people either shut down or overshare. Pay close attention to the trainees and if you notice someone having a hard time, either take a break or arrange to talk with them after the session or both. If someone begins to overshare and their experiences start to take over the discussion, politely and respectfully express the need to move on with the material and offer them time to speak with you privately after the training. Review the learning objectives with the trainees.

After completion of Module 2, you will understand:

- Who lives in long-term care facilities
- Why people enter long-term care
- Why people stay in long-term care
- The impact of loss when residents enter long-term care
- Common diagnoses and their impact on residents and importance to the Long-Term Care Ombudsman program (LTCOP)
- Common health concerns in long-term care
Module 2 Key Words and Terms

The key words and terms are defined relative to Ombudsman program practices and are found throughout this Module. Take a moment to familiarize yourself with this important information.

Activities of Daily Living (ADLs) – Basic tasks and fundamental skills necessary to independently care for oneself, such as eating, bathing, and mobility.

Centers for Medicare & Medicaid Services (CMS) – A division within the U.S. Department of Health and Human Services, CMS administers the nation’s major healthcare programs including Medicare and Medicaid.

Demographics – Statistical data relating to the population and particular groups within it. For the purposes of this training, the demographics used are from federal resources. States may include their own state-specific data from state resources.

Home and Community-Based Services (HCBS) – Provides consumers needing long-term care services more choices in where and how they receive those services.3

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) – The ICF/IID benefit is an optional Medicaid benefit; however, all states offer this. ICF/IID provide active treatment for individuals with intellectual disabilities and other related conditions. Residents in ICF/IID may be non-ambulatory, have seizure disorders, mental illness, visual or hearing problems, or a combination of conditions. Currently, the Ombudsman program in very few states either visit or respond to complaints from ICF/IID.4

Minimum Data Set 3.0 (MDS, MDS 3.0) – A federally mandated assessment of all residents of Medicare and Medicaid certified nursing homes. MDS assessments are conducted upon admission, throughout the resident’s stay, and upon discharge. The data from the assessments are transmitted electronically using the MDS national database at CMS.5

Office of the State Long-Term Care Ombudsman (Office, OSLTCO) – As used in sections 711 and 712 of the Act, means the organizational unit in a State or territory which is headed by a State Long-Term Care Ombudsman.6

Ombudsman – A Swedish word meaning agent, representative, or someone who speaks on behalf of another. For the purposes of this manual, the word “Ombudsman” means the State Long-Term Care Ombudsman.

3 Home and Community Based Services National Long-Term Care Ombudsman Resource Center https://ltcombudsman.org/home-and-community-based-services
4 https://www.cms.gov/Medicare/Provider-Repayment-and-Certification/CertificationandCompliance/ICFIID
6 45 CFR Part 1324 Subpart A §1324.1 Definitions
Representatives of the Office of the State Long-Term Care Ombudsman (Representatives) – As used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in §1324.19(a), whether personnel supervision is provided by the Ombudsman or his or her designees, or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.7

Residential Care Community (RCC) – A type of long-term care facility as described in the Older Americans Act (Act) that, regardless of setting, provides at a minimum, room and board, around-the-clock on-site supervision, and help with personal care such as bathing and dressing or health-related services such as medication management. Facility types include but are not limited to, assisted living; board and care home; congregate care; enriched housing programs; homes for the aged; personal care homes; adult foster/family homes; and shared housing establishments that are licensed, registered, listed, certified, or otherwise regulated by a state.8

Serious Mental Illness – A mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.9

Skilled Nursing Facility or Nursing Facility – Also known as a “nursing home,” is a certified facility that provides skilled nursing care for residents who require medical or nursing care rehabilitation or provides health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities.10 For the purposes of this training and to be consistent with the National Ombudsman Reporting System (NORS), we use the term “nursing facility” for both skilled nursing facilities and nursing facilities.11

State Long-Term Care Ombudsman (Ombudsman, State Ombudsman) – As used in sections 711 and 712 of the Act, means the individual who heads the Office and is responsible personally, or through representatives of the Office, to fulfill the functions, responsibilities, and duties set forth in §1324.13 and §1324.19.12

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7 45 CFR Part 1324 Subpart A §1324.1 Definitions
8 CA-04 02 Residential Care Community Table 1 Part C Case and Complaint Definitions
https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
9 National Institute of Mental Health retrieved from www.nimh.nih.gov
10 This definition is a combination of Requirements for, and assuring Quality of Care in, Skilled Nursing Facilities, Section 1819(a) of the Social Security Act [42 U.S.C. 1395i–3(a)]
11 NORS Table 1 https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
12 45 CFR Part 1324 Subpart A §1324.1 Definitions
State Long-Term Care Ombudsman program (Ombudsman program, the program, LTCOP) – As used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.\textsuperscript{13}

Subsection Symbol (§) – The subsection symbol is used to denote an individual numeric statute or regulation (rule).

\textsuperscript{13} 45 CFR Part 1324 Subpart A §1324.1 Definitions
Section 2:
Who Lives in Long-Term Care Settings and Why?

If you’re a caregiver, you don’t just insert a hearing aid for a hearing-deprived resident; you don’t just give a shower to a manually disabled resident; you don’t just wipe a totally dependent resident. In short, you do more than assist a resident with performing the Activities of Daily Living. You become the human bridge that carries a trace of dignity to the helpless, that empathizes with their inability and uncertainty.

- David
When many people think about residents, they imagine older individuals with a variety of ailments associated with aging, who are bedridden or immobile. Sometimes lost is the realization that residents vary in the same respect as individuals who live in the community. Residents have a variety of backgrounds, life experiences, and roles, such as: mother, father, friend, sibling, son, daughter, teacher, nurse, doctor, engineer, coach, farmer, and social worker. The list goes on and on. Some residents had a hard life, some were abused as a child or an adult. Some residents are veterans, some have seen combat, some are Holocaust survivors, and some marched for civil rights and/or made great contributions to their communities. Each one of us can be found in the face of a resident.

**Trainer's Note:** Show the video below and let the trainees know the video was made to inform residents about diversity. After showing the video, ask the following questions.

Watch the video titled [LTC Informational Series Video 9 – Diversity in Long-Term Care Facilities](https://www.youtube.com/watch?v=wYeyXzRSwwI&list=PLSu_zY6vP6REXfjgVt7E-F9CG2K_9P-F&index=11) and answer the following questions.  

1. According to the video, what is the facility’s responsibility in terms of discrimination?

   **Answer:** “To ensure that no one is discriminated against at any time when they are a resident of that facility.”

2. According to the video, what is the overall goal of every long-term care facility?

   **Answer:** “To provide a homelike atmosphere for all of their residents. Acknowledge the fact that the residents define homelike according to their own terms and must be allowed to do so without the fear of judgement or critique of others.”

### Myths and Stereotypes about Individuals Living in Long-Term Care

**Trainer's Note:** Allow at least 60 minutes to cover Section 2. Use the chart in Figure 1 to explain common myths and stereotypes about people who live in long-term care facilities. Draw from your experiences – but you do not need to provide an example for each myth/stereotype or reality. There are examples listed below the chart you can use if needed.

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14 Southwestern Commission LTC Informational Series Video 9 – Diversity in Long-Term Care Facilities https://www.youtube.com/watch?v=wYeyXzRSwwI&list=PLSu_zY6vP6REXfjgVt7E-F9CG2K_9P-F&index=11
There are some common myths and stereotypes about older adults and persons living with disabilities\(^{15}\) in long-term care facilities. In reality, residents are not much different from those living in the community at-large. Residents have desires, abilities, and the need to have a sense of purpose. Residents are from all walks of life, are young and old, with or without disabilities. Just as with other populations, it is damaging to stereotype people who live in long-term care facilities.

**COMMON MYTHS AND STEREOTYPES**

<table>
<thead>
<tr>
<th>Myth/Stereotype</th>
<th>Reality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents are not connected to what is going on around them. Residents lose interest in life and become more introspective and withdrawn.</td>
<td>Residents are interested in meaningful relationships. People important to the resident may have died or disengaged from the resident, but that does not mean the resident isn't interested in connecting with others.</td>
</tr>
<tr>
<td>Residents are child-like and should be treated as such.</td>
<td>residents are adults and should be treated with dignity and respect.</td>
</tr>
<tr>
<td>Residents are dependent and want someone to take care of all their needs. People with disabilities always need help.</td>
<td>Most residents maintain abilities and want to care for themselves as much as possible. Most residents do not want to be totally dependent on others to meet their needs. In fact, many residents are not fully dependent and want to be as independent as possible.</td>
</tr>
<tr>
<td>Older people don’t participate in sexual activity. Most people with disabilities cannot have sexual relationships.</td>
<td>Need for sexual expression and intimacy continues throughout life. Anyone can have a sexual relationship by adapting sexual activity. Sexuality is a basic human need and the choice to participate in sexual acts belongs to the resident.</td>
</tr>
<tr>
<td>Younger people do not reside in long-term care facilities.</td>
<td>There are younger residents who live in long-term care facilities. In fact, nearly 17%(^{16}) of nursing facility residents are under 65 years old.</td>
</tr>
<tr>
<td>People with mental illnesses are not admitted into nursing facilities.</td>
<td>There are residents who live in long-term care facilities with a range of mental illness diagnoses.</td>
</tr>
<tr>
<td>Old people are unproductive and set in their ways. They have already made their contribution to society.</td>
<td>The need to feel a sense of purpose in life does not change once one becomes a resident. Residents need to have a reason to wake up in the morning and to feel useful and important. Growing older does not mean one no longer wants to learn.</td>
</tr>
</tbody>
</table>

\(^{15}\) Myths and Facts about People with Disabilities [www.govst.edu](http://www.govst.edu)  
\(^{16}\) Minimum Data Set 3.0 Frequency Report retrieved from [www.cms.gov](http://www.cms.gov)
Residents are interested in meaningful relationships – People important to the resident may have died or disengaged from the resident, but that does not mean the resident isn’t interested in connecting with others. Sometimes residents may appear disengaged and that could be due to difficulty hearing, seeing, remembering, or to the side-effects of medications.

Ken always appears disinterested in what is going on around him and does not talk to the other residents. During a doctor’s appointment, the doctor finds a great deal of wax build-up in Ken’s ears and cleans them out. Since his appointment, Ken is much more social with the other residents.

Residents are adults and should be treated with dignity and respect – Sometimes when people live in long-term care facilities others treat them as though they are children and don’t treat them with the respect they deserve.

Howard is a former engineer and says he does not appreciate how staff call him “honey” and “sweetie,” or tell him when to go to bed. He says he is not a child and does not want to be treated in that manner.

Most residents maintain abilities and want to care for themselves as much as possible – Often, residents help each other and will alert staff if their roommate or neighbor needs assistance.

Jan always looks out for her roommate, Ethel, who cannot communicate. Jan knows from the look on Ethel’s face when she needs help and gets someone to help her.

**Trainer’s Note:** *If you need additional experiences to share with trainees you may want to read the book “Counting on Kindness – The Dilemmas of Dependency” by Wendy Lustbader, MSW. The stories shared are from individuals that rely on caregivers to show how it feels to be dependent on others.*

Need for sexual expression and intimacy continues throughout life – People often assume that older adults or adults with disabilities lose their desire to be intimate. Residents often have a desire for intimacy which can come in several different forms.

Two residents, Mae and George, become quite close and want to be alone with the door shut. Mae’s daughter is extremely upset and vocal that it is outside of her mother’s character to be alone with a man other than Mae’s deceased husband. The daughter believes George is taking advantage of Mae. Mae is uncomfortable that her relationship with George has become a problem for her daughter and does not want to discuss it with her. Mae talks to the social service director and the representative and states she wants to spend alone time with George. Mae states she likes their intimate relationship.
There are younger people who live in long-term care facilities – A common misconception is that younger residents do not reside in long-term care facilities and if they do, it must be a result of an accident. While that may be the case with some residents, most younger residents in long-term care facilities reside there due to a chronic illness and/or mental illness. During this training you will learn about community options and services to help people live in the least restrictive setting possible.

Jimmy is 36 years old and lives in a Residential Care Community (RCC) because he is unable to manage his medications prescribed for his mental illness. He needs medication reminders and structure to support his mental health.

The need to feel a sense of purpose in life does not change once one becomes a resident – While declining health and disabilities can restrict a resident from doing what used to give them a sense of purpose, it does not mean that new activities cannot foster the same feelings of purpose.

An excellent example is found in an Arizona assisted living for memory care. The facility partners with a local animal shelter and residents are provided with the opportunity to feed and play with kittens who are in constant need of care. The residents feel a sense of purpose in taking care of the kittens. Residents who struggled to communicate verbally prior to the program suddenly began to talk.

Watch the video titled Adorable Kittens & Seniors Come Together and Help Each Other. 

1. What are your thoughts about the video?

2. Did your perceptions about the importance of feeling a sense of purpose change after watching the video?

Trainer’s Note: Ask the following question: “Why is it important to talk about assumptions made about individuals living in long-term care?”

Responses should include: to check preconceived notions, to gain a clear understanding about the people we will be assisting, and/or to understand others’ stereotypes.
Resident Demographics

→ Share state-specific nursing facility demographics. The Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Frequency Report\(^\text{18}\) summarizes information from the MDS for residents currently in nursing facilities. You can search for information by state and use it for demographics.

→ Provide state-specific information for residential care communities:

- Types of residential care communities
- Any requirements for providing specific services for residents (e.g., dementia care)
- Demographic data, if available, or from the 2016 National Study of Long-Term Care Providers\(^\text{19}\)

**Trainer’s Note:** If you have facilities in your area that primarily serve a specific demographic, share that information with the trainees. Point out the major differences and make sure to cover the percentages of residents age 65 and younger.

The data in Figure 2 comes from the Minimum Data Set 3.0 (MDS 3.0) Frequency Report from 2021 first quarter. The MDS 3.0 is a federally mandated assessment of all residents in Medicare and Medicaid certified nursing facilities. Nursing facilities conduct MDS assessments upon admission, throughout the resident’s stay and upon discharge. Data from the assessments is transmitted electronically using the MDS national database at CMS.

Data in Figure 3 comes from the 2016 National Study of Long-Term Care Providers.

Not all long-term care facilities are nursing facilities. Module 3 provides detailed information about nursing facilities and the different types of residential care communities (RCCs).

RCCs are a type of long-term care facility as described in the Older Americans Act that, regardless of setting, provide at a minimum, room and board, around-the-clock on-site supervision, and help with personal care such as bathing and dressing or health-related services such as medication management. RCCs vary from state to state. Not all facilities provide the same level of supports and services and some may specialize in certain areas (e.g., memory care). Entrance is determined through a series of assessments and evaluations (discussed in Module 3). With the development of assisted living facilities and


\(^{19}\) [https://www.cdc.gov/nchs/data/nsltcp/State_estimates_for_NCHS_Data_Brief_299.pdf](https://www.cdc.gov/nchs/data/nsltcp/State_estimates_for_NCHS_Data_Brief_299.pdf)
other state-licensed homes, the number of residents has increased in RCCs and has decreased in nursing facilities.

The demographics of long-term care residents have changed over the years. While most residents are white females 85 years of age and older, it is not unusual for the LTCOP to work with residents who are under age 65, or from various cultures, backgrounds, and experiences.

The second largest age group living in long-term care facilities are people between the ages of 75 and 84 years old. Residents who are age 64 or younger are increasing in numbers and have become the fastest growing population in long-term care facilities.

While most nursing facilities have this generational overlap of residents, the interests of the younger residents in terms of music, activities, and culture may be quite different than those of the older residents. Facilities may need to expand their activities calendars, rethink their menus, and offer activities that interest younger individuals.

Figure 2

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20 Centers for Disease Control Table 1 Resident population, by age, sex, race, and Hispanic origin: United States, selected years 1950-2016 https://www.cdc.gov/nchs/data/hus/2017/001.pdf

21 The Society for Post-Acute and Long-Term Care Medicine: The Younger Adult in the Long-Term Care Setting https://paltc.org/product-store/younger-adult-long-term-care-setting

**Trainer’s Note:** In Figure 3, the Centers for Disease Control and Prevention (CDC) 2019 report on vital and health statistics for the National Center for Health Statistics reflects data from 2015-2016. The report breaks down certain resident demographics and lists the percentage distribution of residents by demographics within residential care communities. The chart is reflective of the demographic language used at the time of the report. The denominator used to calculate percentages for RCCs was the number of residents on a given day in 2016.

Figure 3

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[Image: National Residential Care Communities Population]

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[23](https://www.cdc.gov/nchs/data/nsltcp/State_estimates_for_NCHS_Data_Brief_299.pdf)
Residents with Intellectual and Developmental Disabilities

-> Review state-specific information about individuals with intellectual and developmental disabilities and where individuals with such disabilities live (e.g., in the community, Intermediate Care Facilities for Individuals with Intellectual Disabilities [ICF/IID], group homes, and personal care homes).

Trainer’s Note: Not all Ombudsman programs visit facilities such as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). However, the Ombudsman program assists residents in nursing facilities and residential care communities who may have intellectual or developmental disabilities. Share an example of your program’s experience working with this population and talk about programs and services that support community living rather than institutional care.

People with developmental disabilities (DD) may have difficulties with things such as speaking, learning, caring for themselves, moving around, making decisions, living independently, and making and managing money. Their difficulties start before age 22. They continue throughout life and are severe enough that the person needs ongoing supports.

Intellectual disability (ID) begins before age 22. People with ID have trouble learning and solving problems. They also have difficulties with practical skills such as dressing or shopping, social skills such as making and keeping friends and keeping others from hurting them, and with skills such as reading and doing math.

In the United States, about 2.3% of the people have ID/DD. About 7 in 100 children have ID/DD. Some children no longer have significant disabilities by the time they are adults. Fewer than 1 in 100 adults have ID/DD.

Historically, doctors and teachers told parents that institutions were the best place for people with ID/DD to live, learn, and be safe. But many families kept their children at home. Many professionals believed that people with ID/DD could not learn, hold a job, or live with their families. Beginning in the 1960’s many laws passed that supported the rights of persons with intellectual and developmental disabilities including the Developmental Disabilities Assistance and Bill of Rights Act, the Individuals with Disabilities Education Act, The Americans with Disabilities Act and the Supreme Court’s Olmstead decision, to name a few. These laws support and require equal access in education, the ability to live in a community, and equal access to health care and services.

24 Most of the information in this section has been adapted from Administration for Community Living: 30 Years of Community Living for Individuals with Intellectual and/or Developmental Disabilities
Federal laws and policies continue to require supportive services in the least restrictive settings. Data indicates that in response to these changes:

- Four of every five people with ID/DD who lived in an institution in 1987 moved to a community home by 2017.
- The number of people with ID/DD supported to work in community jobs increased from 33,000 in 1987 to 135,000 in 2017.
- Medicaid spending to support people with ID/DD increased by three and a half times (from $15.7 billion to $55.3 billion in 2017 dollars). For example, the number of people with ID/DD getting Medicaid-funded supports in home and community-based settings exploded from 22,869 people to 860,500 people.

Each state makes different choices about how to use tax dollars to pay for supports for people with ID/DD. Thus, the amount of money spent on supports for people with ID/DD varies across states. However, most spending has shifted from institutions to community settings. Most people with ID/DD live in homes in the community, not in institutions. The number of people with ID/DD who receive paid support and do not live with a family member more than doubled between 1987 and 2017. By 2017, most people with ID/DD not living with a family member lived in homes shared by six or fewer people with ID/DD.

In summary, people with ID/DD want:

- Homes of their own, not institutions
- Jobs and meaningful ways to spend their days
- Access to funded supports
- Access to easy-to-use technology

Learn more about individuals with intellectual and/or developmental disabilities here.25

There were many years I had to fight just to be in the community … and not end up back in an institution.” – Heidi Myhre

25 Administration for Community Living: 30 Years of Community Living for Individuals with Intellectual and/or Developmental Disabilities
https://acl.gov/sites/default/files/Aging%20and%20Disability%20in%20America/30%20Years%20Report.pdf
Events and Situations that Lead to Long-Term Care

*Trainer’s Note: The other ~10% not listed in the statistics below are residents who come from psychiatric hospitals, inpatient rehabilitation facilities, long-term care hospitals, hospice, etc.*

Nearly 80% of nursing facility residents come from an acute care hospital and require some short-term skilled care such as physical therapy, wound care, or IV medication. Only 9.4% of residents enter a nursing facility from the community.26

There are several reasons individuals enter a nursing facility or a residential care community. These include but are not limited to:

- A sudden medical event
- The progression of dementia
- The progression of a chronic or a terminal illness

Individuals sometimes decide to go to a long-term care facility due to the recommendation from a physician, or concerns raised by family members.

*A medical event*

Sometimes a medical event prompts consideration of a long-term care facility. In some cases, a medical event can lead to an individual suddenly and unexpectedly needing long-term care. Even when the harm is low from a medical event, having that experience may cause a person to become fearful of living alone and that fear may be the driving factor to enter a long-term care facility.

Examples of medical events include accidents, strokes, and falls.

- Accidents can lead to paralysis, brain injury, fractures, chronic pain, and more. Some accidents are a result of the progression of dementia (e.g., the individual leaves the stove on and a fire starts).
- Strokes are another example of a medical event that could lead to long-term care. Strokes can cause memory loss, paralysis, and/or an inability to verbally communicate.
- Falls can also be a signal for individuals and family members that the individual’s health is declining, and more assistance is needed. Falls can cause fractures, brain bleeds, paralysis, traumatic brain injury, internal bleeding, pain, and more.

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Alison Parker

I am 45 years old and was in a car accident and almost died. I woke up from a coma 2 months later in the hospital and was told I have a traumatic brain injury. I was discharged from the hospital to the nursing facility for physical and speech therapies. I still struggle with my memory and speech and my right side is also affected from the brain injury; but I am working on getting stronger. I rely on others to help me with my activities of daily living, but I’m getting better. I can brush my teeth and feed myself, but I need someone to set everything up for me. I cannot completely wash myself or get dressed on my own. I am working with the facility to help me find a place to live in the community.

The progression of Alzheimer’s disease or other dementias

The progression of Alzheimer’s disease or other dementias is overwhelming for individuals and caregivers and often leads to consideration of long-term care. Alzheimer’s disease and other dementias can cause:\(^{27}\)

- Memory loss
- Disorientation
- Confusion
- Delusions or hallucinations
- Behavior changes
- Difficulty eating or swallowing
- Difficulty speaking
- Weight loss
- Wandering
- Incontinence

Although supports and services may be in place, the progression may become more than caregivers can manage at home.

Bernie Ford

My father lived at home with his wife until she passed away. After she died, it became clear that his dementia was much worse than I had thought. His wife did everything for him and tried not to worry me with the worsening symptoms of Alzheimer’s. My father moved in with me and after 6 months, I knew I was in over my head. He began wandering in the middle of the night and a couple of times was brought back to my home by the neighbors. At times he would hallucinate and become combative due to fear and confusion. I knew I could no longer manage his care. I found an assisted living facility for him that specializes in memory care.

\(^{27}\) Alzheimer’s Association [www.alz.org](http://www.alz.org)
The progression of chronic or terminal illnesses

The progression of chronic or terminal illnesses such as cancer, congestive heart failure, liver disease, diabetes, COPD (chronic obstructive pulmonary disease), ALS (Lou Gehrig’s disease or amyotrophic lateral sclerosis), MS (multiple sclerosis), renal failure, and others can cause symptoms that cannot be managed without long-term supports and services. Some of these illnesses can lead to severe pain, fatigue, extreme weight loss, and muscle wasting.

Carolyn Dunn

I moved into the nursing facility because I have COPD and struggle with breathing. One afternoon, I had a terrible coughing episode and passed out in my home. As luck would have it, my son happened to stop by and found me laying on the floor. I went to the hospital and was told my lungs are damaged. I need help and I’m too scared to live alone so I decided to move to a nursing facility. My doctor agreed with my decision, and I know my son feels better now that I’m not alone.

Why Do People Continue to Live in Long-Term Care Facilities?

Many, but not all, residents who receive skilled care stay for a short time and are able to return to their home after they have improved. Others may choose to go to a residential care community (RCC) rather than return home. Those who are unable to do either continue to stay in the nursing facility.

Some reasons individuals do not return home include:

- The resident’s health declined or did not improve enough to go home, even with home care services.
- The resident does not have available supports and services to successfully live at home alone.
- The resident has a need for care services and does not have a home to return to. For example, the resident:
  - Lost their home because of financial hardship
  - Had to give up their apartment to pay for their nursing care
  - Was homeless prior to entering the facility

This will be discussed more in Module 4, but even when a resident encounters barriers to returning to their home or a community setting it does not mean they have no other options. Nursing facilities are required to ask all residents if they would like to receive information on how to return to a community setting and, if so, connect the resident to resources that can help them transition out of a nursing facility.

Depending on the state licensure and type of care provided in residential care communities, residents in RCCs may be more independent and physically healthier than
those living in a nursing facility. Their reasons for living in an RCC vary and may be different than for those living in a nursing facility.

Some reasons include:

- Feelings of loneliness and isolation
- The RCC meets the specific needs of the resident
- The RCC fills the gap between living independently and living in a nursing facility
- The state has increased opportunities for Medicaid to pay for services provided in RCCs through Home and Community-Based Services (HCBS) waiver programs (discussed more in Module 4)
Quality is about meaningful interactions and relationships. There was an extraordinary aide, Jan, who worked overnight and regularly came in to awaken me at about 6:15 a.m. She started the one cup coffee maker, reset the thermostat in the room, and smiled as she left the room telling me, “Have a good day.” It is the little things in life that matter – meaningful interactions and relationships. - Terry
*Trainer’s Note:* Allow at least 45 minutes for Section 3.

**When Residents Enter Long-Term Care**

**Activity: Daily Routines and Activities**

*Trainer’s Note:* Allow about 15 minutes for this activity. The time frame will depend on your class size.

This activity allows trainees to think about the experience of moving into a long-term care facility. It asks them about their own personal routines and daily activities and what they would not want to give up if they had to move to a nursing facility tomorrow.

**Step 1** - Tell the trainees to **write down their daily routines and activities** and give them a few minutes to do so.

**Step 2** - Tell the trainees **they are going to live in a nursing facility tomorrow, and they must cross off all but one daily routine or activity.** That is the routine or activity they get to keep while living in the nursing facility.

If conducting the session virtually, consider the number of trainees and the ability of the trainees to provide verbal responses. If they are unable to respond verbally, they can enter them into the virtual platform (e.g., via a chat box).

**Step 3** - Start with your own example then **ask each trainee to tell the group which activity they have chosen.**

**Step 4** - You may choose to keep a running visual list or not. Once all trainees have answered the first question, ask them to **look at their daily routines and activities again, including other people involved regularly in their routines.** Ask the three bulleted questions below (and in the PowerPoint Slide) to the entire class and acknowledge/process their responses (all trainees do not need to share their response).

- Why are your routines important to you?
- Should you have to give up your daily routines?
- If you had to modify your routines, what would make the transition easier?

**Step 5** - Then ask the trainees to **picture the personal possessions in their home that are most important to them and ask them to start writing them down.** Allow a few minutes to do so.

**Step 6** - Tell the trainees to **cross off all but three items** and those are the possessions they can take with them to the nursing facility.
Step 7 - Again, start with your example then allow for all trainees to share their choices. Once everyone has answered, ask the three bulleted questions below (and in the PowerPoint Slide) to the entire class and acknowledge/process their responses (all trainees do not need to share their response).

- Why are your possessions so important to you?
- Should you have to give up all but three of them?
- What would help ease you into your new surroundings without your familiar and beloved possessions?

Step 8 - After everyone has responded, ask them “What did it feel like to have to choose only a few of your items and one routine?”

As you work your way through the material in this Module, use the examples given by the trainees to point out the uniqueness of the individuals and the importance our preferences play in the overall quality of life.

Explain to the trainees that the activity was intended to give you an idea of how life-altering moving into a long-term care facility can feel. However, it is important to know that due to federal and/or state requirements long-term care facilities are supposed to provide resident-centered care and honor residents' rights (e.g., respecting resident choices and preferences for their care and routines). This will be discussed more in Module 3.

Consider your thoughts and feelings stimulated by the activity. Think about all the changes people make when they move into a long-term care facility and the effect changes have on them. It’s not surprising that the move into a long-term care facility can be extremely difficult, often resulting in feelings of grief and loss.

Experiences of Loss

**Trainer’s Note:** Before you start this part of the training, read the following paragraph. If someone does step out, check in with that individual privately, after the session or at the next break.

Sometimes a discussion of loss and grief can bring up your own personal feelings of past experiences. The training content is not intended to make you feel sad or uncomfortable. However, if something is triggered and you need to step away, please feel free to do so.

* Loss and grief – What do those words mean to you?

**Trainer’s Note:** Give the trainees time to think about and to share what these words mean, even if the room is quiet for a bit. Remind them of the feelings they just expressed during the previous activity. Tell them their reactions are no different than those of people entering long-term care.
Feelings of loss are often associated with life-changing events, such as moving to a nursing facility or other long-term care setting. However, when most people think of loss, they think of death, but death is not the only loss that people need to grieve.

Residents have experienced significant losses in a short period of time which can have damaging effects on their physical and mental wellness. Look at the chart below to review some of the major losses people experience when moving into a long-term care facility and the effects it may have on their health and wellness.

**Trainer's Note:** Go over the Figure 4 chart and connect the “Possible Effects” to the trainees' responses shared in the activity above. Use the narrative in the trainer’s notes below to guide you through the chart. Give examples from your experience working with residents or use the examples provided in the trainer’s notes featuring a resident named “Jane.”

### EFFECTS OF LOSS ON RESIDENTS

<table>
<thead>
<tr>
<th>Loss</th>
<th>New Circumstances</th>
<th>Possible Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>Coming to terms with managing a new or worsening illness and/or disability</td>
<td>Feeling anxiety, fear, frustration, anger, despair</td>
</tr>
<tr>
<td>Home</td>
<td>Moved (voluntarily or involuntarily) away from a familiar home or setting to an unknown, unfamiliar place</td>
<td>Feeling uneasy, anxious, confused on whereabouts</td>
</tr>
<tr>
<td>Family, Friends, Neighbors</td>
<td>Separated from loved ones whom you lived with or visited often - perhaps the resident’s partner or caregiver passed away</td>
<td>Feeling sad, lonely, forgotten, isolated, missing loved ones</td>
</tr>
<tr>
<td>Freedom</td>
<td>Adjusting to new routines and activities, and feeling that you must conform to a new environment with new rules and guidelines</td>
<td>Feeling frustrated, angry, hopeless, loss of control over daily life; having no autonomy, feeling like a child again</td>
</tr>
</tbody>
</table>
Privacy

| Possibly sharing a room with a stranger, staff walking in and out, people asking personal questions, staff may assist you with bathing, dressing, and/or taking you to the bathroom |
| Feeling humiliated, embarrassed, loss of dignity, frustration, anger |

Personal Property

| Loss of personal belongings with special meaning or memories |
| Feeling disconnected |

**Loss of health:** Loss of health is often the reason someone enters a long-term care facility. With loss of health, one may struggle with coming to terms with managing a new or worsening illness and/or disability. Loss of health can cause feelings of anxiety, fear, frustration, anger, or despair.

**Example:** Jane had trouble with her balance while living alone in her apartment. She had a few falls, but the last fall resulted in a broken hip. She is now receiving physical therapy in a nursing facility. She is afraid of being alone and falling again, but at the same time, she is angry at her limited mobility. She has always been very independent and can’t bear to think about not living life as she did prior to breaking her hip.

**Loss of home:** Every person in a long-term care facility has left their previous home and now may be living in an unknown and unfamiliar setting. Residents can feel a sense of uneasiness, anxiousness, and even confusion about their surroundings. Many may feel uncomfortable in their new home.

**Example:** Jane has a hard time relaxing in the nursing facility with all the commotion going on in the halls. She doesn’t sleep well because her bed is not as comfortable as her bed at home. When she does fall asleep, she wakes up confused. Jane is at risk of losing her senior housing if she stays in the nursing facility much longer and she has a great deal of anxiety about it.

**Loss of family, friends, and neighbors:** Most people in long-term care are newly separated from their loved ones. Not just those who lived in the same home, but friends and neighbors as well. Some residents enter a long-term care facility because the person taking care of them passes away. When people lose someone they love, whether through death or separation, it can be devastating and may bring about feelings of sadness, loneliness, isolation, and missing loved ones.

**Example:** When Jane lived in her apartment, she played cards with four friends from her floor every Tuesday night. Most were single, without a lot of family around, so the five of them became each other’s family. Jane’s friends rely on public
transportation and the nursing facility isn’t in a convenient area for them to visit. She misses them terribly.

**Loss of freedom:** Individuals go from making all decisions about their daily life to adjusting to new routines, scheduled and non-scheduled activities, and the confines of living in a facility with new rules and guidelines. No longer living on one’s own can lead individuals to feeling frustrated, angry, hopeless, and/or a loss of control over their daily life. Having no autonomy and being told what to do can make one feel like a child again.

**Example:** Jane feels very frustrated and angry with her new set daily schedule. She used to sleep in and slowly get out of bed, make her coffee, and have toast with jam. Sometimes she would invite her friends over mid-morning for coffee and cookies. In the evening she liked to eat dinner and watch her shows. At 9:00 p.m. every night, Jane would take a bath, then make herself a bowl of ice cream and eat it in bed while watching the news. Now, staff get her up early to go to physical therapy, then take her to breakfast where she is served too much food. She feels guilty if she doesn’t eat it, but she just wants some toast and coffee and quiet time in her room. Jane only gets showers twice a week at 11:00 a.m. Her roommate’s TV is too loud for Jane to watch her evening shows and since her roommate was there first, Jane is uncomfortable asking her to turn her TV down. Jane feels as though her life is now all on the facility’s schedule and feels a complete loss of control over her own life.

**Loss of privacy:** Most residents share a room with a stranger. All residents deal with staff walking in and out and asking very personal questions. In addition, some residents have strangers washing and dressing them and taking them to the bathroom. These are very intimate acts and can lead to feeling humiliated, embarrassed, frustrated, angry, and even feeling a loss of dignity.

**Example:** When Jane lived alone, she was used to taking care of herself. She likes her roommate in the nursing facility and enjoys their conversations, but she feels so humiliated and embarrassed when staff assist her in the shower and in the bathroom, especially when the male aides help her. It makes her feel sick to her stomach every time she needs assistance in the bathroom or shower.

**Loss of property:** Residents can only bring a few personal items when they move in. Often, personal items or possessions make people feel a sense of belonging or may remind them of special memories. Without those items some people feel disconnected from their former life.

**Example:** Jane has a special clock that was handed down to her from her grandparents. The clock chimes every hour, and the sound always reminds her of her childhood. She misses her clock and the memories it brought to her.
To manage feelings of loss, individuals must grieve those losses. Feelings of grief and loss can cause some residents to respond in a manner which may be perceived as being “difficult.” When a resident experiences multiple, significant losses in a short period of time, it can impact the resident’s ability or desire to: be involved with decisions related to their care; develop new relationships; accept help; eat; and/or sleep.

Representatives are not social workers or therapists and should not act in such a manner. The purpose of understanding grief and loss is to consider whether a specific loss or the grief process is at the core of an issue which helps weigh options in the problem-solving process. This also offers opportunities for you to promote, and advocate for, facility practices that embody resident-centered care, such as choice in daily routines, rather than residents following routines of the staff and facility.
What Residents Say About Living in Long-Term Care

Residents have the right to know when and why a medication or dosage has been changed. - Louella

There is one charge nurse that upsets everyone in the dining room. She treats us like kids. - Karen

Don’t answer call lights. I have sat on the pot for an hour. - John

The staff think they have authority over you. - Mickey

Staff don’t like to have to lift people. - Otis

So, what makes a good day for you here in the nursing home?

When I wake up and I get my cup of caffeinated coffee. I get hot water for caffeinated coffee, I have instant coffee and that makes my day, my caffeinated coffee. I go to breakfast, a lot of people don’t but I’m able to and if there is some activity going on that I especially like, like cards or bingo, or a nice amusement and then if I have a nice supper and then I usually go to bed early, I watch television, Wheel of Fortune, Jeopardy. - Fran

What’s important to you in a day?

Um, getting up early, which I’ve had a tough time convincing them that that’s what we need. Um, having breakfast in the morning, that’s good. I have time after breakfast to do some physical therapy if I could find someone to help me. Um, which is about always available most of the time. And then it’s sitting outside with some friends, breathing in the good air, or going upstairs and watching TV or reading, all those exciting things. Then it’s lunch and then you go back to, going outside, and if you get tired of that, then you go back upstairs to your room, watch TV, and read, come down for dinner and when that’s done, you go outside and you go upstairs, you watch TV or read. - Jessica
Section 4:
Common Health Experiences

I don't ever want to be in a nursing home, I used to say. I fell and broke bones, went to the nursing home, went home, fell again, went back to the nursing home.

I need to be in a nursing home - I want to be in a nursing home.

- Betty
Common Physical Health Diagnoses and Their Importance to the Ombudsman Program

Trainer’s Note: Allow at least 60 minutes to cover Section 4. Explain the common diagnoses and their importance to the LTCOP. The data in Figure 5 is from the MDS 3.0 Frequency Report during 2021, second quarter. As mentioned below, remind trainees that this section is intended to enhance their understanding of these common mental and physical health conditions and needs. However, it is important to remember that each resident has unique needs and preferences related to their experiences living with chronic illness and/or disability and are entitled to receive individualized, resident-centered care. To provide resident-directed advocacy, representatives must understand individual needs and preferences.

Optional Prework: You may consider asking trainees to read Section 4 prior to training. Section 4 includes a lot of detailed information, so it may be helpful for trainees to read it prior to classroom discussion.

Individuals living in long-term care facilities need a variety of supports and services related to their diagnosis or diagnoses. Most people living in long-term care facilities are there not because of the diagnosis, but because they cannot manage their illness or illnesses on their own. Many residents have more than one illness.

Residents who experience chronic illness and/or have a disability have unique needs and ways of living with their condition(s). It is important to see the person, not the disease or disability, and to understand individual needs and preferences in order to provide resident-directed advocacy. In addition to understanding the resident’s individual experiences, needs, and preferences related to their diagnoses and/or disability, it is important to know how they want to be acknowledged. Module 3 will discuss person-first and identity-first language.

According to resident data, some of the most common physical health diagnoses in nursing facilities include hypertension (high blood pressure), hyperlipidemia (high cholesterol), diabetes, heart disease, and arthritis. Although the common physical health diagnosis discussed in this section are based on data from nursing facilities, residents in RCCs often have similar chronic health issues.
Hypertension: Why is this important information for the LTCOP?

Residents may have concerns about their health and whether the facility staff are appropriately providing the medication, diet, exercise, and stress reduction necessary for them to remain as healthy as possible. On the other hand, residents may wish to go against doctor’s orders and ask you to advocate on their behalf to eat whatever they want, to decline their medication, or to not engage in physical activity.

Hypertension

Commonly referred to as high blood pressure, hypertension is the most common diagnosis of long-term care residents. High blood pressure can lead to severe health complications, including heart disease, stroke, and even death. High blood pressure can be treated through medication, diet, and exercise as well as stress reduction.²⁹

We’ve talked about the role of the LTCOP and taking resident direction, but not focusing on best interest. At times, by following resident direction the LTCOP may advocate for something we think is not best for the resident.

If a resident wants to go against doctor’s orders, how would you start that conversation with the nurse?

**Trainer’s Note:** Start with obtaining permission from the resident to talk to the nurse. Ask the resident if they are comfortable talking with the nurse while you are there and encourage the resident to explain why they want to go against doctor’s orders. If the resident does not want to talk to the nurse with you, relay the resident’s concerns and desired outcomes in their own words. For example, say, “the resident told me the

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²⁹ Healthline: Everything You Need to Know About High Blood Pressure (Hypertension) [https://www.healthline.com/health/high-blood-pressure-hypertension](https://www.healthline.com/health/high-blood-pressure-hypertension)
Heart Disease & High Cholesterol: Why is this information important for the LTCOP?

Some residents with a history of heart attack have expressed fear and anxiety. For example, residents may worry they could have a heart attack, and no one will come in time. The LTCOP may advocate for residents to keep their nitroglycerin tablets in their room.

Heart Disease & High Cholesterol
Heart disease describes a range of conditions affecting the heart that involve narrowing or blocking of blood vessels. Such conditions can lead to heart attack or stroke. Other heart conditions affecting the heart’s muscle, valves, or rhythm are also considered to be forms of heart disease. Heart disease and high cholesterol are significant diagnoses in long-term care residents. Both can be treated through diet, exercise, a healthy lifestyle, and medication.

Often heart disease is viewed only as a physical condition. However, according to the National Institutes of Mental Health, up to 65% of people with heart disease and a history of heart attack experience various forms of depression.

**Trainer’s Note:** If the question is asked, yes, a resident may be allowed to keep medication in their room if they are able to manage it but don’t go into details about that issue. It can be addressed during the care plan module. Nitroglycerin is a medication that is often prescribed to help stop chest pain.

Diabetes
Diabetes is a disease in which the body’s blood sugar (glucose) is too high. Insulin is the hormone that helps blood sugar get into cells. Type 1 diabetes occurs when the body does not make insulin. Type 2 diabetes is more common and occurs when the body does not make or use insulin well. When there is not enough insulin, too much glucose stays in the blood and over time, too much glucose can lead to serious health problems affecting one’s eyes, kidneys, and nerves.

Diabetes: Why is this important information for the LTCOP?

The LTCOP often works with residents who have concerns related to the management of their diabetes. Residents consider not just their health, but their quality of life.

Such concerns may include:
- Uncontrolled blood sugar levels.
- Insulin not checked per doctor’s orders.
- Proper diet not being served.
- Facility not honoring the resident’s right to decline dietary restrictions.
- Possible amputation.

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30 Mayo Clinic retrieved from [https://www.mayoclinic.org/](https://www.mayoclinic.org/)
People with Type 1 diabetes take insulin to control their blood sugar. Type 2 diabetes is treated through diet, exercise, and sometimes medication and/or insulin. The term “brittle diabetes” may be used to describe uncontrolled diabetes with drastic swings between too high or too low blood sugar. Some people may refer to their “sugars” when talking about diabetes or their sugar levels.

**Arthritis**

Arthritis\(^{32}\) is the swelling and tenderness of one’s joints. The main symptoms of arthritis are joint pain and stiffness that can worsen with age. Some residents have severe and painful arthritis that impacts their daily life. Treatments are used to reduce the pain and symptoms and improve quality of life.

The two most common types of arthritis are osteoarthritis and rheumatoid arthritis (RA).\(^{33}\)

- **Osteoarthritis (OA)** is the most common form of arthritis (over 32.5 million adults in the United States have OA). Some people call it degenerative joint disease or “wear and tear” arthritis. It occurs most frequently in the hands, hips, and knees.

  With OA, the cartilage within a joint begins to break down and the underlying bone begins to change. These changes usually develop slowly and get worse over time. OA can cause pain, stiffness, and swelling. In some cases, it also causes reduced function and disability; some people are no longer able to do daily tasks or work.

- **Rheumatoid arthritis (RA)** is an autoimmune and inflammatory disease, which means that your immune system attacks healthy cells in your body by mistake, causing inflammation (painful swelling) in the affected parts of the body.

  RA mainly attacks the joints, usually many joints at once. RA commonly affects joints in the hands, wrists, and knees. In a joint with RA, the lining of the joint becomes inflamed, causing damage to joint tissue. This tissue damage can cause long-lasting or chronic pain, unsteadiness (lack of balance), and deformity (misshapenness). RA can also affect other tissues throughout the body and cause problems in organs such as the lungs, heart, and eyes.

Arthritis can be very debilitating, both physically and mentally. The pain and restrictions of arthritis can make it difficult to perform daily tasks. Due to the pain and restrictions related to arthritis some individuals are more susceptible to developing anxiety and depression.

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\(^{32}\) Mayo Clinic retrieved from [www.mayoclinic.org](http://www.mayoclinic.org)

\(^{33}\) Information regarding OA and RA is from the Centers for Disease Control and Prevention (CDC), Arthritis Types, [https://www.cdc.gov/arthritis/basics/types.html](https://www.cdc.gov/arthritis/basics/types.html)
It’s important to remember that the Ombudsman program does not serve as a source of medical advice or expertise (even if a representative has such expertise) but serves to represent resident concerns and ensure that the resident has access to medical information and their health care providers.

While advocating for appropriate treatment and care, talk about the concern from the resident’s perspective. For example, instead of saying, “the resident needs more appropriate treatment,” you could say, “the resident is telling me that her pain medication is not working.”

Cognitive Disorders, Mental Health, and Their Importance to the Ombudsman Program

*Trainer’s Note:* The data in Figure 6 is from the MDS 3.0 Frequency Report during 2021 second quarter. Go over the chart and point out the percentages of nursing facility residents with each of the diagnoses.

Some residents have illnesses such as cognitive disorders and mental health disorders. While you can’t see cognitive disorders and mental illness, both can be very debilitating. Some people cannot manage their cognitive disorder or mental health disorder and require the supports and services of long-term care.

Figure 6

![2021 National Cognitive Disorders & Mental Health Diagnoses in Nursing Facilities](image)

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**Dementia**

Dementia is a general term for a decline in memory, reasoning, or other thinking skills that interferes with daily life. There are many different types of dementia. Over half of residents in nursing facilities have a diagnosis of dementia or Alzheimer’s disease. Dementia is not a normal part of aging.

Dementia is not a single disease. It’s an overall term — like heart disease — that covers a wide range of specific medical conditions, including Alzheimer’s disease. Disorders grouped under the general term “dementia” are caused by abnormal brain changes. These changes trigger a decline in thinking skills, also known as cognitive abilities, severe enough to impair daily life and independent function. They also affect behavior, feelings, and relationships.

Treatment for dementia depends upon the cause of the dementia. There are many conditions that can cause symptoms of dementia and some of those conditions are reversible.

The Ombudsman program works with and takes direction from residents living with dementia to the extent that they can provide direction. Often, others prematurely take charge and make decisions for residents with Alzheimer’s or dementia without the input of the resident. The representative may be the only person who brings the resident’s wishes to the table.

**Alzheimer’s Disease**

Alzheimer’s disease is the most common cause of dementia, accounting for 60-80% of dementia diagnoses. Alzheimer’s disease is a deteriorating brain disease that is caused by cell damage. It leads to dementia symptoms that gradually worsen over time. The most common early symptom of Alzheimer’s is trouble remembering. As Alzheimer’s advances, symptoms get more severe and could include disorientation, confusion,

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35 Most of the information below for dementia and Alzheimer’s Disease is from The Alzheimer’s Association, *Dementia vs. Alzheimer’s Disease: What’s the Difference?* https://www.alz.org/alzheimers-dementia/difference-between-dementia-and-alzheimer-s
behavior changes, weight loss, incontinence, delusions, or hallucinations. Eventually, speaking, swallowing, and walking become difficult.

There is no way to prevent, cure, or even slow Alzheimer's disease. However, there are several treatment options to help manage the symptoms of the disease including medications for memory and treatment for behavior and sleep changes.36

**Trainer’s Note:** Don’t go into too much detail here with complaint resolution. The point is that you can take direction from each resident below regarding these concerns regardless of their memory problem. You can provide your own examples of working with and taking direction from someone with dementia or use the examples here.

Many people have questions about the LTCOP taking direction from someone living with Alzheimer’s disease or dementia. Here are two examples of situations in which the LTCOP may assist.

**Example:** Greta says she feels scared at night when they turn all the lights off in her room.

**Example:** Doris complains that someone stole her ring, and she wants it back.

Regardless of their diagnosis, the LTCOP can talk to staff with each resident's permission to resolve their concerns.

**Trainer’s Note:** Show the video below and let the trainees know the video was made to inform residents about Alzheimer's disease and dementia. At the end of the video advance directives are mentioned. Let the trainees know advance directives are discussed in Module 3.

Watch the video titled LTC Informational Series Video 7 Addressing Dementia in Long-Term Care Facilities37 to summarize the discussion about Alzheimer's disease and dementia.

According to the video, what statements are true about people living with dementia?

1. The person may not remember who or where they are.  
2. All individuals living with dementia are alike.  
3. Residents with dementia need advocates.

**Answer:** Numbers 1 and 3 are true. Number two is false – no two individuals with dementia are alike.

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37 Southwestern Commission, LTC Informational Series Video 7 - Addressing Dementia in Long-Term Care Facilities, [https://www.youtube.com/watch?v=W6ILW0kHA9M&list=PLSu_zY6vP6REXfvjqVf7E-F9CG2K_9P-F&index=7](https://www.youtube.com/watch?v=W6ILW0kHA9M&list=PLSu_zY6vP6REXfvjqVf7E-F9CG2K_9P-F&index=7)
Learn more about dementia and Alzheimer’s disease.38

Mental Illness39
Mental illnesses are health conditions involving changes in emotion, thinking, or behavior (or a combination of these). Mental illnesses are associated with distress and/or problems functioning in social, work, or family activities.

Mental illness is common. In a given year:

- Nearly one in five (19 percent) U.S. adults experience some form of mental illness
- One in 24 (4.1 percent) has a serious mental illness
- One in 12 (8.5 percent) has a diagnosable substance use disorder

Mental illness is treatable. Most individuals with mental illness continue to function in their daily lives. People living with mental illness reside in the community-at-large and in long-term care settings. Some residents with mental illness are in long-term care facilities because community services and supports to help manage their symptoms and/or medication are not available.

Serious Mental Illness (SMI)40
A mental illness that interferes with a person’s life and ability to function is called a serious mental illness (SMI). With the right treatment, people with SMI can live productive and enjoyable lives.

There are many kinds of serious mental illness. Common types include:

**Bipolar disorder** -- a brain disorder that causes intense shifts in mood, energy, and activity levels. People have manic episodes in which they feel extremely happy or euphoric, and energized. Usually, they also have depressive episodes in which they feel deeply sad and have low energy.

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38 The Alzheimer’s Association [https://www.alz.org/alzheimers-dementia/what-is-dementia#symptoms](https://www.alz.org/alzheimers-dementia/what-is-dementia#symptoms)
39 Adapted from American Psychiatric Association, What is Mental Illness? [https://www.psychiatry.org/patients-families/what-is-mental-illness](https://www.psychiatry.org/patients-families/what-is-mental-illness)
40 Adapted from the U.S. Department of Health & Human Services, Substance Abuse and Mental Health Administration (SAMHSA), Living Well with Serious Mental Illness. [https://www.samhsa.gov/serious-mental-illness](https://www.samhsa.gov/serious-mental-illness)
**Major depressive disorder** (MDD) -- one of the most common mental disorders. Symptoms vary from person to person, but may include sadness, hopelessness, anxiety, pessimism, irritability, worthlessness, and fatigue. These symptoms interfere with a person’s ability to work, sleep, eat, and enjoy their life.

**Schizophrenia** -- a chronic and severe mental disorder that causes people to interpret reality abnormally. People may experience hallucinations, delusions, extremely disordered thinking, and a reduced ability to function in their daily lives.

Despite common misperceptions, having a serious mental illness is not a choice, a weakness, or a character flaw. It is not something that just “passes” or can be “snapped out of” with willpower. The specific causes are unknown, but various factors can increase someone’s risk for mental illness including, family history, brain chemistry, and significant life events such as experiencing a trauma or death of a loved one.

Learn more about living with [serious mental illness](https://www.samhsa.gov/serious-mental-illness).

**Trainer’s Note:** Discharge is referenced in the text box on the right. No need to get into a discussion about discharges at this point in the training; transfer and discharge are discussed in more detail later.

**Depression**

Depression is also called depressive disorder, or clinical depression, and is a mood disorder. Depression is a constant loss of interest or pleasure in normal activities that lasts for at least two weeks and significantly interferes with a person’s daily activities. Unfortunately, over one-half of nursing facility residents are diagnosed with depression. Depression can be treated with medication and various forms of therapy.

Depression symptoms can vary from mild to severe and can include:

- Feeling sad or having a depressed mood
- Loss of interest or pleasure in activities once enjoyed
- Changes in appetite — weight loss or gain unrelated to dieting
- Trouble sleeping or sleeping too much
- Loss of energy or increased fatigue
- Increase in purposeless physical activity (e.g., inability to sit still, pacing, handwringing) or slowed

![Depression: Why is this important information for the LTCOP?](https://www.samhsa.gov/serious-mental-illness)

It is important to attempt to visit residents who seem withdrawn and tend to stay in their room. It may take multiple visits, but the resident may share their experiences if they believe you are willing to take time to be present with them and listen.

Sometimes just sitting quietly with a resident can be helpful.

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41 [https://www.samhsa.gov/serious-mental-illness](https://www.samhsa.gov/serious-mental-illness)
42 Mayo Clinic [https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007](https://www.mayoclinic.org/diseases-conditions/depression/symptoms-causes/syc-20356007)
43 American Psychiatric Association [https://www.psychiatry.org/patients-families/depression/what-is-depression](https://www.psychiatry.org/patients-families/depression/what-is-depression)
movements or speech (these actions must be severe enough to be observable by others)
- Feeling worthless or guilty
- Difficulty thinking, concentrating, or making decisions
- Thoughts of death or suicide

Many residents experience a feeling of sadness or grief at one time or another. Clinical depression is more than a feeling of temporary sadness and one cannot simply get better by changing one’s attitude. Residents with a diagnosis of depression may choose not to seek assistance from the LTCOP or may stay in their room or sleep often during LTCOP visits. Such residents may be hard to reach.

Learn more about depression. 44

Anxiety Disorders
People with anxiety disorders experience persistent, excessive fear or worry in situations that are not threatening. 45 There are various types of anxiety disorders, and each has its own specific symptoms and treatments. According to the National Alliance on Mental Illness (NAMI), typical symptoms of anxiety disorder can be broken into two groups - emotional symptoms and physical symptoms.

Emotional Symptoms
- Feelings of apprehension or dread
- Feeling tense or jumpy
- Restlessness
- Irritability
- Anticipating the worst
- Being watchful for signs of danger

Physical Symptoms
- Pounding or racing heart and shortness of breath
- Sweating, tremors, and twitches
- Headaches
- Fatigue and insomnia
- Upset stomach

Anxiety Disorders: Why is this important information for the LTCOP?
Residents with anxiety disorders often have issues related to trust and may not believe you are able or willing to make a difference. They may be agitated and have a hard time focusing on the issue at hand.

Representatives should be honest, relatable, and respectful to build a trusting relationship.

44 American Psychiatric Association https://www.psychiatry.org/patients-families/depression/what-is-depression
45 National Alliance on Mental Illness retrieved from www.nami.org
• Frequent urination, or diarrhea

In closing, it is important to understand that mental illness is treatable. Treatment varies depending upon the diagnosis and individualized plan. With early and consistent treatment individuals with serious mental illness can lead meaningful, productive lives.\(^46\)

**Other Health Concerns**

*Trainer’s Note: Follow the PowerPoint when discussing falls, incontinence, pain, and pressure ulcers. The statistics provided are to give the trainees an idea of the frequency of each concern presented. Make sure you share your experiences with each of these concerns.*

There are other health concerns that residents may experience while living in a long-term care facility.

Some of those concerns include:

- Falls
- Incontinence
- Pain
- Pressure ulcers

**Falls**

Falls can have damaging effects on residents from cuts and scrapes, to fractured bones, to brain bleeds, and even death.

Common reasons residents fall include:\(^47\)

- Medical conditions (e.g., muscle weakness, dizziness, balance issues)
- Medication side-effects (e.g., lightheadedness, groggy)
- Accidents while moving residents from one location to another (e.g., dropping residents during a transfer between their wheelchair and the toilet)
- Not receiving timely help so the resident attempts to complete the activity on their own (e.g., walk without assistance)
- Hazards and spills on the floor

While some falls are unavoidable, there are prevention measures facilities can take to lower the likelihood of a fall, such as:

- Conduct fall risk assessments
- Train staff on proper transferring techniques and fall prevention techniques

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\(^46\) Paragraph adapted from two sources. SAMHSA, Serious Mental Illness – Multimedia Resources, [https://www.samhsa.gov/serious-mental-illness/resources](https://www.samhsa.gov/serious-mental-illness/resources) and American Psychiatric Association, What is Mental Illness, [https://www.psychiatry.org/patients-families/what-is-mental-illness](https://www.psychiatry.org/patients-families/what-is-mental-illness).

\(^47\) Nursing Home Abuse Center retrieved from [www.nursinghomeabusecenter.org](http://www.nursinghomeabusecenter.org)
• Have adequate staff to meet all resident needs
• Ensure equipment used to transfer residents is functioning properly
• Ensure there are no environmental hazards that would cause a resident to slip, trip, or fall
• Offer exercise programs, physical therapy, stretching, and balancing

Incontinence

**Trainer's Note:** Share deidentified case examples to show what it is like for residents to be incontinent and wait for someone to change and clean them. When residents ask for assistance to the restroom some have been told to just go in their bed or incontinence brief. Staff may say, “just go in your bed, I’ll clean you up later.” This is humiliating and undignified.

There’s no easy or comfortable way to talk about going to the bathroom. There are many terms used casually (e.g., going #1 or #2) and more clinical terms (e.g., urinating, defecating, having a bowel movement). “Stool,” “excrement,” and “feces” are other terms used to describe the body’s waste.

Incontinence means the inability to control urination or defecation. Incontinence is a significant concern that impacts more than one-half of nursing facility residents. Problems associated with incontinence are urinary tract infections (UTIs), other infections, risk of pressure ulcers or skin irritation, as well as feelings of embarrassment and humiliation.

Concerns shared with the Ombudsman program about incontinence include:
• Residents being left in their own waste
• Lack of privacy during incontinence care
• Call lights not answered timely which can lead to accidents
• Residents’ clothing or bedding not changed often enough
• Residents not being taken to the bathroom and told to “go in place/go in their brief”

Pain

**Trainer's Note:** Make sure to share the quotes from residents in the sidebar. The quotes came from a project titled “The Effects of the Opioid Crisis on Residents: Points of Advocacy,” by the National Long-Term Care Ombudsman Resource Center (NORC), the National Consumer Voice for Quality Long-Term Care (CV), and the National Center on Elder Abuse (NCEA). Face-to-face interviews with residents about opioid use were conducted. Another questionnaire was sent to Ombudsman programs asking about their experiences on the topic.

Fentanyl is an opioid pain medication. The resident quote in the sidebar on diverting fentanyl patches is referring to a staff member stealing the patch to either sell or to use. The result is that the resident who was prescribed the patch would not receive their pain medication for at least 3 days (or as prescribed).
Residents’ quotes on pain

“The pain is always there… it will never go away completely.”

“Opioid medications are the ones that work best to manage pain.”

“…only thing that works is the opioids, but it doesn’t always help. Sometimes it takes 1 hour to kick in.”

“…meds were not always ordered on time from the pharmacy so may have to go one or more days without treatment.”

One resident said she has to be assertive to get her meds – says she “rounds up” staff to get them.

“Sometimes medication isn’t effective for entire window of time.”

“Was an instance of a nurse diverting fentanyl patches for herself.”

Many residents experience pain at one time or another, while some experience chronic pain. With pain comes other factors such as loss of appetite, loss of interest in activities, and difficulty sleeping. Pain assessments should be done on a regular basis and as prescribed in the resident’s care plan. Treatment for pain ranges from non-medical techniques (e.g., aroma therapy, massage, music therapy) to various levels of pain medications (e.g., over-the-counter medication or prescription medication, including the use of opioids).

While many nursing facility residents are in persistent pain, the pain is often under-treated, and alternatives are not widely available or used. Residents report not being involved or informed of changes of their pain medication. Residents also report delays in getting their pain medication or even missing doses. The most common opioid related complaints are drug diversion (e.g., theft or misuse of resident medication by facility staff) and medication unaccounted for. Residents express a great deal of concern about pain management and a lack of knowledge about their own treatment and other treatments.

One representative said, “There have been residents who complain that they don’t feel they are getting their pain addressed or getting their pain medicine that helps with their pain.” Another representative stated, “Residents have reported that they are in so much pain that they have attempted suicide due to their untreated pain. This is very disturbing.”

The National Long-Term Care Ombudsman Resource Center (NORC), the National Consumer Voice for Quality Long-Term Care (CV), and the National Center on Elder Abuse partnered on a study titled “The Effects of the Opioid Crisis on Residents: Points of Advocacy”^48 where residents were interviewed, and representatives were asked to complete a questionnaire.

^48 https://ltcombudsman.org/issues/pain-management
Pressure Ulcers
Pressure ulcers, often referred to as pressure sores, decubitus ulcers, or bed sores, are caused by pressure to areas of the skin when resting in one position for too long, thereby restricting blood flow. According to MayoClinic.org,49 “the degree of skin and tissue damage ranges from red, unbroken skin to a deep injury involving muscle and bone.” Pressure ulcers are serious and can lead to infections which may result in death if not properly treated.

Many residents have risk factors to develop a pressure ulcer including:
• Immobility
• Incontinence
• Spinal cord injuries, neurological disorders, etc.
• Poor nutrition and hydration
• Medical conditions affecting blood flow

No Two Residents are Alike
There’s a saying within the Ombudsman program, “If you’ve talked to one resident, you’ve talked to one resident.” Each resident has their own unique background and experience. The key point to take away from this Module is to approach each resident with dignity, respect, and an open mind. While it is important to understand resident demographics, common health experiences, and reasons why individuals receive long-term care services and supports, remember that the resident comes first. Residents are more than their diagnoses and ensuring they receive resident-centered, quality care is your primary goal as a representative.

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49 Mayo Clinic retrieved from: https://www.mayoclinic.org/diseases-conditions/bed-sores/symptoms-causes/syc-20355893
Residents need to feel needed. So many times, one sits in the long-term care facility day after day with nothing to do. Life becomes mundane and boring. When asked to help or do something new, whether it be large or small, it is a boon to our spirits. Once again, we begin to feel life is not as bad after all; that we and our opinions are of value to others. What a wonderful feeling that is as it spreads from that resident to others---a whole change taking place with all. -Jan
Module 2 Questions

_Trainer’s Note_: Allow at least 15 minutes for Section 5. These questions are meant to determine if the trainees learned the fundamental learning objectives and may illicit discussion about the answers. The questions and answers are not meant to be rushed through.

1. Select the statements that are true about individuals who live in long-term care facilities. Residents
   a. May be of any ethnicity
   b. Are not under the age of 65 years
   c. Are primarily men
   d. Are primarily white
   e. Are primarily over 85 years

   **Answers**: The correct answers are _a, d, and e_.
   The incorrect answers are _b – some residents are under 65; c – most residents are female._

2. Name some reasons people enter long-term care facilities.

   **Answers**: A medical event, the progression of Alzheimer’s disease or other dementias, the progression of chronic or terminal diseases, loneliness and isolation, the need for supports and services not accessible within the community.

3. Name some of the losses that residents may experience when they enter a long-term care facility and how those losses affect residents.

   **Answers**: Health, home, family, friends, neighbors, freedom, privacy, personal property, dignity. Effects include feelings of anxiety, fear, frustration, anger, despair, sadness, hopelessness, humiliation, embarrassment and/or sense of uneasiness, anxiousness, confusion on whereabouts, uncomfortableness, loneliness, loss of control over daily life, being forgotten, feeling isolated, missing loved ones, feeling like a child.

4. Name some of the common diagnoses and other health concerns of residents.

   **Answers**: Hypertension, Alzheimer’s disease or other dementias, depression, heart disease, diabetes, arthritis, bipolar disorder, schizophrenia, anxiety disorder, falls, pressure ulcers, pain, incontinence.

5. Why is it important for representatives to understand resident experiences?

   **Answers may include**: to empathize with the resident’s situation, to clarify any myths or preconceived notions, to be prepared for what representatives may encounter.
Module 2 Additional Resources

Caregiving
*Counting on Kindness – The Dilemmas of Dependency* by, Wendy Lustbader, MSW

Dementia


[https://ltcombudsman.org/issues/dementia-care](https://ltcombudsman.org/issues/dementia-care)

Mental Health

[https://ltcombudsman.org/issues/mental-health-mental-illness](https://ltcombudsman.org/issues/mental-health-mental-illness)


Dr. Susan Wehry “Mental Health in Nursing Homes”

Disabilities

[https://ltcombudsman.org/issues/disabilities](https://ltcombudsman.org/issues/disabilities)
MODULE THREE

Putting the Resident First

TRAINER GUIDE

January 2022
Table of Contents

Module 3 State-Specific Information ................................................................. 2
Section 1: Welcome and Introduction ............................................................... 3
Section 2: Person-Centered Care ................................................................. 10
Section 3: Decision-Making ................................................................. 17
Section 4: Advance Planning and Third-Party Decision Makers .................. 21
Section 5: Empowerment ................................................................. 29
Section 6: Resident Assessments and Care Plans ........................................ 34
Section 7: Resident Councils and Family Councils ....................................... 42
Section 8: Conclusion ........................................................................... 48

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Module 3 State-Specific Information

The list below outlines state-specific information for trainers to discuss, provide a link to, or add directly to the Trainer Guide, Trainee Manual, and/or PowerPoints. When you get to the point in the training where you need to discuss, include a link to, or add state-specific information, you will see a **bold, blue arrow (→)** and a brief description of what to include.

→ **State-Specific Information**

**Section 2 Person-Centered Care**

- Add state-specific regulations regarding person-centered care in nursing facilities and residential care communities, if applicable.

**Section 3 Decision-Making**

- Add state-specific policies and procedures about working with residents when decisional capacity is unclear.
- Include state-specific definitions of relevant advance care planning documents, such as Living Will, Health Care Directive, Physicians Orders for Life Sustaining Treatment (POLST), or Physician/Medical Orders for Scope of Treatment (POST/MOST), or cardiopulmonary resuscitation (CPR) directive.
- Include state-specific laws and/or policies and procedures about communicating with resident representatives.
- Include state-specific laws and/or policies and procedures about communicating with a guardian or conservator. Explain any state-specific information necessary for trainees including whether a representative should speak to their supervisor in cases involving a guardian. List each type of guardianship, conservatorship, etc., and provide links to those documents or state resources when applicable.

**Section 7 Resident Councils and Family Councils**

- Add state-specific requirements and information about Resident Councils in nursing facilities (NFs) and residential care communities (RCCs), if applicable.
- Add state-specific requirements and information about Family Councils in nursing facilities (NFs) and residential care communities (RCCs), if applicable.
Section 1:
Welcome and Introduction
Welcome

*Trainer’s Note:* Allow at least 15 minutes for Section 1.

Begin the session by welcoming the trainees to the training session and thanking them for their continued interest in the program. Make sure everyone introduces themselves – even if they come late.

To begin, please share:
- Your name
- Where you are from
- One thing you learned from Module 2 - something that really stuck with you or surprised you
- What you hope to learn since the last module

After introductions, thank the trainees for their information and explain any housekeeping items that need to be addressed including the time frame of the training day, breaks, location of restrooms, refreshments, etc. Ask the trainees to speak up if they have any questions throughout the training.

Welcome to Module 3 of certification training, *Putting the Resident First.* Thank you for being here to learn more about the Long-Term Care Ombudsman program and resident-centered advocacy.
Module 3 Agenda

*Trainer's Note:* The timeframes for each Section are approximate. Allow at least 4 hours for this Module.

Section 1: Welcome and Introduction *(15 minutes)*  
Section 2: Person-Centered Care *(60 Minutes)*  
Section 3: Decision Making *(30 Minutes)*  
Section 4: Advance Planning and Third-Party Decision Makers *(20 Minutes)*  
**BREAK** *(10-15 Minutes)*  
Section 5: Empowerment *(30 Minutes)*  
Section 6: Resident Assessments and Care Plans *(30 Minutes)*  
Section 7: Resident Councils and Family Councils *(15 minutes)*  
Section 8: Conclusion *(15 Minutes)*  

Module 3 Learning Objectives

*Trainer's Note:* Go over the Module 3 learning objectives.

After completion of Module 3 you will understand:
- Person-centered care
- Advance planning and decision-making authority
- The importance of empowerment
- Assessment and care plans
- Resident Councils and Family Councils
Module 3 Key Words and Terms

The key words and terms are defined relative to Ombudsman program practices and are found throughout this Module. Take a moment to familiarize yourself with this important information.

**Centers for Medicare & Medicaid Services (CMS)** – A division within the U.S. Department of Health and Human Services. CMS administers the nation’s major healthcare programs, including Medicare and Medicaid.

**Culture Change** – The common name given to the national movement based on person-directed values and practices to ensure long-term services and supports are “directed by and centered on” the person receiving care.¹

**Empowerment** – This is a primary role of the Long-Term Care Ombudsman program in which representatives provide the tools (e.g., information about residents’ rights, facility responsibilities), encouragement, and assistance to promote resident self-advocacy.

**Family Council** – A group of residents’ family members that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents’ care, treatment, and quality of life; support each other; plan resident and family activities; participate in educational activities; or for any other purpose.²

**Fiduciary** – A person or organization with a legal or ethical relationship with an individual who is required to act in the individual’s best interest.

**Highest Practicable Level of Well-Being** – The highest possible level of physical, mental, and psychosocial function a resident can maintain or achieve.

**Hospice** – An agency or organization that provides care to terminally ill individuals and has a valid Medicare provider agreement. Some hospices are located within a hospital, nursing facility, or a home health agency.³

**Informed Consent** – The permission from a resident or a resident representative after a full explanation has been given of the facts, options, and possible outcomes of such options in the manner and language in which the resident or resident representative understands.

**Medicaid** – A state and federal assistance program that serves low-income people of every age. It is run by state and local governments following federal guidelines.⁴

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¹ What Is Culture Change? Pioneer Network. [https://www.pioneernetwork.net/elders-families/what-is-culture-change/](https://www.pioneernetwork.net/elders-families/what-is-culture-change/)

² State Operations Manual Appendix PP Guidance to Surveyors DEFINITIONS §483.10(f)(5)-(7)

³ [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospices](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Hospices)

**Medicare** – A federal insurance program run by CMS for those who have paid into the program. It serves people over 65 years of age, regardless of their income, younger individuals with disabilities, and persons on dialysis.5

**Minimum Data Set 3.0 (MDS, MDS 3.0)** – A federally mandated assessment of all residents in Medicare and Medicaid certified nursing facilities. MDS assessments are conducted upon admission, throughout the resident’s stay and upon discharge. The data from the assessments is transmitted electronically using the MDS national database at CMS.6

**Office of the State Long-Term Care Ombudsman (Office, OSLTCO)** – As used in sections 711 and 712 of the Act, means the organizational unit in a State or territory which is headed by a State Long-Term Care Ombudsman.7

**Ombudsman** – A Swedish word meaning agent, representative, or someone who speaks on behalf of another. For the purposes of this manual, the word “Ombudsman” means the State Long-Term Care Ombudsman.

**Omnibus Budget Reconciliation Act of 1987 (OBRA ’87)** – Also known as the “Federal Nursing Home Reform Act.”

**Preadmission Screening and Resident Review (PASRR)** – A federally required assessment tool to help ensure that persons with mental illness or developmental disabilities are not inappropriately admitted to nursing facilities.

**Representatives of the Office of the State Long-Term Care Ombudsman (Representatives)** – As used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in §1324.19(a), whether personnel supervision is provided by the Ombudsman or his or her designee or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.8

**Resident Council** – A group of residents that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents’ care, treatment, and quality of life; support each other; plan resident and family activities; participate in educational activities; or for any other purpose.9

**Resident Representative** – An individual chosen by the resident to act on their behalf, or a person authorized by federal or state law (e.g., agent under a Power of Attorney, representative payee, and other fiduciaries) to act on behalf of a resident in order to support the resident in decision-making; access medical, social, or other personal information of the

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5 [http://www.medicare.gov](http://www.medicare.gov)
7 45 CFR Part 1324 Subpart A §1324.1 Definitions
8 45 CFR Part 1324 Subpart A §1324.1 Definitions
9 State Operations Manual Appendix PP Guidance to Surveyors DEFINITIONS §483.10(f)(5)-(7)
residents; manage financial matters; or receive notifications; legal representative (as used in Section 712 of the Act), or a court-appointed guardian or conservator of a resident.  

**Residential Care Community (RCC)** – A type of long-term care facility as described in the Older Americans Act (Act) that, regardless of setting, provides, at a minimum, room and board, around-the-clock on-site supervision, and help with personal care such as bathing and dressing or health-related services such as medication management. Facility types include but are not limited to: assisted living; board and care homes; congregate care; enriched housing programs; homes for the aged; personal care homes; adult foster/ family homes; and shared housing establishments that are licensed, registered, listed, certified, or otherwise regulated by a state.  

**Skilled Nursing Facility or Nursing Facility** – Also known as a “nursing home,” is a certified facility that provides skilled nursing care for residents who require medical or nursing care rehabilitation or provides health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities.  

For the purposes of this training and to be consistent with the National Ombudsman Reporting System (NORS), we use the term “nursing facility” for both skilled nursing facilities and nursing facilities.  

**Social Security Administration (SSA)** – A government agency that administers Social Security, a social insurance program with retirement, disability, and survivor benefits.  

**State Long-Term Care Ombudsman (Ombudsman, State Ombudsman)** – As used in sections 711 and 712 of the Act, means the individual who heads the Office and is responsible personally, or through representatives of the Office, to fulfill the functions, responsibilities, and duties set forth in §1324.13 and §1324.19.  

**State Long-Term Care Ombudsman program (Ombudsman program, the program, LTCOP)** – As used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.  

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11 CA-04 02 Residential Care Community Table 1 Part C Case and Complaint Definitions https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf  
12 This definition is a combination of Requirements for, and assuring Quality of Care in, Skilled Nursing Facilities, Section 1819(a) of the Social Security Act [42 U.S.C. 1396i–3(a)] https://www.ssa.gov/OP_Home/ssact/title18/1819.htm and Requirements for Nursing Facilities, Section 1919(a) of the Social Security Act [42 U.S.C. 1396r(a)] https://www.ssa.gov/OP_Home/ssact/title19/1919.htm  
13 NORS Table 1 https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf  
14 Social Security Administration https://www.ssa.gov/  
15 45 CFR Part 1324 Subpart A § 1324.1 Definitions
State Long-Term Care Ombudsman Programs Rule (LTCOP Rule) – The Federal Rule that governs the Long-Term Care Ombudsman program (45 CFR Part 1324).\(^\text{16}\)

State Survey Agency – The state agency responsible for certifying and/or licensing long-term care facilities and conducting inspections and investigations to ensure federal and state compliance.

State Surveyor – An individual who works for the State Survey Agency to conduct in-depth surveys, inspections, and investigations of long-term care facilities.

Subsection Symbol (§) – The subsection symbol is used to denote an individual numeric statute or regulation (rule).

Section 2: Person-Centered Care
Trainer’s Note: Allow at least 60 minutes for Section 2.

Person-Centered Care

Person-centered care\(^{17}\) is a process for selecting and organizing the services and supports that an older adult or person with a disability may need to live to their fullest potential. Most importantly, the person who receives the services and supports directs and makes decisions about how they receive care.

Person-centered care places decision-making and self-determination in the hands of individual residents to express choices and preferences about their care and day-to-day activities to the maximum extent possible.

Areas in which person-centered, individualized care can be implemented include, but are not limited to:

- Activities
- Bathing
- Care
- Death and dying
- Dining
- Dressing
- Engagement in community
- Medication administration
- Relationships
- Staff assignments
- Work

Person-centered practices:

- Put residents at the center of decision-making
- Recognize residents are experts about their lives
- Acknowledge residents have individual interests, needs, and abilities
- Emphasize person-first language to eliminate stereotypes and labeling

Person-First Language

Part of person-centered care is using appropriate language that puts the resident before the diagnosis or disability and is sensitive and respectful to the resident. This type of language is called “person-first.”

\(^{17}\) The terms “person-centered” and “person-directed” are often used interchangeably. Since “person-centered” care and planning is used in federal law, we are using “person-centered” care in these training materials.
Person-First Language:

- **Refers to the person first and the diagnosis or disability second.**
  Appropriate: “A resident living with dementia.”
  Not appropriate: “A confused resident.”

- **Uses neutral language that does not describe the resident as lacking or deficient.**
  Appropriate: “June had a stroke.” “June uses a wheelchair.”
  Not appropriate: “June is a victim of a stroke.” “June is confined to a wheelchair.”

- **Does not use a label to describe someone instead of using their name.**
  Appropriate: Bill, Jack, Doris, Mr. Davis, Ms. Combs
  Not appropriate: “feeders,” “honey,” “sweetie,” “confused.”

Watch the video titled [Person-Centered Care: Person-Centered Language](https://www.youtube.com/watch?v=zP2FqgHD6Lc).

1. What are your takeaways from the video?

**Trainer’s Note:** Show the video titled, Person-Centered Care: Person-Centered Language by Texas Health and Human Services. This video sets the tone for person-centered care and language. Explain to the trainees that representatives demonstrate appropriate language and behaviors by using person-first language when talking with and about residents.

Ask the trainees: “What are your takeaways from the video?”

“**When staff put residents first in their language, they recognize the whole person and don’t let disabilities define a resident.**”

Person-Centered Care: Person-Centered Language

Responses may include, facilities should partner with a resident when discussing their care. Simple changes such as putting the person first in language can redefine how residents are perceived. Not defining residents by a label such as a “walker” or a “talker” is a more respectful way to talk to or about a resident.

Summarize with a quote from the video: “When staff put residents first in their language, they recognize the whole person and don’t let disabilities define a resident.”

**Person-Centered Care Based in Law**

Awareness of and requirements to provide person-centered care or planning are growing.

Federal regulations for nursing facilities and for Medicaid-funded long-term services and

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18 This video series was developed by the Texas Department of Aging and Disability Services in coordination with the Texas Long-Term Care Ombudsman Program. [https://www.youtube.com/watch?v=zP2FqgHD6Lc](https://www.youtube.com/watch?v=zP2FqgHD6Lc)

supports require person-centered care and planning. Brief examples from federal requirements are below. Person-centered care and residents' rights will be discussed more in the next module.

**Omnibus Budget Reconciliation Act of 1987** - The first federal law to refer to person-centered care is the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), also known as the Nursing Home Reform Act.

While the primary goals of OBRA '87 were to improve the quality of care provided to residents and establish uniform standards for nursing facilities, OBRA '87 also required **nursing facilities** to:

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

Additionally, OBRA '87 required **state and federal governments** to:

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

**Federal Requirements for States and Long-Term Care Facilities** – Person-centered care is a requirement of the federal nursing facility regulations. The regulations define resident-centered care as follows:

“...person-centered care means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.”

**Home and Community-Based Services Final Regulation**

For many years, there have been efforts on the national and state levels to give individuals needing long-term services and supports more choices as to where and how they receive those services, offering options to receive services in their home or community setting rather than an institutional setting (such as a nursing facility).

On January 10, 2014, the Centers for Medicare & Medicaid Services (CMS) issued the Medicaid Home and Community-Based Services (HCBS) settings final rule. The final rule addresses several sections of Medicaid law under which states may use federal Medicaid funds to pay for HCBS, meaning some residential care communities may accept Medicaid under an HCBS waiver. Nearly all states and DC offer services through HCBS waivers.

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In addition to how states may use waivers, the final rule specifies that service planning for participants in Medicaid HCBS programs under section 1915(c) and 1915(i) of the Act must be developed through a person-centered planning process that addresses health and long-term services and support needs in a manner that reflects individual preferences and goals. Person-centered planning will be discussed more in a future section, but the rule clearly states the importance of person-centered care.

“The individual will lead the person-centered planning process where possible.”

Add state-specific regulations regarding person-centered care in nursing facilities and residential care communities, if applicable.

What Does Resident-Centered Care Look Like?

Trainee’s Note: Depending on how you conduct the activity, allow 15-30 minutes. Go to the Consumer Voice tool called My Personal Directions for Quality of Life.

If conducting the training virtually, go to the link and ask the trainees to write their answers down to some or all the questions. You will need to scroll down to see all the questions. Or send the document to the trainees and ask them to complete it prior to the training so you can discuss the answers as a group and/or put responses in the chat box. Ask the trainees how they think sharing this information will impact their relationship with a caregiver and/or the care they receive.

If conducting the training in-person, print copies of the tool ahead of time. One per trainee is needed and ask them to complete some or all the questions. Or you can leave the questions up on the PowerPoint screen and the trainees can write their answers on the paper provided at the training session. Alternatively, you can send the document to the trainees and ask them to complete it prior to training. Once the questions are answered, ask trainees to find a partner whom they do not know and share their responses to 3 or 4 of the questions. Give them 10 minutes to answer the questions and 10 minutes to talk to their partner.

Reconvene the class and ask the trainees to share what they learned about their partner and if they feel like they know them a little better.

Ask the trainees how they think sharing this information will impact their relationship with a caregiver and/or the care they receive.

The following activity uses a tool designed for individuals who are entering long-term care. To help understand the basics of resident-centered care, complete the answers in My Personal Directions for Quality of Life.

23 42 C.F.R. §441.540(a) and 42 C.F.R. §441.725(a).
Activity

1. Complete the My Personal Directions for Quality of Life document.\(^{24}\)
2. Review your answers as instructed during training (by yourself, with someone else, or through group discussion).
3. Should you ever need long-term services and supports, how do you think sharing this information will impact your relationship with a caregiver and the care you receive?

Facilities that operate using a more institutional care model usually focus on what works best for the facility. Management makes most of the decisions, and daily schedules accommodate staff preferences and facility routines. Facilities that truly practice person-centered care make decisions based on the residents' preferences, care needs, and routines. The chart below illustrates some of the differences between a traditional, institutional model of care and person-centered care.

**EXAMPLES OF TRADITIONAL VS. PERSON-CENTERED CARE MODELS**\(^{25}\)

<table>
<thead>
<tr>
<th><strong>Traditional Care</strong></th>
<th><strong>Person-Centered Care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents are told when to wake up, go to bed, eat, and bathe based upon facility schedules and set routines.</td>
<td>Residents wake up, go to bed, eat, and bathe when they choose. Staff alters their work routines to honor residents' preferences.</td>
</tr>
<tr>
<td>Residents frequently have different care staff. Therefore, the staff do not know the residents well and are not familiar with their preferences or routines. Residents often feel unknown, insecure, scared, and they don’t always get their needs met.</td>
<td>The same staff takes care of the same residents. They know each other, and caring relationships develop. Research indicates that consistent staffing results in better care and can help residents feel more secure, content, and happy.</td>
</tr>
<tr>
<td>There is a structured activity schedule with little input from residents.</td>
<td>There are daily activities, whether individual or in a group, planned or spontaneous, which consider residents' interests.</td>
</tr>
<tr>
<td>Residents may feel as if they have reached the end of the road and see the facility as a place to die.</td>
<td>Rituals and celebrations acknowledge life and establish an environment where everyone is recognized.</td>
</tr>
</tbody>
</table>


\(^{25}\) The information in the Figure 1 and the paragraph introducing the chart was adapted from The Pioneer Network, *Moving to Person-Directed Care*, [https://www.pioneernetwork.net/eldeers-families/care-changing/](https://www.pioneernetwork.net/eldeers-families/care-changing/).
How the Ombudsman Program Promotes Resident-Centered Care

Trainer's Note: After reviewing the following information with trainees, share state or local examples of your program’s involvement with culture change initiatives and/or in-service training you provide facilities regarding person-centered care.

It is the role of the Ombudsman program to advocate for residents’ rights and person-centered care empowering residents to direct their care and life. How does the LTCOP promote resident-centered care? This is accomplished though educating and empowering residents, modeling person-centered communication, and promoting resident participation in the care plan process.

Educate and Empower

A key responsibility of the Ombudsman program is to inform individuals about residents’ rights. Representatives continually educate residents, family members, staff members, and the public. By providing information about residents’ rights and person-centered care representatives empower residents to voice their concerns and be part of the complaint resolution process to the extent possible or desired.

The Ombudsman program also serves as a resource to staff by sharing promising practices and providing training on residents’ rights and person-centered care. Many Ombudsman programs are involved in local coalitions and initiatives in support of culture change and person-centered care.

Model Person-Centered Behavior

Representatives model how to work and communicate with residents. Representatives always treat residents with dignity and respect. For example, by following the direction of the resident and involving the resident throughout the problem-solving process (to the extent possible or desired), the Ombudsman program models person-centered care to facility staff, family members, and others.

Promote Resident Involvement in the Care Plan Process

Representatives support resident participation during the care plan process to ensure the resident’s needs and preferences are heard, incorporated, and implemented. The care plan process is discussed in more detail later in this Module.

Learn more by visiting the NORC website on person-centered care.

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26 To learn about culture change, visit the Pioneer Network website: https://www.pioneernetwork.net/
27 The National Long-Term Care Ombudsman Resource Center Person-Centered Care
   https://ltcombudsman.org/issues/person-centered-care
Section 3: 
Decision-Making
Decision-Making Capacity

*Trainer's Note: Allow at least 30 minutes for Section 3.*

This may be one of the most challenging topics to explain and to work with in the field. Caution the trainees that others may label a resident as “lacking capacity” (believing or suggesting that the resident cannot make any decisions). Direct the trainees to challenge that label by questioning what decisions the resident is unable to make – all decisions or some decisions (e.g., decisions regarding their daily routine, but not financial decisions) and ask for documentation explaining decision-making capacity. Share examples from your work with residents who had diminished capacity. Since this is a complicated topic, it may be helpful to invite an attorney with whom you work closely who understands the Ombudsman program and long-term care to provide training on decision-making capacity for this section and advance care planning and third-party decision makers in Section 4.

**Understanding Capacity**

Capacity is the ability to make and communicate an informed choice. There is no simple test for capacity. Often, understanding the person’s personal values, preferences, or goals can assist in understanding their capacity to make decisions.

Capacity is issue-specific, a spectrum, and transient. The first question is: “capacity to decide what?” Different types of decisions require varying levels of memory and distinct cognitive skills. The memory needed depends on how relevant past information is to the choice at hand. For example, very little memory is needed to decide what to wear or eat today. Different decisions require different cognitive skills, such as calculation, comparison, or organizing data.

Capacity is a spectrum. The ability to understand and make choices is not an on-off function. Capacity varies in subtle degrees, from no or very low levels of understanding, to the ability to understand and make decisions on very sophisticated and complex issues. Capacity is affected by health, pain, medication, illness, or injury. Capacity can be developed by learning and experience, and it can decrease with illness or injury. As these factors change, capacity can increase, decrease, and return.

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Decision-making capacity applies to all areas, including health, legal, financial, daily life, visitors, etc. Regardless of capacity, residents make decisions every day about how they want to spend their time. For example, a resident may not know what year it is, but may be able to communicate whether they want a specific family member or friend to visit them and what activities and food they prefer. Or a resident may not be able to manage their finances but can determine who they want to manage their affairs.

Decision-making capacity is not a one-time determination; rather it is on a spectrum and can change from hour to hour or day to day. Like someone coming out of anesthesia or experiencing mind-altering effects of some medication, a resident may have decision-making capacity in some areas of their life, but not others.

The goal of the Ombudsman program is to focus on the resident and their wishes even if the resident is not able to make all their decisions. For example, a resident may determine their daily routine, go out and visit with friends, or spend “pocket money,” but leave major financial and complex medical decisions up to an individual acting as their representative (e.g., the agent on a Durable Power of Attorney). Communicate with residents and assume they can make their own decisions. The next section will discuss third-party decision makers (also known as resident representatives) and documentation to review in order to determine if a resident has an assigned decision-maker and which decisions they can make on behalf of a resident.

When Decision-Making Capacity is Unclear

→ Refer to state-specific policies and procedures about working with residents when decisional capacity is unclear.

As resident advocates, it is a core program responsibility to empower residents and encourage others to realize the extent of the resident’s decision-making abilities.

When you are unsure of a resident’s decision-making capacity, some questions to consider include:

- Does the resident understand the information?
• Can the resident relate the information to their situation?
• Does the resident understand the possible outcomes of their decision?
• Can the resident retain the information long enough to make a decision?
• Can the resident communicate their decision in some way?

If the resident’s ability to make decisions is still not clear, or the status of the resident’s capacity is uncertain, you may consider the following:

• Ask the resident for permission to speak with their representative (i.e., decision-maker)
• Follow state program policies and procedures for working with residents when capacity is unclear
• Consult your supervisor for guidance

To empower residents to exercise their right to choose and participate in their care (to the greatest extent possible), ensure that:

• Information presented to the resident is in a language and manner in which the resident understands
• Choices and outcomes are discussed fairly and evenly and without other people influencing the resident
• The resident is given the opportunity to talk to anyone they rely upon to make important decisions
• The resident is given enough time to consider their options
Section 4:
Advance Planning and Third-Party Decision Makers
Advance Planning

*Trainer’s Note:* Allow at least 20 minutes to cover Section 4.

Representatives of the Office do not serve as attorneys. However, they may come across advance directives and other health care decision-making documents during their work. This section is intended to provide a basic overview of advance planning options and decision-making authority. The overview includes information about why it is important for representatives to have knowledge of such documents.

→ Refer to state-specific definitions of relevant advance care planning documents such as a health care advance directive, portable medical order (e.g., POLST/MOLST), CPR (cardiopulmonary resuscitation) directive, or supported decision-making agreement.

→ Review state-specific laws and/or policies and procedures about communicating with resident representatives.

The Patient Self-Determination Act (PSDA) requires most hospitals, nursing facilities, home health agencies, hospice programs, and HMOs (health management organizations) to provide information on advance directives at the time of admission. The PSDA strengthened residents’ rights to be informed of, and establish, advance directives.

Advance care planning involves learning about the types of decisions that might need to be made, considering those decisions ahead of time, and then letting others know (e.g., family members and health care providers) about their preferences. These preferences are often put into an *advance directive*, a legal document that goes into effect only if an individual is incapacitated and unable to speak for themself.

**Health Care Advance Directives**

Per the American Bar Association, a health care advance directive is the primary legal tool for any health care decision made on behalf of an individual should the individual become unable to speak for themself. "Health care advance directive" is the general term for any

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32 This paragraph was adapted from the Law for Older Americans. Health Care Advance Directives. April 2012. American Bar Association. https://www.americanbar.org/groups/public_education/resources/law_issues_for_consumers/directive_whatis/
written statement someone makes while competent concerning their future health care wishes. Formal advance directives include the Living Will and the Healthcare Power of Attorney.

Other types of advance care directives involve discussions with a person’s doctor, and these are written in the form of a medical order.

**Cardiopulmonary Resuscitation (CPR) Directive**
Health care advance directives may also have other terms like, “Cardiopulmonary Resuscitation (CPR) Directive” or “Do Not Resuscitate (DNR) Order.” This type of medical order is signed by the doctor and patient and instructs providers on the patient’s desire about resuscitation if the person’s heart or breathing stops. Some states call this directive an “Out-of-the-Hospital DNR.” The form for this, and who must sign it, varies from state to state.

**Portable Medical Orders**
Portable medical orders are often referred to as POLST. However, states use other names or different acronym definitions [e.g., POLST (Practitioner/Provider/Physician Orders for Life-Sustaining Treatment), POST (Physician Orders for Scope of Treatment), MOLST (Medical Orders for Life-Sustaining Treatment), MOST (Medical Orders for Scope of Treatment)]. A POLST form tells health care providers what treatments the individual wants and the individual’s goals of care, even if transferring from the hospital to a nursing facility, or to hospice or another setting. Points to remember about this type of order:

- POLST is for people who are seriously ill or have advanced frailty.
- It is a form that is signed by both the patient, or in many states by the health care representative if the patient is unable to do so, and the doctor.
- Most important is that it involves a discussion between the doctor and the patient.

Learn more about portable medical order forms in your [state].

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33 Information adapted from POLST Basics. National POLST. [https://polst.org/about/](https://polst.org/about/)

34 [https://polst.org/programs-in-your-state/](https://polst.org/programs-in-your-state/)
Third-Party Decision Makers
The advance directives discussed include information about specific documents and physician’s orders that express an individual’s preferences for health care treatment. Some advance directives allow for individuals to name someone else to make decisions on their behalf.

The Ombudsman program follows the direction of the resident. However, there are residents who lack the ability to communicate their wishes, needs, or preferences. Then whose direction does the program follow? It depends. Some residents have chosen a decision maker, and some have been assigned a decision maker by the courts. Other residents rely upon someone who helps them make medical and financial decisions. In this section, we will explore the different types of decision makers and their authority to make decisions with or on behalf of residents.

There are two types of decision makers. Those that are assigned by the resident and those that are assigned for the resident. Decision makers may only act within the guidelines granted by or for the resident.

*Decision Makers Assigned by the Resident*

**Power of Attorney (POA)**

→ Refer to Power of Attorney information specific to your state, including a sample POA, if available.
A power of attorney is a legal document in which a person appoints another individual(s) to be their decision maker if/when they are no longer able to do so or earlier in some situations.

Power of Attorney Facts
- “Power of attorney” is the document.
- “Principal” is the person appointing the decision maker (agent).
- “Agent” is the person who is appointed by the principal.
- Agents are required to act with the highest degree of good faith.
- An agent’s authority can be revoked by the principal.

There are different types of POAs. For example, a durable power of attorney comes into effect as soon as the document is signed. A springing power of attorney “springs” into effect if the principal becomes unable to communicate informed consent. There are POAs specific to health care decisions and some that are specific to finances and property. Every state has their own specific power of attorney terminology, forms, and laws.

Learn more about POAs here.35

Trainer’s Note: The LTCOP often works in situations where agents try to wield more power than has been granted by the resident. Agents under a POA are normally given the authority to make health care decisions, or in some cases financial decisions, on behalf of the resident. Agents normally DO NOT have the authority to tell the facility who may or may not visit with the resident, restrict the resident from going outside, etc.

**Decision Makers Assigned for the Resident**

**Guardianship and Conservatorship**

→ Include state-specific laws and/or policies and procedures about communicating with a guardian or conservator. Explain any state-specific information necessary for trainees including whether a representative should speak to their supervisor in cases involving a guardian. List each type of

35 [https://www.americanbar.org/groups/real_property_trust_estate/resources/estate_planning/power_of_attorney/](https://www.americanbar.org/groups/real_property_trust_estate/resources/estate_planning/power_of_attorney/)
guardianship, conservatorship, etc., and provide links to those documents or state resources when applicable.

The definitions of guardianship and conservatorship vary from state to state. In most states, when a guardian or conservator is appointed, the court removes some or all the individual’s rights and deems the individual incapable of administering their own affairs. Those affairs may be financial, personal, day-to-day, or other. Guardianships and conservatorships may be limited in scope and in length of time.

Some guardians or conservators are family or friends of residents who know their values and goals, and others are court-appointed professionals who do not know or may have never met the resident.

The Ombudsman program advocates that the resident choose who their decision maker is and what authority they are giving to the person, as opposed to having the court make these decisions. Because guardianships and conservatorships remove individuals’ rights, they should be considered as a last resort.

Learn more about guardianship.36

Representative Payee
A representative payee37 is a person or an organization appointed to receive Social Security or Supplemental Security Income (SSI)38 benefits for anyone who can’t manage or direct the management of their benefits for themself. SSI is designed to help people who are aged, blind, or have disabilities and who have little or no income. SSI provides cash to meet basic needs for food, clothing, and shelter.

Default Health Care Decision Makers
Most, but not all, states have a statute that provides guidance for who can make health care decisions for a patient who is unable to make or communicate a health care decision, has not named someone to help with health care decisions, and does not have a court-appointed representative. The statutes vary from state to state, but most commonly the statutes empower immediate family; some include other persons in a close relationship to the patient.39 These default decision makers are limited to health care decisions only as allowed in the statute in that state.

36 American Bar Association https://www.americanbar.org/groups/law_aging/resources/guardianship_law_practice/
37 Social Security Administration Representative Payee https://www.ssa.gov/payee/
38 Social Security Administration Supplemental Security Income https://www.ssa.gov/ssi/
Role of a Resident Representative

Trainer’s Note: This is the first time introducing the term “resident representative.” Explain the definition as defined in Key Words and Terms: An individual chosen by a resident to act on their behalf, or an agent under a power of attorney, or other legally authorized representative, etc., or a court-appointed guardian or conservator of a resident. This term is further defined in the LTCOP Rule and is not intended to include a representative of the Office.

The LTCOP Rule defines “resident representative” as “an individual chosen by the resident to act on their behalf, or a person authorized by federal or state law (e.g., agent under a Power of Attorney, representative payee, and other fiduciaries) to act on behalf of a resident in order to support the resident in decision-making; access medical, social, or other personal information of the resident; manage financial matters; or receive notifications; legal representative (as used in Section 712 of the Act), or a court-appointed guardian or conservator of a resident.”

When working with or on behalf of a resident, there are times when the Ombudsman program takes direction from the resident’s representative.

Once the LTCOP has determined the resident is not able to communicate informed consent and before the LTCOP takes direction from someone other than the resident, consider the following questions:

- Does the resident have an advance planning directive? If so, what kind of directive?
- Does the resident have a supported decision maker?
- Does the resident have a guardian or conservator?
- Is there evidence of the resident representative’s authority?

When it comes to investigating complaints, the LTCOP Rule is clear, requiring the Ombudsman program to determine and verify the authority of a decision maker. The Rule states that the Ombudsman program:

“...shall ascertain the extent of the authority that has been granted to the resident representative under court order (in the case of a guardian or conservator), by power of attorney or other document by which the resident has granted authority to the representative, or under other applicable State or Federal law.”

Fiduciary Definition

A fiduciary is a person or organization with a legal or ethical relationship with a resident who is required to act in the resident’s best interests (e.g., guardian to resident, agent under a POA to a principal, trustee to beneficiary, executor of a will to the will beneficiaries, etc.).

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In other words, the Ombudsman program reviews the relevant documentation to determine in what circumstances they are to follow the direction of the resident representative. The resident representative can only act within the scope of the authority granted. For example, a daughter may say that she has power of attorney to make health care decisions. The Ombudsman program must ask for proof and verify the accuracy and details of decision-making authority. This may also require the Ombudsman program to consult with the program’s legal counsel or local legal services if there are questions or concerns about the form.
Section 5:
Empowerment
**Trainer’s Note:** Allow at least 30 minutes for Section 5.

### Empowerment

Empowerment is a primary role of the Long-Term Care Ombudsman program in which representatives provide the tools (e.g., information about residents’ rights, facility responsibilities), encouragement, and assistance to promote resident self-advocacy. Empowering residents helps them to become stronger and more confident. In an ideal world, when a resident has a concern, they feel assured to approach staff or others for help. However, there are factors that may affect a resident’s sense of empowerment.

The Ombudsman program was created to help restore the balance of power between residents and staff, as well as between residents and their family members. The LTCOP ensures residents have someone on their side who helps empower them and, if necessary, be their advocate.

### Barriers to Empowerment

*Trainer’s Note:* Provide your own examples of situations when residents have experienced some of the barriers listed below.

Barriers that may influence a resident’s sense of empowerment are numerous.

Residents may…

- Feel hopeless
- Experience physical, emotional, psychological, social, and/or mental challenges that make it difficult to voice concerns
- Accept ongoing rights violations as a regular part of living in a nursing facility
- Express not wanting to “rock the boat”
- Fear getting someone in trouble
- Feel isolated
- Not want to be labeled as “a troublemaker” or “difficult”
- Experience side-effects of medication that interfere with a resident’s ability to voice concerns
- Feel as though complaining won’t help
- Not have been educated about their rights or how to assert their rights
- Be treated differently for complaining
- Fear retaliation

Staff may…

- Run resident council meetings resulting in residents not speaking out about concerns
- Not have been trained on residents’ rights
- Be ambivalent or negative when responding to residents
- Ignore residents completely
Fear of Retaliation

Watch this video titled Voices Speak out Against Retaliation

**Trainer’s Note:** Allow 30 minutes to watch and discuss the video. After viewing the video, facilitate a small or large group discussion using the questions below.

If conducting the session virtually, ask the questions in a large group format.

If presenting the session in person, break the trainees into groups, and tell them they have 10 minutes to discuss the four questions. One person from the group will need to report answers back to the entire class. Depending on the time allowed and the size of the class, you may just ask each group to report on one question, even though they should discuss all questions.

1. What reasons are given for not reporting poor treatment or problems within the facility?
   
   **Possible responses:** fear, dependency on staff, not knowing what will happen if problems are reported.

2. What concerns or fears are brought up by the residents?
   
   **Possible responses:** retaliation, dependency, fear of speaking out, not knowing who to go to for help.

3. What examples of retaliation did you hear from the video?
   
   **Possible responses:** being treated like a child, being picked on, not answering call lights, dinner tray delivered last, asking for help and staff walk by, being bullied.

4. What examples to overcome the fear of retaliation are discussed in the video?
   
   **Possible responses:** Find another resident or the Resident Council President, or staff to help confront a problem; call the Ombudsman program; go to resident activities and the Resident Council; create a paper trail for follow-up to problems; know residents’ rights; ask staff to put themselves in the residents’ shoes; create an atmosphere of open communication in the facility.

**Trainer’s Note:** End the video discussion with the quote in the text box from Ronnie.

Retaliation is one of the most common reasons expressed by residents for not seeking resolution to their concern. It may be real or perceived, but in either situation, it is frightening to residents. When instances of retaliation occur, they can range from subtle to obvious.

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42Connecticut Long-Term Care Ombudsman Program [https://www.youtube.com/watch?v=feoQjiW3_bc](https://www.youtube.com/watch?v=feoQjiW3_bc)
Subtle instances of retaliation include but are not limited to:
- Call lights not answered or are delayed in being answered
- Staff ignoring resident requests for help
- Nurses withholding pain medication or late when distributing medication

Obvious instances of retaliation include but are not limited to:
- Rough care
- Abusive treatment
- Eviction or attempted eviction
- Withholding food and water

**Partnering with Residents for Self-Advocacy**
Representatives all have one thing in common: they want to help residents. Often the first thought that comes to mind is to take action for them, but that is not empowering. The Ombudsmen program plays an important role in helping people restore their own sense of self and regain their personal power and voice. Residents who have always found it easy to speak up may merely need to be pointed in the right direction and be given a little assurance that they are within their rights. Others may need a lot more encouragement; they may need you to go for them or with them.

The first step in this process of empowering residents is simply to have genuine, meaningful connection with residents, to get to know them as individuals. Start by listening to the resident's concerns, their ideas about resolving their concerns, and the actions they have already taken to address the problem. Listening to the resident shows them that their thoughts and feelings are important.

Some steps to take to encourage empowerment for self-advocacy include but are not limited to:
- Educating residents about their rights, including their right to present grievances without fear of retaliation
- Educating staff about residents’ rights
- Encouraging residents to participate and address their concern in the care plan meeting (discussed later in this Module)
- Encouraging residents to participate and address their concern in the Resident Council meetings (discussed later in this Module)
- Talking about which staff member may most effectively address the problem
- Explaining how to file a complaint with the state agency responsible for investigations in long-term care facilities, and the pros and cons of doing so

When talking to a resident about their concerns, suggest the resident meet with the staff person whom you both have identified as the person most likely to help resolve the problem. When you make this suggestion, it may be helpful to offer to attend the meeting with the
resident. The Ombudsman program’s presence may increase the resident’s confidence that their concern will be heard and resolved.

If you attend a meeting with the resident and the staff member, make sure you and the resident have a clear understanding of what will be discussed and who will take the lead in the discussion. Always go with the resident’s preference. Talk to the resident about their desired outcome of the discussion so you understand their goal of the meeting. Remember you are there to promote resident empowerment and advocate for resident rights, not to bring the resident in line with the facility’s preferences.

Encourage family members and friends of residents to speak out when they have concerns. Often, the Ombudsman program works with the resident representative when the resident is unable to communicate informed consent. When working with the resident representative, it is equally important to use empowerment strategies as a tool to resolve concerns.

**Trainer’s Note:** Show the 3-minute video titled Residents’ Rights Month as a summary to the information discussed about empowerment and retaliation. Clarify that Raegan and Teresa are both representatives with the Texas LTCOP. Ask the trainees if they have any questions about the role of the LTCOP and empowering residents. Ask if anyone would like to share their own experience with fear of retaliation in a nursing facility or an RCC.

Watch the video titled [Residents’ Rights Month](https://www.youtube.com/watch?v=B9mm9EBkUMw) which summarizes the information discussed on empowerment and retaliation.\(^4^3\)

\(^4^3\)Weld County, Texas Area Agency on Aging
Section 6:

Resident Assessments and Care Plans
Assessments

**Trainer’s Note:** Allow at least 30 minutes for Section 6. If your state has assessment requirements for residential care communities, please include pertinent information in this section.

All nursing facilities are required by federal regulations to provide supports and services necessary to help residents reach or maintain their highest practicable level of well-being. Nursing facilities are required to conduct initial and periodic comprehensive and accurate assessments. An initial assessment evaluates functional capacity and helps staff learn about the resident and their needs. The Resident Assessment Instrument-Minimum Data Set, often referred to as the “MDS” is the required assessment tool used in nursing facilities. It is designed to collect the minimum amount of data to guide care planning and monitoring for residents. It is from this assessment that care plans are developed.

The most important tools for assuring that residents receive adequate care are through resident assessment, care plan development, and the care plan meeting.

**When Does the Nursing Facility Assess the Resident?**
- At the time of admission (details below)
- When readmitted following hospitalization
- Quarterly
- Annually
- After a significant change in condition
- When a significant change to a prior assessment needs to be made
- At the time of discharge

**Trainer’s Note:** When Medicare is paying for the resident’s stay, the facility must complete an assessment at the following specific intervals, different from the list above: 5-day, 14-day, 30-day, and 90-day mark.

**What is the Ombudsman Program’s Role in an Assessment?**
The Ombudsman program can help residents participate in the assessment process to the greatest extent possible by:
- Suggesting that residents prepare for the assessment by thinking about daily routines, activity preferences, and goals before staff begin interviews
- Reminding residents that they can request activities or daily routines that are not included in the list provided on the MDS assessment
- Helping residents work with facility staff to resolve any issues related to assessment interview procedures
Baseline Care Plan
Within 48 hours of admission, nursing facilities are required to develop a baseline care plan for each resident. It must include the instructions needed to provide effective and person-centered care of the resident and meet professional standards of quality care.

The nursing facility is required to provide the resident and their decision maker with a summary of the baseline care plan including but not limited to the following information:
- The initial goals of the resident
- A summary of the resident’s medications and dietary instructions
- Any services and treatments to be administered by the facility

The Care Plan
The care plan must include resident-specific, measurable objectives, and timeframes to meet the resident’s medical, physical, mental, and psychosocial needs identified in their MDS. The care plan must also describe services that will be used to help the resident attain or maintain their highest practicable physical, mental, and psychosocial well-being. Care plans must include the resident’s preferences, including the right to refuse treatment, and potential for discharge.

A thorough care plan is:
- Individualized
- Specific
- Comprehensive
- Written in a language everyone can understand
- Reflective of the resident’s concerns, preferences, and goals
- Supportive of the resident’s well-being, abilities, and rights

Residents’ rights to participate in the development and implementation of their person-centered care plan are clear. The mere existence of the regulations, however, does not guarantee that these planning processes will operate in a person-centered way. Some nursing facilities may be inclined to treat the planning regulations as a bothersome requirement, which makes it essential that residents effectively assert both their right to participate and their preferences for care and discharge. This is where the Ombudsman program can provide an extra voice of knowledge and support to help the resident achieve their goals.

Federal regulations require facilities to develop and implement a comprehensive person-centered care plan within seven days after completion of the MDS assessment, but not more than 21 days after admission.
Residents’ Rights Related to Care Planning\textsuperscript{44}

✓ The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings, and the right to request revisions to the person-centered plan of care.

✓ The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

✓ The right to be informed, in advance, of changes to the plan of care.

✓ The right to receive the services and/or items included in the plan of care.

✓ The right to see the care plan, including the right to sign it after significant changes to the plan of care are made.

The nursing facility is required to inform the resident of their right to participate in their treatment plan and support them in doing so. The planning process is required to include the resident and/or the resident’s representative, an assessment of the resident’s strengths and needs, and to incorporate the resident’s personal and cultural preferences in developing goals of care.

Once the MDS assessment is complete and a care plan is written, a care plan meeting is held no later than 21 days after admission, every three months, or after a significant change in condition. The care plan meeting is supposed to be scheduled to accommodate the resident and/or the resident’s representative.

**The Care Plan Meeting**

The care plan meeting is a conference where staff, the resident, and persons of the resident’s choice go over the care plan. Care plans are a great tool to use when resolving a complaint. Representatives of the Office can participate in a care plan meeting with permission of the resident. It is a good idea to request a copy of the current care plan as well as the proposed care plan (if available) prior to the meeting. Review both care plans with the resident and talk about the resident’s concerns and goals and expectations of the representative’s role during the care plan meeting.

While an effective care plan requires the involvement of several individuals, all members of the care plan team may not actually attend the meeting.

\textsuperscript{44} 42 CFR Part 483 Requirements for Long-Term Care Facilities, § 483.21 Comprehensive person-centered care planning. [https://www.govinfo.gov/content/pkg/FR-2016-10-04/pdf/2016-23503.pdf](https://www.govinfo.gov/content/pkg/FR-2016-10-04/pdf/2016-23503.pdf)
Person-Centered Planning in Home and Community-Based Services (HCBS)

As mentioned earlier, CMS published a rule in 2014 that defined “home and community-based services” for services states provide under HCBS waivers. The rule explains what states must do in their Medicaid HCBS programs by establishing rights for HCBS recipients and requirements for service providers. The HCBS Rule applies to all settings in which an HCBS recipient lives or receives the HCBS services, including residential care communities that accept Medicaid coverage for services.

The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually identified goals and preferences.45

Similar to federal nursing facility requirements for assessment and care planning, the HCBS Rule requires the development of a person-centered service plan that is developed using a person-centered planning process driven by the individual receiving services.

The Rule includes four main steps for the person-centered plan process:46

1. **Assessment**

An assessment, in consultation with the individual and/or their representative, is required to identify the individual’s functional needs; physical, cognitive, and behavioral health care and support needs; strengths and preferences; available service and housing options; and a caregiver assessment (if needed), to develop a person-centered service plan.

2. **Person-Centered Planning Meetings**

Based on the assessment, a written service plan is developed with the individual (and/or their representative). According to the rule, “the person-centered planning process is driven by the individual.” This means that the individual chooses who participates in the meetings; meeting times and locations are convenient to the individual; choices for services and living options are discussed, and the individual can request meetings to update/change their choices. Additionally, the information provided should be in plain language that is accessible to the individual.

3. **Writing the Plan**

The plan should be written in a language and manner the individual understands and at a minimum should include the following:

- Where the individual chooses to live and receive other services, like supported employment

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46 Steps below adapted from the HCBS Rule §441.720 and §441.725(a) and the Person-Centered Planning and Home and Community-Based Services fact sheet [https://prod.nmhealth.org/publication/view/help/3792/](https://prod.nmhealth.org/publication/view/help/3792/)
• Strengths, preferences, and need
• Supports needed, both paid and unpaid
• The individual’s goals and how the individual will know the goal is accomplished
• Potential risks and plans to deal with them
• The name of the person responsible for making sure the plan is followed
• After the individual agrees with the plan, everyone that participated in the planning meeting signs the plan and receives a copy

4. Reviewing the Plan

The plan should be reviewed at least every 12 months, but the individual can request a meeting to review and update or change the plan at any time.


**Trainer’s Note:** Show the video Person-Centered Care: Care Plans to give the trainees an introduction to care plans and the care planning process. Ask trainees to write down specifics they remember about the care plan meeting. Mention to trainees that as an example of person-first language and person-centered care, although the video says the facility develops a care plan for the resident the facility is required to develop a care plan with the resident. The LTCOP advocates to ensure residents are involved in their care (to the extent possible).

Watch the video called Person-Centered Care: Care Plans as an introduction to care plans and the care plan process. While watching the video consider:

1. What key points does the video explain?

   **Answers:** A care plan must be individualized; residents are partners in the planning process; a resident’s social and emotional life are just as important as physical health; and problem solving is a key part of care plan meetings.

2. Have you participated in a care plan meeting?

   **Answers will vary.** Some may not have attended one. Be prepared to share some thoughts about your experiences to help the trainees get insight into care plan meetings to support residents.

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48 Texas Health and Human Services in coordination with the Texas Long-Term Care Ombudsman Program [https://www.youtube.com/watch?v=JGgCJp2XQpY](https://www.youtube.com/watch?v=JGgCJp2XQpY)
Key Care Plan Meeting Participants

- Resident
- Resident’s legal representative
- Care Plan Coordinator
- Physician(s)
- Nursing staff, including certified nursing assistants (CNAs)
- Dietary staff
- Therapy staff
- Social services staff
- Activities staff
- Anyone else invited by the resident (e.g., family members, representative of the Office)

*Trainer's Note:* Ask the trainees, “who did you see in attendance at Ms. Durham’s care plan meeting?” Answers include, Ms. Durham, her daughter, a nurse, a doctor, a CNA, and a representative of the Office.

What is Discussed at the Care Plan Meeting?

- Resident needs and preferences
- Supports and services to be provided
- The staff responsible for providing the supports and services
- Resident’s preferred daily routines
- Dietary preferences, concerns, and needs
- Resident’s preferred activities and interests
- Medication
- Desire to leave the nursing facility/return to the community

*Trainer's Note:* Ask, “how is Ms. Durham treated as a partner in the care planning process?” Answers:

- She was asked who she wanted to invite.
- Staff encourage Ms. Durham to discuss new things she would like to try.
- They involve Ms. Durham in problem solving and talk with her about why she is reluctant to shower.
- Staff follows up with Ms. Durham to see how the changes to her care plan are working.
Ombudsman Program Advocacy Before, During, and After the Care Plan Meeting

Preparing for the Care Plan Meeting
Nursing facilities are required to hold care plan meetings at the time of day that works best for the resident and accommodates a resident’s representative. This may include conducting the meeting in-person, via a conference call, or video conferencing. The meeting should be held in a location of the resident’s choosing that ensures privacy. The facility must provide sufficient advance notice of the meeting and plan enough time for discussion and decision-making.

The Ombudsman program can empower the resident and/or their representative to speak up if they would like the meeting to be longer than the scheduled timeframe or prefer/need the meeting to be scheduled differently. The representative can offer to attend the meeting. If the resident would like for you to attend, talk with them about their expectations about everyone’s role in the care plan meeting as well as the resident’s concerns and goals.

You can further empower the resident by suggesting they prepare a list of the assistance, activities, or other preferences that they want to have included in their care plan. Ask the resident to think of how to explain those preferences and how to present them to the nursing facility staff. Residents and their families are likely to be unfamiliar with the care planning process, at least at first, so good preparation is an important way to ensure that the care plan meeting is properly focused on the resident’s needs, goals, and preferences.

During the Care Plan Meeting
Ombudsman program advocacy during the care plan meeting includes ensuring:

- The resident has an opportunity to speak
- The resident’s questions are answered
- The resident’s preferences are addressed
- Supports and services options are discussed
- The resident understands and agrees with the care plan
- The resident receives a copy of the plan if requested
- The resident knows who to talk to if there are changes to be made to the care plan
- The resident understands there are options to leave the nursing facility and receive long-term services and supports in the community and how to seek assistance, if applicable (transitioning to the community is discussed more in future modules)

**Trainer’s Note:** Ask, “why is it important for direct care staff to be involved in the resident care plan meeting?”

**Answers:** Direct care staff/CNAs:
- Know the person
- Understand what is important to the person
• Understand the person’s communication style and may best interpret nonverbal communication
• Have a trusting relationship with the person
• Support the person in different environments
• Can be the person the resident turns to for assistance and support

After the Care Plan Meeting
LTCOP actions may include but are not limited to:
• Following up with the resident to find out if their care plan is being followed and asking if they are satisfied with the supports and services received
• Asking them if changes need to be made to the care plan
• Explaining their right to request another care plan meeting at any time to make modifications, advising them that if something is not included in their care plan, it will likely not happen

**Trainer's Note:** Ask, “how can residents who are unable to go to the meeting room attend or participate in their care plan meeting?”

**Answer:** Offer to hold the meeting in their room.

Ask, “how can staff ensure residents, whose ability to make decisions about care and treatment is impaired, participate in their care plan to the best of their ability?”

**Answer:** Plan enough time for information exchange and decision-making. Ask residents who they would like to attend the meeting to support them in decision-making.

Learn more about assessments and care plans. For additional training on person-centered care, go to the Texas Long-Term Care Ombudsman Person-Centered Care Video Series Teaching Guide.
Section 7:

Resident Councils and Family Councils
Resident Councils

→ Add state-specific requirements and information about Resident Councils in nursing facilities (NFs) and residential care communities (RCCs), if applicable.

Allow at least 15 minutes for Section 7.

Trainer’s Note: Not all facilities have Resident Councils. Share your experience of attending Resident Council meetings.

A Resident Council is an independent group of residents that meets regularly to discuss and seek resolution to concerns; offer suggestions about facility policies and procedures affecting residents’ care, treatment, and quality of life; support each other; plan resident and family activities; participate in educational activities; or for any other purpose.

Some states have regulations pertaining to Resident Councils in both nursing facilities and RCCs. These state regulations often mirror the federal regulations below.

Federal Regulations

Federal nursing facility regulations include the following requirements for Resident Councils:

- The facility must provide a Resident Council, if one exists, with a private space for meetings.
- The facility must take reasonable steps, with the approval of the Resident Council, to make residents aware of upcoming meetings in a timely manner.
- The facility must provide a designated staff person who is approved by the Resident Council and the facility to provide assistance and respond to written requests from the Resident Council.
- The facility must consider the views of a Resident Council and act promptly upon grievances and recommendations of the Resident Council concerning issues of resident care and life in the facility.
  - The facility must be able to demonstrate their response and rationale for their response.
  - The right to a response does not mean facilities are required to implement every request of the Resident Council.
- The Resident Council meetings are closed to staff, visitors, and other guests. For staff, visitors, or other guests to attend, the Resident Council must invite them.

The Ombudsman Program and the Resident Council

The Ombudsman program is required to assist with the development of Resident Councils when asked. Representatives often encourage residents to share their concerns during the Resident Council meeting to address concerns that may affect all or some residents, such as call lights not being answered in a timely manner or cold food.
Representatives of the Office must have the approval of the Council Members to attend the meetings. Often, representatives are welcome to attend and do so on a regular basis. There are great benefits in attending the Resident Council meetings, such as getting to know residents, being a familiar support to residents, and getting a sense of how the residents are treated and how the facility is managed.

It is a good idea to check in with the Resident Council President or another Council Member during regular visits to get a sense of what is going on in the facility.

**Family Councils**

*Trainer’s Note: Many facilities do not have Family Councils. Share your experience of attending Family Council meetings or assisting members of the Council.*

A Family Council is a group of residents’ family members that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents’ care, treatment, and quality of life; support each other; plan resident and family activities; participate in educational activities; or, for any other purpose.51

Members form a united consumer voice which can play a crucial role in voicing concerns, requesting improvements, supporting new family members and residents, and supporting facility efforts to make care and life in the facility the best it can be.

Similar to how parents’ associations work with schools, Family Councils provide a way for concerned persons to actively participate in helping the facility to be the best it can be, through combining and prioritizing shared concerns and then communicating them to facility administrators, making recommendations, and suggesting solutions, sharing answers and information when replies are received, and supplementing staff services via additional actions which enhance residential life.

A Family Council meets regularly and promotes communication, action, support, and education. The specific activities of the Council depend upon the needs of the residents and the choices made by Council members.

Family Councils operate on the premises that:

- There is strength in numbers and that combined voices garner more attention than just one
- Increased family involvement fosters greater staff accountability, which in turn decreases possible neglect and abuse
- Streamlining concerns is more efficient and reduces the time staff ultimately spends addressing repeat issues

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51 State Operations Manual Appendix PP Guidance to Surveyors DEFINITIONS §483.10(f)(5)-(7)
Federal Law
The 1987 Nursing Home Reform Act guarantees the families of nursing facility residents a number of important rights to enhance a loved one’s nursing facility experience and improve facility-wide services and conditions. Key among these rights is the right to form a Family Council and hold regular private meetings.

Nursing facilities must provide a meeting space, cooperate with the Council’s activities, and respond to the group’s concerns. Nursing facilities must appoint a staff advisor or liaison to the Family Council, but staff and administrators have access to Council meetings only by invitation. While the federal law specifically references “families” of residents, close friends of residents are encouraged to play an active role in Family Councils, too.

Specifically, the federal law includes the following requirements on Family Councils:

- A resident’s family has the right to meet in the facility with the families of other residents in the facility.
- The facility must provide a family group, if one exists, with private space.
- Staff or visitors may attend meetings at the group’s invitation.
- The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.
- When a family group exists, the facility must listen to 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.

These federal requirements are often supplemented by State Statutes.

→ Add state-specific requirements and information about Family Councils in nursing facilities (NFs) and residential care communities (RCCs), if applicable.

The Ombudsman Program and the Family Council
In addition to acting as an advocate for residents, the Ombudsman program can educate residents, families, and friends about residents’ rights, state surveys, and federal and state laws that are applicable to nursing facilities and other long-term care facilities. The LTCOP also provides support and advocacy to Family Councils when asked by the Council.

Successful Family Councils maintain open communications with the LTCOP which is mutually beneficial: the program is kept informed of concerns which reflect multiple residents’ experiences (which often reflect the facility culture) and the Council has a human resource which can help to differentiate fact from fiction when members seek to clarify and correct problematic situations.
Even if a state does not have regulations for residential care communities regarding Resident Councils and/or Family Councils, there are no requirements restricting the councils and the Ombudsman program providing support to councils in RCCs.

Learn more about Resident and Family Councils.\footnote{The National Long-Term Care Ombudsman Resource Center Family and Resident Councils \url{https://ltcombudsman.org/issues/family-and-resident-councils}}
Section 8:

Conclusion
Module 3 Questions

**Trainer’s Note:** Allow at least 15 minutes for Section 8. Ask the following questions and make sure the correct answer is discussed. These questions are meant to determine if the trainees learned the fundamental learning objectives and may illicit discussion about the answers. The questions and answers are not meant to be rushed through.

1. Why is it important for a representative to know about advance planning and third-party decision makers?

   These documents show the resident’s wishes and may also name someone else to make decisions on the resident’s behalf when or if the time comes that the resident is unable to do so.

   The LTCOP Rule requires the LTCOP to determine the extent of the authority that has been granted to the resident representative (e.g., agent under a POA, guardian, etc.). Therefore, if/when the LTCOP follows the direction of someone named as the resident’s decision maker, it is crucial to understand the limits of their authority to make such decisions.

2. Explain what “empowerment” means to you.

   Empowerment is the process of becoming stronger and more confident, especially in controlling one’s life and claiming one’s rights. Empowerment is encouraging others to speak out and resolve their own concerns.

3. When a resident is hesitant to speak up about a concern, what can you do to help? Hint: Look at Section 3.

   - Educate residents about their rights, including their right to present grievances without fear of retaliation
   - Educate staff about residents’ rights, especially that the resident has the right to bring up concerns or complaints
   - Encourage residents to participate and address their concern in the care plan meeting
   - Encourage residents to participate and address their concern in the Resident Council meetings
   - Talk about which staff member may most effectively address the problem
   - Explain the pros and cons of speaking up, of asking the LTCOP for help, and of filing a complaint with the state survey agency
4. Name four residents’ rights that are related to care planning.

- Participate in the planning process
- Identify individuals or roles to be included in the planning process
- Request meetings
- Request revisions to the person-centered plan of care
- Participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care
- Be informed, in advance, of changes to the plan of care
- Receive the services and/or items included in the plan of care
- See the care plan, including the right to sign after significant changes to the plan of care are made

5. Name two things a facility must do to assist Resident Councils and Family Councils.

*Possible answers:* provide private space for meetings; make residents (or family members) aware of upcoming meetings in a timely manner; designate a staff person to provide assistance; and respond to written requests.

**True or False:**

a. The charge nurse is responsible for assuring the nursing care provided by other nurses and nursing aides meets federal and state requirements.

*False*

b. The care plan coordinator is a social worker who works with other facility staff, residents, and residents’ family members to conduct assessments and to coordinate individual nursing care.

*False*
Module 3 Additional Resources

Centers for Medicare & Medicaid Services

- Long-Term Care Facilities
  https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/LTC

Residents’ Rights

- Bingo Game
  https://mightyrightspress.org/product/residents-rights-bingo/
- Card Game
  https://theconsumervoicce.org/product/residents-rights-playing-cards

Person-Centered Care

NORC Resource
https://ltcombudsman.org/issues/person-centered-care

Person-centered language suggestions

Nursing Facility Staffing Levels in your State

- Long-Term Care Community Coalition
  https://nursinghome411.org/data/staffing/
- CMS Payroll-Based Journal (PBJ) staffing data submitted by long-term care facilities

LTC Informational Series Video 6 Effective Advocacy & Complaint Management for Residents
Southwestern Commission AAA, LTCOP, Sylva, North Carolina
https://www.youtube.com/watch?v=8s7d1oE8_Q0&list=PLSu_zY6vP6REXfVf7E-F9CG2K_9P-F&index=6
MODULE FOUR

Long-Term Care Settings, Residents’ Rights, and Enforcement

January 2022
# Table of Contents

Module 4 State-Specific Information........................................................................................................... 2

Section 1: Welcome and Introduction........................................................................................................... 4

Section 2: Long-Term Care Settings ........................................................................................................... 10

Section 3: Who’s Who in Long-Term Care Facilities ................................................................................. 19

Section 4: Residents’ Rights in Nursing Facilities ....................................................................................... 25

Section 5: Regulatory Process for Nursing Facilities.................................................................................... 40

Section 6: Residents’ Rights in Residential Care Communities and the Regulatory Process ....................... 47

Section 7: Conclusion................................................................................................................................... 53
Module 4 State-Specific Information

The list below outlines state-specific information for trainers to discuss, provide a link to, or add directly to the Trainer Guide, Trainee Manual, and/or PowerPoints. When you get to the point in the training where you need to discuss, include a link to, or add state-specific information, you will see a **bold, blue arrow (→)** and a brief description of what to include.

→ State-Specific Information

Section 2 Long-Term Care Settings

- Add state-specific long-term care facility types, their definitions, and links to the state rules and/or regulations.

Section 3 Who’s Who in Long-Term Care Facilities

- Add state-specific positions if not included in the list for both nursing facilities and residential care communities (RCCs).
- Add state staffing requirements for nursing facilities, if applicable.

Section 4 Nursing Facility Residents' Rights in Federal Law

- If your state has additional residents' rights for nursing facilities based on state regulations, please include them within this section.

Section 5 Regulatory Process for Nursing Facilities

- If your state has additional enforcement requirements for nursing facilities, please include them in this section.
- Explain how and when the Long-Term Care Ombudsman program (LTCOP) is notified of an annual survey. For example, is the state Office and/or the local Ombudsman entity notified?
- Explain state program requirements for sharing complaints and concerns with the survey agency prior to and/or during a survey. For example, does your state have an offsite survey form for the LTCOP to complete prior to a survey?
- Explain how to access the annual survey findings.
Include your program’s process for participation before, during, and after the resident meeting.

Add pertinent state-specific information about complaint investigations (e.g., how to access the findings of the investigations).

Section 6 Residents’ Rights in Residential Care Communities

Add information on residential care communities (RCCs) as defined in your state including types of RCCs, characteristics and level of services provided, and residents’ rights, as applicable in state law.

If your state has a Medicaid waiver that pays for assisted living, adult foster care, a personal care home, or any other non-nursing facility, or non-residential setting, then include the Centers for Medicare & Medicaid Services (CMS) Home and Community-Based Services (HCBS) settings requirements, as applicable.

Section 7 Regulatory Process for Residential Care Communities

Explain how and when the Ombudsman program is notified of an RCC annual inspection. For example, is the state Office or the local Ombudsman office notified? Is the LTCOP notified prior to the surveyor’s entrance to the facility or the same day?

Explain your program’s process for participation before, during, and after an RCC inspection.

Explain state program requirements for sharing complaints and concerns with the survey agency prior to and/or during an RCC survey. For example, does your state have an offsite survey form for the LTCOP to complete prior to a survey?

Add pertinent state-specific information about RCC complaint investigations. Information may include whether your program is notified in advance of complaint investigations and how to access the findings of the investigations.

Explain how to access RCC inspection results.
Section 1:
Welcome and Introduction
Welcome

*Trainer’s Note:* Allow at least 15 minutes for Section 1.

Begin the session by welcoming the trainees to the training session and thanking them for their continued interest in the program. Make sure everyone introduces themselves – even if they come late.

To begin please share:

- Your name
- Where you are from
- One thing you learned from Module 3 - something that really stuck with you or surprised you
- What you hope to learn since the last module

After introductions, thank the trainees for their information and explain any housekeeping items that need to be addressed including the time frame of the training day, breaks, location of restrooms, refreshments, etc. Ask the trainees to speak up if they have any questions throughout the training.

Welcome to Module 4 of certification training *Long-Term Care Settings, Residents’ Rights, and Enforcement.* Thank you for being here to learn more about the Long-Term Care Ombudsman program and the certification process.
Module 4 Agenda

*Trainer's Note:* *The timeframes for each Section are approximate. Allow at least 4 hours for this session.*

Section 1: Welcome and Introduction *(15 Minutes)*
Section 2: Long-Term Care Settings *(20 Minutes)*
Section 3: Who’s Who in Long-Term Care Facilities *(30 Minutes)*
**BREAK** *(5-10 Minutes)*
Section 4: Residents’ Rights in Nursing Facilities *(60 Minutes)*
**BREAK** *(5-10 Minutes)*
Section 5: Regulatory Process for Nursing Facilities *(30 Minutes)*
Section 6: Residents’ Rights in Residential Care Communities and the Regulatory Process *(Timeframe depends on your state-specific information)*
Section 7: Conclusion *(15 Minutes)*

Module 4 Learning Objectives

*Trainer's Note:* *Go over the Module 4 learning objectives.*

By the end of this Module, you will understand the following:

- The different types of long-term care settings, including home and community-based services
- The various staff positions in nursing facilities and residential care communities (RCCs)
- Residents’ rights in long-term care facilities and how the Ombudsman program can help when those rights are violated
- Residents’ rights in residential care communities
- The regulatory process for both nursing facilities and RCCs
Module 4 Key Words and Terms

The key words and terms are defined relative to Ombudsman program practices and are found throughout this Module. Take a moment to familiarize yourself with this important information.

Centers for Medicare & Medicaid Services (CMS) – A division within the U.S. Department of Health and Human Services, CMS administers the nation’s major healthcare programs including Medicare and Medicaid.

Critical Access Hospital (CAH) – A rural hospital certified by CMS as a CAH with beds that can be used as equivalent to skilled nursing facility care. Those beds must meet the requirements of the Federal Nursing Facilities Regulations.¹

Empowerment – This is a primary role of the Long-Term Care Ombudsman program in which representatives provide the tools (e.g., information about residents’ rights, facility responsibilities), encouragement, and assistance to promote resident self-advocacy.

Highest Practicable Level of Well-Being – The highest possible level of physical, mental, and psychosocial functioning a resident can maintain or achieve.

Hospice – An agency or organization that provides care to terminally ill individuals and has a valid Medicare provider agreement. Some hospices are located within a hospital, nursing facility, or a home health agency.²

Informed Consent – The permission from a resident or a resident representative after a full explanation has been given of the facts, options, and possible outcomes of such options in a manner and language in which the resident or resident representative understands.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) – The ICF/IID benefit is an optional Medicaid benefit; however, all states offer this. ICF/IID provide active treatment for individuals with intellectual disabilities and other related conditions. Residents in ICF/IID may be non-ambulatory, have seizure disorders, mental illness, visual or hearing problems, or a combination of conditions. Currently, the Ombudsman program in very few states either visit or respond to complaints from ICF/IID.³

Medicaid – A state and federal assistance program that serves low-income people of every age. It is run by state and local governments following federal guidelines.⁴

¹ [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CAHs](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CAHs)
² [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospices](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Hospices)
³ [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/ICF-IID](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/ICF-IID)
Medicare – A federal insurance program run by CMS for those who have paid into the program. It serves people over 65 years of age, regardless of their income; younger individuals with disabilities; and persons on dialysis.\(^5\)

Minimum Data Set 3.0 (MDS, MDS 3.0) – A federally mandated assessment of all residents in Medicare and Medicaid certified nursing facilities. MDS assessments are conducted upon admission, throughout the resident’s stay and upon discharge. The data from the assessments is transmitted electronically using the MDS national database at CMS.\(^6\)

Office of the State Long-Term Care Ombudsman (Office, OSLTCO) – As used in sections 711 and 712 of the Act, means the organizational unit in a State or territory which is headed by a State Long-Term Care Ombudsman.\(^7\)

Ombudsman – A Swedish word meaning agent, representative, or someone who speaks on behalf of another. For the purposes of this manual, the word “Ombudsman” means the State Long-Term Care Ombudsman.

Representatives of the Office of the Long-Term Care Ombudsman (Representatives) – As used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in §1324.19(a), whether personnel supervision is provided by the Ombudsman or his or her designees or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.\(^8\)

Resident Representative – An individual chosen by the resident to act on their behalf, or a person authorized by federal or state law (e.g., agent under a Power of Attorney, representative payee, and other fiduciaries) to act on behalf of a resident in order to support the resident in decision-making; accessing medical, social, or other personal information of the resident; managing financial matters; or receiving notifications; legal representative (as used in Section 712 of the Act), or a court-appointed guardian or conservator of a resident.\(^9\)

Residential Care Community (RCC) – A type of long-term care facility as described in the Older Americans Act (Act) that, regardless of setting, provides at a minimum, room and board, around-the-clock on-site supervision, and help with personal care such as bathing and dressing or health-related services such as medication management. Facility types include but are not limited to, assisted living; board and care homes; congregate care; enriched housing programs; homes for the aged; personal care homes; adult foster/

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5 http://www.medicare.gov  
7 45 CFR Part 1324 Subpart A §1324.1 Definitions  
8 45 CFR Part 1324 Subpart A §1324.1 Definitions  
family homes and shared housing establishments that are licensed, registered, listed, certified, or otherwise regulated by a state.¹⁰

**Social Security Administration (SSA)** – A government agency that administers Social Security, a social insurance program with retirement, disability, and survivor benefits.¹¹

**Skilled Nursing Facility or Nursing Facility** – Also known as a “nursing home,” is a certified facility that provides skilled nursing care for residents who require medical or nursing care rehabilitation or provides health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities.¹² For the purposes of this training and to be consistent with the National Ombudsman Reporting System (NORS), we use the term “nursing facility” for both skilled nursing facilities and nursing facilities.¹³

**State Long-Term Care Ombudsman (Ombudsman, State Ombudsman)** – As used in sections 711 and 712 of the Act, means the individual who heads the Office and is responsible personally, or through representatives of the Office, to fulfill the functions, responsibilities and duties set forth in §1324.13 and §1324.19.

**State Long-Term Care Ombudsman Program (Ombudsman program, the program, LTCOP)** – As used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.¹⁴

**State Survey Agency** – The state agency responsible for certifying and/or licensing long-term care facilities and conducting inspections and investigations to ensure federal and state compliance.

**State Surveyor** – An individual who works for the state survey agency and conducts in-depth surveys, inspections, and investigations of long-term care facilities.

**Subsection symbol (§)** – The subsection symbol is used to denote an individual numeric statute or regulation (rule).

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¹⁰ CA-04 02 Residential Care Community Table 1 Part C Case and Complaint Definitions https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
¹¹ Social Security Administration https://www.ssa.gov/
¹² This definition is a combination of Requirements for, and assuring Quality of Care in, Skilled Nursing Facilities, Section 1819(a) of the Social Security Act [42 U.S.C. 1395i–3(a)] https://www.ssa.gov/OP_Home/ssact/title18/1819.htm and Requirements for Nursing Facilities, Section 1919(a) of the Social Security Act [42 U.S.C. 1396r(a)] https://www.ssa.gov/OP_Home/ssact/title19/1919.htm
¹³ NORS Table 1 https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
¹⁴ 45 CFR Part 1324 Subpart A §1324.1 Definitions
Section 2:
Long-Term Care Settings
Trainer’s Note: Allow at least 20 minutes for Section 2.

Long-Term Services and Supports

“Long-term services and supports” describes a range of services for older adults and people with disabilities. Services and supports are provided to help people live as independently as possible by assisting with healthcare needs and activities of daily living. Examples of supports include assistance with meals, bathing, grooming, dressing, managing medication, managing money, walking, and providing medical care. Care and services are provided in a variety of settings such as individuals’ homes, community-based settings, residential care communities, and nursing facilities.

Long-term care facilities (residential care communities and nursing facilities) provide a variety of supports and services. The supports and services depend upon the facility’s certification and/or license. It is important to get to know the structure and the supports and services of the facilities that you visit.

Paying for Long-Term Services and Supports

There are a variety of ways in which services and supports are paid for or supplemented. Some individuals pay “out of pocket” and others rely on government payer sources to cover all or most of their care.

Resident Funds

“Private pay” is a term used to describe payment when a resident does not use state or federal assistance to pay for long-term services and supports. Private pay could include using the resident’s income, such as Social Security, pensions, other funds, and/or insurance (e.g., supplemental insurance, life insurance policies, long-term care insurance). Insurance policies, including long-term care insurance, vary in coverage of services.

Veterans’ Assistance

Veterans may be eligible for services through federal or state Veterans Affairs (VA) benefits. Some veterans can receive nursing and medical care, physical therapy, help with activities of daily living (ADLs), pain management, etc. These services can be provided in various settings such as residential care communities (RCCs), nursing facilities, adult day centers, and at home.
Learn more about federal VA benefits [here].

**Medicare and Medicaid**

Medicare and Medicaid are both public insurance programs that help cover the cost of medical care. Many people in nursing facilities rely on these programs to help cover a portion of their stay. However, residents and family members often confuse the two programs.

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal funds</td>
<td>Combination of state and federal funds</td>
</tr>
<tr>
<td>Administered by Centers for Medicare &amp; Medicaid Services (CMS)</td>
<td>Administered by CMS and the state</td>
</tr>
<tr>
<td>65 years of age and older or age 64 and younger with certain disabilities or illnesses</td>
<td>No age requirement</td>
</tr>
<tr>
<td>Individual has worked and paid Medicare taxes and/or pays a Medicare premium</td>
<td>Income requirements for eligibility</td>
</tr>
<tr>
<td>Limited long-term care coverage</td>
<td>Covers room and board and the cost of supports and services</td>
</tr>
<tr>
<td>Skilled nursing care benefit period up to 100 days</td>
<td>Benefits are long-term</td>
</tr>
</tbody>
</table>

**Medicare**

Medicare is a health insurance program for people who are 65 years of age or older, or age 64 and younger with certain disabilities or illnesses. It helps with the cost of health care, but it does not cover all medical expenses or the cost of most long-term care. Medicare covers *skilled care* in a nursing facility when the individual has a qualifying three-day stay in a hospital and meets all other criteria. Medicare benefits may be paid toward skilled care for up to 100 days (Medicare pays approximately 80% of the cost of skilled care for days 21-100).

**Medicare Part A** (hospital insurance) helps pay for inpatient care in a hospital or limited time at a skilled nursing facility (following a hospital stay). Part A also pays for some home health care and hospice care.

**Medicare Part B** (medical insurance) helps pay for services from doctors and other health care providers, outpatient care, home health care, durable medical equipment, and some preventive services.

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16 Social Security Administration [Medicare Benefits](https://www.ssa.gov/benefits/medicare/)

17 Medicare Skilled nursing facility (SNF) care [https://www.medicare.gov/coverage/skilled-nursing-facility-snif-care](https://www.medicare.gov/coverage/skilled-nursing-facility-snif-care)
Other parts of Medicare are run by private insurance companies that follow rules set by Medicare.

Medicare coverage depends upon the resident’s care needs as well as their Medicare Plan and may include, but is not limited to:

- Home health care
- Care in a skilled nursing facility after a 3-day hospital stay
- Certain prescription drugs
- Skilled rehabilitation (therapy) either inpatient or at home
- Hospice services

**Medicaid**

*Trainer’s Note: If you feel it is appropriate, include your state’s Medicaid eligibility information as well as instances where Medicaid is the payer of last resort. Indicate whether the RCCs in your state accept Medicaid or how individuals in RCCs receive Medicaid.*

Medicaid is the most common payer source for nursing facility residents. Medicaid eligibility requirements for nursing facility care are based on income and level of care, determined by each state. Medicaid covers room and board as well as the cost of supports and services in certified nursing facilities after the resident’s income sources and insurance have been exhausted. When a resident has their care covered by Medicaid, they are only allowed a set amount of money (that varies from state to state) considered as their personal spending money. This is called the “Personal Needs Allowance.”

Medical services provided under Medicaid include, but are not limited to:

- Occupational therapy
- Physical therapy
- Prescribed drugs and other medications
- Eyeglasses
- Transportation
- Medical equipment and supplies
- Medication

There are limitations on the services and equipment provided by Medicaid. For example, Medicaid may limit the number of pairs of glasses it will purchase. This can be a problem when glasses are often lost or broken.
Medicaid Home and Community-Based Services (HCBS) Waiver Programs

*Trainer's Note: If you haven’t already, mention if residents who live in RCCs are eligible for HCBS.*

Home and Community-Based Services (HCBS) are a Medicaid state plan option that allows states to provide services to individuals eligible for Medicaid in their own home or a community-based setting (including some residential care communities), instead of an “institutional” setting such as a nursing facility. States provide services under Medicaid waivers according to provisions in Section 1915(c) of the Social Security Act. These services are determined through person-centered planning. Several states include HCBS services in their Medicaid State plans. As of 2021, 47 states and Washington, D.C. are operating at least one 1915(c) waiver. Payment for these services are a combination of federal and state funds and some contribution from the individual receiving services.

**Long-Term Care Services**

**Skilled Nursing Facility or Nursing Facility (SNF/NF)**

Skilled nursing facilities or nursing facilities are certified facilities that provide skilled nursing care for residents who require medical or nursing care rehabilitation. SNF/NF also provide health care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities.

Nursing facilities must be licensed by individual states and certified as a nursing facility, skilled nursing facility, or both, to participate in Medicare and Medicaid. Medicare and Medicaid are the primary payment sources for most residents in nursing facilities. Federal law and regulation govern skilled nursing/nursing facilities. State law and regulation govern the few nursing facilities that do not accept federal funds and do not operate under a Medicare/Medicaid contract.

*Trainer's Note: If applicable, point out the nursing facilities in your state that do not accept Medicare/Medicaid funds.*

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18 Medicare [https://www.medicare.gov/](https://www.medicare.gov/)
19 Medicaid [https://www.medicaid.gov/](https://www.medicaid.gov/)
Most nursing facilities are “dually certified” for Medicare and Medicaid, meaning that if qualified, a resident's stay is partially paid for by either government program. Federal certification is further discussed in Section 5.

Dually certified beds offer more flexibility for a resident to stay in that room/bed if their Medicare days are over and they apply for Medicaid to continue their coverage. The resident cannot be forced to leave that bed just because of their payment source.

**Skilled Care**

Skilled care is usually short-term and can only be performed by skilled or licensed professionals such as a registered nurse or a physical therapist.

Examples of skilled care include but are not limited to:
- Physical therapy
- Wound care
- Speech therapy
- IV medication

Residents may have a short stay in a skilled nursing facility as part of their Medicare benefit; typically, this is for specialized nursing or rehabilitation services.

**Long-Term Care**

Some people may stay in a nursing facility long-term because they have continuous care needs that may require both skilled care and assistance with activities of daily living, such as bathing, grooming, assistance with walking and exercise, and medication management.

Nursing facilities are to follow the same set of regulations and offered skilled services for both short- and long-term stays.

*Trainer’s Note: The following facility types: RCCs, ICFs/IDs, CAHs, and CCRCs all vary from state to state. Make sure you understand the facility types in your state and only present those applicable to your area.*

**Residential Care Community (RCC)**

An RCC is a type of long-term care facility as described in the Older Americans Act that, regardless of setting, provides at a minimum: room and board, around-the-clock on-site supervision, and help with personal care such as bathing and dressing or health-related services such as medication management.

Facility types include but are not limited to: assisted living; board and care homes; congregate care; enriched housing programs; homes for the aged; personal care homes; adult foster/ family homes; and shared housing establishments that are licensed, registered, listed, certified, or otherwise regulated by the state.
Services offered by RCCs vary by state law and regulation. Residents may receive skilled nursing or rehabilitation services in these settings from an outside provider (e.g., home health).

→ Add state-specific long-term care facility types, their definitions, and links to the applicable state rule or regulation.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)20

ICF/IID provide active treatment (AT) for individuals with intellectual disabilities and other related conditions.21

Intermediate Care Facilities for Individuals with Intellectual disability (ICF/IID) are an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. Although it is an optional benefit, all states offer it, if only as an alternative to home and community-based services waivers for individuals at the ICF/IID level of care.

ICF/IID are available only for individuals in need of, and receiving, active treatment (AT) services. AT refers to aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services. AT does not include services to maintain generally independent clients who are able to function with little supervision and who do not require a continuous program of habilitation services. States may not limit access to ICF/IID service, or make it subject to waiting lists, as they may for Home and Community Based Services (HCBS). Therefore, in some cases ICF/IID services may be more immediately available than other long-term care options. Many individuals who require this level of service have already established disability status and Medicaid eligibility.

Need for ICF/IID is specifically defined by states, all of whom have established ICF/IID level of care criteria. State level of care requirements must provide access to individuals who meet the coverage criteria defined in federal law and regulation. In addition to level of care for AT, the need for AT must arise from an intellectual disability or a related condition.

Many ICF/IID residents work in the community with supports or participate in vocational or other activities outside of the residence and engage in community interests of their choice. These activities are collectively often referred to as day programs. The ICF/IID is

20 Most of the information in this section was adapted from the Centers for Medicare & Medicaid Services (CMS) Medicaid.gov Intermediate Care Facilities for Individuals with Intellectual Disability https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/intermediate-care-facilities-individuals-intellectual-disability/index.html
responsible for all activities, including day programs, because the concept of AT is that all aspects of support and service to the individual are coordinated towards specific individualized goals in the individual performance plan (IPP).

Learn more about Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID).

Critical Access Hospital (CAH)
A rural hospital certified by Centers for Medicaid and Medicare Services (CMS) as a CAH with beds (known as “swing beds”) that can be used as equivalent to skilled nursing facility care. CAHs must follow the federal nursing facilities regulations for all certified beds.

Continuing Care Retirement Communities (CCRC)
*Trainer’s Note: Provide examples if your state has CCRCs.*
Sometimes CCRCs are called continuing care communities, life care communities, or other variations. CCRCs are usually on a campus and provide accommodations for independent living, residential care communities, and nursing facility care. Each individual care setting must meet state and federal requirements, when applicable.

Other Services that may be Provided in a Long-Term Care Facility
**Home Health Services**
Home health services provide a range of health care services in individuals’ homes, hospice facilities, residential care communities, and nursing facilities. Medicare, Medicaid, and other insurance may reimburse home health providers for services for eligible individuals.

Learn more about home health services [here](https://www.medicare.gov/coverage/home-health-services).

**Palliative Care and Hospice Care**
Both palliative care and hospice care provide comfort. Palliative care can begin at diagnosis and at the same time as treatment, whereas hospice care begins after treatment of the disease is stopped and when it is clear that the person is not going to survive the illness.

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23 Medicare Home health services [https://www.medicare.gov/coverage/home-health-services](https://www.medicare.gov/coverage/home-health-services)
25 [https://medlineplus.gov/ency/patientinstructions/000536.htm](https://medlineplus.gov/ency/patientinstructions/000536.htm)
**Palliative care** is a resource for anyone living with a serious and/or chronic illness. Palliative care teams work with the resident and others to provide coordinated medical, social, and emotional support. The team is made of palliative care specialist doctors and nurses, and includes others such as social workers, nutritionists, and chaplains.

**Hospice care** is for terminally ill individuals whose doctors believe have six or fewer months to live if the illness runs its natural course. Hospice provides comfort care to the resident as well as support for the family. Once a person decides to receive hospice services, attempts to cure the illness are stopped.

Learn more about hospice and palliative care click [here](https://www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care).

**Home and Community-Based Services**

Home and community-based services (HCBS) provide opportunities for individuals eligible for Medicaid to receive services in their own home or community rather than an institution (e.g., long-term care facility) or other isolated setting. These programs serve a variety of individuals, including people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.

All LTCOPs provide information and assistance regarding long-term services and supports, but only a few programs provide services to individuals receiving home and community-based services. Those Ombudsman services should have funding separate from the Older Americans Act. However, to support independence, the Older Americans Act does allow for Ombudsman programs to provide authorized advocacy for residents transitioning to a home care setting. Follow your state policies and procedures.

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Section 3: Who’s Who in Long-Term Care Facilities
Trainer’s Note: Allow at least 30 minutes for Section 3.

Long-term care facilities are owned and operated by different entities. They may be non-profit or for profit and may be run as a single facility or be part of a state or national corporation. The owner or governing body of a facility has the overall responsibility for the operation of the facility, including budgetary decisions and the development of policies and procedures, and assuring compliance with all federal and state requirements. When resolving facility-wide complaints, it is helpful for the LTCOP to learn which party is best suited to resolve the concern.

During your visits to the facility, you will get to know staff and the role that they play. You may find that some are more responsive than others in resolving resident complaints. Through experience you will learn the responsibilities of each staff member and their willingness to assist, so you can identify who will best be able to address the resident’s concern.

→ Add state-specific positions if not included in the list for both nursing facilities and RCCs.

Each residential care community is unique. The organizational structure differs from one to another, and each may use different terms or titles when referring to the employees. Depending on size, a small facility may operate with a manager and attendants, caregiver, or aides, while a large facility may have a variety of departments with multiple staff.

The following are key staff members in nursing facilities. RCCs may or may not have similar positions but an asterisk (*) below indicates common RCC terminology.

Administrator (*Manager, Director, Operator, etc.)
The administrator operates and manages the nursing facility and is responsible for supervising the work of all employees. The administrator is also responsible for ensuring the facility meets federal and state requirements.

Director of Nursing (DON)
The DON is responsible for ensuring the nursing care provided by other nurses and nursing aides meets federal and state requirements.

Assistant Director of Nursing (ADON)
Not all nursing facilities have an ADON. The ADON helps the DON with their duties.

Charge Nurse
The charge nurse is a registered nurse (RN) or a licensed practical nurse (LPN) who supervises nursing care during a given shift. Depending on the size of the facility, there may be more than one charge nurse.
Certified Nursing Assistant (CNA)
CNAs provide the personal care residents receive each day. CNAs assist residents with activities of daily living and often spend more time with the residents than anyone else that works in the facility.

*Non-Certified Attendant, Assistant, or Caregiver*
Individuals working in an RCC who perform various functions but are not required to be licensed or certified.

MDS Coordinator
The MDS coordinator is often the Medicare coverage expert responsible for coding the Minimum Data Set (MDS) resident assessments. MDS coordinators are typically RNs who may serve in a variety of roles in the nursing facility.

Care Plan Coordinator
The care plan coordinator is a nurse who works with other facility staff, residents, and residents’ family members to conduct assessments and to coordinate individual nursing care. The care plan coordinator is responsible for writing care plans and conducting care plan meetings.

Social Worker or Social Services Director
The facility social worker provides services to assist with the well-being of residents and acts as a liaison between residents and/or family members and facility staff. Facility social workers are typically familiar with resources within the community and may be involved with the discharge process or assisting a resident with accessing services inside and outside of the facility.

Activities Director
The activities director plans and implements an activity program designed to meet the individual needs of the residents. Scheduled activities may be large or small group activities or may even be one-on-one.

Dietary Manager or Director of Food Services
The dietary manager is responsible for the receipt and storage of food supplies and provides oversight for meal preparation to meet the individual dietary needs of each resident. Some larger facilities have a corporate dietitian who is responsible for meeting the dietary needs of residents in several facilities and may develop a set menu for the dietary manager to follow. Other dietary staff include cooks and servers.
Physical, Speech, and Occupational Therapists
These therapists may work for an outside agency that contracts with the facility, which means the therapists may not be actual employees of the facility. **Physical therapists** assist residents with restoring their physical mobility and function following a serious injury or illness. **Speech therapists** assist residents who have problems with verbal communication as well as problems with swallowing. **Occupational therapists** assist residents with regaining their ability to perform activities of daily living (e.g., eating, dressing, grooming).

Laundry Supervisor
The laundry supervisor is responsible for managing the residents’ laundry.

Housekeeping Manager or Director of Housekeeping
The housekeeping manager is responsible for ensuring the entire facility, including resident rooms, are clean and orderly. The housekeeping manager is responsible for the housekeeping staff who clean the facility.

Maintenance Supervisor
The maintenance supervisor is responsible for maintaining the facility’s building, equipment, and grounds.

Business Office Manager
The business office manager is responsible for overseeing the financial operations of the facility, which includes billing and keeping track of any resident funds held by the facility.

Admissions Coordinator
The admissions coordinator is likely the first person a resident or family member meets. The admissions coordinator works with other facility staff to determine the capacity of the facility to accept new residents.

Medical Director
The medical director is a physician who assists in the development and implementation of policies and procedures related to the health and care of residents. The medical director may serve as a consultant to the resident’s physician or may be the resident’s physician or may oversee a nurse practitioner.

Pharmacist Consultant
While not an employee in most facilities, a pharmacist consultant is a person who establishes, evaluates, and coordinates all aspects of pharmaceutical services provided to all residents within a facility by all providers (e.g., pharmacy, prescription drug plan, prescribers). They can initiate conversations with facility staff that may lead to medication changes.
Other personnel in the facility may include a receptionist, medical records staff, and a religious figure.

**Activity: Who would you go to?**

*Trainer’s Note: Allow at least 10 minutes for the activity. This can be conducted individually or as a large group discussion. If conducting individually, ask the trainees to draw a line from the concern to the staff member or members they think would best be able to resolve the concern. If conducting as a large group discussion, ask the trainees who they would go to for each concern and follow the instruction on the PowerPoint slide.*

Match the staff member who may be best to speak with about the concern. Some concerns may involve one or more staff member.

<table>
<thead>
<tr>
<th>Concern</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question about a resident’s bill</td>
<td>Administrator or Manager</td>
</tr>
<tr>
<td>Call lights aren’t being answered</td>
<td>DON</td>
</tr>
<tr>
<td>Residents are bored</td>
<td>Charge nurse</td>
</tr>
<tr>
<td>Cold food</td>
<td>Maintenance supervisor</td>
</tr>
<tr>
<td>Sticky floors</td>
<td>Activities director</td>
</tr>
<tr>
<td>Poor staff attitudes towards residents</td>
<td>Housekeeping manager</td>
</tr>
<tr>
<td>Broken sink</td>
<td>CNA</td>
</tr>
<tr>
<td>Soiled laundry in the resident’s room</td>
<td>Business office manager</td>
</tr>
<tr>
<td>Not included on shopping trips</td>
<td>Social service director</td>
</tr>
<tr>
<td>CNAs waking residents at 4:00 a.m.</td>
<td>Dietary manager</td>
</tr>
</tbody>
</table>

*Trainer’s Note: Tell the trainees it is always best to resolve the concern at the lowest possible level of authority. Possible answers are listed below:*

- Call lights not being answered – CNA, charge nurse, DON
- Residents are bored – Activities director
- Cold food – Dietary manager
- Sticky floors – Housekeeping manager
- Poor staff attitudes towards residents – Charge nurse, DON, Administrator
- Broken sink – Maintenance supervisor
- Soiled laundry in the resident’s room – CNA, housekeeping manager
- Question about a resident’s bill – Business office manager
- CNAs waking residents at 4:00 a.m. – Charge nurse, DON
- Being left out of going on shopping trips – Activities Director, Social service director
Nursing Facility Staffing Requirements

The LTCOP often receives complaints about “lack of staff.” Federal nursing facilities regulations do not require a specific number of staff per residents (i.e., resident to staff ratio); however, some state regulations do.

→ Add state staffing requirements for nursing facilities, if applicable.

Federal nursing facility staffing requirements:

- at least 1 RN on duty no less than 8 hours per day, 7 days per week;
- the DON may serve as the 1 RN on duty if the facility has fewer than 60 beds;
- a licensed nurse on duty for evening and night shifts; and
- a sufficient level of additional staff, including CNAs.

What do the federal regulations say about training or skill requirements?

**Trainer’s Note:** Explain that the requirements for all staff listed below indicate knowledge and skill sets to care for residents based on resident assessments and as described in the resident’s plan of care.

**Nursing Staff:** The facility must have sufficient nursing staff with the appropriate knowledge and skill sets to provide nursing and related services to assure resident safety and 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 and considering the number, acuity, and diagnoses of the facility’s resident population in accordance with the facility assessment requirements.

**Licensed Nurses:** The facility must ensure that licensed nurses have the competencies and skill sets necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.

**Certified Nursing Aides:** The facility must ensure that CNAs are able to demonstrate competency in skills and techniques necessary to care for residents’ needs, as identified through resident assessments, and described in the plan of care.
Section 4:

Residents’ Rights in Nursing Facilities
**Trainer’s Note:** Allow at least 60 minutes for Section 4.

**Introduction to Residents’ Rights and the Role of the Ombudsman Program**

Understanding residents’ rights is essential as the Ombudsman program is responsible for sharing information about residents’ rights and supporting residents in exercising their rights. This section provides an overview of residents’ rights and the role of the LTCOP.

**Ombudsman Program Role**

The role of the Ombudsman program is to educate individuals on residents’ rights and to advocate that those rights are honored and respected.

The Ombudsman program can play an important role in helping people restore their sense of self and regain their personal power and voice.

For example, if a resident:

- Is comfortable speaking up to address concerns, a representative can provide information and reassure them of their rights
- Wants more support, a representative can be present as the resident expresses their needs and preferences or speak on the resident’s behalf
- Is unable to communicate their needs and preferences, a representative may work with the resident representative to address a concern

The first step is to get to know residents as individuals. It is important to relate honestly and authentically to the resident and their situation. After establishing a meaningful connection with a resident, they may share their experiences and concerns with you. How you respond and work with these concerns can go a long way in empowering residents and restoring their sense of self.

The Ombudsman program role, process, and approach are generally the same whether a resident resides in a nursing facility, residential care community, or other setting. Charts found in this section under “Ombudsman Program Advocacy Examples” share potential approaches to address residents’ rights violations.

It is important for representatives to understand residents’ rights, laws, and regulations to use them as advocacy tools. However, it is the role of the state survey agency (surveyors) to enforce regulations, not the Ombudsman program.

Laws and regulations for long-term care settings vary. This section references federal laws and regulations that are applicable only to nursing facilities (NFs) that accept Medicaid or Medicare. There are no comparable federal laws or regulations for residential care communities (RCCs). Refer to state laws and regulations for residential care
communities and nursing facilities that do not accept Medicaid or Medicare. Although laws and regulations vary, most of the Ombudsman program advocacy examples in the charts below apply regardless of setting.

**Nursing Facility Residents’ Rights**

*Trainer’s Note: Ask the trainees to fill in the blank with the options of “all,” “some,” or “none.” “Individuals lose __________ of their rights when they move into a nursing facility.”*

*The answer is “none.”*

*Then ask: “True or False? Long-term care residents are afforded additional rights under federal law.”*

*The answer is “True.” Residents are afforded additional rights under state and federal laws. Tell the trainees that these two facts are two of the most important facts they will learn about residents’ rights. Tell them to think about the answer to the first question anytime someone asks them “does a resident have the right to…?” Also, explain that just because a person moves to a nursing facility or an RCC, does not mean they no longer have rights and that they cannot make their own decisions.*

All United States citizens have rights set forth by the Constitution of the United States. Individuals do not lose these rights when they become a resident of a long-term care facility. In fact, they are guaranteed additional rights under federal laws specific to their status as residents. The current federal law pertaining to residents’ rights is [42 U.S. Code of Federal Regulations Part 483 Requirements for States and Long-Term Care Facilities](https://www.govinfo.gov/content/pkg/FR-2016-10-04/pdf/2016-23503.pdf) (Federal Nursing Facilities Regulations).  

**Federal Nursing Facilities Regulations**

The federal nursing facilities regulations clarify required actions and responsibilities of nursing facilities. In addition, the regulations specifically describe each right an individual has as a resident of a nursing facility.

The state survey agency, sometimes referred to as “the state,” is responsible for certifying and/or licensing long-term care facilities and conducting inspections and investigations to ensure federal and state compliance.

A state surveyor is someone who works for the state survey agency to conduct in-depth surveys, inspections, and investigations of long-term care facilities.

→ *If your state has additional residents’ rights for nursing facilities based on state regulations, please include them within this section.*
Residents’ Rights in Federal Nursing Facilities Regulations

The following is a summary of residents' rights as spelled out in the federal nursing facilities regulations, specifically, §483.10 resident rights and §483.12 freedom from abuse, neglect, and exploitation and §483.15 admission, transfer, and discharge rights. Following the summary, the charts show examples of rights violations and how the Ombudsman program (LTCOP) can begin to address these residents’ rights violations.

Note: For purposes of this training, the advocacy examples are intended to be simple and are not inclusive of all resolution strategies. Assume all necessary permission has been granted by the resident or the resident’s representative for the Ombudsman program to proceed with the advocacy examples in the chart.

Trainer’s Note: The rights in this manual are in order of the federal regulations. Reiterate that representatives educate individuals on residents’ rights, follow the direction of the resident, and work to ensure rights are protected. Explain to the trainees that the examples of LTCOP advocacy mentioned in the charts are not the only steps the representative could take. The examples are meant to give an idea about where one could begin. Specific steps toward resolution are covered in Modules 6 and 7.

When discussing the examples, refer to the PowerPoint or choose 1 or 2 different examples of rights violations from the chart. Feel free to use your own examples if you wish.

Tell the trainees to assume resident permission has been given to advocate on their behalf. Also, when providing examples, make sure to discuss what possible empowerment techniques were used.

The Ombudsman Program Advocacy examples are meant to be general because advocacy always depends upon the direction given by the resident.

The link below is to a web-based presentation that NORC and the Consumer Voice developed called Residents’ Rights. There is also a transcript that goes along with the web-based presentation. You do not have time to show the presentation so encourage the trainees to review it on their own time.

Learn more about residents’ rights [here](https://youtu.be/34Z0LYhLts) by watching a video that can be viewed for additional information or used as a presentation for facility staff, consumer groups, or community education.

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29 National Long-Term Care Resource Center Residents’ Rights [https://youtu.be/34Z0LYhLts](https://youtu.be/34Z0LYhLts)
Residents’ rights
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility.

A facility must:
- Treat each resident with dignity and respect
- Care for each resident in a manner that promotes quality of life
- Recognize each resident’s individuality
- Protect and promote the rights of the resident
- Provide equal access to care

Exercise of rights
The resident has a right to exercise their rights as a resident and as a citizen of the United States.

*Trainer’s Note: Ask the trainees, “What rights do all citizens of the United States have?” Responses may include freedom to gather, freedom of religion, freedom of speech, right to vote.*

A facility must:
- Ensure the resident can exercise rights without interference, coercion, discrimination, or reprisal
- Support the resident in exercising their rights

These initial regulations are the foundation for residents’ rights requirements. Each resident has the right to be treated with dignity and respect. To do so, staff must focus on assisting the resident in maintaining and enhancing their self-esteem and self-worth and including the resident’s goals, preferences, and choices. When providing care and services, staff must respect each resident’s individuality, as well as honor and value their input.

<table>
<thead>
<tr>
<th>Rights Violations</th>
<th>Ombudsman Program Advocacy Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff do not knock or obtain permission before entering a resident’s room.</td>
<td>Talk to facility staff about respecting the resident’s personal space. Offer to conduct a staff in-service training on dignity and respect.</td>
</tr>
<tr>
<td>A staff member stands over Mary when they assist her with eating and refer to her as a “feeder.”</td>
<td>Talk to the supervisor about the use of the word “feeder” or any other disrespectful term used to describe a resident. Also discuss the demeaning practice of standing over Mary to help her eat. Offer to provide training to staff on dignity and respect.</td>
</tr>
</tbody>
</table>
Susan’s mail is being opened by the receptionist without her permission. Explain Susan’s right to receive her mail unopened and her right to privacy. Ask the facility if this is common practice, reminding them of the regulations and requesting that this practice stop.

While providing care, staff ignore residents and talk to each other about their boyfriends and local parties. Talk to staff about the importance of recognizing each resident as a person and providing care with the resident not to the resident. Offer to provide training on person-directed care, dignity, and respect.

After talking to a representative, Stan was told by facility staff not to share his concerns with anyone outside of the facility; he should talk to the Social Service Director and not the LTCOP. Explain Stan’s rights to communicate with a representative without interference from facility staff. Offer to provide training on residents’ rights and the LTCOP and ask Stan if he would like you to attend a Resident Council meeting to remind residents of their right to speak with the Ombudsman.

Planning and implementing care
The resident has the right to be informed of, and participate in, their treatment, including the right to:

- Be fully informed of their health status and medical condition in a language they can understand
- Participate in the development and implementation of their person-centered plan of care

This regulation is intended to ensure that residents and resident representatives are included in all areas of person-centered and person-directed care planning and that the planning supports the resident’s goals, choices, and preferences related to daily routines, care, and treatment.

<table>
<thead>
<tr>
<th>Rights Violations</th>
<th>Ombudsman Program Advocacy Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>The facility has a care plan meeting without allowing Carl to participate.</td>
<td>Explain Carl’s right to participate in decisions affecting his care and life in the facility. Encourage Carl to request another meeting where he can be involved.</td>
</tr>
<tr>
<td>Anna tells the nurse and several CNAs that she no longer wants to be on dialysis, but her request is not addressed in her care plan.</td>
<td>Explain Anna’s right to be informed of the consequences of stopping dialysis and her right to refuse treatment. Empower Anna to talk to her doctor and to request another care plan meeting. Let her know she can invite anyone she feels should attend.</td>
</tr>
<tr>
<td>Margaret has dementia and is very</td>
<td>Encourage Margaret and her daughter to</td>
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scared and uncomfortable with male CNAs giving her a shower, but they are often assigned to her. Margaret has begun to express her fear and has hit a CNA. Although her daughter addressed this concern during the care plan meeting, nothing was changed in the care plan. **request another care plan meeting to discuss the specific concern. Offer to attend in support of Margaret and explain Margaret’s right to feel safe during her shower and the responsibility of the facility to ensure her needs and preferences are met.**

Dan repeatedly says he wants to move out of the nursing facility and into the assisted living where his wife resides, but his goal is not included in the care plan. **Talk to the facility about Dan’s wishes to move out and encourage Dan to request a care plan meeting to address his goal.**

**Choice of attending physician**
The resident has the right to choose their attending physician.

While the resident has a right to choose a personal physician, this does not mean that a resident is required to do so. It also does not mean the physician chosen by the resident is obligated to provide services to the resident.

Facility staff may not interfere with the resident’s choice of a physician(s) (e.g., primary care or specialist). If a resident does not have a physician, or if the resident’s physician becomes unable or unwilling to continue providing care to the resident, facility staff must assist the resident or the resident’s representative in finding a replacement.

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<tr>
<td>The facility automatically assigned its medical director as Tony’s physician when he entered the facility. He was not given the choice to use his own doctor whom he has seen for 20 years.</td>
<td>Explain Tony’s right to choose his own physician and encourage him to ask if his doctor is willing to continue to treat him while he stays in the nursing facility.</td>
</tr>
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</table>

**Respect and dignity**
The resident has a right to be treated with dignity and respect, including the right to:

- Be free from physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms
- Retain and use personal possessions
- Receive services in the facility with reasonable accommodation of resident needs and preferences
• Share a room with a spouse or another resident when both individuals live in the facility and both consent to the living arrangement
• Receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed

All residents have a right to be treated with dignity and respect. In addition, all residents' possessions, regardless of their value, must be treated with respect. Providing for resident needs and preferences is essential to creating an individualized home environment. Residents have the right to share a room with whomever they wish if both residents agree. These arrangements could include opposite-sex and same-sex married couples or domestic partners, siblings, or friends.

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<td>Dorothy is new to the facility and has some problems with her memory. She was found in the facility kitchen one night so the facility put a chair alarm on her recliner and told her she can't leave her room.</td>
<td>Explain that the facility cannot restrain Dorothy for their own convenience. Determine what the concern is with Dorothy walking around the facility and discuss appropriate means to assure her independence, mobility, and safety.</td>
</tr>
<tr>
<td>Charles moved into the nursing facility and his only remaining possession is a quilt that his wife made. He has asked that staff do not touch it, but they don't respect his wishes. One time, he found it in another resident's room.</td>
<td>Explain that the facility staff should be respectful of Charles' personal property. The facility has a responsibility to ensure all staff understand and respect his wishes.</td>
</tr>
<tr>
<td>Diane and Denise develop a same-sex relationship while living in the facility and want to share a room. Both have decisional capacity. There is an open room, but the facility will not let them move in together because Diane's son refuses to agree to the arrangement.</td>
<td>Remind the facility of Diane and Denise’s right to live together. Encourage all parties to meet and discuss the concern but point out that the decision is ultimately up to the Diane and Denise.</td>
</tr>
</tbody>
</table>

Self-determination
The resident has the right to, and the facility must promote and facilitate, resident self-determination through support of resident choice including, but not limited to, the right to:
• Choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with their interests, assessments, and plan of care
• Make choices about important aspects of their life in the facility
• Interact with members of the community and participate in community activities both inside and outside the facility
• Receive visitors of their choosing at the time of their choosing
• Deny visitors
• Immediate access to the Ombudsman program
• Organize and participate in resident and family groups
• Participate in other activities, including social, religious, and community activities
• Choose to or refuse to perform services for the facility
• Manage their financial affairs

The facility must support and accommodate each resident to exercise their autonomy regarding those things that are important in their life, including interests and preferences. Residents have the right to make choices about their schedules that are consistent with their interests, assessments, and care plans. Facilities must not develop a schedule for care, such as waking or bathing schedules, for staff convenience and without the input of the residents.

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<td>Marie says she is bored and wants to feel useful. She asked staff if she can help around the facility, such as folding napkins, or helping the Activity Director with setting up activities, but was told no because they can’t allow residents to “work” in the facility.</td>
<td>Encourage Marie to talk with the Activity Director again and offer to go with her. Encourage Marie to request a care plan meeting to address her boredom and desire to help around the facility. Offer to talk to facility staff about Marie’s right to choose her activities. Residents can perform duties of their choice within the facility if it does not infringe upon other resident’s rights.</td>
</tr>
<tr>
<td>Jack is the Resident Council President, and he says the Council does not want staff to be in the meeting the entire time, only when there are specific concerns the Council wants to address with staff. Staff insist on staying throughout the entire meeting.</td>
<td>Explain to Jack and the Council that they have a right to meet independently and others who are not residents must be granted permission from the Council to attend all or part of any Resident Council meeting. Offer to go with Jack to talk to the staff members who are infringing upon the Council’s rights.</td>
</tr>
<tr>
<td>Staff are waking residents at 4:00 a.m. to get ready for their day. During the Resident Council meeting, residents complain and say they don’t want to get up that early.</td>
<td>Explain to the residents they have a right to get up at a time of their choosing. Empower the Council to address their concern with the facility and offer to talk to the DON about residents’ right to wake up at the time of their choosing.</td>
</tr>
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</table>

**Information and communication**
The resident has the right to be informed of their rights and of all rules and regulations governing resident conduct and responsibilities during their stay in the facility.

The resident has the right to access their personal and medical records.
• When *accessing* records, the facility is required to provide the information in the form or format requested (if available) within **24 hours**, excluding weekends.
• The resident has a right to *obtain a copy* of their records within **2 working days** of request.

The resident has a right to send and receive mail. The facility must protect and facilitate residents’ right to communicate, including reasonable access to:

• a telephone;
• the internet (where available); and
• stationery, postage, writing implements and the ability to send mail.

The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and internet research.

The facility is required to ensure each resident knows their rights and responsibilities prior to or upon arriving, as appropriate during the resident’s stay, and when the facility’s rules change. Residents may verbally request to see their personal and medical records. The facility may charge a reasonable fee for providing a copy of the requested records, whether in paper or electronic form. Reasonable access means that telephones, computers, and other communication devices are easily accessible to residents and are adapted to accommodate residents’ needs and abilities, such as hearing or vision loss.

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<td>Mae asks to see her records but is told that they are all in electronic form and no one has time to sit with her and go through them.</td>
<td>Explain Mae’s right to see her records within 24 hours of her verbal request.</td>
</tr>
<tr>
<td>George can only visit his daughter via video calls because she lives in another state. When he asks to use the residents’ computer, he is always told it is not working properly or that someone else is using it. George hasn’t talked to his daughter in months.</td>
<td>Talk to the facility about figuring out a way for George to communicate with his daughter and providing him reasonable access to the computer.</td>
</tr>
<tr>
<td>The facility refuses to post the most recent survey or make available the survey results.</td>
<td>Talk to the facility administrator about the requirement to post and prominently display survey results in an easily accessible manner and in a common area.</td>
</tr>
</tbody>
</table>
**Privacy and confidentiality**

The resident has a right to personal privacy and confidentiality of their personal and medical records.

Personal privacy includes:

- Accommodations
- Medical treatment
- Written, telephone, and electronic communications
- Personal care
- Visits
- Meetings of family council and resident council

This regulation confirms that each resident has the right to privacy and confidentiality for all aspects of care and services. Residents have the right to personal privacy of their body, personal space, and personal care.

During the delivery of personal care and services, staff must remove residents from public view, pull privacy curtains or close doors, and provide clothing or draping to prevent exposure of body parts.

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<td>You walk by Sara’s room and notice that she is sleeping and completely exposed from the waist down.</td>
<td>Immediately go to a staff member and ask them to cover up Sara. Investigate if others are also exposed while their door is open.</td>
</tr>
<tr>
<td>You are talking to Mike in his room when the CNA comes in to provide personal care to Matt, his roommate. The aide does not pull the curtain and does nothing to seek privacy for Matt.</td>
<td>Ask the aide to pull the curtain and excuse yourself to the hall until the CNA is finished providing care.</td>
</tr>
<tr>
<td>You are visiting Velma, a resident whom the facility has described as a “chronic complainer.” During your visit, staff come in and out of her room several times. Velma expresses her annoyance with the interruptions.</td>
<td>Politey ask the staff to either stop interrupting the visit or to provide a space in which there will be no interruptions – whichever makes Velma more comfortable.</td>
</tr>
<tr>
<td>Mildred and Sam have begun an intimate relationship and want to spend some alone time in Sam’s room with the door shut, but facility staff keeps opening the door when they are together.</td>
<td>Explain Mildred and Sam’s right to privacy and encourage both residents and the facility to come up with an agreed-upon way to let staff know when the door is to remain closed.</td>
</tr>
</tbody>
</table>
Safe environment
The resident has a right to a safe, clean, comfortable, and homelike environment including, but not limited to, safely receiving treatment and supports for daily living.

The facility is required to be orderly, sanitary, and free from hazards. It also means lighting, temperatures, and sound levels should be comfortable to the residents. The environment refers to all areas where residents are free to go. The term “homelike environment” in the regulations de-emphasizes the institutional settings and allows the resident to use their personal belongings that support the resident’s opinion of a comfortable living environment.

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<td>A puddle of liquid is in the middle of the hallway.</td>
<td>Immediately locate a staff member and ask them to clean it up. Residents are at risk to slip and fall. Stand and wait for the staff to clean the floor.</td>
</tr>
<tr>
<td>The night shift staff leaves dirty food trays in the hallway for hours after dinner is served to residents in their rooms.</td>
<td>Talk to facility staff about the unsanitary practice and potential risks to residents.</td>
</tr>
</tbody>
</table>

Grievances
The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal.

Residents have a right to complain about treatment, care, management of funds, lost clothing, or violation of rights, etc. This regulation also ensures that the facility has a policy to address all grievances. Facility staff are responsible for making prompt efforts to resolve a grievance and to keep the resident up to date about any progress toward resolution.

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<td>During your last visit, Connie asked for your help with a concern. At the next visit, Connie says staff treat her differently now, after talking to you. Connie says staff are rude and ignore her requests for help.</td>
<td>Explain Connie’s right to present complaints without the fear of retaliation. Offer to talk to staff about the recent concern and offer to provide staff training about residents’ rights and retaliation.</td>
</tr>
<tr>
<td>Mark states he has complained several times about cold food but feels like he is getting the run-around from staff.</td>
<td>Explain Mark’s right to receive a prompt response and updates towards getting his complaint resolved. Offer to address his concern with staff.</td>
</tr>
</tbody>
</table>
Contact with external entities

**Trainer’s Note:** Explain that the protection and advocacy programs (P&A) provide legal representation and other advocacy services to secure the rights of persons with all types of disabilities wherever they live. Include the name of your state’s P&A.

A facility must not prohibit or discourage a resident from communicating with federal, state, or local officials.

This includes, but is not limited to:
- federal and state surveyors;
- other federal or state health department employees;
- representatives of the Office;
- any representative of the protection and advocacy systems, as designated by the state; and
- any representative of the agency responsible for the protection and advocacy systems for individuals with a mental illness.

This means that facility staff must ensure that residents are able to communicate freely with the LTCOP and representatives of federal, state, or local officials.

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<tr>
<td>James tells the facility that he wants to talk to the surveyor during the investigation, but the facility does not inform the survey agency of his wishes.</td>
<td>Explain James's right to talk to the surveyor and give him the number to the state survey agency so he can speak to a surveyor.</td>
</tr>
</tbody>
</table>

**Freedom from abuse, neglect, and exploitation**

**Trainer’s Note:** This section on abuse and neglect is about rights. Let the trainees know that there will be more training on the facility requirements, the role of the Ombudsman program, and other agencies regarding abuse, neglect, and exploitation in the complaint-handling module.

The resident has the right to be free from abuse, neglect, misuse of resident property, and exploitation.

This includes, but is not limited to, freedom from physical punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.

Each resident has the right to be free from abuse, neglect, and physical punishment of any type by anyone. When a nursing facility accepts a resident, the facility assumes the responsibility of ensuring the safety and well-being of the resident. It is the facility's
responsibility to ensure staff know how to support residents and respond appropriately by providing training on how to prevent, identify, and report abuse, neglect, and exploitation.

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<tr>
<td>Joan complains that the aides are rough with her while providing care.</td>
<td>Discuss Joan’s right to have care provided in a manner that does not result in pain and offer to talk to the supervising nurse.</td>
</tr>
<tr>
<td>The LTCOP receives a complaint that residents in the dementia unit are locked in their bedrooms at night.</td>
<td>Visit the dementia unit in the evening, make observations and talk with residents and staff. Educate the staff about the residents’ right to be free from involuntary seclusion.</td>
</tr>
<tr>
<td>Albert has Alzheimer’s disease and when he’s in pain or confused he begins to wave his arms. He hit an aide and she hit him back.</td>
<td>Explain Albert’s right to be free from physical harm. Offer to conduct a staff in-service on residents’ rights and abuse and/or suggest the facility seek an expert in dementia to provide training to staff.</td>
</tr>
</tbody>
</table>

**Admission, transfer, and discharge**

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

- The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility
- The transfer or discharge is appropriate because the resident’s health has improved sufficiently so the resident no longer needs the services provided by the facility
- The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident
- The health of individuals in the facility would otherwise be endangered
- The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility
- The facility ceases to operate

Residents have the right to receive a 30-day written notice of a facility-initiated transfer or discharge.

Once the resident enters the facility, it becomes the resident’s home. Facilities are required to determine their capacity and capability to care for the residents they admit. Therefore, facilities should not admit residents whose needs they cannot meet based on the facility assessment. The regulation also explains the limited conditions under which a nursing facility can discharge or transfer a resident.
Improper transfers and discharges are complicated. There are several advocacy tools that representatives use to prevent facility-initiated transfers and discharges which will be discussed later in the training.

**Discharge/Transfer Definitions Pertaining to Nursing Facilities**

**Discharge** – The movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.

**Transfer** – The movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility.

**Facility-initiated transfer or discharge** – A transfer or discharge to which the resident objects, did not originate through a resident’s verbal or written request, and/or is not in alignment with the resident’s stated goals for care and preferences.

**Resident-initiated transfer or discharge** – Means the resident or, if appropriate, the resident representative has provided verbal or written notice of intent to leave the facility. Leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment.
Section 5:
Regulatory Process for Nursing Facilities
**Trainer’s Note:** Allow at least 30 minutes for Section 5.

**The Centers for Medicare & Medicaid Services**
The Centers for Medicare & Medicaid Services (CMS)\(^{31}\) is an agency within the U.S. Department of Health and Human Services (HHS). CMS is responsible for the administration of Medicare and Medicaid services. Certified nursing facilities are “certified” to be able to accept payments from Medicare and/or Medicaid for providing certain services to residents. Certified nursing facilities must comply with certain federal regulations. The specific federal regulation discussed in this Section is the Requirements for Long Term Care Facilities, also known as federal nursing facilities regulations.\(^{32}\)

**Enforcement of Residents’ Rights**

→ *If your state has additional enforcement requirements for nursing facilities, please include them in this section.*

Among other federal and state laws, nursing facility residents’ rights are defined and clarified in the federal nursing facilities regulations. Rights for individuals living in homes or facilities only regulated by the state are defined and clarified in state rule. Facilities are required to ensure those residents’ rights are upheld.

Learn more about nursing facility enforcement [here].\(^{33}\)

**State Survey Agency**

**Trainer’s Note:** Tell the trainees the name of the state survey agency in your state responsible for surveying nursing facilities.

CMS has an agreement with the state survey agency to conduct surveys (inspections) to determine whether facilities are in compliance with federal regulations. CMS also provides direction to the state survey agency nursing facility inspectors, who are called “surveyors” about how to respond to and investigate complaints and how to conduct annual surveys. There are two types of surveys: the standard survey and the abbreviated standard survey.

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\(^{31}\) Centers for Medicare & Medicaid Services Nursing Homes [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/NHs](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/NHs)

\(^{32}\) CFR 42 Chapter IV Subchapter G Part 483 Requirements for States and Long Term Care Facilities Subpart B - Requirements for Long Term Care Facilities [https://www.ecfr.gov/cgi-bin/text-idx?SID=f64b6edcc2b2ee52bf5de8e19a340569&mc=true&node=sp42.5.483.b&rgn=div6](https://www.ecfr.gov/cgi-bin/text-idx?SID=f64b6edcc2b2ee52bf5de8e19a340569&mc=true&node=sp42.5.483.b&rgn=div6)

The Standard Survey

→ Explain how and when the Ombudsman program is notified of an annual survey. For example, is the state Office or the local Ombudsman entity notified?

→ Explain state program requirements for sharing complaints and concerns with the survey agency prior to and/or during a survey. For example, does your state have an offsite survey form for the LTCOP to complete prior to a survey?

→ Explain how to access the annual survey findings.

The standard survey, also called the annual survey, is conducted between 9 and 15 months from the date of the previous year’s survey by a designated team of surveyors. Federal regulations do not allow states to conduct surveys less frequently when facilities have a history of low or no deficiencies from annual inspections. The state survey agency is responsible for assuring federal and state regulations regarding quality of care and quality of life are met.

According to the Long-Term Care Survey Process (LTCSP) Procedure Guide, surveyors are required to “Contact the Ombudsman in accordance with State policy. Notify the ombudsman of the proposed day of entrance into the facility and if applicable, obtain any information/concerns. Ascertain whether the ombudsman will be available if residents wish her/him to be present during the Resident Council Interview. Enter the Ombudsman’s name, number, contact date, and areas of concern.”

Learn more about how and when the state surveyors are to contact the Ombudsman program here.

Trainer’s Note: Tell the trainees that it is helpful to talk to residents and family members throughout the year who have concerns and ask them for permission to give their name to surveyors during annual surveys. Inform the trainees that they can never divulge the dates of a survey. This information is confidential. Explain to the trainees what happens in your state when a representative discloses survey dates prior to the survey and that they should never tell anyone about a survey until they have confirmed that surveyors are in the building.

The Survey Team
The survey team consists of:
- Registered nurses
- Nutritionists
- Sanitarians
- Environmental specialists
- Other professionals

The Survey Process
The survey team begins the survey process before entering the building. Offsite preparation for a standard survey includes, but is not limited to:
- Reviewing the facility’s Minimum Data Set (MDS) data (resident assessment data)
- Ensuring enough residents are in the sample pool for interview and/or record review
- Reviewing discharged residents’ records
- Reviewing past or repeat deficiencies
- Reviewing complaints investigated since the last survey
- Reviewing any facility-reported incidents since the last survey
- Determining if complaints will also need to be investigated during the survey
- Assigning surveyors particular tasks and areas to observe

The survey team enters the facility unannounced at any time or day of the week, but usually during normal working hours.

Upon Entering the Facility
- The survey team coordinator holds a brief entrance conference with the facility administrator to discuss the survey and to ask for items specific for the survey.
- The survey team members begin the survey by going to their assigned area.
- The surveyor assigned to the kitchen conducts a brief initial visit to the kitchen.
- The team coordinator is required to call the LTCOP.

During the Survey
- Surveyors are required to observe and screen all residents in their assigned area and observe, interview, and complete a limited record review to determine an initial pool of residents.
  Trainer’s Note: The initial pool includes about eight residents who were selected offsite and onsite, are considered at risk for poor outcomes, disclosed complaints during the initial interview, were admitted within the last 30 days, and those identified through the screening process.
Surveyors conduct resident representative interviews (RRI)/family interviews for residents who are unable to be interviewed. The goal is at least three RRIs the first day.

Records and MDS indicators are reviewed. 

**Trainer’s Note:** Surveyors review an MDS Indicator Facility Rate Report to get a sense of how many residents and which MDS indicators are of potential concern at the facility.

All resident observations and interviews from the initial pool are completed.

The first scheduled full meal is observed.

The surveyors select a sample of residents based on concerns that were observed or disclosed on day one and conduct an in-depth investigation for any area of concern.

All concerns identified during the survey are investigated.

Surveyors check for breakdowns in infection control throughout the survey.

Medication passes and storage are observed.

Sufficient and competent nursing staffing is considered.

Learn more about Quality Indicator and Resident Reports [here](#).\(^{36}\)

**Resident Meeting**

→ **Include your program’s process for participation before, during, and after the resident meeting.**

**Trainer’s Note:** For facilities that do not have a Resident Council, the directive to the surveyor is to “not conduct this step.” However, Surveyors are required to determine whether residents have attempted to form a Council and have been unsuccessful and if so, why?

The surveyor works with the Resident Council President or an active member of the Council to arrange the resident meeting. Surveyors can invite any resident to the meeting. With permission of the Resident Council President, the surveyor reviews three months of Council minutes prior to the meeting to identify any unresolved concerns. If there is no Resident Council, surveyors do not conduct a group resident meeting.

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If the representative of the Office has indicated to a surveyor that they want to attend the resident meeting and if the Resident Council President is agreeable, a surveyor informs the LTCOP of the date and time of the resident meeting. Representatives attend the resident meeting to primarily observe the meeting and to support residents. The goal of the meeting is for residents to express concerns and give the surveyor some insight into the care residents receive.

**Exit Conference**
The exit conference is conducted with the facility administrator to inform the facility of the survey team’s observations and preliminary findings. The representative of the Office, the Resident Council President, and one or two other residents are invited to attend. The facility can supply additional information they believe is pertinent to the findings.

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


**Abbreviated Standard Survey**

→ Add pertinent state-specific information about complaint investigations (e.g., how to access the findings of the investigations).

An abbreviated standard survey is also known as a complaint investigation. The timing, scope, duration, and conduct of a complaint investigation are at the discretion of the state survey agency.

The complaint investigation is unannounced and is supposed to occur on the specific day or shift of the complaint, when applicable. For instance, if the complaint is about resident neglect that occurs on the weekends, the investigation should take place on the weekends.

When the state survey agency investigates a nursing facility complaint, the surveyor(s) observations, record reviews, and interviews all pertain to the complaint.

The surveyor will determine whether:
- The allegations are substantiated or unsubstantiated
- The facility failed to meet any of the regulatory requirements

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• The facility practice or procedure that contributed to the complaint has been changed to achieve and/or maintain compliance

Keep in mind that the purpose of a complaint investigation is to determine if the facility is in compliance with federal and state regulations. An investigation may not always achieve the desired result of the resident or complainant. In most situations, the LTCOP works with the resident and facility staff to try to resolve the complaint before contacting the state survey agency.
Section 6:

Residents’ Rights in Residential Care Communities and the Regulatory Process
Trainer’s Note: The timeframe for Section 6 will depend on your state-specific information. The similarities and differences are generalized across the country and may need to be modified significantly for your state.

The role of the Ombudsman program and core advocacy approaches are the same regardless of the setting (e.g., all work is resident-centered; the investigation techniques and resolution process is the same). However, when working with residents in residential care communities there may need to be changes made in advocacy strategies to resolve issues to the satisfaction of the residents. Key similarities and differences between nursing facilities (NFs) and residential care communities (RCCs) are below.

**Similarities include:**

- Most residents in both environments are older adults.\(^{38}\)
- Many of the same services are provided in both settings (e.g., administering medications and providing assistance with activities of daily living).
- Characteristics of residential care community residents are becoming increasingly like those of nursing facility residents (e.g., similar acuity levels, many of the residents have some form of dementia).\(^{39}\)
- Residents in residential care communities often experience a sense of loss and grief similar to individuals living in nursing facilities.

**Differences include:**

- Unlike nursing facilities, there are no federal regulations specifically for residential care communities, and state regulations and enforcement vary. However, there is a federal regulation regarding how states use federal Medicaid funds to pay for home and community-based services (Home and Community Based Services [HCBS] final rule).\(^{40}\) Despite federal regulations related to Medicaid-funded HCBS services there is no Medicaid entitlement to HCBS services. Therefore, in some states there may be wait lists or no services available for people who rely on Medicaid to pay for their long-term services and supports.
- Residential care community operators and staff frequently have less training than nursing facility administrators and staff.
- Operators in some residential care communities are providing care in their own personal home.
- States may or may not have a “Bill of Rights” for residential care communities.

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\(^{40}\) NORC Home and Community Based Services (HCBS) page includes information regarding the final rule. http://ltcombudsman.org/home-and-community-based-services/hcbs-reports-resources#regulations
• Some residential care communities serve individuals with mental or behavioral health needs.

The unique features of residential care communities, such as the lack of federal regulations, variation in state regulatory oversight, and small size of some homes, require adapting some advocacy and/or communication strategies or developing new strategies. Ombudsman program representatives must utilize approaches that are based more on resident agreement or contract provisions, their ability to develop a connection with the provider, and their skills in convincing the provider to take certain actions. These strategies are also used in advocacy for residents living in nursing facilities but become much more important in residential care communities due to the differences in regulations.

Residential care communities (RCCs) vary from state to state. RCCs are required to follow state regulations pertaining to each license or certification type.

Add information on residential care communities (RCCs) as defined in your state including types of RCCs, characteristics and level of services provided, and residents’ rights, as applicable in state law.

If Medicaid is paying for a non-nursing facility setting, such as an assisted living or a personal care home, then the federal government has some basic standards and requirements for states to meet. States are required to develop plans that align with the Home and Community-Based Services federal regulations. These regulations can also be an extra advocacy tool for LTCOPs.

If your state has a Medicaid waiver that pays for assisted living, adult foster care, a personal care home, or any other non-nursing facility, non-residential setting, then include the Centers for Medicare & Medicaid Services (CMS) Home and Community-Based Services (HCBS) settings requirements, as applicable.

The HCBS Settings Rule requires that all home and community-based settings meet certain qualifications. These include:

• the setting is integrated in and supports full access to the greater community;
• the setting is selected by the individual from among setting options;
• individual rights of privacy, dignity and respect, and freedom from coercion and restraint are ensured;
• autonomy and independence in making life choices are optimized; and
• choice regarding services and who provides them are facilitated.
The HCBS Settings Rule includes additional requirements for provider-owned or controlled home and community-based residential settings.

These requirements include:

- the individual has a lease or other legally enforceable agreement providing similar protections;
- the individual has privacy in their unit including lockable doors, choice of roommates, and freedom to furnish or decorate the unit;
- the individual controls his/her own schedule including access to food at any time;
- the individual can have visitors at any time; and
- the setting is physically accessible.

The experiences and concerns expressed by residents in RCCs could be similar or different than those living in nursing facilities. The concepts such as person-directedness, self-determination, empowerment, and proper assessments and care or service planning discussed in this training apply to residents in all settings. Despite differences in laws and regulations, most of the advocacy examples discussed in the previous section apply to residents living in residential care communities. Regardless of the facility type, the role of the Ombudsman program does not change.

**Trainer’s Note:** The Thin Edge of Dignity video is 20 minutes long. Determine if you want to show none of, a portion of, or all the video, then determine which discussion questions you want to ask.

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**Optional Prework:** To maximize classroom training time, you could ask trainees to watch the video and prepare for discussion prior to classroom training.

The following video: The Thin Edge of Dignity,41 is about Dick Weinman, retired professor of broadcast communications at Oregon State University, author, and former radio personality. Dick delivers a moving presentation about his experience in an assisted living facility.

When viewing this video, think about what types of person-centered practices might be put into place to better accommodate older adults and people with disabilities.

**Discussion questions:**

1. **What is your biggest take-away from the video?**
   **Possible responses:** residents feel they lose their identity when they move into a facility, have no privacy, feel humiliated, are treated like objects not human beings.

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41Oregon Department of Human Services, Silverman Studios Video Production, The Thin Edge of Dignity Dick Weinman | Assisted Living Documentary https://www.youtube.com/watch?v=UciTFCPCivil
2. When admitted, Dick became #108, which is his room number - this is how staff refer to him. Further, staff call him Richard as opposed to his preference to be called Dick. How do you think it feels not being called by your preferred name, and instead to be referred to by your room number?
   **Possible responses:** disrespectful, offensive, not person-centered.

3. Dick talked about showering and how it makes one feel vulnerable and uncomfortable. He also talked about going to the bathroom and how it can be a degrading experience when you cannot do it yourself. How would you begin to talk with facility caregivers about this?
   **Possible responses:** “It makes me uncomfortable having you watch while I’m going to the bathroom.” “Could you stand outside?” “I don’t have the answer, but how could we do this differently?” “I prefer having privacy while in the bathroom.”

4. Dick mentioned that he had an active social life prior to his accident but activities in the assisted living are minimal. What are some of the activities he mentioned available to him at the assisted living? Do these activities sound like things you would want to do?
   **Possible responses:** BINGO and Yahtzee. The response may be yes or no, but it could develop into a conversation that there could be other activities identified from all residents.

5. What do you think about Dick’s idea that when a new resident moves in there should be a “welcome wagon” group to help mentor and get the new person oriented to their new home?
   **Possible responses:** Love it, great idea, should happen in every facility.
Regulatory Process for Residential Care Communities

→ Explain how and when the Ombudsman program is notified of an RCC annual inspection. For example, is the state Office and/or the local Ombudsman entity notified? Is the LTCOP notified prior to the surveyor’s entrance to the facility or the same day?

→ Explain your program’s process for participation before, during, and after an RCC inspection.

→ Explain state program requirements for sharing complaints and concerns with the survey agency prior to and/or during an RCC survey. For example, does your state have an offsite survey form for the LTCOP to complete prior to a survey?

→ Add pertinent state-specific information about RCC complaint investigations. Information may include whether your program is notified in advance of complaint investigations and how to access the findings of the investigations.

→ Explain how to access RCC inspection results.
Section 7:

Conclusion
Module 4 Questions

**Trainer’s Note:** Allow approximately 15 minutes for Section 7. Ask the following questions and make sure the correct answer is discussed. These questions are meant to determine if the trainees learned the fundamental learning objectives and may illicit discussion about the answers. The questions and answers are not meant to be rushed through.

1. The LTCOP advocates for quality of ____________ and quality of ____________ for people who live in nursing facilities and __________________________.
   
   Answer: quality of care and quality of life. For people who live in RCCs. The trainees may list the specific types of RCCs in your state.

2. Name three rights all residents have and explain how you might advocate when they are violated.
   
   **Trainer’s Note:** Refer to Sections 4 & 6 for possible answers.

3. A nursing facility changed breakfast time from 8:00 a.m. to 7:00 a.m., but a group of residents don’t want to get up that early. Do residents have a say in the time change?
   
   **Answer:** Yes, residents have a voice in changes that impact their schedules. However, the facility is not obligated to change the time back to 8:00 a.m. but must accommodate the individual preferences of residents.

4. A resident tells you they want to watch television in the living room of the assisted living in the late hours of the evening. The manager said no because the TV must be off at 8:00 p.m. as it keeps other residents awake. Who does the LTCOP represent, the complainant or those who go to bed at 8:00 p.m.?
   
   **Answer:** The Ombudsman program represents both.

5. Name one thing a state surveyor looks at when they enter the facility for a standard survey.
   
   **Trainer’s Note:** Refer to Sections 3 & 5 for possible answers.

6. True or False? Surveyors are required to notify the LTCOP after entering an RCC.
   
   **Answers will depend on state requirements.**
Module 4 Additional Resources

Centers for Medicare & Medicaid Services

- Long-Term Care Facilities
  https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/LTC
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
- Critical Access Hospitals
  https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CAHs
- Nursing Homes https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/NHs

ICFs/IID Federal Guidance and Regulations

- 42 CFR Subpart I - Conditions of Participation for Intermediate Care Facilities for Individuals with Intellectual Disabilities
  https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=bcb07ac9e7a980644699b8b324808743&mc=true&n=pt42.5.483&r=PART&ty=HTML#sp42.5.483.i

State Operations Manual Appendix J - Guidance to Surveyors

- Intermediate Care Facilities for Individuals with Intellectual Disabilities

Residents’ Rights

- BINGO Game
  https://mightyrightspress.org/product/residents-rights-bingo/
- Card Game
  https://theconsumervoice.org/product/residents-rights-playing-cards
- LTC Informational Series Video 5 Understanding Rights for Residents
Southwestern Commission AAA, LTCOP, Sylva, North Carolina
https://www.youtube.com/watch?v=e1R6axGdHJA&list=PLSu_zY6vP6REXfvjgVf7E-F9CG2K_9P-F&index=5

**Ombudsman Advocacy and Culture Change**

- Ombudsman Advocacy and Culture Change: Achieving Resident-Directed Care in Daily Advocacy
- LTCOP Innovative Practices: Incorporating Person-Centered Care in Ombudsman Training, Complaint Investigation and Advocacy
MODULE FIVE
Access & Communication

TRAINER GUIDE

January 2022
Table of Contents

Module 5 State-Specific Information.................................................................2
Section 1: Welcome and Introduction.............................................................4
Section 2: Access.............................................................................................10
Section 3: Confidentiality and Disclosure of Ombudsman Program Information....21
Section 4: Communication Strategies .............................................................29
Section 5: Conclusion......................................................................................41

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Module 5 State-Specific Information

The list below outlines state-specific information for trainers to discuss, provide a link to, or add directly to the Trainer Guide, Trainee Manual, and/or PowerPoints. When you get to the point in the training where you need to discuss, include a link to, or add state-specific information, you will see a bold, blue arrow (→) and a brief description of what to include.

→ State-Specific Information

Section 2 Access

- Share state-specific regulations regarding residents of nursing facilities and/or residential care communities right to access the Long-Term Care Ombudsman program (LTCOP).

- Include state-specific policies and procedures regarding Ombudsman program access to residents’ medical, social, administrative, and other records, including the requirements and steps to obtain consent to access resident records, even when a resident is unable to communicate informed consent and has no resident representative.

- Include state-specific policies and procedures regarding LTCOP access to facilities after regular visiting hours and any other time when access may be required by the circumstances to be investigated.

- Include state-specific policies and procedures regarding LTCOP access to residents.

- Include state-specific policies and procedures about LTCOP access to facility records, including administrative records, policies, and documents, to which the residents and public have access. If applicable, provide information about state laws that may provide additional access than what federal requirements provide.

- Include state-specific policies and procedures on what to do when access is impeded or denied.

- Add state laws, regulations, or policies pertaining to willful interference and any other penalty information.

Section 3 Confidentiality and Disclosure

- Include state-specific policies and procedures related to confidentiality.

- Include state-specific policies and procedures on disclosure of resident information and program records, including required steps to disclose the information and records.
• Include state-specific policies and procedures for when a resident is unable to communicate informed consent to disclose information and the LTCOP believes that an action, inaction, or decision may adversely affect the health, safety, welfare, or rights of the resident. Include steps when the resident has a representative who is not acting in the best interest of the resident, and when the resident does not have a representative.

Section 4 Communication Strategies

• Insert state-specific policies and resources related to the use of interpreters and auxiliary aids.
Section 1:
Welcome and Introduction
Welcome

*Trainer’s Note:* Allow at least 15 minutes for Section 1.

Begin the session by welcoming the trainees to the training session and thanking them for their continued interest in the program. Make sure everyone introduces themselves – even if they come late.

To begin please share:

- Your name
- Where you are from
- One thing you learned from Module 4 - something that really stuck with you or surprised you
- What you hope to learn since the last module

After introductions, thank the trainees for their information and explain any housekeeping items that need to be addressed including the time frame of the training day, breaks, location of restrooms, refreshments, etc. Ask the trainees to speak up if they have any questions throughout the training.

Welcome to Module 5 of certification training *Access and Communication.* Thank you for being here to learn more about the Long-Term Care Ombudsman program and the certification process.

**Module 5 Agenda**

*Trainer’s Note: The timeframes for each Section are approximate. Allow at least 2.5 hours for Module 5.*

- **Section 1:** Welcome and Introduction *(15 minutes)*
- **Section 2:** Access *(45 minutes)*
  - **BREAK** *(5-10 minutes)*
- **Section 3:** Confidentiality and Disclosure of Ombudsman Program Information *(30 minutes)*
  - **BREAK** *(5-10 minutes)*
- **Section 4:** Communication Strategies *(45 minutes)*
- **Section 5:** Conclusion *(15 minutes)*
Module 5 Learning Objectives

**Trainer's Note**: Go over the Module 5 learning objectives.

After completion of Module 5 you will understand:

- Ombudsman program authority to access
  - long-term care facilities
  - residents
  - records
- What to do when access is denied
- What information you can and cannot disclose
- Communication strategies
Module 5 Key Words and Terms

The key words and terms are defined relative to Ombudsman program practices and are found throughout this Module. Take a moment to familiarize yourself with this important information.

**Auxiliary Aids and Services** – Accommodations such as interpreters, items, equipment, or services that assist with effective communication.

**Centers for Medicare & Medicaid Services (CMS)** – A division within the U.S. Department of Health and Human Services, CMS administers the nation’s major healthcare programs including Medicare and Medicaid.

**Complainant** – An individual who requests Ombudsman program complaint investigation services regarding one or more complaints made by, or on behalf of, residents.¹

**Confidentiality** – Federal and state laws mandate that the Long-Term Care Ombudsman program keep all identifying information about a resident and a complainant private, within the Ombudsman program.

**Disclose** – To make known or public; to expose to view.²

**Health Insurance Portability and Accountability Act of 1996 (HIPAA, Privacy Rule)** – A federal law that required the creation of national standards to protect patient health information from being disclosed without the patient’s consent or knowledge. HIPAA sets rules and limits on who can use, review, and disclose individuals’ health information.³

**Incident Report (Accident Report)** – A document that records details when an unexpected event occurs, such as an accident, injury to a resident or staff, or potential abuse.

**Informed Consent** - The permission from a resident or a resident representative after a full explanation has been given of the facts, options, and possible outcomes of such options in a manner and language in which the resident or resident representative understands.

**Office of the State Long-Term Care Ombudsman (Office, OSLTCO)** – As used in sections 711 and 712 of the Act, means the organizational unit in a State or territory which is headed by a State Long-Term Care Ombudsman.⁴

**Ombudsman** – A Swedish word meaning agent, representative, or someone who speaks on behalf of another. For the purposes of this manual, the word “Ombudsman” means the State Long-Term Care Ombudsman.

¹ [https://ltcombsudsman.org/omb_support/nors](https://ltcombsudsman.org/omb_support/nors)
⁴ 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule
Representatives of the Office of the State Long-Term Care Ombudsman (Representatives) - As used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in §1324.19(a), whether personnel supervision is provided by the Ombudsman or his or her designees or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.

Residential Care Community (RCC) – A type of long-term care facility as described in the Older Americans Act (Act) that, regardless of setting, provides at a minimum, room and board, around-the-clock on-site supervision, and help with personal care such as bathing and dressing or health-related services such as medication management. Facility types include but are not limited to assisted living; board and care homes; congregate care; enriched housing programs; homes for the aged; personal care homes; adult foster/family homes and shared housing establishments that are licensed, registered, listed, certified, or otherwise regulated by a state.

Skilled Nursing Facility or Nursing Facility – Also known as a “nursing home,” is a certified facility that provides skilled nursing care for residents who require medical or nursing care rehabilitation or provides health-related care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities. For the purposes of this training and to be consistent with the National Ombudsman Reporting System (NORS), we use the term “nursing facility” for both skilled nursing facilities and nursing facilities.

State Long-Term Care Ombudsman (Ombudsman, State Ombudsman) – As used in sections 711 and 712 of the Act, means the individual who heads the Office and is responsible personally, or through representatives of the Office, to fulfill the functions, responsibilities, and duties set forth in §1324.13 and §1324.19.

State Long-Term Care Ombudsman Program (Long-Term Care Ombudsman program, the program, LTCOP) – As used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.

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5 45 CFR Part 1324 Subpart A § 1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule
6 42 Code of Federal Regulations, Part 1324 Subpart A Definitions Long-Term Care Ombudsman Programs Final Rule
7 This definition is a combination of Requirements for, and assuring Quality of Care in, Skilled Nursing Facilities, Section 1819(a) of the Social Security Act [42 U.S.C. 1395i–3(a)]
8 NORS Table 1 [https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf] and Requirements for Nursing Facilities, Section 1919(a) of the Social Security Act [42 U.S.C. 1396r(a)] [https://www.ssa.gov/OP_Home/ssact/title19/1919.htm]
9 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule
State Long-Term Care Ombudsman Programs Rule (LTCOP Rule) – The Federal Rule that governs the Long-Term Care Ombudsman program (45 CFR Part 1324).\(^{10}\)

Subsection Symbol (§) – The subsection symbol is used to signify an individual numeric statute or regulation (rule).

Willful Interference – Actions or inactions taken by an individual in an attempt to intentionally prevent, interfere with, or attempt to impede the Ombudsman from performing any of the functions or responsibilities set forth in §1324.13 or the Ombudsman or a representative of the Office from performing any of the duties set forth in §1324.19.\(^{11}\)

\(^{11}\) 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule
Section 2:

Access
Trainer’s Note: Allow at least 45 minutes for Section 2.

Clarify that access refers to the resident’s access to the Ombudsman program and the LTCOP’s access to residents, facilities, and records. Residents have the right to access. LTCOP has the authority to access.

What Does Access Mean and Why Is It Important?
In this section, access is described in two different manners. Access applies to both the residents’ rights to contact the Long-Term Care Ombudsman program (LTCOP) and speak in-person with a representative of the Office (representative) during a facility visit, and it applies to the Ombudsman program’s authority to access residents, facilities, and records.

Access is crucial when conducting the functions and duties of the Ombudsman program, such as complaint investigation and resolution, as discussed in Module 1 and determined in the LTCOP Rule. Access allows representatives to hear from residents about their experiences, to provide information and assistance, and to let residents know they have an advocate if or when needed.

Access may be difficult when the facility lacks communication devices such as cell phones, computers, or other electronic devices to assist residents in communicating with the LTCOP, as well as family and friends.

Regulations Pertaining to Residents’ Right to Access the Ombudsman Program

→ Share state-specific regulations regarding residents of nursing facilities and/or residential care communities right to access the Long-Term Care Ombudsman program (LTCOP).

State laws and regulations ensure that residents in nursing facilities and other residential care communities have access to the Ombudsman program. Nursing facility residents’ rights to access the LTCOP are addressed in the federal nursing facilities regulations.¹²

Facilities must:

- Provide immediate access to any resident by a representative of the Office of the State Long-Term Care Ombudsman (the Office)

¹² CFR 42 Chapter IV Subchapter G Part 483 Requirements for States and Long Term Care Facilities Subpart B – Requirements for Long Term Care Facilities https://www.ecfr.gov/cgi-bin/text-idx?SID=f64b6edcc2b2ee52bf5de8e19a340569&mc=true&node=sp42.5.483.b&rgn=div6
• Allow representatives of the Office to examine a resident’s medical, social, and administrative records\textsuperscript{13}
• Not prohibit or discourage a resident from communicating with a representative of the Office

\textit{Trainer's Note: Denial of access and interference is discussed later in this Module.}

\section*{Authority of the Ombudsman Program to Access Long-Term Care Facilities, Residents, and Records}

The authority of the Ombudsman program to access long-term care facilities, residents, and records is defined in the \textit{Older Americans Act} (OAA)\textsuperscript{14} and the \textit{LTCOP Rule}.\textsuperscript{15} State laws and regulations also ensure the LTCOP has access to residents in long-term care facilities. The OAA clarifies that access to residents and facilities shall be private and unimpeded, provides conditions when access to records is appropriate, and instructs states to have procedures related to access.

The LTCOP Rule expands upon the OAA and states that representatives of the Office have authority to:

• Enter nursing facilities and residential care communities at any time during a facility’s regular business hours or regular visiting hours, and at any other time when access may be required by the circumstances to be investigated

\textit{Trainer's Note: Reinforce that representatives cannot be denied access to the facility or residents outside of visiting hours (just like any other visitor).}

• Access all residents

• Access the name and contact information of the resident representative, if any, where needed to perform the Ombudsman representatives’ functions and duties

• Review medical, social, administrative, and other records relating to the resident when specific factors apply

• Access long-term care facility administrative records, policies, and documents, to which the residents or the public have access

The State Ombudsman has authority to access, and, upon request, obtain copies of all licensing and certification records maintained by the State with respect to long-term care facilities.

\textsuperscript{13} Social records may include information from social services, activities, and non-medical information. Administrative records may include financial records, admissions records, etc.
\textsuperscript{14} Older Americans Act \url{https://acl.gov/sites/default/files/about-acl/2020-04/Older%20Americans%20Act%20OFA%201965%20as%20amended%20by%20Public%20Law%20116-131%20on%203-25-2020.pdf}
The Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) – sometimes referred to as the Privacy Rule - is a federal law that sets rules and limits on who can look at and receive an individual’s health information. Under HIPAA, the Ombudsman program is considered a “health oversight agency.” As such, nursing facilities and other long-term care facilities may, in response to appropriate Ombudsman program requests, share other information without fear of violating the Privacy Rule. Such information includes, but is not limited to, residents' medical, social, or other records; a list of resident names and room numbers; and the name and contact information of resident representatives. As noted above, access to records must be consistent with the LTCOP policies and procedures in accordance with the OAA and the LTCOP Rule.

Access to Resident Records

It is not always necessary to review resident records during an investigation. Representatives use other investigatory tools (e.g., interviews and observation) and often find it is not necessary to review records. If you do access resident records, make sure to document the reason (e.g., a care complaint that requires review of the care plan), use your program’s consent form, and be prepared to share that information with your supervisor and the Ombudsman.

The Ombudsman program only accesses records when necessary to investigate a complaint. According to the OAA, representatives must have access to resident records if:

- The representative of the Office has permission of the resident or the resident representative, or
- The resident is unable to communicate consent to the review and has no resident representative, or
- Access is necessary to investigate a complaint and: the resident representative refuses permission to consent to the

Authority to access records

The LTCOP’s authority to access resident records comes from the OAA Sec 712 (b). Additional clarification on accessing records is included in the LTCOP Rule1324.11 (e)(2). In addition, all LTCOPs are required to have policies and procedures on accessing records.

What if facility staff say they can’t share information with me due to HIPAA?

Politely explain that the LTCOP is considered to be a health oversight agency.

If staff still do not provide the requested information, ask to speak to the staff person’s supervisor.

If the facility refuses to provide the requested information because they believe they will be in violation of HIPAA, contact your supervisor or the state Office for further direction.
access; a representative of the Office has reasonable cause to believe that the resident representative is not acting in the best interests of the resident; and the representative of the Office obtains the approval of the State Ombudsman.

→ Include state-specific policies and procedures regarding Ombudsman program access to residents’ medical, social, administrative, and other records, including the requirements and steps to obtain consent to access resident records, and when a resident is unable to communicate informed consent and has no resident representative.

Access is discussed in more detail during Module 6. Use the information in Figure 1 as an introduction to the topic to explain when/why resident records would be accessed. How to review them is discussed in Module 6. The paragraph below explains the process to obtain informed consent to review a resident’s record.

According to the LTCOP Rule:

- the resident or resident representative communicates informed consent, and
  - the consent is given in writing, verbally or using auxiliary aids and services (i.e., accommodations that assist with communication) and
  - when verbal or by other means, consent is documented at the time or shortly after consent is given;

- access is necessary to investigate a complaint, the resident’s representative refuses to consent to the access, and
  - the LTCOP has reasonable cause to believe the resident representative is not acting in the best interests of the resident, and
  - the representative of the Office obtains approval from the State Ombudsman.

If there is no resident representative and the resident cannot communicate informed consent, follow program policies and procedures for accessing records.
THE PROCESS TO OBTAIN INFORMED CONSENT TO REVIEW A RESIDENT’S RECORD

Figure 1

Informed consent must...
- Come from a resident or resident representative and
- Be given in writing, orally, visually, or through auxiliary aids and services

Consent is documented...
- Per LTCOP policies (e.g., form or case notes)
- At the time the consent is given and
- In the LTCOP’s resident case file.

Access to records is necessary to investigate the complaint and the resident is unable to communicate informed consent and...
- The resident representative refuses to consent and
- The LTCOP has reasonable cause to believe the resident representative is not acting in the best interests of the resident and
- Approval is obtained from the Ombudsman.

Access to records is necessary to investigate the complaint and...
- The resident is unable to communicate informed consent and has no resident representative
  then follow your program’s policies and procedures

If access is necessary to investigate a complaint and the resident cannot communicate informed consent - what do you do?

Obtain consent from the resident representative.

What if the resident representative says no?

If the LTCOP has reasonable cause to believe the resident representative is not acting in the best interests of the resident, and the representative of the Office obtains approval from the Ombudsman – then the LTCOP may access the resident’s records.

In summary, you must have informed consent from the resident, or the resident representative when the resident is unable to communicate informed consent, or the

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16 45 CFR Part 1324 Subpart A §1324.11 (e)(2) and Older Americans Act, Section 712(b)
approval from the Ombudsman to access the residents’ records. If there is no resident representative and the resident cannot communicate informed consent, the program may access the records in accordance with the program policies and procedures. In all circumstances, follow your state program’s policies and procedures.

Access to Other Records
Consent is not required for the Ombudsman program to access facility administrative records and documents that are available to residents and the public, which can include:

- Activity calendar
- Current state survey/inspection results
- Facility admission contract
- Facility policies, especially those related to residents’ rights
- Menus
- Number of staff per shift

The LTCOP also has access to the list of resident names and room numbers (i.e., resident roster or resident census).

State Ombudsman Program Policies and Procedures to Access
As per the LTCOP Rule, the State Ombudsman is required to develop policies and procedures that include timeframes for access to facilities, residents, and appropriate records.

→ Include state-specific policies and procedures regarding LTCOP access to facilities after regular visiting hours and any other time when access may be required by the circumstances to be investigated.

→ Include state-specific policies and procedures regarding LTCOP access to residents.

→ Include state-specific policies and procedures about LTCOP access to facility records, including administrative records, policies, and documents, to which the residents and the public have access. If applicable, provide information about state laws that may provide additional access than what federal requirements provide.
Information not Required to be Shared

*Trainer’s Note:* Share program examples of when the LTCOP requested information that the facility is not required to provide. If your state law provides additional access to facility information (e.g., incident reports, staffing records) review that information and your state process to access the information.

The LTCOP does not have access to all records and documentation maintained by the facility. Information the facility does not have to share with the Ombudsman program includes but is not limited to:

- Incident reports
- Personnel information on facility staff such as resumes, application information, etc.
- Non-public financial information

When the Facility Interferes with, or Denies, Access

→ *Include state-specific policies and procedures on what to do when access is impeded or denied.*

→ *Add state laws, regulations, or policies pertaining to willful interference and any other penalty information.*

*Trainer’s Note:* Share program examples of when access has been impeded or denied.

Interference

There are several ways in which facility staff may attempt to restrict the Ombudsman program’s access to residents and residents’ records. Some actions are subtle, and some actions are more obvious.

For example, facility staff might:

- Come in and out of the room during a visit
- Linger outside of the room during a visit
- Suggest walking around the facility with you and/or ask who you are visiting
- Ask about all concerns brought up during the visit
- Tell residents not to share information with you
- Purposefully schedule conflicts to prevent a resident from visiting with you
- Agree to give you the requested records or information, but never do
- Give you only part of the requested records

On their own, not all actions listed above are always considered interference. For example, staff coming in and out of the room or asking about concerns brought up during the visit may not be intended to interfere. Sometimes facility staff do not understand the authority of the LTCOP, do not know who you are, or are simply attempting to be helpful.
However, when those actions are meant to intentionally impede the LTCOP, it becomes willful interference (see sidebar).

In whatever form the interference occurs, it is important to take the opportunity to talk to staff and explain to them your role, your authority to visit with the resident privately, and the resident’s right to meet with a representative of the Office.

**Denied Access**

When access to the facility or to a resident is denied, at the time of denial, ask the person for the reasoning behind the decision. There may be a reasonable cause for the denial. For example, during an infectious disease outbreak, the LTCOP may be asked to temporarily refrain from visiting the building. When such situations arise, follow your program’s policies and procedures.

If you are denied a visit with a resident because the resident is receiving care, or the resident is bathing, these are reasonable explanations. Plan to come back at a more convenient time for the resident. Be respectful of the resident’s schedule and privacy and do not interfere with resident activities or care.

There are times, however, when access to a facility or a resident is denied, and the restriction is not reasonable and is a violation of residents’ rights and the Ombudsman program authority.

Examples include but are not limited to:
- A family member denies access to a resident who wants to visit with a representative
- Staff denies access at the direction of the resident’s guardian, or staff believe that because the resident has a guardian, that access is limited
- The provider does not answer the door or the phone
- Staff denies access to the building saying the residents get “too worked up” when the representative visits and explains residents’ rights

**Activity**

**Role-Play**

**Trainer’s Note:** Conduct as a role-play, considering the questions below – provide multiple opportunities or different groups of 2 to demonstrate the situation. Or conduct as a large group discussion.
Please use your own examples and share the outcomes of the denial of access with the trainees.

1. The Ombudsman program receives a phone message from a resident named Brian saying he is being evicted in three days. Brian asks that someone call him back on the facility phone before coming to see him. When the representative tries to contact Brian, the staff refuse to take the phone to him.
   a. What would you say to the staff person on the phone?
   b. Who else might you speak to at the facility?
   c. At what point do you visit the facility?

   **Trainer’s Note:** Responses may include:
   a. Why isn’t the resident able to come to the phone? Is there a problem? Please transfer me to your supervisor.
   b. The charge nurse, Director of Nursing (DON), or the Administrator, perhaps the Social Services Director.
   c. Speak with your supervisor about the facility’s actions, develop a plan of action, then visit the facility. Once at the facility, visit the resident when no staff are around, talk to the resident about the failed attempts to call and if there is an alternate way to communicate in the future.

2. Sonya, the Social Services Director, asks the representative to leave the facility because they are “riling up residents” by explaining their rights.
   a. How would you respond to Sonya?
   b. Who else might you speak to at the facility?
   c. How do you respond to residents?
   d. At what point do you leave?
   e. What do you do next?

   **Trainer’s Note:** Make sure you tell the trainees to follow the policies and procedures when access to residents is being denied. Responses may include:
   a. Maintain a calm and professional demeanor. Do not argue. Inform Sonya about residents’ rights and the authority of the Ombudsman program to access residents. Give her a program brochure that includes information about residents’ rights and the LTCOP. Offer to send additional information on residents’ rights and the Ombudsman program. Let her know if she still has concerns, you could go with her to talk with the Administrator.
b. The Administrator. May consider calling your supervisor or State Ombudsman for direction.

c. Explain to the residents that there is some confusion, and you will work it out with the facility. Reassure residents and let them know that you will be back or will stay to address their questions and concerns.

d. Leave if/when feeling threatened, if your presence is having a negative effect on residents, or when told to leave by your supervisor.

e. Immediately notify your supervisor, document the occurrence, and follow all requirements in the program’s policies and procedures for when access is denied.

3. During your visit, you notice a facility staff member following you around. What would you say to the staff member?

**Responses may include:**

- Ask if the staff member has a question or concern.
- Explain the authority of the LTCOP to unimpeled access to residents.
- Politely ask them not to follow you on your visits.
- If the staff member protests, don’t argue. Talk to the person in charge. After the visit, inform your supervisor of the occurrence.
Section 3: Confidentiality and Disclosure of Ombudsman Program Information
**Trainer’s Note:** Allow at least 30 minutes for Section 3. Documentation is discussed in detail during Module 9.

Access allows you to gather information through observations, interviews, and record reviews. It is important to have a system to document your initial findings. Most representatives take notes during their visit or phone calls via pen and paper or an electronic device. Others take notes immediately after. The notes taken will be entered into an electronic-based system managed by the Office. Requirements for documentation are discussed in more detail during Module 10.

**Confidentiality**

It is essential to recognize what information gathered is confidential. All records and information obtained by the LTCOP during conversations with residents and complainants must be held in confidence. It is important to explain to residents and complainants that the information they share with the program is confidential, meaning the information will not be shared (disclosed) with anyone outside of the Ombudsman program without their permission. In addition to federal guidance, always follow the program policies and procedures for confidentiality and disclosure of program information.

As a representative, you must maintain confidentiality by:

- Not identifying residents or complainants without their consent
- Not disclosing any information about a resident or complainant
- Explaining your program’s confidentiality and disclosure requirements to facility staff and others who may expect or request confidential program information

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**Include state-specific policies and procedures related to confidentiality.**

**Why is confidentiality important?**

Confidential conversations with the LTCOP allow residents and complainants a level of comfort when discussing concerns. When the resident and complainant understand that the information cannot be shared with anyone without their approval, it encourages them to be open about details of their complaints. Maintaining confidentiality is the best way for the Ombudsman program to earn and keep the trust of residents and ensure that actions are resident-directed.

When a complainant is not the resident, the Ombudsman program:

- Cannot disclose the identity without their permission
- Must have the resident’s permission to report back to the complainant
- Is required to honor both the resident’s and the complainant’s rights to confidentiality
What information is not confidential?

*Trainer’s Note:* Information about visits and observations will be discussed in more detail during Module 6. The point of providing this information is to let the trainees know that some information can be shared with facility staff so long as the information does not violate confidentiality and disclosure requirements.

General observations identified about the facility that do not identify any resident or complainant in any way can be shared with facility staff.

Such observations include but are not limited to:
- Call lights not being answered
- Cleanliness of the facility
- Cluttered hallways that restrict residents and/or staff
- Odors
- Visible safety hazards

**Confidential or Not Confidential?**

*Trainer’s Note:* Ask the following questions and make sure the appropriate answers are discussed.

Review the following scenarios and indicate if the information gathered is confidential or not and whether the information should or should not be shared.

1. You tell the housekeeping supervisor that you noticed the garbage cans in several residents’ rooms on Hallway A are overflowing.

   **Answer:** This information is not confidential and is okay to share with facility staff. It is based on your observations and does not identify any specific resident.

2. You observe Mildred’s call light has been left unanswered for 20 minutes. Before you talk to Mildred, you see a CNA and tell them what you observed.

   **Answer:** This information is confidential. Because the concern directly impacts Mildred, it is not okay to share the information with facility staff without Mildred’s permission. You should first talk to Mildred to see if she wants assistance from the LTCOP. During observations and interviews, you should also check to see if other residents have an issue with their call lights being answered in a timely manner. If so, you could talk to facility staff about “several resident complaints” about call lights. You can only use the name of a resident with their permission.
3. You tell the charge nurse about a strong feces/urine odor on the 2\textsuperscript{nd} floor.

\textit{Answer: This information is not confidential and is okay to share with facility staff.}

4. You visit Darla after her son calls you about a family conflict over moving Darla to another facility. Darla tells you her son is causing problems and she is considering moving in with her daughter, not another facility. Darla said her doctor and other family members are against her moving in with her daughter, but she wants to do it regardless of what they say. You forgot to ask her if you can tell her son about her plan. Her son calls you the next day and asks you about your visit with his mother. You are worried about Darla’s safety, so you tell him about the plan to move back into the community.

\textit{Answer: This information is confidential. You did not receive permission to share the information with the complainant. Therefore, it should not be shared until or unless permission is granted.}
Confidentiality Dos & Don’ts
Confidentiality applies to all records and communications including verbal, non-verbal (includes sign language), observations, and written (e.g., letters, emails, texts, etc.).

**Do**
Respect the resident as the “client” and take direction from them regardless of who files the complaint.

Follow the direction of the resident representative when the resident cannot communicate informed consent and is acting in the best interest of the resident or if the resident gives you permission to follow the direction of their representative.

Keep the identity of the resident and the complainant confidential.

**Don't**
Reveal information to anyone without permission from the resident.

Tell facility staff who you are visiting.

Read a resident's chart that is offered to you by a facility staff member without the resident's consent or attempt to access a resident's chart without the consent of the resident or the resident representative.

Reveal the identity of the complainant or the resident without permission.

Show program records to anyone outside of the LTCOP.

Allow staff to follow you on your visits.
Disclosure of Resident and Complainant Information

Disclosure of information simply means the releasing of information either verbally or in writing. Details of when and why to disclose resident or complainant identifying information will be explored further in the complaint-handling Modules. Quite often some kind of disclosure of resident information is required to resolve a complaint.

Regardless of where the Ombudsman program is located, all files, records, and information maintained by representatives of the Office pertaining to program activities and complaints are the property of the Office of the State Long-Term Care Ombudsman. Such information is not the property of the individual representatives nor the local Ombudsman entity (LOE).

Disclosure of such information, including identifying information about a resident or a complainant may only occur under the following circumstances and as determined by the State Ombudsman in their program’s policies and procedures:

- Permission from the resident (or a resident’s representative when applicable)
- Permission from the complainant
- An order from the court

Otherwise, disclosure of files, records, and information maintained by the LTCOP pertaining to program activities and complaints is prohibited.

When might the Ombudsman program disclose resident or complainant identifying information, and for what purpose?

Some common reasons for disclosure include:
- To resolve a complaint with facility staff
- To refer a complaint to an outside agency
- To discuss resident concerns with their representative or other family or friends

Disclosure will be further reviewed in Modules 6 and 7 during the complaint processing sections.

→ Include state-specific policies and procedures on disclosure of resident information and program records, including required steps to disclose the information and records.

→ Include state-specific policies and procedures for when a resident is unable to communicate informed consent to disclose information and the LTCOP believes that an action, inaction, or decision may adversely affect the health, safety, welfare, or rights of the resident. Include steps when the resident has a representative who is not acting in the best interest of the resident, and when the resident does not have a representative.

**Trainer’s Note:** Clarify your program’s policies and procedures on disclosure and let the trainees know when and how they are required to notify the Office when they receive a request to disclose information or records.

### Confidentiality and Disclosure of Information:
#### What Would You Do?

**Trainer’s Note:** Ask the trainees the following questions and make sure the appropriate answer is covered.

1. Lisa, a representative of the Office, goes to Mrs. Jones’s room to follow up on a complaint, but she is not there. Lisa asks the social worker where to find Mrs. Jones because her daughter called the Office with a concern.

   **Did Lisa breach confidentiality? If so, how should Lisa have handled this situation?**

   **Trainer’s Note:** Yes, Lisa breached confidentiality. Lisa should visit with other residents, then go back to Mrs. Jones’s room. If she still isn’t there, casually ask her roommate if she knows the whereabouts of Mrs. Jones. Do not tell staff or anyone that you are responding to a complaint. You may have to go back to the facility at another time. Follow up with the resident’s daughter to see if there is a better time to attempt a visit.

2. A local law enforcement officer calls the Ombudsman program and asks if the representative knows anything about a resident named Daniel Johnson. Kari, the representative, knows Daniel well. They have had conversations about his family’s
management of his money, but he has not asked Kari to act on his concerns. Relieved the police are investigating, Kari tells the Officer about her concerns and offers to send her case notes to him.

**Did Kari follow program requirements for disclosure of information? If not, what should she have done?**

*Trainer’s Note: No, Kari did not follow the requirements. She did not have permission to disclose information from the resident or from the State Ombudsman. Instead, Kari could have asked the officer for his contact information and told him she could not indicate whether she was aware of Daniel Johnson or the concerns surrounding the information shared by the officer. Kari could then say that someone from the program will follow-up with him after they spoke with the resident. Then Kari should contact the resident and follow program policies and procedures regarding consent and disclosure of information.*

3. Jane is a representative of the Office. A law firm serves her with a subpoena at her home. The subpoena asks for the dates of visits to “Caring Touch” personal care home, the names of the residents and staff that she spoke to, and for her impressions of the home.

**What would you do?**

*Trainer’s Note: For Ombudsman program purposes, a subpoena issued by someone other than a judge, such as a court clerk or an attorney in a case, is different from a court order.*

You should contact your supervisor and give them the subpoena. Do not share or acknowledge that you visited “Caring Touch.” Your supervisor should review all activity and alert the State Ombudsman for follow-up.
Section 4:

Communication Strategies
Trainer’s Note: Allow at least 45 minutes for Section 4.

Communication
Communication is the act of exchanging ideas, knowledge, information, and sharing personal experiences. Regular and timely access to long-term care facilities and residents is essential for Ombudsman program communication with residents, resident representatives, family members, visitors, and facility staff. The way you speak to and listen to an individual builds trust and meaningful connection, which is an important part of complaint intake and investigation, specifically discussed in Module 6.

Trainer’s Note: Show the video, Residents Speak Out: Resident’s Rights, then facilitate a discussion about communication from the resident’s perspective. Ask the trainees the questions below.

Watch the video Residents Speak Out: Resident's Rights.¹⁹

- What are your thoughts on the video?
- What are some common themes related to communication?

Trainer’s Note: Responses may include residents express wanting to be engaged and spoken to as a person, not just a “room number,” and residents indicate wanting someone to pay attention to them and value them. Tell the trainees to keep the video in mind as this section on communication is discussed.

Effective communication is a two-way process of how information is provided and received.²⁰ Both verbal and non-verbal communication contributes to how one interprets information. Word choice, tone of voice, and body language all contribute to successful communication.

From a total of 100%, the following is true of how information is communicated.

Trainer’s Note: Ask trainees from a total of 100% what percentages they think words or speech, tone of voice, and body language is communicated. The answers are below.

- 10% is communication through words or speech.
- 40% is communication through our tone of voice.
- 50% is communication through body language.

¹⁹ MedSchool Maryland Productions https://youtu.be/NbpvWaKTD80
²⁰ https://theinvestorsbook.com/effective-communication.html
Words or Speech
The words you choose and how you say them set the stage for building relationships. It is common for family members to contact you because someone has told them, “The Ombudsman program can help.” Most have no idea about LTCOP responsibilities and what representatives can and cannot do, so it is critical to provide them with a clear understanding of your role right from the very beginning. Family members may expect you to share all information gathered and may request your follow-up on their concerns. Take particular care to explain that the resident is your client, not them.

Here are some possible responses you can use:
- “The resident - your mother- is our client and we’re going to do the best we can for her.”
- “I am a resident advocate. I am here for your mother and what she needs, and hopefully we can all work together on this.”

As opposed to saying:
- “I work for the resident, not the family.”
- “I can’t tell you anything about my visit with the resident.”

Another common situation you may encounter is when the complainant tells you the resident has dementia so there is no point in speaking with them.

Here are some responses you can use:
**Trainer’s Note:** Meeting face to face or in-person visits may not be possible in all circumstances. Communication with the resident may take different forms. If this is the case in your area, please indicate as such.

- “Please understand that I am required to meet with the resident face to face.”
- “I will go and see the resident and talk with them about this. Then, we can see where we’ll go from there.”
- “I understand what you are saying, but my obligation is to go and speak with the resident first. It’s important that I see for myself.”

As opposed to saying:
- “Regardless of what you say, I have to talk to the resident.”
- “Thanks for the information, but I need to find out for myself.”

Tone of Voice
**Trainer’s Note:** The PowerPoint slide has the sentence “I didn’t say that.” Ask trainees to volunteer to read the sentence and emphasize one word in the sentence. Make sure all words in the sentence have been individually emphasized. Ask the trainees the intent of the varying messages. The trainer should then very loudly and angrily read the sentence. Ask the trainees the intent of the sentence now.
Your tone of voice impacts how a message is heard. Emphasizing a specific word in a sentence can result in different interpretations of the intent of your message.

For example, the following statements have different meaning, depending on which word is emphasized.

“I didn’t say that.”
“I didn’t say that.”
“I didn’t say that.”
“I didn’t say that.”
“**I didn’t say that.**”

**Body Language**

Body language speaks volumes. Be aware of the impact your non-verbal cues have on those with whom you are speaking. There are many ways to effectively communicate without using words, such as:

- Positioning yourself at the resident’s eye level
- Leaning forward when listening
- Facing the person
- Nodding your head
- Relaxing and acting natural
- Using positive facial expressions (e.g., smiling as opposed to frowning)
- Waiting through pauses
- Listening without interrupting

Try not to:

- Cross your arms in front of your body
- Check your phone or divide your attention
- Tap your foot or drum your fingers
- Use negative facial expressions

**Trainer's Note:** Ask the trainees for examples of how they show others they are interested in what is being said and are listening to the individual.

The responses may include verbal or nonverbal such as:

- **Making sure I’m at eye level with the person**
- **Tilting my head**
- **Looking directly at the person and not looking around as they are talking**
- **Saying “what you are telling me is important” and “I’d like to hear more about…”**
Words Matter: Conveying Your Message
Effective communication is more than just relaying your ideas, knowledge, and experience. There are other factors involved that influence how information is received and understood. In addition, you may use different communication approaches depending on the individual receiving the message (e.g., a resident, family member, staff person, etc.).

Whether you are communicating verbally, in writing, or using another means, there are several elements to consider when communicating your message.

To avoid confusion and misunderstandings, don’t:
- Use technical terms, acronyms, vague words, and slang
- Relay conflicting messages
- Use a language that is not understood by the recipient
- Include too much information

To maximize the chance for successful communication, consider the following:
- **Is your message clear?** Use simple and easy-to-understand language.
- **Is your message factually correct?** Ensure information is not vague, subject to interpretation, or false.
- **Is your message complete?** Include all relevant information, particularly if it is the basis for decision-making.
- **Is your message precise?** Provide straightforward and concise information to avoid incorrect interpretations of the message.
- **Are you professional and respectful in your message?** Deliver the message in a manner that is considerate of the person and sensitive to the topic at hand.
- **How do you ensure your message is received?** Consider with whom you are communicating. What is their role, knowledge of the subject, ability to understand, what mode of communication works best, and what language does the receiver understand?

**Trainer’s Note:** Tell the trainees to close their manuals then read the example to them. Ask if the following scenario considers all elements just discussed when talking to Jane.

**Optional Prework:** The answers are in the trainee manuals. If you are running short on time, you can ask the trainees to read the scenarios on their own.

**Example: Rose**
Rose recently came to the facility with chronic pain and some minor memory loss. Rose tells you she has been in terrible pain and doesn’t know if she gets her pain
medication like she did when she was in the hospital. Rose gives you permission to review her chart and speak with anyone in the facility who could help.

You go back to Rose and say:
“I checked your care plan and talked to the care plan coordinator who told me that you should be getting your pain meds every four hours. However, when looking at the med chart, I saw that the pain meds are being distributed PRN. The federal requirements indicate you have a right to be included in the care planning process and in your health decisions. Do you want your medication PRN or every four hours? And who do you want me to talk to about it?”

**Were the elements of effective communication used when talking to Rose?**

The answer is **no**. The information provided does not take into consideration Rose’s ability to understand acronyms and terms used in long-term care. The message delivered was accurate, but not concise and not delivered in a manner to allow Rose to make a good decision. PRN means “as needed.”

**How would you deliver this message?**

Possible response, “I checked on your concern about your pain medication and found out you are supposed to get your pain medication every four hours. The facility had the wrong information and thought you were only supposed to get your pain medication when you asked for it. I talked to the nurse, Michael, and straightened it all out. He said he will come by within the hour to talk to you and set up a schedule. I’ll follow up with Michael and will stop by again in a few days to see how you are doing.”

**Listening Skills**
There are techniques to use when verbally communicating with someone to indicate you are listening. Those methods include demonstrating interest, active listening, affirmation, and validation.

*Trainer’s Note: When talking to residents, be careful not to nod or shake your head when asking a question. This can lead the resident into giving a response meant to please you instead of giving a response that reflects their true thoughts or wishes.*

**Demonstrate Interest**
- Use minimal responses such as, “oh,” “so,” and “I see.”
- Encourage additional information such as, “Is there more you would like to share…” and, “I’m happy to listen…”

**Active Listening**
- Paraphrase what is heard. For example, the resident says that he keeps telling the Certified Nursing Assistant (CNA) not to put his clothes on the floor; she
just doesn’t listen. You paraphrase by saying, “Sounds like you are not feeling heard by the CNA regarding your clothing.”

- Ask open-ended questions for more details instead of closed-ended questions. Open-ended questions are questions that cannot be answered with just a “yes” or “no” response. To allow for more detailed responses, open-ended questions often start with “how,” “tell me about…,” and “why.” Closed-ended questions lead to answers of just, “Yes,” “No,” or a brief piece of specific information.

**Affirmation**

- Restate what is heard in sentence form, such as:
  - “I hear you saying…”
  - “It sounds like…”
  - “It appears as though…”

**Validation**

- Acknowledge the resident’s feelings, such as:
  - “It’s okay to feel sad…”
  - “There is nothing wrong with being angry right now about…”

**Observation**

- Look for non-verbal forms of communication, such as:
  - Facial expressions
  - Eye contact, or lack thereof
  - Posture
  - Gestures

Based on your observation, what is going on in the picture? Does the medical person look as though she is listening to the individual? What would you do in this situation if you were this individual’s advocate?

**Example: Barry, Situation 1**

During a visit with a resident named Barry, you ask him if staff treat him well. Barry tells you that most staff are nice to him. You ask him how the food is, and Barry says it’s okay if you eat it in the dining room. You then ask Barry about the activities, and he replies, “What activities?” and then laughs. A CNA walks into the room and Barry immediately says to you that everything is wonderful and thanks you for stopping by. You continue asking Barry about life in the facility.

**Trainer’s Note:** Ask if effective communication skills for receiving information were used in the case study about Barry. Tell the trainees to close their manuals for the next part of the activity.
This activity can be conducted as a role-play or a large group discussion. If conducting as a role-play, read the first situation then have trainees role-play how to handle the conversation differently.

Did the representative listen to Barry?

How would you have handled the conversation differently?

**Ask:** Did the representative listen to Barry?

The answer is no. The representative did not listen to what Barry was saying and did not ask any follow-up questions to clarify his comments. The representative did not pay attention to the change in Barry when the CNA came into the room.

**Ask or conduct the role-play:** How would you have handled the conversation differently? Allow for trainees to give examples.

Make sure the following revised situation is discussed:

**Example: Barry, Situation 2**

- During a visit with a resident named Barry, you ask him if staff treat him well. Barry tells you most staff are nice to him. You ask Barry, “Most staff? Tell me more about the staff who aren’t nice.”

- You ask Barry how the food is, and he says, “It’s okay if you eat in the dining room.” You ask Barry, “Where do you prefer to eat? What do you mean, ‘if you eat in the dining room’?”

- You ask Barry about the activities, and he replies, “What activities?” and then laughs. You say, “Yes, I noticed there are just a few activities on the calendar. How do you like to spend your time (or, what are your interests)? Are there activities that you would like to see happen in the facility?”

- A CNA walks into the room and Barry immediately says to you that everything is wonderful and thanks you for stopping by. Take the cue from Barry and let him know you appreciate talking to him and end the visit. Revisit Barry at another time to address the concerns brought up during your conversation and ask Barry about his response when the CNA entered the room. Make sure there are no staff around when you meet with him the second time.

If they want your assistance, remind them how you will support them and the next steps. If they do not want to pursue the complaint immediately, reassure them that they have your support, and you will follow-up with them. Before leaving any resident that shared concerns, continue the conversation for a few more minutes that way the conversation didn’t end on a negative note potentially adding to their sense of helplessness or stress.
Communication Tips
Many of the communication tips below apply to communicating with anyone, particularly residents. However, certain tips are even more helpful when communicating with residents who have a disability or a diagnosis that may affect their ability to provide and receive information. To effectively communicate, consider the best way to communicate with each individual resident.

Individuals Living with Memory Loss
Memory loss does not always affect one’s ability to communicate. Therefore, it is important not to make assumptions based on a diagnosis related to dementia or memory loss. 21

- Approach the resident from the front and identify yourself
- Speak to the resident and not about the resident when others are in the room
- Talk to the resident face to face in a quiet space with minimal distractions
- Look at the resident and speak slowly and clearly
- Ask one question at a time
- Ask yes or no questions
- Give the resident ample time to respond to your questions
- Consider the feelings behind words or sounds
- Be respectful

There are also specific communication actions to avoid when talking to individuals who have memory loss.

Don’t:
- Ask the resident if they remember you
- Argue or try to convince
- Explain reality or try to reason
- Get too physically close to the resident, invading their personal space
- Raise your voice, frown, or scold
- Use confusing language, language that could be misinterpreted as romantic (e.g., sweetie, honey), or idioms (e.g., “it’s raining cats and dogs”, or “are you pulling my leg?”) as residents may take the words in literal form
- Take it personally if the resident doesn’t remember you, doesn’t want to talk, or uses offensive language

21 Alzheimer’s Association Communication and Alzheimer’s https://www.alz.org/help-support/caregiving/daily-care/communications
Individuals Who are Blind or Visually Impaired

**Trainer's Note:** Use the PowerPoint slide with small font. Act as though the trainees can see what is on the screen and continue to train the material. If no one mentions they cannot see, ask why they did not mention it. Either way, ask the trainees how the small font affected their ability to focus and pay attention to the trainer.

- Speak to the resident when you approach them
- Face and address the resident directly
- Identify who you are and introduce anyone else with you
- Be descriptive about what you are doing
- Speak in a normal volume and natural tone
- It is okay to use words such as “blind”, “visually impaired”, “seeing”, “looking” and “watching” when speaking with someone who is visually impaired
- Don’t touch or distract their service animal (if applicable)
- If documents must be read or signed, ask the resident what would be most helpful for them to see better (e.g., increased lighting, magnification, etc.)
- Ask in what format they would like to receive information (e.g., Braille, large print, audio, etc.)
- Let the resident know when you enter and leave the area and/or room

Individuals with Speech Impairments

- Concentrate on what the resident is saying
- Be patient – take as much time as necessary
- Don’t speak for the resident or attempt to finish their sentence
- Use your regular voice tone and volume
- Ask questions which require only short answers or a nod. Consider using yes or no questions. Avoid insulting the person’s intelligence with oversimplification
- If you don’t understand what the resident has said, ask them to repeat themselves, or repeat back what you heard to confirm it is correct
- Don’t pretend to understand when you don’t
- If you have difficulty understanding the resident, consider writing or another means of communicating, but first ask the resident if this is acceptable

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Individuals Who are Deaf, Hearing Impaired, or Hard of Hearing\textsuperscript{24}

\textit{Trainer's Note:}

\textbf{If presenting the training virtually,} take a piece of paper and crumple it up near the microphone (but away from the camera). Ask the trainees how the noise affected their experience when trying to learn something new.

\textbf{If presenting the training in-person,} do not look at the trainees and talk quietly; act distracted and rustle papers while going over the bullets below. Ask the trainees how your actions affected their experience when trying to learn something new.

- Gain the resident’s attention before starting a conversation
- Look directly at the individual, face the light, speak clearly in a normal tone of voice, and keep your hands away from your face
- Use short, simple sentences
- Avoid eating or chewing gum
- If the resident uses a sign language interpreter, speak directly to the resident, not the interpreter
- If you are talking to a resident by phone, speak clearly and be prepared to repeat your questions and comments
- If you do not have access to a Text Telephone (TTY), dial 711 to reach the national telecommunications relay service, which facilitates the call between you and an individual who uses a TTY
- If you are having difficulty communicating with the resident – whether in their presence or not - ask the resident if it is acceptable to communicate via written word
- Ask the resident for their preferred form of communication (texting, email, etc.)

Individuals Who Speak Another Language

\textit{Trainer's Note:} Tell the trainees that on your first visit and periodically, it is preferable to ask facility staff if there are residents who are unable to communicate in English and identify the resources staff use to communicate with such resident(s).

- Have program information available in other languages to provide to residents
- When using gestures and nonverbal cues to help the person understand, be sensitive to their reaction. Some American mannerisms – such as pointing directly at a person – may be interpreted differently in other cultures
- Use a communication board or a free application on your phone

\textsuperscript{24} Communicating with Deaf Individuals. National Deaf Center. \url{http://www.nln.org/professional-development-programs/teaching-resources/ace-d/additional-resources/communicating-with-people-with-disabilities}
• Ask the resident if there is someone they trust to interpret
• Following your program policies and procedures, ask the facility how they communicate with the resident
• Ask if the facility has a handheld translation device, and request to use it
• Know your local resources for in-person and telephone language services
• If the options above are not sufficient, use an interpreter. When using an interpreter:
  o Explain LTCOP rules of confidentiality
  o Explain the need to translate word for word (ask them not to put statements into their own words)
  o Ask them to be neutral
  o Direct questions to the resident
  o Look at the resident, not at the interpreter, when talking

Learn more about Residents’ Rights and find Residents’ Rights fact sheets in other languages on the National Consumer Voice for Quality Long-Term Care website.25

→ Insert state-specific policies and resources related to use of interpreters and auxiliary aids.

Trainer’s Note: Provide resources available in your area and how to access those services. Discuss the pros and cons of having a family member act as an interpreter. One benefit to having a family member could be that they are familiar with the resident’s concerns and wishes. However, a family member might reinterpret words to suit their own perspective, the resident may not want the family member to know about the concern, etc.

Every resident is unique and may have different ways in which they communicate with others. As a representative, the key to successful communication with residents, family members, facility staff, and others is the ability to actively listen, identify the best way to connect with the individual, and clearly convey your message in a way the individual understands.

25 The National Consumer Voice for Quality Long-Term Care Residents’ Rights in Other Languages
https://theconsumervoice.org/issues/recipients/nursing-home-residents/residents-rights#Other-Languages
Section 5:
Conclusion
Module 5 Questions

_Trainer's Note:_ Allow approximately 15 minutes for Section 5. Ask the following questions and make sure the correct answer is discussed. These questions are meant to determine if the trainees learned the fundamental learning objectives and may illicit discussion about the answers. The questions and answers are not meant to be rushed through.

1. What information does the Ombudsman program require be kept confidential (unless given permission by the resident or complainant)?
   
   **Answer:** Federal and state laws mandate that the Long-Term Care Ombudsman program keep all identifying information about a resident and a complainant private.

2. Name something federal law authorizes the Ombudsman program to access.
   
   **Answer(s):** Residents, facilities, and medical, social, and administrative records.

3. Describe what you would do if you were denied access to a resident.

   **Answer:** Ask why you cannot visit with the resident. Determine if the reason is valid (e.g., resident receiving care) or not valid (e.g., staff say the resident has dementia and cannot hold a conversation). Explain the authority of the Ombudsman program. Describe the rights of residents to meet with a representative. Move up the “chain of command” within the facility. Call your supervisor or the State Ombudsman. Follow program policies and procedures.

4. True or False? The representative may show their notes to the nurse if they promise not to share the information with anyone else.

   **Answer:** False. In addition to strict federal requirements regarding disclosure of information, the Ombudsman program has specific policies and procedures about disclosure of files, records, and information maintained by the Ombudsman program.

5. When a representative receives a complaint from a family member which of the following statement(s) are true?

   The representative:
   - Must have the complainant’s permission to be identified, whether it is identified to the resident or a staff member or someone else
   - Must have the resident’s permission to report back to the complainant
   - Is required to honor both the resident’s and the complainant’s confidentiality

   **Answer:** All are true.
6. How do you show someone you are listening to them?

Answer(s): Nodding your head; using minimal responses such as “oh,” “so,” and, “I see;” paraphrasing what you heard; asking open-ended questions by beginning with words such as: who, what, when, where, why, how; restating what you heard in sentence form:

- “I hear you saying…”
- “It sounds like…”
- “It appears as though…”

7. Name tips to use when talking to an individual with a speech impairment.

Answer(s):

- Concentrate on what the resident is saying.
- Be patient. Take as much time as necessary.
- Don’t speak for the resident or attempt to finish their sentence.
- Try and ask questions which require only short answers or a nod. Consider using yes or no questions.
- Ask the resident to repeat what was said if you do not understand, then repeat it back; don’t pretend to understand.
- If you have difficulty understanding the resident, consider writing or another means of communicating, but first ask the resident if this is acceptable.
Module 5 Additional Resources

Access and Disclosure

- NORC Resource: The Law and the Rule Pertaining to Access of Records

- NORC Resource: Disclosure of Files, Records, and Other Information Maintained by the LTCOP

Communication

- Overview of Key Communications Techniques

- Communication Tips

- Information on Communication from Washington DC LTCOP

- Navigating the Needs of Long-Term Care Residents Who are Deaf or Hard of Hearing: A Training for Kentucky LTCOP
  https://ltcombudsman.org/uploads/files/support/Kentucky_information_on_Hearing_Impaired_Resources.pdf
MODULE SIX
Facility Visits

TRAINER GUIDE

January 2022
# Table of Contents

Module 6 State-Specific Information.........................................................................................................................2  
Section 1: Welcome and Introduction............................................................................................................................3  
Section 2: Ombudsman Program Advocacy..................................................................................................................7  
Section 3: Facility Visits.................................................................................................................................................10  
Section 4: Conclusion......................................................................................................................................................19

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Module 6 State-Specific Information

The list below outlines state-specific information for trainers to discuss, provide a link to, or add directly to the Trainer Guide, Trainee Manual, and/or PowerPoints. When you get to the point in the training where you need to discuss, include a link to, or add state-specific information, you will see a bold, blue arrow (→) and a brief description of what to include.

→ State-Specific Information

Section 2 Conducting a Facility Visit

• Explain your program policies for field observation (e.g., shadowing, mentoring, etc.) if different than the minimum federal requirements.

• Include your program’s policies and procedures on frequency of routine access visits and any requirements for actions to take during a routine visit.
Section 1:
Welcome and Introduction
Welcome

*Trainer's Note: Allow at least 15 minutes for Section 1.*

Begin the session by welcoming the trainees to the training session and thanking them for their continued interest in the program. Make sure everyone introduces themselves – even if they come late.

To begin please share:

- Your name
- Where you are from
- One thing you learned from Module 5 - something that really stuck with you or surprised you
- What you hope to learn since the last module

After introductions, thank the trainees for their information and explain any housekeeping items that need to be addressed including the timeframe of the training day, breaks, location of restrooms, refreshments, etc. Ask the trainees to speak up if they have any questions throughout the training.

Welcome to Module 6 of certification training, *Facility Visits.* Thank you for being here to learn more about the Long-Term Care Ombudsman program and the certification process.

Module 6 Agenda

*Trainer's Note: The timeframes for each Section are approximate. Allow at least 1.5 hours for this session.*

Section 1: Welcome and Introduction *(15 minutes)*
Section 2: Ombudsman Program Advocacy *(15 Minutes)*
Section 3: Conducting a Facility Visit *(45 Minutes)*
Section 4: Conclusion *(15 Minutes)*

Module 6 Learning Objectives

*Trainer's Note: Go over the Module 6 learning objectives.*

After completion of Module 6 you will understand:

- The dos and don’ts of advocacy
- How to prepare for, and conduct, a facility visit
Module 6 Key Words and Terms

The key words and terms are defined as they are specifically applied to the Ombudsman program and are found throughout this Module. Take a moment to familiarize yourself with this important information.

Complainant – An individual who requests Ombudsman program complaint investigation services regarding one or more complaints made by, or on behalf of, residents.1

Complaint – An expression of dissatisfaction or concern brought to, or initiated by, the Ombudsman program which requires Ombudsman program investigation and resolution on behalf of one or more residents of a long-term care facility.2

Complaint Visit – An Ombudsman program visit to a facility in response to a complaint during which only complaint-related activities are conducted.

Confidentiality – Federal and state laws mandate that the Long-Term Care Ombudsman program keep all identifying information about a resident and a complainant private, within the Ombudsman program.

National Ombudsman Reporting System (NORS) – The uniform data collection and reporting system required for use by all State Long-Term Care Ombudsman programs.

Office of the State Long-Term Care Ombudsman (Office, OSLTCO) – As used in sections 711 and 712 of the Act, means the organizational unit in a State or territory which is headed by a State Long-Term Care Ombudsman.3

Ombudsman – A Swedish word meaning agent, representative, or someone who speaks on behalf of another. For the purposes of this manual, the word “Ombudsman” means the State Long-Term Care Ombudsman.

Representatives of the Office of the State Long-Term Care Ombudsman (Representatives) – As used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in §1324.19(a), whether personnel supervision is provided by the Ombudsman or his or her designees or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.4

Routine Access Visit (Routine Visit) – A representative’s visit to a facility to conduct activities that promote regular and timely access to the LTCOP and as determined in the

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1 https://ltcombudsman.org/omb_support/nors
2 CA-04 Table 1: Part B - Complaint Data Components https://ltcombudsman.org/uploads/files/support/NORS_Table_2_Complaint_Code_10-31-2024.pdf
3 45 CFR Part 1324 Subpart A §1324.1 Definitions
4 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule
state program’s policies and procedures (e.g., visit with multiple residents, share information about the Ombudsman program, observe activities in the facility).\(^5\)

**State Long-Term Care Ombudsman (Ombudsman, State Ombudsman)** – As used in sections 711 and 712 of the Act, means the individual who heads the Office and is responsible personally, or through representatives of the Office, to fulfill the functions, responsibilities, and duties set forth in §1324.13 and §1324.19.

**State Long-Term Care Ombudsman Program (Long-Term Care Ombudsman program, the program, LTCOP)** – As used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.\(^6\)

**State Long-Term Care Ombudsman Programs Rule (LTCOP Rule)** – The Federal Rule that governs the Long-Term Care Ombudsman program (45 CFR Part 1324).\(^7\)

**Subsection Symbol (§)** – The subsection symbol is used to signify an individual numeric statute or regulation (rule).

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\(^5\) National Ombudsman Reporting System (NORS) Table 3

\(^6\) 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule

Section 2:

Ombudsman Program Advocacy
Long-Term Care Ombudsman Program Advocacy

As mentioned throughout the training, the role of a representative is to be the resident’s advocate. The word advocate is defined in Module 1 as, an individual who works on behalf of another individual or group of individuals through an action taken on behalf of an individual or a group of individuals. An advocate does not represent their own views but amplifies those of the person or persons they are supporting. As an advocate, you are often working with individuals during difficult times. They may feel scared, distrustful, and unsure of you and/or the process towards resolution. Establishing a professional relationship with everyone involved increases the likelihood of successful advocacy.

The following charts explain some dos and don’ts of Long-Term Care Ombudsman program (LTCOP) advocacy. There is no need to memorize them all; at some point they will become intuitive, or second nature.

**Long-Term Care Ombudsman Program Advocacy Dos**

1. Speak with the resident in a quiet, private area
2. Communicate in a way the other person can understand
3. Explain your role as a resident-directed advocate
4. Be respectful, considerate, and professional
5. Be clear and succinct
6. Be objective
7. Be accurate and honest
8. Be mindful that the resident may tire easily, have a short attention span, or become confused
9. Empower residents to be involved
10. Explain all possible options and outcomes
11. Be patient, persistent, and thorough when seeking answers
12. Convey the resident’s wishes from their point of view
13. Work with the resident, staff, and administration as appropriate to resolve problems
14. Verify information received
15. Utilize as many sources of information as possible
16. Keep accurate records as required by the LTCOP
17. Maintain confidentiality
18. Follow all state and federal requirements for the Ombudsman program

Long-Term Care Ombudsman Program Advocacy Don’ts

1. Provide any care or physical assistance (e.g., don’t push resident’s wheelchair, help them transfer, assist with eating, etc.)
2. Give the resident anything other than program-related materials or resources (e.g., do not give food, drinks, medication, tobacco products, gifts, etc.)
3. Treat the resident as a child (They have a lifetime of experience)
4. Diagnose or prescribe for a resident
5. Portray yourself as a surveyor or inspector
6. Make promises
7. Use abbreviations, acronyms, or slang
8. Engage in arguments
9. Voice criticism of any resident or the facility
10. Provide business or legal advice
Section 3:

Facility Visits
Trainer’s Note: Allow at least 5 minutes for Section 3.

Preparing for a Facility Visit

→ **Explain your program policies for field observation (e.g., shadowing, mentoring, etc.) if different than the minimum federal requirements.**

Spending at least 10 hours in the field, which may include structured tours and shadowing with an experienced representative of the Office; meeting with resident councils; etc., is a minimum requirement of the certification process. Once designated, you will be able to independently visit long-term care facilities. Now that you understand the role of the Ombudsman program and residents’ rights, you can prepare for your first visit to a facility with an experienced representative.

Types of Facility Visits

→ **Include your program’s policies and procedures on frequency of routine access visits and any requirements for actions to take during a routine visit.**

**Trainer’s Note:** Use state-specific language when explaining the types of visits (e.g., your program uses “non-complaint visits” or “regular presence visits” to mean “routine access visit.” Include program requirements for a routine visit.

There are two types of facility visits: routine access visits and complaint visits. To determine if a visit is a routine access visit or a complaint visit, consider the actions taken during the visit.\(^8\) Regardless of the type of visit, all facility visits need to be documented (documentation is covered in more detail in Module 10).

Routine Access Visit (Routine Visit)

Representatives are required to conduct routine visits that promote regular and timely access. The National Ombudsman Reporting System (NORS) defines routine access as a facility visited, not only in response to a complaint, in all four quarters of the reporting period (federal fiscal year).\(^9\) However, the frequency of visits is determined by your state’s policies and procedures. When you conduct activities in a facility, such as visit with multiple residents, share information about the Ombudsman program, and/or observe activities in the facility all may be considered part of a routine access visit. Complaints may also be addressed during routine access visits if other program required activities are conducted as well. In fact, you will often hear and follow up on complaints during routine access visits.

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\(^8\)National Long-Term Care Ombudsman Resource Center NORS Frequently Asked Questions (FAQs)
https://ltcombudsman.org/omb_support/nors/nors-faqs

\(^9\) NORS Table 3: State Program Information.
Complaint Visit
When you visit the facility in response to a complaint and only conduct complaint-related activities, it is a complaint visit.

Before Your Visit
*Trainer’s Note: Use your program guidelines to determine if you should include information about self-screening, the use of personal protective equipment (PPE), or other considerations regarding potential exposure to communicable diseases such as COVID-19, influenza (flu), or gastroenteritis (stomach flu).*

Many residents have weak immune systems so common illnesses may be a serious concern. Residents live in close quarters, and it is not uncommon for infections to travel from one resident to another. In addition to information discussed in this module, make sure to follow your program’s policies and procedures regarding conducting visits safely, especially during potential exposure to communicable diseases such as COVID-19, influenza (flu), or gastroenteritis (stomach flu).

Learn more about *Coronavirus Prevention in LTC Facilities: Information for Long-Term Care Ombudsman Programs.*

Familiarize yourself with the facility by reviewing:
- Previous LTCOP activities
- Notes from the last visit
- Current and/or recent LTCOP cases
- The Ombudsman program’s experience with the facility during conversations with your supervisor
- The most recent annual survey/licensing or certification inspections and any regulatory agency complaint reports

*Trainer’s Note: Go to your state’s website to show the trainees how to access annual survey/inspection reports, or, if conducting the training in person, bring hard copies of the reports for the trainees to review.*

Supervisors may be able to provide insight into facility staff and indicate their willingness to work with the LTCOP, as well as identify residents who are willing to share current information about their experiences.

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10 The National Long-Term Care Ombudsman Resource Center *Coronavirus Prevention in LTC Facilities: Information for Long-Term Care Ombudsman Programs* [https://ltcombudsman.org/omb_support/COVID-19](https://ltcombudsman.org/omb_support/COVID-19)
Gather Ombudsman program brochures, business cards, posters, and consumer education information to hand out during your visits. Don’t forget to include materials you need for taking notes during or after the visit.

**During Your Visit**
If it is your first visit in the facility, introduce yourself to the administrator, manager, and/or other administrative staff. If this is not your first visit and you have an established contact person, check in with them.

To maintain a professional relationship with staff, upon arrival it is important to announce your visit by notifying a staff member of your arrival, signing the visitor log, etc. If the facility requires all guests to sign in, you may do so, but do not indicate who you plan to visit.

Wear your identification badge or keep it with you at all times and follow your program’s policies and procedures. Ask for a list of resident names and room numbers (may be called a room roster or resident census). Obtaining this list allows you to find residents without spending a lot of time reading names on residents’ doors and can help you keep track of which residents you have visited. As discussed in Modules 4 and 5, facilities are required to provide the LTCOP with this information.

Other activities during a visit may include:
- Determining which residents are new since your last visit so you can introduce yourself and share information about the program
- Asking staff which residents require special resources to facilitate communication
- Visiting with residents on different halls and floors
- Speaking with all residents in small residential care communities
- Visiting with Resident Council members
- Introducing yourself to family, friends, and other visitors and explain the role of the Ombudsman program
- Following-up on open complaints
- Investigating new complaints received during the visit, as necessary and with resident consent
- Checking for placement of Ombudsman program posters
- Documenting your actions per program requirements

**Approach and Introductions**
During visits you will talk with residents with whom you have an established relationship and residents you do not know. You may meet residents in common areas or in their rooms. Before going into any resident’s room, you must knock and receive their permission to enter. Always remember the resident’s room is their home and should be respected as such.
**Trainer’s Note:** Remind trainees that communication was discussed in Module 5 and ask them to keep in mind the communication skills learned while thinking about how to approach a resident and how to introduce themselves and the program.

Ask for a few volunteers to demonstrate how they would ask permission to enter a resident’s room. Make sure examples include knocking on the door and saying something like “Hello, my name is ____, may I come in?” or “I’m here to visit; is this a good time for you?” or, “Hello, I’m with the Ombudsman program, is it okay with you if I come in for a visit today?”

**You knock on a resident’s door; how do you ask for permission to enter?**

Once you’ve approached a resident, or entered their room with permission, begin with an introduction that includes a clear explanation of who you are and why you are visiting.

How you approach a resident you have never met before and introduce yourself and the Ombudsman program is the first impression the resident will have of you and the LTCOP.

When approaching a resident:
- Assume they can understand
- Approach from the front
- Have the person’s attention
- Smile and use a friendly voice
- Respect their personal space
- Be eye level when possible

**How do you start a conversation with a resident you have never met?**

**Trainer’s Note:** Tell the trainees that you need several of them to participate in answering the next question. Ask the first person, “once you approach a resident or enter their room with permission, what is the first thing you say to start a conversation with a resident you have never met? (Just one sentence). Then ask for another trainee to share what they would say next, building off the first response, and so on until the introduction is complete.

Key words to look for in their responses are advocate and/or ombudsman, confidentiality, free advocacy services, resident-directed (or some description of resident-directed), and rights. Listen for responses that include asking the resident their name and other questions to get to know the resident without interrogating them.

Think about how you would describe why you are visiting.

Think about how you would describe the program.

To prepare for introducing yourself and the Ombudsman program to others, consider developing an elevator pitch. An elevator pitch is a brief explanation that is simple and to
the point, lasting about 20-30 seconds. Ask other representatives and/or your supervisor for their elevator pitch to help you determine what kinds of statements work for you.

**Trainer’s Note:** Options for talking about an elevator pitch includes giving the trainees a few minutes to develop or think through what they would say and share their pitch with the class.

*Optional Prework:* Instead of the options above, you could ask trainees to develop and practice their elevator pitch at home and use that to introduce themselves during the next classroom training session.

**Observation**
Observation is an important tool used when investigating complaints. Observation involves using all senses to understand, evaluate, and remember your surroundings and to obtain information during facility visits, intake, and investigation. Observation begins as you enter the facility. Pause a moment and take in the environment by using your senses to identify resident experiences and treatment.

**How do you interpret your observations?**

**Trainer’s Note:** Show “Monkey Business Illusion” below. The video gives instructions for trainees and has questions/comments throughout. After the video, explain that when someone is focused on only one thing, other things may get missed. This also applies when approaching situations with biased perceptions.

Watch the video [Monkey Business Illusion](https://www.youtube.com/watch?v=IGQmdoK_ZfY) and consider the questions and comments mentioned in the video.

As you make observations during facility visits consider:
- Approaching with an open mind
- Being impartial and dismissing preconceived notions to avoid misinterpretations
- Using federal and/or state regulations to help you understand the responsibilities of the facility and residents’ rights
- Documenting your observations as soon as possible for an accurate description of the facility visit

**Trainer’s Note:** Go over the Figure 2 chart to describe how to use different senses and what the information gained through your senses tells you about the facility. Explain that representatives are not expected to notice all examples in the chart during each visit. However, tuning into several of the examples will give them a good idea of what life is like for residents and may help with future investigations. Remind trainees that if they observe something identified in the chart it does not automatically mean something is wrong.

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11 Monkey Business Illusion by Daniel J. Simons [https://www.youtube.com/watch?v=IGQmdoK_ZfY](https://www.youtube.com/watch?v=IGQmdoK_ZfY)
There may be circumstances that explain their observations. For example, some of the residents may enjoy sitting up by the nurses’ station.

Figure 2\textsuperscript{12}

<table>
<thead>
<tr>
<th><strong>Sight</strong></th>
<th><strong>Facility Environment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Does the facility look like an institution or a home?</td>
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<tr>
<td></td>
<td>Are call lights blinking or on for extended periods of time?</td>
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<tr>
<td></td>
<td>Are staff talking or texting on their phones while on duty?</td>
</tr>
<tr>
<td></td>
<td>Is equipment broken?</td>
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<tr>
<td></td>
<td>Are there hazardous areas accessible to residents?</td>
</tr>
<tr>
<td></td>
<td>Are Ombudsman program posters posted?</td>
</tr>
<tr>
<td></td>
<td>Do residents have access to outside space?</td>
</tr>
<tr>
<td></td>
<td>Do staff smile at residents?</td>
</tr>
<tr>
<td></td>
<td>Do staff wear name badges?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Resident Rooms</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are residents’ rooms furnished with their own belongings?</td>
</tr>
<tr>
<td>Do residents have access to their water pitcher or cup?</td>
</tr>
<tr>
<td>Are food trays left out with uneaten or spoiled products?</td>
</tr>
<tr>
<td>Is trash overflowing?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Resident Appearance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are residents groomed?</td>
</tr>
<tr>
<td>Do residents have clean hair, faces, hands, or fingernails?</td>
</tr>
<tr>
<td>How are residents dressed?</td>
</tr>
<tr>
<td>Are they in clothes that do not fit?</td>
</tr>
<tr>
<td>Are their clothes stained or do they have food particles on them?</td>
</tr>
<tr>
<td>Are residents wearing hospital gowns?</td>
</tr>
<tr>
<td>Are residents covered for privacy?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Resident Activities</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the activities calendar posted and followed?</td>
</tr>
<tr>
<td>Is the menu posted and followed?</td>
</tr>
<tr>
<td>Are residents participating in group activities?</td>
</tr>
<tr>
<td>Are any residents doing independent activities?</td>
</tr>
<tr>
<td>Are all or many residents in bed?</td>
</tr>
<tr>
<td>Are several residents sleeping in their wheelchairs?</td>
</tr>
<tr>
<td>Are many residents “parked” near the nurses’ station?</td>
</tr>
</tbody>
</table>

### Sound

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is music throughout the building too loud or too soft?</td>
</tr>
<tr>
<td>Is the music selection based on residents or staff preference?</td>
</tr>
<tr>
<td>Does the intercom system disturb residents?</td>
</tr>
<tr>
<td>Is personal information being broadcast? (e.g., you hear someone say “Mrs. Smith needs help in the bathroom” over the intercom)</td>
</tr>
<tr>
<td>Are residents yelling out without staff response?</td>
</tr>
<tr>
<td>Do staff knock on residents’ doors and get permission to enter their room?</td>
</tr>
<tr>
<td>Do staff call residents by their name?</td>
</tr>
<tr>
<td>Do staff talk pleasantly and respectfully with residents?</td>
</tr>
<tr>
<td>Are staff speaking to residents in a loud, demanding voice or in a dismissive manner?</td>
</tr>
<tr>
<td>Are staff discussing or complaining about residents in front of others?</td>
</tr>
</tbody>
</table>

### Smell

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a strong urine, feces, disinfectant, or chemical odor?</td>
</tr>
<tr>
<td>Do residents smell of urine or feces?</td>
</tr>
<tr>
<td>What does the food smell like?</td>
</tr>
<tr>
<td>Are air fresheners or other scents used to mask unpleasant odors?</td>
</tr>
</tbody>
</table>

### Feel

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the building or are the rooms too hot or too cold for residents?</td>
</tr>
<tr>
<td>Are the floors slippery or sticky?</td>
</tr>
<tr>
<td>Are the chairs or tables sticky or gritty?</td>
</tr>
</tbody>
</table>

There are times when visiting a facility, you may observe issues of concern which don’t require a resident to initiate, such as urine odor or a broken handrail in the hallway. In such instances, you can address these issues with staff directly, because there is no breach of resident identity.

Watch the Anne Walker Video #1 and answer the following questions.

**Trainer’s Note:** Show the 2:35 minute video clip and ask the following questions, making sure the appropriate answers are addressed.

1. What did Gloria observe as she entered the building?

   **Answer:** Someone was at the front desk; the entry way was unobstructed.

---

13 This video series was developed by the Texas Department of Aging and Disability Services in coordination with the Texas Long-Term Care Ombudsman Program. Questions are from both the Long-Term Care Ombudsman Casework: Advocacy and Communication Skills Trainer Guide (https://ltcombudsman.org/uploads/files/support/Texas_Video-Trainee_Doc-Answers-FINAL.pdf) and the Illinois State Long-Term Care Ombudsman Program Level 1 Training manual.
2. What did Gloria do and not do when notifying the facility staff of her arrival?

**Answer:** Gloria wore her identification badge. She introduced herself to the person at the reception desk, but did not sign in. Gloria did not tell the staff member who she was there to visit.

3. Name three things the representative’s investigation should be.

**Answer:** Timely, thorough, and objective.

4. Representatives collect information during an investigation through what three main actions?

**Answer:** Observation, interview, and record review.

5. To protect the integrity of the program, what must you always do?

**Answer:** Follow the direction of the resident, always ask permission to advocate, understand what matters to the resident, and maintain confidentiality.

### Ending Your Visit

**Trainer’s Note:** If you have program policies on ending visits (or if your policies are different than below), explain them here.

When departing the facility let your facility contact person know you are leaving, and/or sign out. If you have observed any concerns that are not resident-specific, you may want to share them at this time. If you have resident-initiated complaints and have permission from the resident to discuss their concerns with staff, make all attempts to do so prior to leaving the facility.

### After Your Visit

**Trainer’s Note:** Feel free to introduce documentation here. Documentation is discussed in more detail in Module 10.

Per program policies and procedures, immediately document all your activities. Review your notes and follow up on any complaints received during the visit and seek assistance from your supervisor if needed.
Section 4:
Conclusion
Module 6 Questions

**Trainer's Note:** Allow approximately 15 minutes for Section 6. Ask the following questions and make sure the correct answers are discussed. These questions are meant to determine if the trainees learned the fundamental learning objectives and may illicit discussion about the answers. Take time reviewing the questions and answers.

1. Which of the following statements are not included in the definition of “advocate?”
   a. An individual who works on behalf of another individual or group of individuals
   b. An action taken on behalf of an individual or a group of individuals
   c. Someone who represents their own views
   d. Someone who amplifies the view of the person or persons they are supporting

   **Answer:** c, someone who represents their own views

2. Which of the following are “advocacy dos?”
   a. Convey the resident's wishes from their point of view
   b. Work with the resident, staff, and administration as appropriate to resolve problems
   c. Portray yourself as a surveyor or inspector
   d. Make promises
   e. Voice criticism of any resident or the facility
   f. Be respectful, considerate, and professional

   **Answers:** a, b, and f

3. What are the two types of facility visits conducted by the LTCOP?

   **Answer:** routine access visits and complaint visits.

4. What are some things you can do to prepare for a facility visit?

   **Answers:**
   - Review previous LTCOP activities
   - Review notes from the last visit
   - Review the most recent annual survey/licensing or certification inspections, regulatory agency complaint reports, current LTCOP cases
   - Discuss the Ombudsman program’s experience with the facility during conversations with your supervisor
Module 6 Additional Resources

COVID-19

- Coronavirus Prevention in LTC Facilities: Information for Long-Term Care Ombudsman Programs [https://ltcombudsman.org/omb_support/COVID-19](https://ltcombudsman.org/omb_support/COVID-19)
MODULE SEVEN
Long-Term Care Ombudsman Program Complaint Processing: Intake and Investigation

TRAINER GUIDE

January 2022
Table of Contents

Module 7 State-Specific Information.........................................................2
Section 1: Welcome and Introduction..........................................................3
Section 2: Introduction to Long-Term Care Ombudsman Program Complaint Processing ..............................................................8
Section 3: Complaint Intake and Initial Plan Development............................12
Section 4: Complaint Investigation ................................................................23
Section 5: Verification.....................................................................................39
Section 6: Common Complaints.................................................................42
Section 7: Conclusion....................................................................................46
Module 7 State-Specific Information

The list below outlines state-specific information for trainers to discuss, provide a link to, or add directly to the Trainer Guide, Trainee Manual, and/or PowerPoints. When you get to the point in the training where you need to discuss, include a link to, or add state specific information, you will see a **bold, blue arrow (→)** and a brief description of what to include.

→ State-Specific Information

Section 3 Complaint Intake and Initial Plan Development
- Describe your complaint intake process, response time to complaints, and include additional information that your state may collect during intake.

Section 4 Complaint Investigation
- Include your program policies and procedures on obtaining a written release of information form for accessing records.

Section 6 Common Complaints
- Include state-specific data, by either running reports from your own data system or OAAPS or go to AGID at a glance [https://agid.acl.gov/DataGlance/NORS/](https://agid.acl.gov/DataGlance/NORS/).
- Add state-specific information on discharges related to residential care communities. Include applicable state laws and regulations.
Section 1:
Welcome and Introduction
Welcome

**Trainer's Note:** Allow at least 15 minutes for Section 1.

Begin the session by welcoming the trainees to the training session and thanking them for their continued interest in the program. Make sure everyone introduces themselves – even if they come late.

**To begin please share:**

- Your name
- Where you are from
- One thing you learned from Module 6 - something that really stuck with you or surprised you
- What you hope to learn since the last module

After introductions, thank the trainees for their information and explain any housekeeping items that need to be addressed including the time frame of the training day, breaks, location of restrooms, refreshments, etc. Ask the trainees to speak up if they have any questions throughout the training.

Welcome to Module 7 of certification training, *Long-Term Care Ombudsman Program Complaint Processing: Intake and Investigation.*¹ Thank you for being here to learn more about the Long-Term Care Ombudsman program and the certification process.

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Module 7 Agenda

*Trainer's Note:* The timeframes for each Section are approximate. Allow at least 3 hours for this session.

- **Section 1:** Welcome and Introduction *(15 minutes)*
- **Section 2:** Introduction to Long-Term Care Ombudsman Program Complaint Processing *(30 Minutes)*
- **Section 3:** Complaint Intake and Initial Plan Development *(30 Minutes)*
- **BREAK** *(15 Minutes)*
- **Section 4:** Complaint Investigation *(45 minutes)*
- **Section 5:** Verification *(5 Minutes)*
- **Section 6:** Common Complaints *(20 Minutes)*
- **Section 7:** Conclusion *(20 Minutes)*

Module 7 Learning Objectives

*Trainer's Note:* Go over the Module 7 learning objectives.

After completion of Module 7 you will understand:

- Long-Term Care Ombudsman program Complaint Processing
- how to gather information during intake and investigation
- effective interviewing techniques
Module 7 Key Words and Terms

The key words and terms are defined as they are specifically applied to the Ombudsman program and are found throughout this Module. Take a moment to familiarize yourself with this important information.

**Complainant** – An individual who requests Ombudsman program complaint investigation services regarding one or more complaints made by, or on behalf of, residents.²

**Complaint** - An expression of dissatisfaction or concern brought to, or initiated by, the Ombudsman program which requires Ombudsman program investigation and resolution on behalf of one or more residents of a long-term care facility.³

**Complaint Verification (Verification)** - Confirmation that most or all facts alleged by the complainant are likely to be true.⁴

**Confidentiality** – Federal and state laws mandate that the Long-Term Care Ombudsman program keep all identifying information about a resident and a complainant private, within the Ombudsman program.

**Discharge** – The movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.⁵

**Facility-Initiated Transfer or Discharge** – A transfer or discharge to which the resident objects, that did not originate through a resident’s verbal or written request, and/or one that is not in alignment with the resident’s stated goals for care and preferences.⁶

**National Ombudsman Reporting System (NORS)** – The uniform data collection and reporting system required for use by all State Long-Term Care Ombudsman programs.

**Office of the State Long-Term Care Ombudsman (Office, OSLTCO)** – As used in sections 711 and 712 of the Act, means the organizational unit in a State or territory which is headed by a State Long-Term Care Ombudsman.⁷

**Ombudsman** – A Swedish word meaning agent, representative, or someone who speaks on behalf of another. For the purposes of this manual, the word “Ombudsman” means the State Long-Term Care Ombudsman.

² [https://ltcombudsman.org/omb_support/nors](https://ltcombudsman.org/omb_support/nors)
³ CA-04 Table 1: Part A - Complaint Data Components
[https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf](https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf)
⁴ CD-07 Table 1: Part B - Complaint Data Components
[https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf](https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf)
⁷ 45 CFR Part 1324 Subpart A §1324.1 Definitions
Representatives of the Office of the State Long-Term Care Ombudsman (Representatives) – As used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in § 1324.19(a), whether personnel supervision is provided by the Ombudsman or his or her designees or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.\(^8\)

State Long-Term Care Ombudsman (Ombudsman, State Ombudsman) – As used in sections 711 and 712 of the Act, means the individual who heads the Office and is responsible personally, or through representatives of the Office, to fulfill the functions, responsibilities, and duties set forth in §1324.13 and §1324.19.

State Long-Term Care Ombudsman program (Long-Term Care Ombudsman program, the program, LTCOP) – As used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.\(^9\)

State Long-Term Care Ombudsman Programs Rule (LTCOP Rule) – The Federal Rule that governs the Long-Term Care Ombudsman program (45 CFR Part 1324).\(^10\)

Subsection Symbol (§) – The subsection symbol is used to signify an individual numeric statute or regulation (rule).

Transfer – The movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility.\(^11\)

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\(^8\) 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule

\(^9\) 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule


Section 2: Introduction to Long-Term Care Ombudsman Program Complaint Processing
Trainer’s Note: Allow at least 30 minutes for Section 2.

Long-Term Care Ombudsman Program Complaint Processing

Trainer’s Note: Refer trainees to the Figure 1 chart to explain the stages of Long-Term Care Program Complaint Processing

The first function of the Ombudsman program listed in the Older Americans Act (OAA) is to identify, investigate, and resolve complaints that are made by, or on behalf of, residents.

To comply with the Older Americans Act, the Ombudsman program follows three stages of complaint processing as noted in the Figure 1 chart.

This Module focuses on Stage 1: Intake, Planning, Investigation, and Verification which entails: receiving problems, complaints, and concerns; confirming the resident’s perspective of the problem; developing an initial plan; gathering information through interviews, records, and observations; as well as determining if the problem is generally accurate. Stages 2 and 3 of complaint processing, shown below, will be addressed in Module 8, “Long-Term Care Ombudsman Program Complaint Processing: Analysis, Planning, Implementation, and Resolution.”

Keep in mind these objectives when handling complaints:

- Empower residents to self-advocate with minimal involvement from the Ombudsman program
- Remain resident-focused and resident-driven
- Maintain confidentiality
## THE STAGES OF LONG-TERM CARE OMBUDSMAN PROGRAM COMPLAINT PROCESSING

**Figure 1**

### STAGE 1
**INTAKE, PLANNING, INVESTIGATION, AND VERIFICATION**

<table>
<thead>
<tr>
<th>Intake</th>
<th>Receive problems, concerns, and complaints. Confirm the resident’s perspective of the problem. Determine if the problem or concern is a complaint as defined by the LTCOP.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop an Initial Plan of Action with the Resident</td>
<td>Advise resident of rights and discuss their desired outcome and possible solutions; obtain consent to act and consent to identify the resident when speaking with involved parties. Seek consent to access records when applicable. Determine who is responsible for all required actions within the plan.</td>
</tr>
<tr>
<td>Investigate</td>
<td>Collect information from interviews, observations, and records (when necessary).</td>
</tr>
<tr>
<td>Verify</td>
<td>Review information gathered. Determine if the complaint is generally accurate and if further action is needed. If no action is needed, complaint processing stops here, except for documentation.</td>
</tr>
</tbody>
</table>

### STAGE 2
**ANALYSIS AND PLANNING**

| Analyze | Once the complaint is identified and verified, consider the root cause(s). If the complaint is not verified, but the resident’s perception of a problem exists, determine the root cause of the problem and if there is a need for LTCOP involvement. |
| Revisit the Plan of Action with the Resident | Review the desired outcome and possible solutions. Determine if any changes need to be made to the plan of action. Anticipate barriers to select an appropriate approach and identify alternative strategies if needed. |

### STAGE 3
**IMPLEMENTATION AND RESOLUTION**

| Act | Proceed with implementing the agreed-upon plan of action. |
| Assess | Check back with the resident and others involved to measure the progress of the plan. Determine if alternative actions need to be considered. |
| Resolve | Follow up to confirm with the resident that the complaint is resolved or partially resolved to their satisfaction. |

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12 Figure 1 and the section content is adapted from the *Equipment Long-Term Care Ombudsmen for Effective Advocacy: A Basic Curriculum. The Problem-Solving Process – Investigation. NORC.*

As a representative, how you handle complaint processing directly impacts:

- your relationship with residents and facility staff
- your ability to achieve the desired outcome
- future relationships with residents, families, and facility staff
- the reputation of the Ombudsman program

Complaint processing is the primary means that the LTCOP uses to ensure residents’ rights are understood and honored. It involves educating residents, staff members, and others about rights, and helping to find practical solutions to problems that arise when the interests of the facility and the interests of the resident conflict.

Responding to and resolving complaints can be difficult. There will be times when you will be asked to support the resident in a decision that may be potentially harmful to them (e.g., a person wants to move out of the facility to an unsafe environment). There will also be times when you will attempt to balance the rights of one resident with the rights of another.

Whatever the situation or facility type, the process is the same. Complaint processing is really nothing more than problem-solving from receipt of a complaint through investigation and resolution.

**Long-Term Care Ombudsman Program Approach to Complaint Processing**

The Ombudsman program's goal in problem-solving is to achieve satisfaction for residents. The approach you use is critical to the immediate outcome and to future complaint resolution. Therefore, as a representative, you must carefully select your strategies and be skillful and thoughtful when investigating and resolving problems. Sometimes, you will educate, support, and encourage residents to engage in self-advocacy. Other times, you will represent the resident.

Working on behalf of one resident can lead to changes in facility policies and routine practices, which then benefit all residents. Some goals of the Ombudsman program are to help staff become more responsive to residents, and to better equip residents to directly express their concerns to staff (i.e., empower residents).

Another important consideration when presenting concerns to staff is personal style and demeanor. Taking an approach that is hostile, aggressive (rather than assertive), or assigning blame may damage your working relationship and make it difficult for you to collaborate with facility staff in resolving problems. On the other hand, a style that is too passive will not be effective in ensuring that residents’ rights are respected.
Section 3:
Complaint Intake and Initial Plan Development
Trainer’s Note: Allow at least 30 minutes for Section 3.

Complaint Intake

Recognizing and Receiving Complaints

The words “problems” and “concerns” are used in general terms within the LTCOP to explain general expressions of dissatisfaction. As part of the Ombudsman program team, you will hear problems and concerns on a regular basis. Some people complain to process their feelings or “vent” and may not expect or want your intervention. In the LTCOP, concerns, problems, and “venting” are not always complaints.

A “complaint” is the term used specifically regarding issues that the LTCOP works to resolve. A complaint is an expression of dissatisfaction or concern brought to, or initiated by, the Ombudsman program which requires Ombudsman program investigation and resolution on behalf of one or more residents of a long-term care facility.13

A concern or problem turns into a complaint when the following factors are present:

- the resident (or resident representative when applicable) consents to LTCOP assistance
- the concern affects the health, safety, welfare, or rights of a resident
- the concern requires LTCOP action

When a resident shares a problem or concern with you, ask questions to determine the cause and extent of the problem. Module 5 describes two situations regarding a resident named Barry. In the first situation, Barry made statements such as “most staff are nice to me” and “the food is okay if you eat in the dining room.” The representative paid no attention to these subtle statements that implied possible concerns.

In the second situation, the representative noticed a potential problem and asked more questions. Without having done so, Barry’s underlying concerns may not have been addressed.

Not all expressed problems are appropriate for Ombudsman program intervention if they do not directly impact a resident, are outside the scope of the program, or if the resident does not want Ombudsman program assistance. For example, a resident expressing concern because they believe the staff are underpaid is not a complaint for the LTCOP.

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13 NORS Table 1. Part B – Complaint Data Components. CD-04.  
https://ltcombsudman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
To determine if someone is simply expressing a concern or if they are seeking your help, ask such questions as:

- Is there anyone I can talk with about your concerns?
- Is there anything I can help you with today?
- Is this something you would like my help with?
- Is there anything I can do to help your situation?

Don’t be surprised when residents decline your assistance. Give them materials about your program with the appropriate contact information and ask them to contact you if they change their mind and want assistance. Make sure to check on them during your next visit to see if their situation has improved or if they have decided they now want your help.

Not all concerns expressed are issues that the LTCOP works to resolve. Skillful listening, observation, and inquiries can determine when such expressions are actual requests for assistance and indicate a problem that needs to be pursued (i.e., complaints).

**Trainer’s Note:** Go over the examples in the chart to indicate what is a complaint and what is not a complaint. Tell trainees that it helps to give residents generalized, deidentified examples of complaints representatives have resolved so residents understand the process in practical terms and develop trust.

When addressing the problems in the “Not a Complaint” category, let the trainees know that these would be complaints if the resident gives the LTCOP permission to act, but the statements alone do not constitute a complaint. Tell trainees to assume permission was denied. Therefore, these problems are not official complaints. When representatives hear concerns such as those listed under the “Not a Complaint” category, it is good practice to follow up later to see if the concern still exists, be alert to other residents who have the same concern, and if the resident has changed their mind and now wants LTCOP assistance.

Figure 2

<table>
<thead>
<tr>
<th>Complaint</th>
<th>Not a Complaint</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you help me get more therapy?</td>
<td>One aide is rude to me, but I don’t want you to say anything.</td>
</tr>
<tr>
<td>The facility is going to kick me out, can you do something about it?</td>
<td>I don’t want to get up so early in the morning, but it takes me so long to get ready. I’ve learned to accept it.</td>
</tr>
<tr>
<td>I want to be able to use the phone in private, is there anyone you can talk to about it for me?</td>
<td>My kids put me in this home, and I wish I didn’t have to live here.</td>
</tr>
</tbody>
</table>
Sources of Complaints
Complaints are received during facility visits or through contact with the program (e.g., phone calls, emails, website complaint form submissions, etc.). A complainant is an individual who requests Ombudsman program complaint investigation services regarding one or more complaints made by, or on behalf of, residents; complainants are most often residents and family members. However, complainants can be anyone, including facility staff, hospital staff, community members, clergy, legislators, persons who wish to remain anonymous, representatives of the Office, etc.

Residents as Complainants
Oftentimes residents do not realize they have the right to complain, or they feel complaining won't do any good. They may not understand what the LTCOP offers. They may feel uncomfortable complaining to a stranger or have trouble believing that person will maintain confidentiality. For these and other reasons, it is important that you regularly visit the facility and become familiar, so that residents come to know and trust you.

Another source of resident-initiated complaints is through Resident Council meetings. Attending Resident Council meetings, per invitation of the residents, can be an opportunity for residents to reach out to the LTCOP when their efforts to resolve complaints directly with staff have been stalled.

Relatives as Complainants
Family members often reach out to the Ombudsman program for information and assistance as well as for complaint resolution. Sometimes the family member’s concerns align with the resident’s concern and sometimes they do not. Since the Ombudsman program follows resident direction, the needs and interests of family members are not the focus of your attention if they conflict with the resident’s preferences.

Another source of family-initiated complaints is through Family Council meetings. Attending Family Council meetings, per invitation of the members, can be an opportunity for Council members to reach out to the LTCOP when their efforts to resolve complaints directly with staff have been stalled.

Facility Staff as Complainants
Staff complaints may be based on a variety of motives. Most staff are concerned about residents and want to provide the best care possible. When conditions in the facility are poor, staff may reach out to the LTCOP for outside help to address the issues. However, it is important to remember the role of the Ombudsman program, and ensure the focus is the impact on the quality of life and care for residents, not internal employee/employer issues.
Representatives as Complainants
Representatives of the Office may initiate a complaint based on observations that affect multiple residents or when they become aware of actions, inactions, or decisions by the facility such as response to natural disasters, evacuations, infection control, facility closures, etc. Sometimes representatives are the complainant in situations when the resident wants to remain anonymous, but the concern impacts more than one resident.

Unvoiced Concerns
*Trainer's Note: Emphasize that providing a regular presence in facilities promotes a familiarity with the Ombudsman program. Once trust has been established, residents and families may begin to express concerns. Using your observation skills will often point you in the direction of unvoiced concerns.*

Problems sometimes exist in a facility without anyone complaining to the LTCOP. One unique role of the LTCOP is to determine when and where there are problems experienced by residents, even when residents don’t express them. An absence of complaints may not mean that all residents are receiving quality care or experiencing an acceptable quality of life. There are many reasons why residents are reluctant to voice concerns, including fear of retaliation, as well as the issues related to trust.

Information Collected at Intake
Intake is the first step in the investigative process. Determining if a problem or concern is something the Ombudsman program can act upon requires gathering information at intake, reviewing LTCOP policies and procedures, and/or talking to your supervisor, and obtaining permission from the resident to proceed.

→ Describe your complaint intake process, response time to complaints, and include additional information that your state may collect during intake.

Whether through facility visits or through phone calls and emails to the Office, when a problem or concern comes to the LTCOP, it is important to explain your role as a resident-directed advocate and explain that the resident is the program’s client. Any further action that you can take may only occur with the permission of the resident. When the complainant is not the resident, explain that permission from the resident is required to take action on the complaint and to share any information with the complainant or with anyone else.

Regardless of the source of the complaint, attempt to learn as much as possible during the intake to determine if the concern could be a complaint.

Try to find out:
- what has occurred or is occurring
- when the problem occurred and whether it is ongoing
- where the problem occurred or occurs
• who was or is involved
• how resident(s) are affected
• why the problem is occurring or has occurred
• what steps have been taken to resolve the problem
• who has been contacted about the concern
• what the facility has done in response to the problem
• what is the resident’s perspective of the problem
• what the resident’s wishes are regarding complaint resolution

Obtaining this information will help you clarify the problem from the complainant’s point of view. If the complainant is not the resident, you will need to communicate with the resident and possibly ask the resident the same questions that you asked of the complainant to obtain the resident’s perspective of the situation.

Resident Consent

*Trainer’s Note: Show the video titled “How to Obtain Consent (Long-Term Care Ombudsman).”*

Watch the video *How to Obtain Consent (Long-Term Care Ombudsman)*[^14] and consider the following questions:

1. What does the narrator mean when he says to “set the resident up for success”?

   **Answers:**
   - Try to meet with the resident when they are having a good day.
   - Avoid asking for consent when the resident isn’t feeling their best, is too tired, or is not in the mood to talk to you.
   - Make sure the resident understands what they are signing and what actions will be taken on their behalf.
   - Don’t pressure the resident into providing consent in any way or form.

2. What does the narrator say about obtaining consent from residents who experience dementia?

   **Answers:**
   - Residents who experience dementia can express their desire to have problems resolved.
   - The LTCOP must use good judgement when determining someone’s ability to give consent.

3. What is the LTCOP’s objective?

   **Answer:** To resolve the complaint in the way that the resident wants it resolved.

[^14]: Empowered Aging [https://youtu.be/enjd8qQ5bjk](https://youtu.be/enjd8qQ5bjk)
As a resident-directed advocate, you may not act on an individual concern without resident consent. If the resident is not the complainant, you must contact the resident to obtain their perspective of the problem and determine if the resident wants LTCOP involvement.

What if the resident refuses to consent to the LTCOP addressing an individual concern?
- Determine why
- Explain the resident’s options for addressing the concern
- Do not proceed with opening a complaint investigation
- Provide your contact information if they want assistance in the future
- Determine if the concern is systemic in nature

What if the resident asks for LTCOP assistance, then withdraws consent?
- Determine why
- If the problem is recurring, provide other options for the resident to consider, such as expressing their concerns at the Resident Council meeting, talking with family or a trusted staff member
- Stop all advocacy efforts on behalf of the individual resident
- Provide your contact information for future assistance
- Determine if the concern is systemic in nature

If a resident refuses to consent or withdraws consent, determine if the issue affects multiple residents and find out if other residents want your assistance. To do so, you will need to interview other residents without disclosing the identity of any resident or complainant without their permission.

**Informed Consent and Decision-Making Capacity**
Module 3 provides detailed information on when a resident is unable to communicate informed consent and what to do when decisional capacity is unclear. When you receive a complaint on behalf of a resident who has limited decision-making capacity, advocate for the resident’s wishes to the extent that the resident is able to express them. Otherwise, follow the direction of the resident representative and follow your program’s policies and procedures as discussed in Module 3.

**Develop an Initial Plan of Action with the Resident**
When a resident shares a complaint with you, you can immediately develop an initial plan of action with the resident. However, when a complaint is from a source other than the resident, you must reach out to the resident to confirm the resident shares that complaint (or has others), to explain their rights, and then begin to develop an initial plan of action.

- Confirm the resident’s perspective of the problem and determine if the concern is a complaint.
- Consider information gathered during the intake process.
- Discuss applicable residents’ rights with the resident and the complainant.
• Determine if the resident wants LTCOP assistance and if so, engage them in developing an initial plan of action.

When developing the plan, discuss with the resident their perspective of the problem and their desired outcome(s). In addition, explain options and possible solutions. Before putting the plan into action, you must obtain consent to act and consent to identify the resident when speaking with involved parties. Determine who is responsible for all required actions within the plan; the resident and/or a family member may want to complete some of the actions.

If during the investigation you are unable to complete the agreed-upon tasks, go back to the resident and revisit the plan (a step in Stage Two of complaint processing).

**Complaint Intake Dilemmas**
It is inevitable that you will be presented with several complaint situations that pose questions or even ethical dilemmas. The fundamental point to remember is you are resident-directed, meaning you represent the resident. Knowing how to initially respond to these circumstances will avoid future misunderstanding and miscommunication.
# RESPONDING TO COMMON DILEMMAS

**Figure 3**

<table>
<thead>
<tr>
<th>Common Dilemmas</th>
<th>Suggested Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>A family member complains about a resident’s care, but the resident says everything is fine and asks you not to proceed.</td>
<td>Don’t proceed in this situation. However, if other residents express the same problem and want your assistance, you may advocate on their behalf.</td>
</tr>
<tr>
<td>The resident complains and wants your help, but a family member urges you “not to rock the boat.”</td>
<td>The resident has requested assistance and you should honor that request. Explain to the family that you are resident-directed.</td>
</tr>
<tr>
<td>Relatives want you to investigate their complaint, but do not want the resident to know what you are doing.</td>
<td>Remind the family you are resident-directed and cannot proceed without first discussing the issue with the resident. You may talk to the resident without identifying the complainant to see if the resident expresses the same concern and wishes your assistance.</td>
</tr>
<tr>
<td>A resident unable to communicate informed consent asks the LTCOP to help with a concern.</td>
<td>The concern cannot be dismissed just because it comes from someone who is unable to communicate informed consent. However, the resident’s condition should be considered as one factor in determining whether the complaint is valid. Try to understand what the resident is expressing and determine if there is an underlying message or unmet need.</td>
</tr>
<tr>
<td>A resident will not give you permission to reveal her identity but wants your assistance.</td>
<td>Discuss the reasons the resident does not want her identity revealed. If this will limit your ability to resolve the issue, discuss this with the resident and tell her you will do as much as possible without revealing her identity. If you cannot resolve the issue without revealing her identity, tell her what you’ve done and why you cannot take the case further. If appropriate, encourage the resident to discuss her concern with the Resident Council.</td>
</tr>
<tr>
<td>A complainant, other than a resident, insists on remaining anonymous and will not give you any identifying information.</td>
<td>Respect the anonymity of the complainant. Determine if the complaint can be investigated without revealing the identity of the complainant.</td>
</tr>
</tbody>
</table>
Trainer’s Note: Show the 5-minute video clip and ask the following questions, making sure the appropriate answers are covered.

Watch the video, Anne Walker - Intake and Initial Plan\textsuperscript{15} and answer the following questions.

1. What does Gloria do before she enters Ms. Walker’s room?
   
   \textbf{Answer:} Gloria knocks on the door, announces herself, and asks for permission to enter her room.

2. What concerns does Ms. Walker express in this scenario?
   
   \textbf{Answer:} Her shower time is too early in the morning. Ms. Walker expresses feeling that staff do not listen to her or respect her preference. Ms. Walker says staff rush her out of bed in the morning and rush her during and after her showers. Staff have not answered her questions about the shower schedule and one aide treats her like a child.

3. Does Gloria explain Ms. Walker's rights pertaining to her concerns? If so, which rights are explained?
   
   \textbf{Answer:} Yes. Gloria explains the right to be treated with dignity and respect and the right to participate in decisions about daily life, including showering.

4. Do Gloria and Ms. Walker develop an initial plan of action together? What is the plan?
   
   \textbf{Answer:} Gloria will visit in the morning, during shower time to observe staff/resident interaction and she will interview other residents to find out about their shower experiences. Gloria will not disclose Ms. Walker’s name when investigating the complaint.

5. Gloria obtains consent to act, but what parameter does Ms. Walker impose on Gloria?
   
   \textbf{Answer:} Ms. Walker does not want Gloria to use her name during the investigation.

\textsuperscript{15} This video series was developed by the Texas Department of Aging and Disability Services in coordination with the Texas Long-Term Care Ombudsman Program. Questions are from both the Long-Term Care Ombudsman Casework: Advocacy and Communication Skills Trainer Guide (https://ltcombudsman.org/uploads/files/support/Texas_Video-Trainee_Doc-Answers-FINAL.pdf) and the Illinois State Long-Term Care Ombudsman Program Level 1 Training manual.
6. What examples of empowerment did you observe?

**Answer:** Gloria explains residents’ rights and explains that because Ms. Walker expressed her concerns, it could help other residents.

7. Is there anything you would have done differently?

**Trainer’s Note:** Responses may vary. Trainees may ask about Gloria sitting on Ms. Walker’s bed. If this comes up, explain your program’s guidance on this topic.

8. Gloria used both open-ended and closed-ended questions during her complaint intake. What are some examples of each and what information is Gloria trying to gain from asking these questions?

**Answers:**

*Closed-ended question – What time do they come to your room?*
*Information gained - Gloria learns the time aides arrive to take Ms. Walker to the shower.*

*Closed-ended question - When you are in the shower is there anyone else in the area?*
*Information gained - Gloria attempts to learn the identify of other potential residents to speak with regarding the shower schedule.*

*Closed-ended question - What days do you usually shower?*
*Information gained - Gloria learns when Ms. Walker gets her showers.*

*Closed-ended question - Which aides come to get you?*
*Information gained - Gloria learns which staff are treating her poorly and getting her up early.*

*Open-ended question - Why do you think they are coming so early?*
*Information gained - Gloria attempts to determine Ms. Walker’s understanding of the shower schedule and her perspective of the problem.*
Section 4:

Complaint Investigation
Investigation

*Trainer’s Note: Allow at least 45 minutes for Section 4.*

Before you can resolve most complaints, you will need to gather additional information about the situation from a variety of sources. This process, which is the last step in Stage 1 of the Ombudsman Program Problem-Solving Process, is frequently referred to as investigation.

The purpose of the Ombudsman program’s investigation is to gather the information necessary to determine whether the complaint is verified. **Complaint verification (verification) is confirmation that most or all facts alleged by the complainant are likely to be true.** It is important to be objective when gathering information.

Investigations involve preparation, deciding what information is relevant, and then using various techniques to collect evidence. As stated earlier, the most common techniques the LTCOP uses are interviewing, observation, and record review.

**STEPS TO PREPARE FOR AN INVESTIGATION**

1. Separate the problems.
2. Categorize the complaint and identify relevant laws and regulations.
3. Consider potential causes(s).
4. Identify all participants.
5. Identify all steps already taken.
6. Clarify the outcome the resident is seeking.
7. Identify all relevant agencies.

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16 Table 1: NORS Parts A, B, and C – Case and complaint codes, values, and definitions
https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
Example: Mr. Richards

Trainer’s Note: Use the case study to go through the Steps to Prepare for an Investigation. Either read the case study aloud or ask the trainees to read it on their own. Mr. Richards has been in a nursing facility for several months when his wife starts to notice a change in his health. During a visit, Mrs. Richards tells you, “He became chronically sleepy, started losing weight, and the facility has done nothing about it.” She believes that her husband was placed on an improper diet. “How could he be given an appropriate diet when the doctor never sees him? He loves milk, but it’s always warm. I am still trying to get them to replace the hearing aid they lost two months ago! Can you help me?”

Every time you attempt to visit Mr. Richards, you observe that he is sleeping. Mrs. Richards is his agent under a power of attorney. You ask additional questions to determine the facts of the complaint.

Step 1: Separate the Problems
As described in the Intake Section, gather as much specific information as possible during your first contact with the complainant. Separate the problems in clear statements and rank the problems in order of importance to the resident or the complainant. This ranking will set the priority for which problems you address first. After you have a clear list of all the concerns, ask additional questions to fill in the details.

Here are the problems separated out that include all information gathered during intake.

a. Mr. Richards became chronically sleepy about one week ago.
b. Mr. Richards lost 10 pounds in three weeks.
c. The facility did not address the sleepiness or the weight loss in the care plan.
d. The last time Mr. Richards was seen by a doctor was three months ago.
e. Mr. Richards’ hearing aid is missing. The complainant last saw it in its usual place on his bedside table a week ago when she left after dinner at about 6:00 p.m.
f. Mr. Richards’ milk is always warm. This is true at all meals. The milk is served in a plastic glass on the tray with a plastic wrap covering it. Mr. Richards cannot remove the cover without assistance.

Make sure the problems are clear and agreed upon by you, the resident, and the complainant.

Step 2: Categorize the complaint and identify relevant laws or regulations
Categorize the complaint, or in the case of a complex complaint, each of the individual elements. Know what kind of complaint you are dealing with. For the purposes of this
case example, we will focus on the most important issues as related by the complainant.

Example: Mr. Richards has had a change in his medical condition and a new care plan should be developed.

The federal nursing facilities regulations require a facility to develop a comprehensive assessment of a resident when there is a significant change in the resident's physical or mental condition and to revise the care plan to meet his needs and preferences.

In other words, the facility is required to assess Mr. Richards and modify his care plan based on his current symptoms.

Step 3: Consider Potential Cause(s)
Based on your knowledge of the complaint, the resident, and the facility, create a list of possible reasons for the concern(s). This list can help you determine which information will provide a sense of direction for the remainder of the investigatory process.

Example: What are the possible reasons that Mr. Richards’ new medical conditions have not been addressed in his care plan?

- The facility is not aware of the new medical conditions.
- Some staff are aware of the concerns but have not communicated the concerns to prompt an assessment.
- The facility does not regularly weigh Mr. Richards.
- The facility does not have consistent staff assignments and the staff caring for him are not familiar with his past health status.
- Mr. and Mrs. Richards are not aware of his right to request a care plan and do not understand the purpose of a care plan.
- The facility views Mrs. Richards as a frequent complainer and ignores her concerns.
- An assessment was completed, and a care plan conference was held but the Richards were not informed.

Step 4: Identify All Participants
Who is responsible and who has the power to do something about it? It may be important to gather names and contact information of everyone who has some role in the situation. A complaint about resident care could include: the complainant, the resident, the facility nursing staff, the facility administrator, and the resident’s physician. In short, identify anyone who knows anything about the complaint or related circumstances and identify anyone who has the power to do something about the problem.
Example: Mr. and Mrs. Richards, the Care Plan Coordinator, the Director of Nursing, the charge nurse, the certified nursing assistants (CNAs) who cared for Mr. Richards two months ago and currently, and Mr. Richards’ physician all have information that is relevant.

Step 5: Identify Steps Already Taken
Determine if the complaint is new or recurring. What, if anything, has been done to resolve the concern? If anyone has acted, what was the action and what was the outcome? Determine if the resident or complainant has spoken to anyone about the complaint. What was the response? If no actions were taken, suggest possible steps that could be taken to encourage self-advocacy. If actions were taken, what was the result?

Example: Mrs. Richards said that “the facility has done nothing about it.” Who did she talk to at the facility? What was their response? Has Mrs. Richards spoken with Mr. Richards’ physician? What was their response? Ask Mrs. Richards when the last care plan conference was held and if the facility is following the current plan. What changes does she believe need to be made to the care plan?

Step 6: Clarify the Result the Resident is Seeking
What outcome does the resident want? If the complainant and the resident do not want the same outcome, make sure you work on behalf of the resident’s wishes.

Example: The complainant in this case is the resident’s wife and agent under a power of attorney. After several attempts by the LTCOP, the resident has not been able to communicate informed consent. Once verifying that Mrs. Richards has the right to speak for Mr. Richards when he is unable to communicate informed consent, the Ombudsman program follows the direction of Mrs. Richards. She indicates that her wishes are for Mr. Richards to have a comprehensive assessment and a care plan meeting that includes his physician to find out what is causing her husband’s change in condition. She also wants the facility to provide consistent staffing for her husband and to be listened to when she expresses her concerns.

Step 7: Identify Relevant Agencies
Is there an outside entity involved or another agency that needs to be involved? Such entities could be legal services, law enforcement, or the survey agency. If so, they may have information or insights that are helpful.

Example: At the direction of Mrs. Richards and with her consent to disclose resident identifying information, the Ombudsman program may refer the complaint to the survey agency to investigate the facility’s compliance with state and federal regulations.
Interviewing

Interviewing is the most frequently used method of gathering information. Most often interviews are more conversational and less formal. Interviews are used to investigate the concern, determine facts, and assist with complaint resolution. With permission of the resident, you may interview residents, facility staff, and/or family members of residents and anyone else with knowledge of the complaint. Regardless of who you are interviewing, there are several factors to consider when preparing for an interview. Following these guidelines will increase your likelihood of success. Be skillful in listening, questioning, and note-taking.

There are factors beyond your control. You may not be able to see an administrator at a time and place of your choosing. Set your goals beforehand. Know what questions you need answered and what specific information you need. Consider what information is needed to move forward with the complaint resolution. Along with the skills learned in Module 5, use the guidelines below when conducting interviews.
DURING INVESTIGATIVE INTERVIEWS

Figure 5

| Be yourself. Use words, skills, and body language appropriate to the situation in a way that fits your personality. |
| Maintain objectivity. Do not make assumptions about the validity of the information. |
| Establish a rapport before addressing the problem. |
| Explain the purpose of the interview. |
| Use open-ended questions when seeking the perspective of the person being interviewed. |
| Use closed-ended questions to obtain specific details and facts. |
| Use language that is easy to understand. Explain any technical terms. |
| Guide the interview toward the desired goals, yet be flexible enough to follow-up on any new, relevant information received. |
| When relevant, let the interviewee know when the conversation is nearing the end to ensure all questions are addressed. |
| Summarize what has been discussed or accomplished to confirm understanding. |
| Explain how the information will be used and other steps anticipated in conducting the investigation and resolving the complaint. |

**Interview Skill #1: Listening**

**Trainer’s Note:** Give the trainees at least 10 minutes to complete the activity in their manual called Listening-Self Evaluation. Once finished, process the activity by asking if they have learned anything about themselves that they would like to share – this could include what their strengths are or the areas in which they see they can improve. Allow at least 15 minutes for this activity.
**Activity**

How often do you use the following ten important skills of effective listening? Check yourself carefully on each one.

**LISTENING SELF-EVALUATION**

<table>
<thead>
<tr>
<th>Name</th>
<th>Always 10 pts</th>
<th>Usually 8 pts</th>
<th>Sometimes 6 pts</th>
<th>Seldom 4 pts</th>
<th>Never 2 pts</th>
</tr>
</thead>
<tbody>
<tr>
<td>I review mental outlines as I listen, so I don't forget important points.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I encourage others to talk by listening instead of speaking.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I give others my full attention when they speak to me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I assume everyone has something worthwhile to say</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>I use questions to guide speakers so they will make their message clear to me.</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I respond to speakers nonverbally with actions and facial expressions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I give verbal feedback to tell speakers how they are getting through to me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I relay messages for clarity, e.g., “This what I heard you say…”</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am aware of voice tone and body language that give away unstated messages.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I draw mental images as I listen to capture important points.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL =**

A score of 70 or below means you need to work on your listening. A score between 71 and 90 means you listen well. Over 90 means you are a great listener.
GUIDELINES FOR LISTENING DURING INTERVIEWS

Be an active listener. Acknowledge statements either non-verbally or verbally to confirm understanding.

Be alert to more than spoken words when you listen. Notice inflection of speech, qualities and tone of voice, facial expressions, body language, gestures, and general behavior. See if you can detect gaps or omissions in what the person is saying. Sometimes more can be learned from what is not said than from what is said.

Determine whether the complainant is glossing over some fact because they think it detracts from their position. Explain that you are interested in all facts and that you can only be of help if you know the whole situation.

Be comfortable with silence. Don't rush to fill the gap. Use silence to organize what you've heard. Be patient.

Never completely believe or disbelieve everything a person says. Differentiate facts from someone’s opinion. You will have to sort out the difference between the “truth” and fiction. If someone labels a resident as “hostile,” for example, find out what led them to that opinion.

Remember that you are the interviewer. Don’t let yourself be interviewed or drawn in personally. Turn questions into statements and reflect them back. A complainant may ask, “Don’t you think they are short staffed here?” Your reply could elicit more information, “It sounds like you think there is not enough staff. I’d like to know what leads you to that conclusion.”

Be alert to problems that may be unintentionally revealed. The resident may have a limited notion of what help is available or may not want to burden you with too many problems. Listen for “the problem behind the problem.” There is always the possibility that what the complainant is saying is not what is bothering them, and they are instead voicing feelings that reflect a general sense of hopelessness.

Stick to your interview agenda. Don’t be deflected or distracted by other issues. Avoid debates.

Stay focused on the current issue. Avoid discussing prior grievances.

Know and be prepared to cite your investigative authority as a representative of the Office.

Trainer’s Note: Ask the trainees to reflect on their previous answers. Then ask them if the listening skills we discussed helped them to determine what they can implement to improve their listening abilities when interviewing. If so, ask trainees to share what they feel they can improve upon and how they will apply the listening skills.
Interview Skill #2: Questioning

When conducting an interview, think about the information you need and then develop questions to help you obtain the information. Get the facts by asking who, what, where, how, when, and why.

Ask additional questions to get to the root of the problem and to find appropriate solutions to the concern, such as:

- “Help me understand why…”
- “What would happen if…?”
- “How do you feel about…?”
- “What do you think about…?”
- “What can you tell me about…?”
- “Why do you think…?”
- “Are you saying…?”

Interview Skill #3: Note taking

When taking notes during an interview the following tips will be helpful for complaint resolution and state and federal documentation requirements. Module 8 covers additional information on documentation.

**TIPS FOR EFFECTIVE NOTE TAKING**

**Maintain rapport** and a good conversational flow during an interview even if it is necessary for you to take notes.

**If you will be taking notes in person, explain the reasons why** to relieve any anxiety or fear on the part of the person being interviewed. Some examples include “what you are saying is really important to me. I need to take notes because it helps me remember.” Or “I’m not allowed to share my notes without your permission to anyone outside of the Ombudsman program. Taking notes helps me to correctly record your point of view.”

**Take notes of responses that are especially significant** and/or that you think are important to remember accurately.

**Write only information that you are prepared for the interviewee or someone else to see.**

**Keep your notes short, factual, and to the point.** It is acceptable to include your personal observations and judgments; however, *back them up with facts*. For example, if you indicate that the floor was dirty, state that you noticed coffee and juice stains in the day room on Wing C, and that it felt sticky to the touch.

**Avoid judgmental statements** such as “Resident is obviously a chronic complainer,” or “Administrator can’t be trusted.”

**Describe behaviors, do not label them.** For example, if an administrator is unresponsive to your questions write, “Administrator said he had no comment when I
asked about the training and supervision that CNAs receive. After I asked other questions related to the complaint, the administrator said the interview was over and escorted me to the door.”

Observation During an Investigation
Observation is the second most common method of gathering information. Complaints that have to do with staffing, sanitary conditions, and food often can be checked through observation. In addition to sensory observations discussed at the beginning of this Module, the tips below will help you to be successful when using observation during an investigation.

Tips
Approach a situation requiring investigative observation with an open mind and an understanding of what is observed.

Be as impartial as possible. If you only look for evidence that fits a preconceived notion or theory, other evidence may be missed or much of the evidence may be misinterpreted.

Document your observations as soon as possible to ensure accuracy and thoroughness.

Accessing Records During an Investigation

→ Include your program policies and procedures on obtaining a written release of information form for accessing records.

During Module 5, the Ombudsman program authority to access records was explained.

Follow program policies and procedures and state and federal regulations regarding accessing resident records. You may come across a situation where someone other than the resident or complainant offers to show you the resident’s record. Unless you have permission to access the record according to the LTCOP procedures, do not look at the record.

Though most investigations will not require access to resident records, there are important points to remember when the need arises.
At what point during an investigation might you need to access records? The following are some situations when accessing resident records may be appropriate:

- A resident wants to know information that the records contain such as what is written in the care plan, what the physician ordered, or what financial transactions have been made.
- You receive conflicting or vague information from staff. Looking at the record will provide another data source that may be helpful to understand the issue.
- You need to verify the information you have received regarding the resident’s complaint.
- You need facts from the record such as information about guardianship, power of attorney, contact information, the number of times the physician visited the resident, etc.

Further considerations when deciding whether to look at a resident’s record are that records are sometimes not complete, not accurate, and may be difficult to understand.

Because of confidentiality provisions, staff may be apprehensive about allowing you access. When you ask to see a resident’s records, staff may wonder why you want the information and what you are trying to determine. You might encounter some resistance or a lot of questions due to defensiveness and concerns you are “checking up” on them. If you are denied access to records, follow your program’s policies and procedures.

When preparing to access records, have the following information before you ask for a resident’s record:

- A firm knowledge of the basis for your request.
- The appropriate completed release of information form.
- Ideas about what to say if you encounter resistance or questions about the request. Depending upon the circumstances you might give a response like the ones below.

1. *The resident has a right to authorize me to look at their medical record. I’ve given you the consent form. Please give me the record now.*

2. *If I need help understanding the record, I’ll let you know. I just need to review the record by myself right now.*

3. *At this point, I’m looking for information. I haven’t determined if there is a problem.*
4. Due to Ombudsman program confidentiality policies, I cannot discuss specific details with you. If there is an issue that needs your attention, I'll let you know.

**Accessing Records for Residents with a Resident Representative or no Representative**

Residents who have a legal representative with decision-making power still retain some ability to participate in their care and exercising of their rights. For example, a resident with a durable power of attorney for health care still has a voice in their care unless they are unable to communicate informed consent. Residents with guardians still have a right to have their desires and preferences considered even if the guardian has the legal responsibility over that area.

When considering a record review, be sure it is necessary to investigate or resolve a complaint or to protect the rights, health, safety, and welfare of the resident. Follow your program policies and procedures; use all state-required forms for access; and follow the procedures as prescribed in the OAA\textsuperscript{17} and the LTCOP Rule\textsuperscript{18} for access in the chart below.

**Trainer’s Note:** Modify the information in the chart as necessary to conform to your program’s policies and procedures.

**Figure 6**

<table>
<thead>
<tr>
<th>Situation</th>
<th>Procedures for Accessing Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident can communicate informed consent.</td>
<td>1. Exercise good judgement about the resident’s ability to provide informed consent (e.g., the resident can express wishes and opinions on how to resolve the problem).  \n2. Obtain and document consent from the resident. Consent may be obtained in writing, verbally, or through auxiliary means of communication.  \n3. Document consent according to policies and procedures.</td>
</tr>
<tr>
<td>Resident is not able to communicate informed consent and has a resident representative.</td>
<td>1. Confirm the resident representative has authority to grant access.  \n2. Obtain and document consent from the resident representative. Consent may be obtained in writing, verbally, or through auxiliary means of communication.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Situation</th>
<th>Procedures for Accessing Records</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Document consent according to policies and procedures.</td>
<td></td>
</tr>
</tbody>
</table>

**Resident is not able to communicate informed consent and the resident representative refuses to consent to the access and the resident representative is not acting in the best interests of the resident or the resident representative cannot be located despite a reasonable effort.**

| 1. Notify your supervisor and explain why you believe the resident cannot communicate informed consent and why you believe you need to access their records. |
| 2. Document why you believe the resident cannot communicate informed consent. |
| 3. Follow program policies and procedures regarding consent from the State Ombudsman to access records and document the permission. |

**Resident is not able to communicate informed consent and does not have a resident representative.**

| 1. Notify your supervisor and explain why you believe the resident cannot communicate informed consent and why you believe you need to access their records. |
| 2. Document why you believe the resident cannot communicate informed consent. |
| 3. Follow program policies and procedures regarding consent from the State Ombudsman to access records and document the permission. |

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### Example: Mr. Farley

Mr. Farley, a resident, shares a concern and asks you to intervene with the facility on his behalf. He gives you permission to use his name and to talk to any staff who can help resolve the problem. Access to his records is not discussed since you do not anticipate needing to examine his records to deal with the issue. As you are gathering information about Mr. Farley’s concern, the charge nurse tries to show you his record to prove the truthfulness of her response. How do you respond?

**Trainer’s Note:** Ask the trainees how they might respond in this situation.

**Responses may include:**

“I have not discussed reviewing medical records with Mr. Farley. I only want to know....”

Or “I appreciate your help, but don’t have permission to view Mr. Farley’s records.”

Ask the trainees, “why shouldn’t you view Mr. Farley’s record at this time?”

**Responses may include:**
“Mr. Farley only gave permission to talk to staff, not to look at his records.” Or “I should only seek necessary information to understand and resolve the issue.”

Watch the video Anne Walker – Investigation and answer the following questions.

**Trainer’s Note:** Show the 6-minute video clip on investigation and ask the following questions.

1. Why is it important for Gloria to contact her supervisor, Diane, after speaking with Ms. Walker?

**Answer:** To talk with her supervisor about her plan and to receive further tips and guidance. Gloria also speaks with Diane to give her a heads up on visiting at an unusually early hour in case the facility calls to complain.

**Trainer’s Note:** Discuss relevant program policies and procedures regarding communication and technical assistance with supervisors.

2. After talking to her supervisor, what does Gloria do to begin her investigation?

**Answer:** Observation of the shower room, interviews with residents, and a record review of the shower schedule.

3. Why does Gloria visit during the morning shower time?

**Answer:** Gloria visits at that time to observe the shower process. Visiting at this time allows her to experience the issue from the resident’s perspective.

4. How does Gloria use her senses to gather evidence during her visit and complaint investigation related to Ms. Walker’s concerns?

**Answer:** Gloria looks in the shower room for evidence of use and observes residents and staff during her early morning visit.

5. What challenges might you encounter when visiting early morning, evenings, or weekends?

**Answer:** Staff may pay more attention to you during an off-hour visit to see where you go, who you visit, and may ask questions about why you are visiting at that time. It may be difficult to enter the facility if the front door is locked. There are likely fewer staff to respond to questions. Finding managerial staff outside of weekday, daytime shifts may be a challenge and could possibly delay the problem-solving process.

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19 This video series was developed by the Texas Department of Aging and Disability Services in coordination with the Texas Long-Term Care Ombudsman Program. Questions are from both the Long-Term Care Ombudsman Casework: Advocacy and Communication Skills Trainer Guide (https://tcombudsman.org/uploads/files/support/Texas_Video-Trainee_Doc-Answers-FINAL.pdf) and the Illinois State Long-Term Care Ombudsman Program Level 1 Training manual.
6. How does Gloria protect Ms. Walker’s confidentiality during the investigation?

**Answer:** Gloria does not disclose Ms. Walker’s name during conversations with other residents or with staff. Gloria looks at the general shower schedule and does not ask for Ms. Walker’s records.

7. Why doesn’t Gloria review Ms. Walker’s care plan to check her preferences about showers?

**Answer:** In addition to the fact that Ms. Walker’s identity would be revealed if Gloria asks for her records, Gloria needs Ms. Walker’s permission prior to reviewing her care plan and other records. Since Ms. Walker does not want Gloria to disclose her identity during the initial investigation, she uses other strategies such as interviewing other residents and reviewing the shower schedule to gather information.

8. What interviewing tips did you pick up from watching Gloria?

**Answer:** She is relaxed but professional, makes eye contact, and has open, receptive body language such as nodding while residents speak. She paraphrases what they say, showing she is listening and understands their needs. She respects privacy by knocking on the door and waiting to be invited in. Additionally, Gloria sits down when invited to do so, which is important since she is a visitor in the resident’s home.
Section 5: Verification
**Trainer’s Note:** *Allow at least 5 minutes for Section 5.*

The investigation may reveal that the actual problem is not the concern that was reported to you. For example, you may have been told that articles of clothing are being stolen. During your investigation you may learn that clothing is simply not being returned from the laundry room.

Accurately determining the cause of the problem is essential to finding a lasting solution. Examine the information you gained by interviewing, observing, and reviewing documents. Ask yourself, “What is the problem?” Be clear about the underlying problem before you try to resolve the issue.

**Verifying the Complaint(s)**

Verification is the last step in Stage 1 Intake, Planning, Investigation, and Verification. A complaint is verified if it is determined after interviews, record inspection, observation, etc., that you can confirm “that most or all facts alleged by the complainant are likely to be true.”

Verification is simply a matter of:

- reviewing the facts;
- ensuring that you have proper documentation; and
- deciding if the information supports the allegations in the complaint.

The amount of documentation and verification you need will be determined by the complexity of the issue, the willingness of the facility to accommodate the resident, and in some cases, the resident’s cognitive and communication abilities.

Sometimes complaints cannot be verified, but the resident’s perception of the problem still exists. For example, a resident with dementia may believe that someone stole their jewelry and reports the theft daily when they never had that jewelry in the facility. The LTCOP can work with the resident, facility, and a family member to come up with a solution for the resident to not feel the stress of having their jewelry stolen. It could be that the family agrees to bring the jewelry in for the resident to see during their visits or that the resident is provided with inexpensive jewelry to wear. These types of responses can provide a solution which resolves the resident’s concern to their satisfaction, even though the complaint is not verified.

A complaint is not verified when, after investigation, the circumstances of the complaint are found to be untrue. For example, a family member complains that the resident is not getting good care, but the resident is satisfied with the care received and there is no evidence to indicate otherwise. Based on the resident’s perspective and the representative’s observations this complaint cannot be verified.

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20 NORS Table 1: Part B – Complaint Data Components. CD-07.
https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
In summary, the purpose of the LTCOP’s investigation is to determine whether the complaint is verified and to gather the information necessary to resolve it. Representatives use interviews, observations, and documents to gather factual, objective information about a problem.
Section 6:
Common Complaints
Trainer’s Note: Allow at least 20 minutes for Section 6.

National Data
Trainer’s Note: The teaching point of this section is for trainees to understand where the LTCOP spends most of their time and on what type of complaints. Ask the trainees what they think are the most common complaints received by the LTCOP.

Ombudsman programs are required to report their activities such as facility visits, complaints received and investigated, information and assistance provided, systems advocacy, and community education to the Administration for Community Living (ACL) to be summarized in the National Ombudsman Reporting System (NORS).

The most recent reported NORS data\(^1\) shows nursing facilities average 104 beds per facility while residential care communities average 25 beds per RCC. The number of nursing facilities has slowly declined over the last five years while the number of RCCs has steadily increased. Even so, for various reasons, most complaints received and investigated are about nursing facilities. Reasons for variations in complaints may include state routine visit requirements, larger numbers of RCCs, and not enough representatives to provide routine access. Other factors may include a lack of awareness of resident rights in RCCs and differences in the care needs of residents.

Trainer’s Note: Remind the trainees of the state LTCOP requirements for routine visits to nursing facilities and RCCs.

The Figure 7 chart shows the top four complaints for nursing facilities (blue) and residential care communities (red). The two facility types do not equally share the top four complaints. As demonstrated in the chart, care complaints and discharge complaints are a large part of the Ombudsman program’s work.

\(^{1}\) NORS 2019 data [https://ltcombudsman.org/omb_support/nors/nors-data](https://ltcombudsman.org/omb_support/nors/nors-data)
Learn more about the National Ombudsman Reporting System (NORS) [data](https://ltcombudsman.org/omb_support/nors/nors-data).

### State Data

→ Include state-specific data, by either running reports from your own data system or OAAPS or go to AGID at a glance [https://agid.acl.gov/DataGlance/NORS/](https://agid.acl.gov/DataGlance/NORS/).

### Most Common Complaint

During your work as a representative, you will hear the term “facility-initiated discharge.” According to federal guidance for nursing facility surveyors, facility-initiated discharge in a nursing facility is defined as “…a discharge which the resident objects to, did not originate through a resident’s verbal or written request, and/or is not in alignment with the resident’s stated goals for care and preferences.”

22 States may have another term for discharges in RCCs, such as an “involuntary discharge,” “move out,” or “eviction.”

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22 The National Long-Term Ombudsman Resource Center NORS Data [https://ltcombudsman.org/omb_support/nors/nors-data](https://ltcombudsman.org/omb_support/nors/nors-data)

→ Add state-specific information on discharges related to residential care communities. Include applicable state laws and regulations.

Throughout the training, you have learned the Ombudsman program addresses a variety of complaints, often involving residents' rights violations; however, complaints involving discharges are the most common.

A complaint about a discharge is when a resident:
- receives a discharge notice and does not want to leave;
- is discharged without notice or due process;
- is transferred to the hospital and not advised of the facility’s bed-hold policy;
- is not allowed back to the facility after hospitalization; or
- is discharged to an unsuitable setting (e.g., homeless shelter).

Other situations include when the facility fails to provide a written notice of discharge, the notice is incomplete or incorrect, or the reason for the discharge is not in compliance with federal and/or state regulations.

There are significant challenges when it comes to investigating cases involving discharge complaints. Discharge complaints are discussed in more detail in Module 8.

Ongoing training and supervision are necessary to become successful at navigating such cases. The National Ombudsman Resource Center (NORC) has several tools to assist representatives when helping a resident face an inappropriate discharge.

Learn more about discharge.24

24 The National Long-Term Care Ombudsman Resource Center Transfer/Discharge https://ltcombudsman.org/issues/transfer-discharge
Section 7:

Conclusion
Module 7 Questions

Trainer’s Note: Allow approximately 20 minutes for Section 7. Ask the following questions and make sure the correct answer is discussed. These questions are meant to determine if the trainees understood the fundamental learning objectives and may illicit discussion about the answers. The questions and answers are not meant to be rushed through.

Case Study: Mrs. Bronner’s Purse

You are visiting Peaceful Acres Assisted Living. You stop in to see Mrs. Bronner and during your visit she tells you her purse is missing.

1. What are some potential reasons that Mrs. Bronner says her purse is missing?

Possible responses:
- She can’t remember where she put it.
- Her daughter took it for safe keeping.
- Another resident walked into the room and picked up the purse.
- Someone stole it.
- She never had a purse in Peaceful Acres.
- The purse is in her closet where Mrs. Bronner can’t see it.
- What Mrs. Bronner really wants is a special item that she always kept in her purse.
- Mrs. Bronner’s purse is in her room, but she is remembering a favorite purse she had many years ago.
- She left her purse in the dining room, and it is now in the box of “lost and found” items in the facility.

2. Because there are many possible explanations for Mrs. Bronner’s complaint, how would you determine why Mrs. Bronner said her purse is missing? What would you say to Mrs. Bronner?

Tell me about your purse:
- What does it look like?
- What was in your purse?
- Where do you normally keep it?
- Where have you looked?
- Have you talked to anyone about your missing purse?
- Do you want my help in locating your purse?
- Who may I speak with about your purse, and may I use your name when addressing your concern?
Mrs. Bronner tells you her purse is a brown handbag containing her wallet and special pictures. She keeps it on the chair next to her bed. Mrs. Bronner says she looked everywhere in her room. Mrs. Bronner tells you both her daughter, Stephanie, and the Social Services Director, Anita, are aware of her missing purse. Mrs. Bronner gives you permission to talk to her daughter and to facility staff about her missing purse and to use her name when addressing her concern.

3. Before you contact Stephanie and Anita, what observations could be made?

- Do you see a purse in Mrs. Bronner’s room? Reminder - representatives should never open drawers or move clothing to look in the closet.
- Recall if you have seen Mrs. Bronner’s purse during any of your previous visits.
- Do you see other residents with purses or other personal items?
- Is Mrs. Bronner’s room located close to an outside entrance to the facility?
- How are the entrances to the facility monitored?

Mrs. Bronner gives you permission to get staff to see if the purse is somewhere in her room. The staff and Mrs. Bronner check her room, but the purse is not found. You don’t observe anything in her room related to this complaint.

4. You call Mrs. Bronner’s daughter, Stephanie; what do you ask her?

- What can she tell you about Mrs. Bronner’s purse?
- Has she taken any action regarding Mrs. Bronner’s missing purse?
- When did she last see Mrs. Bronner’s purse?
- If she thinks Mrs. Bronner is looking for something else, what might it be?
- Has she had any experiences with other items missing in Peaceful Acres? If so, how has the facility responded?

Stephanie tells you that when her mother first came to Peaceful Acres, she gave her mom an inexpensive purse with an empty wallet and special family pictures. Mrs. Bronner looks at the pictures every night before bed. Stephanie says she is aware of her mother’s concern but hasn’t had a chance to visit and find out what is really going on. Stephanie says her mother has a habit of misplacing her purse and not remembering where she leaves it.

5. What do you ask the Social Services Director, Anita?

- What can you tell me about Mrs. Bronner’s missing purse?
- Has anyone attempted to locate the purse?
• What does the facility do with misplaced items and/or items staff find whose owner can’t be identified?

• What is the facility’s policy for handling missing possessions?

Anita tells you that she is aware of the missing purse and that Mrs. Bronner is always misplacing it. Anita has not attempted to look for it. Anita said Mrs. Bronner usually leaves it in the dining room or the activity room. All misplaced items go into a lost and found box. She assures you she will look for it sometime today.

6. The complaint is about a missing purse. Have you confirmed that the purse is missing (in other words, is the complaint verified)?

Answer: Yes.

This case study illustrates Step 1 of complaint processing. While there is more work to be done, the representative has gathered enough information to verify the problem and work towards resolution.
Module 7 Additional Resources

Facility-Initiated Discharge

- National Ombudsman Resource Center: Transfers and Discharges
  https://ltcombudsman.org/issues/transfer-discharge

- Enhancing Your Advocacy Toolbox – Protecting Residents from Nursing Facility-Initiated Discharges

Interviewing

- Basic Interviewing Skills Oregon

COVID-19

- Complaint Investigation and Resolution During COVID-19: Complaint Scenarios and Documentation

- Responding to Complaints During the COVID-19 Pandemic
MODULE EIGHT

Long-Term Care Ombudsman Program Complaint Processing: Analysis, Planning, Implementation, and Resolution

TRAINER GUIDE

January 2022
## Table of Contents

Module 8 State-Specific Information.........................................................................................2  
Section 1: Welcome and Introduction.........................................................................................3  
Section 2: Analysis and Planning...............................................................................................9  
Section 3: Implementation and Resolution................................................................................18  
Section 4: Conclusion..................................................................................................................32

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Module 8 State-Specific Information

The list below outlines state-specific information for trainers to discuss, provide a link to, or add directly to the Trainer Guide, Trainee Manual, and/or PowerPoints. When you get to the point in the training where you need to discuss, include a link to, or add state-specific information, you will see a bold, blue arrow (→) and a brief description of what to include.

→ State-Specific Information

Section 3 Implementation and Resolution

- Reiterate your program’s policies and procedures regarding systems advocacy.
Section 1:
Welcome and Introduction
Welcome

Trainer's Note: Allow at least 15 minutes for Section 1.

Begin the session by welcoming the trainees to the training session and thanking them for their continued interest in the program. Make sure everyone introduces themselves – even if they come late.

To begin, please share:
- Your name
- Where you are from
- One thing you learned from Module 7 - something that really stuck with you or surprised you
- What you hope to learn since the last module

After introductions, thank the trainees for their information and explain any housekeeping items that need to be addressed including the time frame of the training day, breaks, location of restrooms, refreshments, etc. Ask the trainees to speak up if they have any questions throughout the training.

Welcome to Module 8 of certification training, Long-Term Care Ombudsman Program Complaint Processing: Analysis, Planning, Implementation, and Resolution. Thank you for being here to learn more about the Long-Term Care Ombudsman program and the certification process.
Module 8 Agenda

*Trainer's Note:* The timeframes for each Section are approximate. Allow at least 3 hours for Module 8.

Section 1: Welcome and Introduction *(15 minutes)*  
Section 2: Analysis and Planning *(60 Minutes)*  
BREAK *(15 Minutes)*  
Section 3: Implementation and Resolution *(60 Minutes)*  
Section 4: Conclusion *(20 Minutes)*

Module 8 Learning Objectives

*Trainer's Note:* Go over the Module 8 learning objectives.

After completion of Module 8 you will understand:

- the analysis and planning stage of Long-Term Care Ombudsman program Complaint Processing
- the implementation and resolution stage of Long-Term Care Ombudsman program Complaint Processing
Module 8 Key Words and Terms

The key words and terms are defined as they are specifically applied to the Ombudsman program and are found throughout this Module. Take a moment to familiarize yourself with this important information.

**Appeal Hearing** – A process that occurs after a resident appeals a notice of transfer or discharge to determine if the facility or the resident prevails. In some states, appeal hearings may also be referred to as “administrative hearing” or “fair hearing.”

**Case** – Each case must have a minimum of one complaint. A case must contain a complainant, complaint code(s), a setting, verification, resolution, and information regarding whether a complaint was referred to another agency. For abuse, neglect, and exploitation codes, a perpetrator code is also required.1

**Code** – An alphanumeric assignment to a data element of a case (e.g., complaint code, verification code, disposition code, etc.).2

**Complainant** – An individual who requests Ombudsman program complaint investigation services regarding one or more complaints made by, or on behalf of, residents.3

**Complaint** - An expression of dissatisfaction or concern brought to, or initiated by, the Ombudsman program which requires Ombudsman program investigation and resolution on behalf of one or more residents of a long-term care facility.4

**Complaint Disposition (Resolution)** – Final resolution or outcome of the complaint.

**Complaint Verification (Verification)** – Confirmation that most or all facts alleged by the complainant are likely to be true.5

**National Ombudsman Reporting System (NORS)** – The uniform data collection and reporting system required for use by all State Long-Term Care Ombudsman programs.

**Office of the State Long-Term Care Ombudsman (Office, OSLTCO)** – As used in sections 711 and 712 of the Act, means the organizational unit in a State or territory which is headed by a State Long-Term Care Ombudsman.6

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1 CA-04 Table 1: Part A https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
2 These codes are also referred to as “element numbers” in NORS Tables 1, 2, and 3. Links to NORS Tables are available here: https://ltcombudsman.org/omb_support/nors/nors-training
3 https://ltcombudsman.org/omb_support/nors
4 CA-04 Table 1: Part B - Complaint Data Components https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
5 CD-07 Table 1: - Complaint Data Components https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
6 45 CFR Part 1324 Subpart A §1324.1 Definitions
Ombudsman – A Swedish word meaning agent, representative, or someone who speaks on behalf of another. For the purposes of this manual, the word “Ombudsman” means the State Long-Term Care Ombudsman.

PEP Method (Point, Evidence, Repeat Point) - A method of specific communication skills and problem-solving approaches.

Perpetrator – Person(s) who appear to have caused the abuse, neglect, or exploitation.

Protection and Advocacy (P&A) - A system to protect and advocate for the rights of individuals with developmental disabilities; as designated by the State, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.).

Referral Agency - The agency or agencies to which a complaint was referred as part of the Ombudsman program’s plan of action for complaint resolution.

Representatives of the Office of the State Long-Term Care Ombudsman (Representatives) – As used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in §1324.19(a), whether personnel supervision is provided by the Ombudsman or his or her designees or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.

Setting – Description of where Ombudsman services are provided.

State Long-Term Care Ombudsman (Ombudsman, State Ombudsman) – As used in sections 711 and 712 of the Act, means the individual who heads the Office and is responsible personally, or through representatives of the Office, to fulfill the functions, responsibilities, and duties set forth in §1324.13 and §1324.19.

State Long-Term Care Ombudsman program (Long-Term Care Ombudsman program, the program, LTCOP) – As used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.
State Long-Term Care Ombudsman Programs Rule (LTCOP Rule) – The Federal Rule that governs the Long-Term Care Ombudsman program (45 CFR Part 1324).\textsuperscript{13}

Subsection Symbol (§) – The subsection symbol is used to denote an individual numeric statute or regulation (rule).

Systems Advocacy – Work to change a system (e.g., a long-term care facility, a government agency, an organization, a corporation, policies, regulations, and laws) to benefit long-term care residents.\textsuperscript{14}

\textsuperscript{14} https://ltcombudsman.org/uploads/files/support/systems-advocacy-ltco.pdf
Section 2:
Analysis and Planning
Long-Term Care Ombudsman Program Complaint Processing

**Trainer’s Note:** Allow at least 60 minutes for Section 2. Remind the trainees that Long-Term Care Ombudsman Program Complaint Processing was introduced in Module 7 and Stage 1 was covered in detail. This Module describes Stages 2 and 3 of Long-Term Care Ombudsman Program Complaint Processing. Review the Figure 1 chart once again.

Ombudsman Program Complaint Processing was introduced in Module 7 with Stage 1: Intake, Planning, Investigation, and Verification covered in detail. Representatives analyze the information gathered during intake and investigation and use it to develop a resolution strategy with the resident. This Module describes Stage 2: Analysis and Planning, and Stage 3: Implementation and Resolution. Remember, regardless of the facility or setting, representatives use the same complaint processing method to work towards complaint resolution.

**The Stages of Long-Term Care Ombudsman Program Complaint Processing**

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Intake, Planning, Investigation, and Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake</td>
<td>Receive problems, concerns, and complaints. Confirm the resident’s perspective of the problem. Determine if the problem or concern is a complaint as defined by the LTCOP.</td>
</tr>
<tr>
<td>Develop an Initial Plan of Action with the Resident</td>
<td>Advise resident of rights and discuss their desired outcome and possible solutions; obtain consent to act and consent to identify the resident when speaking with involved parties. Seek consent to access records when applicable. Determine who is responsible for all required actions within the plan.</td>
</tr>
<tr>
<td>Investigate</td>
<td>Collect information from interviews, observations, and records (when necessary).</td>
</tr>
<tr>
<td>Verify</td>
<td>Review information gathered. Determine if the complaint is generally accurate and if further action is needed. If no action is needed, complaint processing stops here, except for documentation.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 2</th>
<th>Analysis and Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analyze</td>
<td>Once the complaint is identified and verified, consider the root cause(s). If the complaint is not verified, but the resident’s perception of a problem exists, determine the root cause of the problem and if there is a need for LTCOP involvement.</td>
</tr>
<tr>
<td>Revisit the Plan of Action with the</td>
<td>Review the desired outcome and possible solutions. Determine if any changes need to be made to the plan of action.</td>
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</tbody>
</table>
Resident | Anticipate barriers to select an appropriate approach and identify alternative strategies if needed.

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<tr>
<th><strong>STAGE 3</strong></th>
<th><strong>IMPLEMENTATION AND RESOLUTION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Act</strong></td>
<td>Proceed with implementing the agreed-upon plan of action.</td>
</tr>
<tr>
<td><strong>Assess</strong></td>
<td>Check back with the resident and others involved to measure the progress of the plan. Determine if alternative actions need to be considered.</td>
</tr>
<tr>
<td><strong>Resolve</strong></td>
<td>Follow up to confirm with the resident that the complaint is resolved or partially resolved to their satisfaction.</td>
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</tbody>
</table>

## Analysis and Planning

*Trainer’s Note:* A case study was conducted in Module 7 demonstrating Stage 1 of Long-Term Care Ombudsman Program Complaint Processing. Use the information about Mrs. Bronner’s purse to preface this section. The module questions will walk trainees through analysis, planning, implementation, and resolution using the Mrs. Bronner case, so you may want to let them know this case will be discussed again at the end of the module.

### Case Study: Mrs. Bronner’s Purse

In Module 7 an investigation into Mrs. Bronner’s missing purse was conducted. Based on interviews and observation, here are the facts of the case:

- The Ombudsman program (LTCOP) has permission from Mrs. Bronner to talk to her daughter, Stephanie, and the Social Services Director, Anita.
- The missing purse is a brown handbag containing a wallet and special pictures.
- Mrs. Bronner keeps the purse on the chair, next to her bed.
- The purse is not in her room.
- Mrs. Bronner often misplaces her purse, usually leaving it in the dining room or the activity room.
- Neither Stephanie nor Anita have attempted to locate the purse.

Once a complaint has been investigated, you are ready to analyze the information gathered to determine the reason the problem occurred. The Mrs. Bronner case study in Module 7 shows the importance of identifying the underlying problem and understanding why the problem occurred as one may automatically assume the purse was stolen prior to investigating and gathering facts. This Module will explain Stages 2 and 3 using new case studies and the Module questions will review the Mrs. Bronner case study through both stages. The analysis and planning stage will enable you to prepare more effectively by defining potential solutions and identifying barriers that may be encountered.
There are two parts to the Analysis and Planning Stage:

1. Analyze the situation.
2. Revisit the plan of action with the resident.

**Analyze the Situation – Why Did the Problem Occur?**

The information you gather during an investigation should give you some idea about the cause of the problem. The investigation may reveal that the underlying or root problem is not the one that was reported to you. For example, you may have been told that articles of clothing are being stolen. During your investigation, you learn that clothing is simply not being returned from the laundry room. Therefore, the root of the problem is not an issue with theft, but laundry management.

Sometimes complaints that are not verified might still warrant further action on the part of the LTCOP. Those situations usually include when the resident, due to problems with memory or other cognitive issues, believes the complaint to be true even after your investigation proves otherwise. You may still work with the resident, and others, with the resident’s permission, to come up with a solution that would satisfy the resident.

**Example: Jessica**

Jessica complains to you that the facility does not bring her ice cream in the evening (it is in the care plan that Jessica gets ice cream every night before bedtime). The facility says that they bring it, but Jessica doesn’t remember eating it and accuses them of not providing it. Jessica’s daughter confirms with you this also happened when her mom lived with her and has witnessed it happening in the facility. You review case records and see that staff document bringing her ice cream. You cannot prove that Jessica isn’t getting ice cream. After brainstorming with the resident and facility staff, the staff have the idea to create a form for Jessica to choose the ice cream flavor and to initial it after receiving the ice cream. The form will be left in Jessica’s room for her to see any time. This will hold the facility accountable and will show Jessica that she did receive her ice cream. All parties, including Jessica, agree to the solution. On a future visit, you can visit with Jessica to see if the form has been helpful to her.

There is a lot to consider when determining the root cause of a complaint. You will learn what questions to ask through experience. You are not expected to memorize the following questions; rather, you may use this manual as a reference when processing a complaint. Thinking through the cause of a complaint leads to identifying potential solutions.
When determining the possible causes, consider the following:

- Was there an oversight on the part of facility staff?
- Was there deliberate retaliation against the resident?
- Is the problem related to the facility’s policies and procedures?
- Is there a problem with communication (e.g., are staff aware of the contents of the care plan, how is shift-to-shift communication, etc.)?
- Are there issues related to trust?
- Is the facility frequently short staffed?
- Does the staff spend the time necessary to address individual physical or mental needs?
- Does the resident need a different level of care than the facility is providing or is able to provide?
- Is the quality of care provided by staff related to the resident’s method of payment (e.g., Medicaid vs. private pay)?
- Are other residents part of the complaint (e.g., resident-to-resident mistreatment, bullying, roommate conflicts, etc.)?
- Are family members part of the complaint (e.g., interfering with care, or denying visitors)?

A thorough analysis includes considering each party’s perspective of the problem, including staff members involved. The facility’s explanations of the issue may also reveal possible barriers to resolution.

Examples of statements you might hear include:

- There is no problem.
- The problem is due to a “difficult” resident or family member.
- The facility’s action is based on medical/professional judgment.
- The care is as good as it can be considering the low rate of reimbursement.
- The facility meets regulations and has good inspection reports.

While you may not agree with the facility’s response, it is helpful to understand their point of view to know how to approach the situation from their perspective while investigating the problem from the resident’s standpoint.
CONSIDER THE CAUSES - WHO OR WHAT IS RESPONSIBLE FOR THE PROBLEM?

Knowing who or what is responsible for the problem is helpful when moving into the resolution stage.

The responsibility may rest with one or more of the following:
- Facility staff failed to perform their duties properly
- Facility policies and procedures are not person-centered
- State/federal regulations are vague or confusing regarding the issue(s) raised in the complaint(s)
- Third-party reimbursement programs may not pay for certain procedures, services, or items
- Independent professionals (e.g., doctor, physical therapist) may not provide appropriate services for residents
- The resident’s condition (e.g., adverse reaction to medication, dementia, etc.)
- Family members’ involvement (conflicting requests or concerns, interfering with care)
- Resident representative (absent, doesn’t represent the resident’s best interest, doesn’t respond to staff, etc.)

Use the information from your analysis of the situation to begin planning the next stage of complaint processing. Always keep the resident’s or complainant’s goals in mind.

Revisit the Plan with the Resident
When a complaint is verified and you understand the cause of the complaint as well as the facility’s response to the complaint, make sure you revisit the plan of action with the resident to determine if any modifications need to be made. Has anything changed or is there new information which affects the initial plan? When revisiting, you can develop another plan which includes the following factors.

Questions to help determine if the plan needs to change:
- Has the resident’s desired outcome changed?
- Are there new or different concerns?
- Has the resident’s desire to participate in actions related to resolving the problem changed?
- Does anyone else need to be involved?
- What might resolve the problem?
- What will it take to keep the problem from recurring?
- What possible solutions does the resident want to try first?
- What barriers might be encountered?
**Identify Barriers**

Once possible solutions are identified, anticipate barriers that might affect resolution. You do this by examining each potential solution and asking, “What barriers might be encountered when seeking this outcome?”

Using your list of potential solutions and barriers, think of other alternatives that can be used to achieve resolution. Remember that your list is not exhaustive, nor is it the only approach that will work. Sometimes there are several ways to resolve a problem. Be prepared with ideas and remain flexible to prevent barriers from ending a resolution discussion.

*Trainer’s Note: Refer trainees to the Figure 2 chart. Ask for a volunteer to read the 1st complaint. Ask for volunteers to read the potential barriers, suggestions, and potential solutions.*

*Ask for a volunteer to read the 2nd complaint. Ask for volunteers to read the potential barriers, suggestions, and potential solutions.*

*Ask the trainees to close their manuals. Read the last quote then ask the trainees to come up with potential barriers, suggestions, and potential solutions. Make sure the corresponding information in the chart is covered.*

### Identifying and Addressing Potential Barriers

<table>
<thead>
<tr>
<th>Complaints</th>
<th>Potential Solutions</th>
<th>Potential Barriers</th>
<th>Suggestions to Address Barriers</th>
</tr>
</thead>
</table>
| “I have to keep telling staff not to wake me up before 9:00 a.m.” | • Care plan reflects resident’s preferences and staff follow the care plan.  
• Consistent staff assignments.  
• Improved communication between staff. | • Care plan does not reflect the resident’s preferences and/or is not followed.  
• The rate of staff turnover is so high that consistent staff assignment is meaningless.  
• Administration does not want to do consistent assignments. | • Advocate for a care plan that reflects resident’s preferences and ask how staff will be informed and trained to ensure this preference is honored.  
• Share resources on consistent staff assignments, culture change, and care planning.  
• Encourage training on consistent staff assignments, culture change and care planning. |
“Staff keeps repositioning me in my wheelchair by pulling me up by my waistband or belt loops which rips my pants.”

- Staff are all trained to appropriately reposition all residents.
- Supervisors ensure proper techniques are followed.
- Staff are not trained on repositioning.
- Staff don’t apply training.
- There is no supervision or follow up after the training.
- Supervisors’ attitudes and expectations do not change to reflect a new approach.
- Encourage all staff to attend repositioning training.
- Determine how training will be applied to daily staff routines and addressed in supervision.
- Determine how staff will identify changes made.

“I can’t get the wrapping off of my meal when it is left on my bedside table.”

- Care plan reflects resident’s preferences and staff follow the care plan.
- Improved communication between staff.
- The care plan is completed without the input of the resident.
- Staff are not informed of the resident’s need.
- No one checks with the resident to see if they have eaten.
- Advocate for a care plan that is clear, specific, and understood by all.
- Ask how all staff will implement the care plan.
- Be sure the resident knows who to contact if concerns arise.
- Confirm implementation of agreed upon plan.

**IDENTIFY ALTERNATIVE STRATEGIES**

Once the plan of action has been determined and potential barriers are identified, you may need to discuss alternative strategies with the resident. This action is not always necessary but is beneficial when the initial strategies are unsuccessful. Because each case is different, there could be numerous potential strategies.

Alternative strategies may include, but are not limited to:
- involving different facility staff members
- involving other family or friends of the resident
- seeking the input of the resident’s physician or seeking a second opinion from another doctor
- referring the complaint to another entity, such as the state survey agency

**Analysis and Planning – Putting it Together**

*Trainer’s Note:* Show the 6-minute video “Anne Walker – Analysis and Planning” and ask the trainees the following questions. Make sure the appropriate responses are
addressed. The video refers to LTCOP Complaint Processing by its former name, “Ombudsman Program Problem-Solving Process” but the stages are still the same.

The following video addresses Stage 2 of LTCOP Complaint Processing: Analysis and Planning. Consider the questions below as you watch the video.

Watch the video: Anne Walker – Analysis and Planning\(^1\) and answer the following questions.

1. What options does Gloria present to Anne Walker to work towards resolution?
   \textbf{Answer:} The options are to either address the concern at the Resident Council meeting or to meet with Carol Lee, the Director of Nursing.

2. Is Gloria effective in facilitating the conversation between Ms. Walker and the Director of Nursing (DON), Ms. Lee? Why or why not?
   \textbf{Answer:} Yes, Gloria waits until Ms. Walker gives her a nonverbal cue to share her concerns and then provides an overview of Ms. Walker’s concerns. Once Ms. Walker feels comfortable speaking, she shares her perspective with Gloria’s support. Gloria makes sure all of Ms. Walker’s points are addressed, stresses her rights, and guides the conversation to a resolution Ms. Walker appreciates.

3. How does Gloria respond to the DON’s pushback on changing the bathing schedule?
   \textbf{Answer:} Gloria treats the DON with professional respect, reiterates the resident’s wishes, and reminds the DON of Ms. Walker’s right to have her showers at her preferred time.

4. Is there anything you would do differently in this scenario?

\textbf{Trainer’s Note:} Highlight how Gloria focuses her advocacy on Ms. Walker’s preferences and empowers Ms. Walker to share her experience as Gloria facilitates the meeting between Ms. Walker and Ms. Lee. The decision for Ms. Walker to verbalize her preferences to the DON instead of focusing on the written care plan is an effective strategy as it may be more convincing for staff to hear directly from the resident. Gloria focused on what is most important in this situation: the current shower situation, Ms. Walker’s wishes, how the aides interact with Ms. Walker, and how to ensure that her bathing preferences are upheld in the future.

\(^1\) This video clip is part of the \textit{Long-Term Care Ombudsman Program: Advocacy and Communication Skills Training Kit} developed by the Texas Department of Aging and Disability Services in coordination with the Texas Long-Term Care Ombudsman Program. Questions are from both the \textit{Long-Term Care Ombudsman Casework: Advocacy and Communication Skills Trainer Guide with Answers} and the Illinois State Long-Term Care Ombudsman Program Level 1 Training manual.
Section 3:
Implementation and Resolution
Trainer’s Note: Allow at least 60 minutes for Section 3.
The next step of Ombudsman Program Complaint Processing is Stage 3: Implementation and Resolution. During this stage, you will act on the developed plan, assess the effectiveness of the intervention, and attempt to resolve the complaint(s) to the satisfaction of the resident.

Prior to acting on behalf of the resident, check back with the resident to ensure you are still in agreement about what measures will be taken.

- Share all information gathered with the resident.
- Be sure the resident still wants your help.
- Determine the level of involvement from the resident, the resident representative, or anyone else when addressing the complaint(s).
- Confirm all individuals with whom you have permission to address the complaint(s) and if there are individuals with whom you may not address the complaint(s).
- Confirm the plan of action.
- Explain all potential outcomes of the plan of action.
- Verify the outcome the resident is seeking.

Implementation
Implementation is putting your plan of action into effect. The action taken depends upon the problem, the resident’s preferences, direction, and involvement.

The following are implementation options:
- no action needed;
- self-advocacy;
- direct advocacy;
- negotiation;
- mediation;
- represent the resident in an appeal hearing;
- referrals; and
- systems advocacy.

No Action Needed
Once the facts surrounding the complaint have been investigated and the circumstances surrounding the events described in the complaint have been explained to the resident, the resident may feel that no further intervention is necessary.

Self-Advocacy
Trainer’s Note: “Self-advocacy” will be discussed in more detail in this Module after the implementation options are covered.
If it is determined that action is needed, the first option to consider is self-advocacy when possible. This occurs when the resident is empowered to speak for themselves. Residents who self-advocate are able to ask for what they need and want, and to express their thoughts and feelings. Residents who advocate on their own behalf know their rights and responsibilities, speak-up for these rights, and are able to make choices and decisions that affect their lives.  

Self-advocacy will be discussed in greater detail later in this section.

**Direct Advocacy**

Direct advocacy is when a representative of the Office advocates on behalf of the resident with facility staff, a family member, or another entity responsible for the concern. Where possible, first utilize the techniques for self-advocacy and ask the resident to attend meetings with you, facility staff, and/or family members. During such meetings, give the resident an opportunity to express their concern(s) in their own words. It may be necessary for you to encourage facility staff and/or family members to listen to what the resident says.

**Negotiation**

*Trainer’s Note: “Negotiation” will be discussed in more detail in this Module after the implementation options are covered.*

Negotiation is a planned discussion to resolve an issue in a way that both parties find agreeable. If the findings of your investigation determine an agreement with facility staff or other relevant parties is necessary to resolve the problem to the resident’s satisfaction, you may use negotiation to achieve resolution. Because negotiation involves give and take from each party, you must be careful to never negotiate in a way that will weaken residents’ rights. Negotiation will be discussed in greater detail at the end of this section.

**Mediation**

When the complaint involves conflict between two or more residents, you may serve as an impartial mediator to help the conflicting parties reach an agreement to resolve the complaint.

Examples of when mediation can be used as an effective tool are when roommates have a dispute over the volume of the television or the temperature of the room and need to come up with an agreed-upon outcome.

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16 Texas State Long-Term Care Ombudsman Program Initial Certification Training
Represent the Resident in an Appeal Hearing

*Trainer’s Note:* Clarify with the trainees if residents in RCCs have rights to a fair hearing. Insert information if your state LTCOP represents residents in other types of hearings such as Medicaid eligibility.

All residents in nursing facilities have a right to a fair hearing when they disagree with the decision of a facility to issue a facility-initiated transfer or discharge. An appeal hearing is a process that allows both parties to explain their case. You may be instrumental in helping a resident assert their right to an appeal hearing in situations of transfer or discharge. Cases regarding transfers and discharges will be discussed in more detail in the next Module.

**Referrals**

Sometimes a resident may ask you to make a referral to another agency on their behalf. You may also coordinate referrals to agencies that provide services that are outside the scope of the Long-Term Care Ombudsman program (LTCOP), or if you need additional assistance to achieve resolution. Referral agencies are discussed in more detail in Module 8.

**Systems Advocacy**

→ *Reiterate your program’s policies and procedures regarding systems advocacy.*

There are complaints that require work to change a system (e.g., a long-term care facility, a government agency, an organization, a corporation, policies, regulations, and laws) to benefit long-term care residents. If a case requires changes to policies, laws, or regulations, contact your supervisor to learn how your program engages in systems advocacy.

**Self-Advocacy**

Representatives cannot be in the facility 24 hours a day, 7 days a week. It is imperative to encourage residents and provide them with knowledge and skills, so they are empowered to advocate on their own behalf. There are several ways in which the Ombudsman program can use empowerment to support self-advocacy. Some examples include the resident resolving the complaint on their own, with other residents, or with some assistance from the LTCOP. Encourage as much self-advocacy as the resident is comfortable doing.
Ombudsman Program Actions to Empower Resident Self-Advocacy

Figure 3

- **Educate residents on residents' rights.**
- **Support resident participation in their care and care plan.**
- **Coach residents in ways to negotiate with facility staff.**
- **Encourage residents to take their complaint to the Resident Council.**
- **Bring residents with similar concerns together to work on the problem.**
- **Encourage residents to use the facility grievance process.**

**Negotiation**

Negotiation focuses on interests rather than positions. **Interests** are what cause someone to make a decision, such as “I want to be treated with dignity and respect.” **Positions** are decided upon, such as “I don’t want male staff helping me with my shower.” When it comes to residents’ rights, **how** a resident right is met can be negotiated, but not **if** it is met.\(^\text{17}\) Figure 4 provides negotiation tips.

\(^{17}\) Texas State Long-Term Care Ombudsman Program Initial Certification Training
Ombudsman Program Negotiation

**Focus on interests, not positions**
- Determine each party’s interests.
- Find similarities.
- Avoid ultimatums.

**Separate the person from the problem**
- Focus on the complaint.
- Be aware of other’s perspectives.
- Don’t react to emotional outbursts.
- Phrase ideas in terms of problem-solving, not what someone should do.

**Look for options with mutual gain**
- Develop potential options to test.
- Look for options that allow both sides to gain.
- Be open to different options.
- Try to develop a win-win situation.

**Be objective**
- Base your point on laws, regulations, and experts.
- Apply logic, establish and verify facts.

*Trainer’s Note:* Use the negotiation examples to explain the negotiation tips in Figure 4.

**NEGOTIATION EXAMPLES**
The following examples describe the negotiation tips explained in Figure 4.

**Focus on Interests, not Positions**
“We agree residents need the best care possible. Let’s discuss what Mr. Tanaka needs to feel safe and secure in his home.”
Separate the Person from the Problem
“I know your facility strives to meet residents' needs. However, dinner trays left without providing help and removed without the resident being able to eat is a serious issue because they are not getting the nutrition they need. Let’s focus on ways to avoid this. It could help if the staff were clear about which residents need help with eating and drinking, whose responsibility it is to help, and how to assist the residents.”

Look for Options with Mutual Gain
“Based on our discussion, we agree Mr. Dillard needs more opportunities to move around and to be outdoors. In the past, a complaint was filed with the state survey agency after Mr. Dillard fell outside, and because you don’t want another complaint filed, you are concerned when Mr. Dillard goes outside by himself. Can we brainstorm some ideas about how his needs can be met while considering his safety and need for supervision?”

Use Objective Criteria
“I understand your concern that Mrs. Everett’s health will decline if she doesn’t take the medicine her doctor ordered. You have explained the consequences of her decision and offered other options. Nevertheless, you cannot discharge Mrs. Everett for exercising her right to refuse treatment.”

Activity: Putting Your Negotiation Skills to the Test

**Trainer’s Note:** Separate the trainees into groups of two and ask one of the trainees in each group to negotiate with the other to switch seats. Give them 5 minutes to do so. Ask each pair about the outcome of the negotiation.

If you are conducting this session virtually, ask the trainees to negotiate with you to end the training 15 minutes early. Give them 5 minutes to do so.

Developing a Professional Relationship with Facility Staff
To be an effective representative, one needs to build a professional working relationship with staff. Relationship building is key to conflict resolution and negotiation. In a professional relationship, everyone needs to feel safe and secure, to feel respected and valued, and to know their voice is heard. To achieve this, the representative must be self-assured, respectful, and have a good attitude.

**Trainer’s Note:** Explain that while the Figure 5 and 6 charts focus on relationship building with staff, many of the tips are also effective when building relationships with residents and family members.
## TIPS FOR ADDRESSING COMPLAINTS WITH FACILITY STAFF

**Figure 5**

<table>
<thead>
<tr>
<th>Do</th>
<th></th>
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<tbody>
<tr>
<td>Stick to the outcome that the resident wants without being sidetracked on other issues.</td>
<td></td>
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<tr>
<td>Start with the assumption that the other person has good intentions.</td>
<td></td>
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<tr>
<td>Consider your words, voice tone, and nonverbal communication such as posture, facial expressions, eye contact, and gestures.</td>
<td></td>
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<tr>
<td>Be assertive.</td>
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<tr>
<td>Know the applicable laws or regulations in case you have to use these to reach a resolution.</td>
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<tr>
<td>Be uncompromising on points that clearly violate laws or regulations.</td>
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<tr>
<td>Be prepared with examples of how other facilities have benefited from similar changes, if applicable.</td>
<td></td>
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<tr>
<td>Show how the changes will benefit the staff as well as the residents.</td>
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<tr>
<td>Offer staff clear reasons to change their minds—reasons that are important to them.</td>
<td></td>
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<tr>
<td>Allow staff to contribute to the resolution, identify actions, and make decisions.</td>
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<tr>
<td>Listen carefully to what is being said.</td>
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<tr>
<td>Restate to clarify and show understanding.</td>
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<tr>
<td>Have a plan in mind in case the staff does not identify an appropriate plan for resolution.</td>
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<tr>
<td>Persist in seeking resolution. If the facility refuses to agree to an acceptable resolution, inform them of your next step.</td>
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<tr>
<td>Set a time for follow-up to see if the resolution achieved the desired outcome.</td>
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</table>
The following video illustrates how a representative addresses conflict and negotiation. Consider the questions below as you watch the video.

Watch the video: Brian Brashear\(^{18}\) and answer the following questions.

**Trainer’s Note:** Show the 13-minute video on conflict and negotiation. Ask the following questions and make sure the correct responses are addressed.

1. What concerns does Mr. Brashear express in the video? Are all his concerns addressed?

   **Answer:** Mr. Brashear wants his friends to be able to visit him at any time and he fears being discharged from the facility. Mr. Brashear also says that some nurses ignore him. No, Gloria does not address how the nurses treat Mr. Brashear.

2. What does PEP stand for?

   **Answer:** Point, evidence, repeat point.

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\(^{18}\) This video clip is part of the Long-Term Care Ombudsman Program: Advocacy and Communication Skills Training Kit developed by the Texas Department of Aging and Disability Services in coordination with the Texas Long-Term Care Ombudsman Program. Questions are from both the Long-Term Care Ombudsman Casework: Advocacy and Communication Skills Trainer Guide with Answers and the Illinois State Long-Term Care Ombudsman Program Level 1 Training manual.
Trainer’s Note: PEP is discussed after the questions about the video.

3. How does Gloria address Mr. Brashear’s concerns regarding his rights and other residents’ rights when speaking with the Administrator, Mr. Cook? Is her approach effective?

Answer: Gloria is clear about Mr. Brashear’s right to visitors and asserts that Mr. Brashear and his guests understand they should not interfere with his roommate and other residents’ rights.

Gloria also points out that Mr. Brashear's roommate also enjoys the visits by Mr. Brashear’s friends.

Yes, Gloria’s approach is effective. She demonstrates that Mr. Brashear and his visitors respect the rights of others, yet Mr. Brashear’s right to visitors is not supported by the staff.

4. How does Gloria ensure her complaint investigation is resident-directed while reminding Mr. Cook of the need for resident-directed care and quality of life? How does this impact her credibility with Mr. Brashear and with Mr. Cook?

Answer: Gloria informs Mr. Brashear of how she wants to proceed and asks for his permission before speaking with the Administrator. She invites Mr. Brashear to come with her to talk to Mr. Cook.

She encourages Mr. Cook to speak directly with Mr. Brashear to assure him he isn’t being discharged. Her ability to remain objective and resident-directed enhances her credibility with both Mr. Brashear and Mr. Cook.

5. What is one improvement Gloria could have made during the discussion with Mr. Cook?

Answer: Although Gloria remained resident-directed in her actions while speaking with Mr. Cook, Mr. Brashear was clear in stating he wasn’t ready to speak with Mr. Cook and he preferred that Gloria go on her own. While it was helpful for her to suggest that Mr. Cook speak with Mr. Brashear directly to reassure him that he is not being discharged and his rights will be respected, she should have asked Mr. Brashear if he was ready to speak with Mr. Cook prior to asking Mr. Cook to come back to his room for them to discuss the issue together.

6. The video states that representatives should remain “calm, objective, and in control” at all times, especially when a situation escalates. When speaking with Mr. Cook, what techniques, both verbal and nonverbal, does Gloria use to maintain her professionalism?
**Answer:** Gloria keeps her hands in her lap and looks relaxed. She does not raise her voice or interrupt the Administrator. She is professional and courteous, but explicitly states Mr. Brashear’s concerns, his rights, and her concerns with the facility’s response. She acknowledges the challenges Mr. Cook deals with when running a long-term care facility and that they both have the same goal, to meet the needs of residents.

7. In the follow-up conversation with Mr. Brashear and Mr. Cook, how does Gloria demonstrate her support of Mr. Brashear when facilitating the conversation? Why is that important?

**Answer:** To open the follow-up conversation, Gloria clearly states Mr. Brashear’s concerns and paraphrases her previous conversation with Mr. Cook. After Mr. Brashear shares his perspective, Gloria echoes that she shared the concern regarding the Administrator’s suggestion about Mr. Brashear moving out. She persists until Mr. Cook assures them that Mr. Brashear will not be discharged and his rights to visitors will be supported. Gloria’s obvious support is important because it encourages Mr. Brashear to share his perspective.

8. Is there anything you would do differently in this scenario?

**Answer:** In addition to discussing the other concerns, Gloria could have asked more questions about the night nurse who ignores Mr. Brashear to see if that happens often and if other staff do the same thing.

**Trainer’s Note:** Emphasize how critical it is for representatives to do their homework and build their case before moving to resolution. Remind the trainees that Ombudsman program staff are available to support them when they need assistance (e.g., discussing a case before meeting with residents, family members, or staff). Prior to speaking with Mr. Cook, Gloria makes sure she has the information she needs. She understands residents’ rights and facility requirements and bases her actions on Mr. Brashear’s direction. Gloria knows what she wants to accomplish during the meetings. Due to her preparation, she stays on track, she is confident, and is an effective advocate.
**PEP METHOD: POINT, EVIDENCE, REPEAT POINT**

As demonstrated in the Brian Brashear video, a proven way to reach resolution that works in many types of situations is the PEP method. This method uses the communication skills and problem-solving approaches discussed throughout this training. The PEP method is focused, direct, and respectful of the other person.19

**Trainer’s Note:** Numbers 4 and 5 are information already covered in this Section. You don’t need to repeat the information but do point out that those steps are a part of the PEP Method.

1. **Get Your Message Across.**
   a. Provide a clear statement of the problem.
   b. Present the evidence you have gathered during the investigation. Start with the most factual evidence.
   c. Repeat your statement of the problem.

2. **Receive Feedback.**
   a. Listen attentively and reflectively.
   b. Do not interrupt.
   c. Do not argue.
   d. Find areas of agreement to incorporate into your argument.
   e. If the other person is defensive, it could mean they did not hear your message or that it was not presented clearly.

3. **Repeat the Process.**
   Persistence is the key. It may take 3 – 10 times through this process to change the other’s behavior.
   a. Do not back the other person into a corner.
   b. Allow the other person to retain their dignity.
   c. Do not expect willingness to address the problem. You are asking for changed behavior.
   d. Make sure the solutions meet the resident’s desired outcome.
   e. Arrange a time when you will check back with each other to make sure the solution is working.
   f. Express appreciation.

4. **Formulate an Action Plan.**
   Be sure you and the other person can agree on an action plan.
   a. How will the problem be solved?
   b. Who is responsible for making sure the plan is implemented?

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c. When will the plan be implemented?

5. **Monitor the Implementation of the Action Plan.**
   a. Make sure the resident is satisfied with the action plan.
   b. Keep checking with the resident to make sure the changes are being made.
   c. As needed, contact staff responsible for implementation.

**Assessment and Resolution**

At this point, you have analyzed the information collected during your investigation, verified the complaint(s), identified the root of the problem, identified possible barriers and ways to overcome them, and developed and implemented potential solutions.

Assessment requires checking back with the resident and/or complainant to measure the progress of the plan and to determine if alternative actions need to be considered. To determine if resolution is achieved, follow up to confirm with the resident that the complaint is resolved or partially resolved to their satisfaction.

While you always seek to resolve a problem to the satisfaction of the resident, achieving this goal is not always possible. Some complaints cannot be resolved. In other instances, complaint resolution is not always clear cut.

For instance, sometimes:

- a problem will go away and then reappear;
- only part of a complaint is resolved;
- the resident/complainant is not fully satisfied with the resolution, but there is nothing more that can be done by the Ombudsman program;
- the problem can’t be fully resolved due to lack of resources, a change in the resident’s condition, or the lack of specific regulations; or
- the resident/complainant is satisfied with the situation, but you want to pursue the matter further. It is important to remember, that although you may not be satisfied, it is the satisfaction of the resident/complainant that is relevant. Therefore, you would stop all advocacy efforts.

**Trainer’s Note:** *Don’t go into detail on resolution or disposition codes because they are discussed in more detail during Module 10.*

There are only three possible outcomes to complaint resolution.

1. Partially or fully resolved
2. No action needed or withdrawn
3. Not resolved
Watch the video: Anne Walker - Resolution and answer the following question.

**Trainer’s Note:** Show the video “Anne Walker – Resolution” and ask the trainees the following questions. Make sure the appropriate responses are addressed. At the end of the video, it shows Mrs. Walker walking with her arm around Gloria’s arm as if Gloria is providing support. Remind the trainees that these are actors, and a representative would not walk arm in arm with a resident to provide physical support.

1. What are some reasons to revisit a resident to ensure the resolution lasts?
   
   **Answers:** Reasons include changes in direct care staff, changes in management, changes with residents, and to identify new problems or systemic problems.

As you can see from the video, Gloria follows up with resident, Anne Walker, to ensure her complaints have been resolved. The best way to determine resolution is to go back and visit the resident to see if the resident is satisfied with the results. If the resident cannot communicate their satisfaction, then the representative should seek input from the resident representative and/or the complainant to determine if resolution has been met.

Despite barriers, the Ombudsman program resolves most complaints to the satisfaction or partial satisfaction of the resident or complainant. Representatives take a complaint as far as possible to accomplish the resident’s desired outcome.

Sometimes further action needs to be taken by an outside agency, whether at the beginning, middle, or end of a case. In these instances, a referral can be made to an outside agency. This is discussed in Module 9.

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20 This video clip is part of the Long-Term Care Ombudsman Program: Advocacy and Communication Skills Training Kit developed by the Texas Department of Aging and Disability Services in coordination with the Texas Long-Term Care Ombudsman Program. Questions are from both the Long-Term Care Ombudsman Casework: Advocacy and Communication Skills Trainer Guide with Answers and the Illinois State Long-Term Care Ombudsman Program Level 1 Training manual.
Section 4:

Conclusion
Module 8 Questions

**Trainer’s Note:** Allow approximately 20 minutes for this section. Ask the following questions and make sure the correct answer is discussed. Use Mrs. Bronner’s Purse case study from Module 7 to cover the rest of complaint processing.

**Case Study: Mrs. Bronner’s Purse**

Stage 2 of Ombudsman Program Complaint Processing is Analysis and Planning.

1. The problem is a missing purse. Based on the information you gathered, what is the likely cause of the missing purse?

   **Answer:** Mrs. Bronner likely misplaced her purse.

2. To develop a plan of action with Mrs. Bronner, what questions do you ask her to determine her desired outcome? Think of all possible outcomes and anticipate obstacles.

   **Possible responses** — “Do you want to go together with me to Anita’s office to see if she has located your purse?” “I understand you have misplaced your purse before; do you want to talk with Anita about coming up with a plan to make sure your purse doesn’t get misplaced in the future?” “What do you want to do if we cannot find your purse?”

Mrs. Bronner tells you she wants both of you to go to Anita’s office to find out if she has found her purse. You meet with Anita, and she looked but has not found the
purse. Mrs. Bronner begins to cry. Anita said she will look one more time and will come down to Mrs. Bronner’s room to talk with her.

You and Mrs. Bronner return to her room. What questions do you ask her now to find out what she wants to do knowing her purse is still not found?

**Possible responses** – “What do you want to do if we cannot find your purse?” Do you want to come up with a plan to make sure your purse doesn’t get misplaced in the future?”

Mrs. Bronner says if her purse is not found, she wants a new one. She also says that she wants her daughter to bring her more pictures and a new wallet to keep in her new purse. Mrs. Bronner says she wants you to work with Anita to come up with a plan to make sure her purse stays with her and does not get lost.

**Stage 3 of the Ombudsman Problem Solving Process is Implementation and Resolution.**

3. How do you proceed with implementing the agreed-upon plan of action?

**Responses may include** - “Follow up with Anita to see if her second attempt to locate the purse was successful.” “Talk with Anita and Stephanie to determine who will get Mrs. Bronner a new purse if the other purse is not located.” “Talk with Stephanie about bringing the items Mrs. Bronner requested.” “Schedule a meeting to determine what can be done to assure Mrs. Bronner doesn’t continue to misplace her purse.” “Make sure Mrs. Bronner is included in the meeting and is agreeable to the plan.”

4. How do you measure the progress of the plan?

**Answer:** Follow up with all parties involved and determine what has or has not been accomplished.

5. How do you know if the complaint is resolved?

**Answer:** When Mrs. Bronner has a purse and is satisfied with the outcome.
Module 8 Additional Resources

**PEP Method** [https://issuu.com/consumervoice/docs/pep_method](https://issuu.com/consumervoice/docs/pep_method)

*The Resident Advocate* is a newsletter for residents of long-term care facilities.

It provides:
- Information on residents' rights and care issues
- News and updates on national policy
- Self-advocacy tips for obtaining person-centered, quality care

[https://theconsumervoice.org/issues/recipients/nursing-home-residents/resident-advocate](https://theconsumervoice.org/issues/recipients/nursing-home-residents/resident-advocate)

**Negotiation**

“Getting to Yes” the video.
[https://youtu.be/VCXsiCpfXqg](https://youtu.be/VCXsiCpfXqg)

**Mediation**

*Uses of Mediation in Assisted Living – And Some Advice Thrown In: An Ombudsman Training*
Prepared by the National Association of State Units on Aging (now ADvancing States)
# Table of Contents

Module 9 State-Specific Information.................................................................................................................. 2
Section 1: Welcome and Introduction.................................................................................................................. 4
Section 2: Challenging Complaints .................................................................................................................... 11
Section 3: Additional Referral Agencies ........................................................................................................... 34
Section 4: Conclusion.......................................................................................................................................... 40

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Module 9 State-Specific Information

The list below outlines state-specific information for trainers to discuss, provide a link to, or add directly to the Trainer Guide, Trainee Manual, and/or PowerPoints. When you get to the point in the training where you need to discuss, include a link to, or add state-specific information, you will see a **bold, blue arrow (➔)** and a brief description of what to include.

➔ State-Specific Information

**Section 2 Difficult Cases**

- Include state-specific requirements for each type of residential care community (RCC) regarding reporting and investigating allegations of abuse, neglect, and exploitation (ANE). Clarify whether all RCC staff and other contracted service providers are mandated reporters.

- Indicate the state agency(ies) responsible for investigating ANE for each facility type.

- Include your procedures for filing complaints with the state survey agency for each type of facility. Include the contact information of the State Survey Agency(ies), information to be included in the referral, and required forms (paper or electronic) as applicable.

- Explain whether Adult Protective Services (APS) investigates ANE in long-term care facilities in your state. It could depend on the facility type or where the ANE allegedly occurred, or whether the alleged perpetrator is a staff member, a family member, or a visitor. Explain the relationship your program has with APS, including when and how you would make a referral.

- Explain your state’s policies and procedures on when and how a referral would be made to law enforcement, including the Medicaid Fraud Control Unit and any other offices within the Attorney General’s office.

**Section 3 Additional Referral Agencies**

- Include the name(s) of the legal assistance program(s) in your area and discuss when and how you would make a referral.

- Include the name of the Protection and Advocacy (P&A) entity in your area and explain the relationship your program has with the P&A, including when and how you would make a referral.
• Add state-specific contact information for the entity or entities that provide guardianship or conservatorship, other than private guardians/conservators. Those entities could be state or county guardians, for example.

• Include state-specific information about when and how to contact the Aging and Disability Resource Center (ADRC) in your area.

• Include state-specific information about the Money Follows the Person program (if applicable in your state).

• Include the contact information for the agency responsible for Home and Community-Based Services (HCBS) in your area and explain the relationship your program has with them, including when and how you would make a referral.

• Include the contact information for the Centers for Independent Living (CILs) in your area and explain the relationship your program has with the CILs, including when and how you would make a referral.

• Include information about the State Health Insurance Assistance Program (SHIP) in your state and explain the relationship your program has with SHIP, including when and how you would make a referral.

• Include information about the Senior Medicare Patrol program (SMP) in your area and explain the relationship your program has with the SMP, including when and how you would make a referral.
Section 1:
Welcome and Introduction
Welcome

*Trainer’s Note:* Allow at least 15 minutes for Section 1.

Begin the session by welcoming the trainees to the training session and thanking them for their interest in the program. Make sure everyone introduces themselves – even if they come late.

To begin, please share:

- Your name
- Where you are from
- One thing you learned from Module 8 - something that really stuck with you or surprised you
- What you hope to learn since the last module

After introductions, thank the trainees for their information and explain any housekeeping items that need to be addressed including the time frame of the training day, breaks, location of restrooms, refreshments, etc. Ask the trainees to speak up if they have any questions throughout the training.

Welcome to Module 9 of certification training, **Challenging Complaints and Referral Sources**. Thank you for being here to learn more about the Long-Term Care Ombudsman program and the certification process.

**Module 9 Agenda**

*Trainer’s Note:* The time frames for each Section are approximate. Allow at least 3 hours for this session.

**Optional Prework:** Prior to meeting for classroom training ask the trainees to read about one of the referral agencies/entities and be ready to share one or two facts about the agency/entity.

Section 1: Welcome and Introduction *(15 Minutes)*
Section 2: Challenging Complaints *(90 Minutes)*
BREAK *(15 Minutes)*
Section 3: Additional Referral Agencies *(45 Minutes)*
Section 4: Conclusion *(15 Minutes)*
Module 9 Learning Objectives

*Trainer's Note: Go over the Module 9 learning objectives.*

After completion of Module 9 you will understand:

- Common challenges when investigating complaints involving facility-initiated discharges and available resources
- The role of the Long-Term Care Ombudsman program (LTCOP) and other entities when complaints of abuse, neglect, and exploitation are made
- The various referral agencies utilized by the LTCOP and how they assist individuals
Module 9 Key Words and Terms

The key words and terms are defined as they are specifically applied to the Ombudsman program and are found throughout this Module. Take a moment to familiarize yourself with this important information.

Abuse – Any willful mistreatment of residents by facility staff, resident representative/family/friend, other residents, or an outside individual. There are three categories of abuse: physical, sexual, and psychological.¹

Adult Protective Services (APS) – A social services program provided by state and local governments serving older adults and, in some states, adults with disabilities who need assistance because of abuse, neglect, self-neglect, or financial exploitation.²

ANE – Abuse, neglect, and exploitation.

Case – Each case must have a minimum of one complaint. A case must contain a complainant, complaint code(s), a setting, verification, resolution, and information regarding whether a complaint was referred to another agency. For abuse, neglect, and exploitation codes, a perpetrator code is also required.³

Code – An alphanumeric assignment to a data element of a case (e.g., complaint code, verification code, disposition code, etc.).⁴

Complainant – An individual who requests Ombudsman program complaint investigation services regarding one or more complaints made by, or on behalf of, residents.⁵

Complaint – An expression of dissatisfaction or concern brought to, or initiated by, the Ombudsman program that requires Ombudsman program investigation and resolution on behalf of one or more residents of a long-term care facility.⁶

Complaint Disposition (Resolution) – Final resolution or outcome of the complaint.

Complaint Verification (Verification) – Confirmation that most or all facts alleged by the complainant are likely to be true.⁷

Complaint Visit – An Ombudsman program visit to a facility in response to a complaint when only complaint-related activities are conducted.

³ CA-02 Table 1 Part A https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
⁴ These codes are also referred to as “element numbers” in NORS Tables 1, 2, and 3. Links to NORS Tables are available here: https://ltcombudsman.org/omb_support/nors/nors-training
⁵ https://ltcombudsman.org/omb_support/nors
⁶ CA-04 Table 1: Part B - Complaint Data Components https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
⁷ CD-07 Table 1: - Complaint Data Components https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
Confidentiality – Federal and state laws mandate that the Long-Term Care Ombudsman program keep all identifying information about a resident and a complainant private, within the LTCOP.

Discharge – The movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.\(^8\)

Facility-Initiated Transfer or Discharge – A transfer or discharge to which the resident objects, which did not originate through a resident’s verbal or written request, and/or is not in alignment with the resident’s stated goals for care and preferences.\(^9\)

Financial Exploitation (Exploitation) – The illegal or improper use of an individual’s funds, property, or assets for another person’s profit or advantage.\(^10\)

Gross Neglect (Neglect) – The failure to protect a resident from harm or the failure to meet their needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living, or shelter, which results in a serious risk of compromised health and/or safety, relative to age, health status, and cultural norms.\(^11\)

Informed Consent – The permission from a resident or a resident representative after a full explanation has been given of the facts, options, and possible outcomes of such options in a manner and language in which the resident or resident representative understands.

Law Enforcement – People employed by a local, state, tribal, or federal justice agency. This includes police, courts, district attorney’s office, probation, or other community corrections agency, and correctional facilities; including the State Medicaid Fraud Control Unit, as defined in section 1903(q) of the Social Security Act (42 U.S.C. 1396b(q)).\(^12\)

Legal Services – Entity or individual attorney providing legal representation and/or consultation to residents including but not limited to legal services funded through Older Americans Act or Legal Services Corporation funds, Ombudsman legal counsel, or any other attorney.

Long-Term Services and Supports (LTSS) – Services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting

\(^12\) CD-06 Table 1 Part C https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
of their choice, which may include the individual’s home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.\(^{13}\)

**Mandated (or Mandatory) Reporter** – An individual who holds a professional position or license that requires them to report known or suspected abuse to the appropriate state agency.

**National Ombudsman Reporting System (NORS)** – The uniform data collection and reporting system required for use by all State Long-Term Care Ombudsman programs.

**Office of the State Long-Term Care Ombudsman (Office, OSLTCO)** – As used in sections 711 and 712 of the Act, means the organizational unit in a State or territory which is headed by a State Long-Term Care Ombudsman.\(^{14}\)

**Ombudsman** – A Swedish word meaning agent, representative, or someone who speaks on behalf of another. For the purposes of this manual, the word “Ombudsman” means the State Long-Term Care Ombudsman.

**Protection and Advocacy (P&A)** - A system to protect and advocate for the rights of individuals with developmental disabilities; as designated by the State, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.).\(^{15}\)

**Resident-Initiated Transfer or Discharge** – Means the resident or, if appropriate, the resident representative, has provided verbal or written notice of intent to leave the facility. Leaving the facility does not include the general expression of a desire to return home or the elopement of residents with cognitive impairment.\(^{16}\)

**Referral Agency** - The agency or agencies to which a complaint was referred as part of the Ombudsman program’s plan of action for complaint resolution.\(^{17}\)

**Representatives of the Office of the State Long-Term Care Ombudsman (Representatives)** – As used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in §1324.19(a), whether personnel supervision is provided by the Ombudsman or his or her designees or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.\(^{18}\)

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\(^{13}\) [https://www.law.cornell.edu/cfr/text/42/438.2](https://www.law.cornell.edu/cfr/text/42/438.2)

\(^{14}\) 45 CFR Part 1324 Subpart A §1324.1 Definitions


\(^{17}\) CD-06 Table 1 Part B – Complaint Data Components [https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf](https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf)

\(^{18}\) 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule
State Long-Term Care Ombudsman (Ombudsman, State Ombudsman) – As used in sections 711 and 712 of the Act, means the individual who heads the Office and is responsible to personally, or through representatives of the Office, fulfill the functions, responsibilities and duties set forth in §1324.13 and §1324.19.

State Long-Term Care Ombudsman program (Long-Term Care Ombudsman program, the program, LTCOP) – As used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.¹⁹

State Long-Term Care Ombudsman Programs Rule (LTCOP Rule) – The Federal Rule that governs the Long-Term Care Ombudsman program (45 CFR Part 1324).²⁰

Subsection Symbol (§) – The subsection symbol is used to denote an individual numeric statute or regulation (rule).

Transfer – The movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility.²¹

¹⁹ 45 CFR Part 1324 Subpart A § 1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule
Section 2:
Challenging Complaints
There is a significant variety of complaints as residents’ needs and preferences vary. Some complaints are complex and take a long time to reach a resolution and others are simpler and are closed within a visit or a few days. While every case is different, there are some issues that are particularly challenging. For example, cases involving discharge or abuse, neglect, and/or financial exploitation (ANE) are often more difficult than others. This module will review examples of difficult cases and the role of potential referral sources when the Ombudsman program needs to refer a complaint as part of the plan for resolution.

Discharge Complaints

**Trainer’s Note:** Explain that the definitions of transfer and discharge may vary for residential care communities (RCCs), depending on state regulations. Remind the trainees that they are not expected to memorize this material and they will not be alone while working with residents on these difficult cases.

The terms “transfer” and “discharge” are often used together or interchangeably to mean relocating a resident. However, they have very different meanings. In general, a discharge happens when a resident decides to move out of the facility or when the facility initiates a discharge against the resident’s wishes. Discharge complaints usually occur when the resident does not want to leave the facility, but the facility attempts to discharge them against their will. In general, transfers happen when a resident is moved from one facility to another and is expected to return to the original facility. Complaints about transfers are not as common as complaints about discharges.

Residential Care Communities (RCCs)

While there are state rules and/or regulations for residential care communities, there are no federal regulations. It is likely that state requirements for RCCs differ from the federal regulations for nursing facilities. If your state has multiple RCC types, then there may be separate state requirements pertaining to each specific facility type.

**Trainer’s Note:** Explain to the trainees how they will learn more about state regulations related to discharges in RCCs. You may have additional training and/or resources on the topic. The point of this section is to give them an initial foundation about discharge complaints.
Differing rules and/or regulations for RCCs may mean different:

- Definitions or terminology
- Reasons for discharge
- Notification requirements for residents and the LTCOP

Despite the lack of federal requirements for RCCs, similar Long-Term Care Ombudsman program (LTCOP) advocacy strategies can be applied in these settings. In addition, you will find that many of the issues related to discharge complaints are the same as the issues residents experience in nursing homes.

Learn more about transfers and discharges in RCCs, here and here.

Nursing Facilities

There are several reasons discharge cases can be complicated. To begin with, federal and state regulations are not always the same. Nursing facilities are required to follow the nursing facilities federal regulations and state regulations pertaining to nursing facilities.

Nursing facilities federal regulations distinctly clarify the terms transfer and discharge as noted in the sidebar on the left. *(Trainer’s Note: Go over the definitions of discharge and transfer.)* In addition to transfer and discharge definitions, it is important to understand who initiated the transfer or discharge and why it is relevant (definitions included in the sidebar on the left).

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23 https://consumervoice.app.box.com/s/j4rwm0sgzyijhv7gf0go7onx327q0pi
**Trainer’s Note:** Go over the definitions of Facility-Initiated and Resident-Initiated.  

As discussed in Module 4, there are only six specific reasons nursing facilities may discharge a resident:

- The facility cannot meet the resident’s needs
- The resident no longer needs the services provided by the facility
- The resident endangers the safety of individuals in the facility
- The resident endangers the health of individuals in the facility
- The resident fails to pay for their stay at the facility
- The facility closes

Discharges are complicated cases. **It is not expected that new, or even experienced representatives, manage such cases without guidance and supervision.** Representatives need a strong working knowledge of federal and state requirements and Ombudsman program policies, including when to consult your supervisor and/or Ombudsman on a complaint.

**What makes discharge cases difficult?**

Each case is different and has its own challenges. Some reasons discharge cases are difficult could be:

- Federal and state regulations may be interpreted differently by different parties, or individuals may not understand the regulations
- By the time a facility issues a discharge notice, the root cause(s) may have been going on for months and can be hard to resolve in a short period of time
- Most residents and family members experience feelings of anger, fear, sadness, and anxiousness when told the facility is attempting to discharge the resident against their wishes
- Multiple problems occurring at the same time
- The facility doesn’t follow regulations pertaining to discharge or other areas related to the problem
- The resident’s representative is not fulfilling their fiduciary duties
- Investigations are time-consuming

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Some discharges may seem to have a valid reason, such as non-payment. However, through investigation you may find that the resident doesn't know they are in arrears. If the resident representative is responsible then the root cause could be miscommunication, misunderstanding, mismanagement, or financial exploitation.

Here’s another example of a discharge that may seem valid on the surface:

_The LTCOP receives a call from Mary Lou, the wife of a resident named Jerry, who received a notice of discharge for hitting a resident. Mary Lou admitted Jerry has been striking out when he gets angry. The discharge notice says that Jerry endangers the safety of individuals in the facility. You know this is a valid reason for discharge. However, after investigating the matter through interviews and record reviews, you notice that Jerry has a history of urinary tract infections (UTI) that, if left untreated, result in Jerry striking out. The care plan states that if any signs or symptoms of a UTI are present, the physician should be notified. You see that the symptoms of blood in his urine and a fever are charted for the last week. However, the facility did not follow the care plan and instead issued a notice of discharge._

All issues above could have been prevented if the facility would have followed the care plan. If the facility would have contacted the physician, Jerry wouldn’t be in pain and in danger of the infection becoming worse, and the resident may not have been hit. The facility must follow the care plan and must make every effort to ensure the safety and well-being of all residents in the facility.

Due to possible reasons (valid or not) for discharge and the multiple regulations involved, it is time-consuming to research and investigate. The LTCOP often refers residents to legal assistance programs (discussed later in the Module) to represent them or to help resolve other legal concerns related to the discharge.

_Trainer’s Note: Refer to the Advocacy Toolbox resource below. Explain that it will be useful when working on complaints about discharges. When mentioned, review the Basic Discharge Complaint Investigation Process Checklist (by clicking the hyperlink), and point out that the checklist (as well as the Advocacy Toolbox) follows the stages of Long-Term Care Ombudsman Complaint Processing._

To assist Ombudsman programs when working with nursing facility residents who are facing a facility-initiated discharge, the National Ombudsman Resource Center developed a resource titled, _Enhancing Your Advocacy Toolbox: Protecting Residents from Nursing_
Facility-Initiated Discharges (Advocacy Toolbox).25 The Advocacy Toolbox is based on federal requirements for certified nursing facilities. This is a resource for you to use once you are certified and have gained experience working in the field.

The Advocacy Toolbox includes charts with resolution strategies, action steps, and the legal basis to address common discharge reasons. Review the chart that is used regardless of the reason for transfer/discharges called Basic Discharge Complaint Investigation Process Checklist.26

Here is an excerpt from page one of three of the chart:

First, the representative educates and empowers the resident by explaining residents’ rights and options.

At a minimum:

- Shares information about the Ombudsman program and how it can help
- Discusses residents’ rights and facility responsibilities related to discharges
- Explains possible advocacy steps (e.g., speaking with the facility staff about the discharge)
- Informs the resident of their right to appeal the notice and the hearing process
- Explains how to access legal counsel
- Offers to assist the resident to resolve the complaint

If the resident provides consent for the Ombudsman program to investigate, the representative then develops an agreed upon plan of action with the resident and follows the wishes of the resident.

The plan could include, but is not limited to:

- Permission to access the resident’s records
- Permission to speak with any necessary party to assist with preventing the discharge
- Request for a care plan meeting and/or a request for a second opinion on a diagnosis
- Appealing the discharge notice
- Referral for legal assistance

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You can see from the Figure 1 chart how the Basic Discharge Complaint Investigation Checklist follows Long-Term Care Ombudsman Program Complaint Processing Stage 1: Intake, Planning, Investigation, and Verification discussed in Module 7.

Figure 1

<table>
<thead>
<tr>
<th>Ombudsman Program Complaint Processing Stage 1</th>
<th>Basic Discharge Complaint Investigation Checklist:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intake</strong></td>
<td>• Begins once the LTCOP receives discharge complaint.</td>
</tr>
<tr>
<td><strong>Initial Plan Development</strong></td>
<td>• Directs the LTCOP to advise resident of rights related to discharges, right to appeal, right to legal counsel, offer to assist resident with complaint resolution.</td>
</tr>
<tr>
<td></td>
<td>• Guides the LTCOP to request a care plan meeting, a second opinion, an appeal of the discharge notice, a referral for legal assistance, a request for permission to access records, and to speak with necessary parties.</td>
</tr>
<tr>
<td><strong>Investigate</strong></td>
<td>• Suggests questions to ask residents and staff members</td>
</tr>
<tr>
<td></td>
<td>• Explains potential resolution strategies and action steps.</td>
</tr>
<tr>
<td></td>
<td>• Provides the legal basis for the LTCOP’s resolution strategies and action steps.</td>
</tr>
<tr>
<td><strong>Verify</strong></td>
<td>• Determines interview questions help clarify verification.</td>
</tr>
</tbody>
</table>

This information is an introduction to discharge issues. Additional training is available to help you respond to complaints about transfers and discharges. Remember you have support from the LTCOP and your supervisor to address challenging cases in addition to outside resources and referral agencies.
**Trainer's Note:** Because this information is hard to learn and potentially emotional, take a short break here and recommend trainees get up and move around for 5-10 minutes.

**Allegations of Abuse, Neglect, & Exploitation and the Role of the Ombudsman Program**

Every resident has a right to be free from abuse, neglect, and exploitation (ANE). The Ombudsman program is required to follow the Older Americans Act (OAA) and the Long-Term Care Ombudsman Programs Rule (LTCOP Rule) regarding confidentiality and disclosure and the unique role representatives of the Office have as resident-directed advocates. The OAA and LTCOP Rule requirements apply to Ombudsman program advocacy in all facility types.

As discussed in Module 1, **representatives are not mandated reporters and shall not report without proper permission.** The LTCOP Rule [§1324.19 Duties of the representatives of the Office (b)(3)(iii)] indicates the LTCOP shall not report suspected abuse, neglect, or exploitation of a resident unless a resident or resident representative (as applicable) has communicated informed consent.27

Federal disclosure requirements for the Ombudsman program do not change when the LTCOP receives a complaint about abuse, neglect, or exploitation of a resident. Regardless of the complainant, representatives are directed by resident goals for complaint resolution.

**Confidentiality**

**Trainer's Note:** Include an example of how you maintain confidentiality.

Respecting resident confidentiality is critical not only to maintain compliance with program requirements, but also to adhere to the fundamental LTCOP role as resident advocates, maintain the integrity of the LTCOP, and foster trust between the representatives and residents.28 Maintaining confidentiality in response to complaints involving abuse, neglect, and exploitation is a challenging, complex situation that requires careful analysis and often, consultation with your supervisor.

[27](#) except as set forth in paragraphs (b)(5) through (7) of this section, notwithstanding State laws to the contrary.

Recognizing Abuse, Neglect, and Exploitation (ANE)

It is important for you to know how to recognize and respond to allegations of ANE. Having a thorough understanding of your responsibilities as a representative of the Office about when and how to report it is crucial. **Representatives do not determine whether ANE occurred for the purposes of legal action or facility compliance with federal or state requirements.** This is the responsibility of the state survey agency and/or law enforcement, or in some states, Adult Protective Services (APS).

**Abuse**

The LTCOP describes abuse as any willful mistreatment of residents by facility staff, resident representative/family/friend, other residents, or an outside individual.29 There are three types of abuse: physical, sexual, and psychological.

- **Physical abuse** is defined as the intentional use of physical force that results in acute or chronic illness, bodily injury, physical pain, functional impairment, distress, or death (e.g., hitting, slapping, pinching, kicking, etc. and/or controlling behavior through corporal punishment).

- **Sexual abuse** is defined as forced and/or unwanted sexual interaction (touching and non-touching acts) of any kind.

- **Psychological abuse** is defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. This includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment.

Examples of abuse may include:
- A staff member slaps a resident
- A physical therapist tells a resident they will never see their family again if they don’t comply with physical therapy
- A staff member yells at a resident who did not make it to the restroom in time
- A CNA pinches a resident’s arm to get them to move out of the way
- A manager shows a resident a video containing nudity, making the resident uncomfortable

**Neglect (Gross Neglect)**

For the purposes of the LTCOP, neglect and gross neglect are used interchangeably. It is the failure to protect a resident from harm or the failure to meet needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living, or shelter, which results in a serious risk of compromised health and/or safety, relative to

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29 NORS Table 2 Complaint Codes and Definitions. [https://ltcombudsman.org/uploads/files/support/NORS_Table_2_Complaint_Code_10-31-2024.pdf](https://ltcombudsman.org/uploads/files/support/NORS_Table_2_Complaint_Code_10-31-2024.pdf)
age, health status, and cultural norms. Review examples of neglect and the effects on residents in the Figure 2 chart below.

Figure 2

<table>
<thead>
<tr>
<th>Cause</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect body positioning leading to…</td>
<td>contractures(^{30}) and pressure sores/pressure ulcers.</td>
</tr>
<tr>
<td>Failure to assist with toileting and/or not changing a disposable brief in a timely manner, leading to…</td>
<td>a resident falling while going to the bathroom alone; a resident sitting in urine or feces which can cause skin breakdown; feelings of shame, indignity, and distress for the resident.</td>
</tr>
<tr>
<td>Lack of assistance eating or drinking leading to…</td>
<td>malnutrition and dehydration.</td>
</tr>
<tr>
<td>Lack of assistance with walking leading to…</td>
<td>immobility.</td>
</tr>
<tr>
<td>Poor hand washing techniques leading to…</td>
<td>infection.</td>
</tr>
<tr>
<td>Lack of assistance with participating in activities of interest leading to…</td>
<td>withdrawal and isolation.</td>
</tr>
<tr>
<td>Ignoring call lights or cries for help leading to…</td>
<td>residents having unnecessary pain, anxiety, increased falls, and losing bladder or bowel control.</td>
</tr>
</tbody>
</table>

**Exploitation (Financial Exploitation)**

For the purposes of the LTCOP, exploitation and financial exploitation are used interchangeably. It is the illegal or improper use of an individual’s funds, property, or assets for another person’s profit or advantage.

Examples of financial exploitation may include:

- Misappropriating income or assets. An individual who obtains access to social security checks, pension payments, checking or savings accounts, credit cards, or ATM (debit) cards, or withholds money and uses the funds for their own benefit.

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\(^{30}\) According to Merriam-Webster Dictionary, a contracture is a permanent shortening (as of muscle, tendon, or scar tissue) producing deformity or distortion.
An aide who provides care to a resident offers to go to the store to buy snacks for the resident. The resident gives the aide a debit card and personal identification number. The aide purchases additional items for themself.

- Charging excessive fees for goods and services.
  - A friend of the resident charges them $200 every week to bring in the resident’s dog for a visit.

- Obtaining money or property by undue influence (e.g., using a position of power to take advantage), misrepresentation, or fraud, often using manipulation and threats.
  - A family member pressures a resident into signing over their home and other assets saying they will stop visiting the resident if they do not do what the family member tells them to do.

- Improper or fraudulent use of power of attorney or legal authority.
  - A resident representative borrows money to buy a boat using the resident’s name without the resident’s permission to do so.

The Ombudsman Program and Complaints about Abuse, Neglect, and Exploitation

The Ombudsman program investigates ANE solely for gathering necessary information to resolve the complaint to the satisfaction of the resident, not to determine whether any law or regulation has been violated for purposes of a potential civil or criminal enforcement action. According to the LTCOP Rule, the Ombudsman program investigates complaints related to abuse, neglect, or exploitation, “for the purposes of resolving the complaint to the resident's satisfaction and of protecting the health, welfare, and rights of the resident.” Therefore, the LTCOP is not the finder of fact, meaning the LTCOP investigation is not for the purposes of determining if the ANE occurred.

After receiving resident consent when investigating a complaint regarding ANE, representatives may:

- Explain residents’ rights and the LTCOP role
- Assist a resident with reporting abuse, neglect, and exploitation
- Meet with residents, including Resident Council members to find out if others have the same or similar experience (without breaking confidentiality)
- Meet with family members, including Family Council members to determine if they have concerns about residents experiencing ANE (without breaking confidentiality)
- Work with the facility to ensure residents feel safe
- Ensure the facility makes efforts to protect residents from further harm
• Follow up with the facility to determine if proper reporting of ANE has been completed (staff ARE mandated reporters)
• Research the facility’s abuse, neglect, and exploitation history if unknown

As with all LTCOP work, advocacy strategies in response to allegations of abuse vary depending on the situation (e.g., type of abuse allegation, type and size of long-term care setting, identity of the perpetrator- family member, visitor, facility staff or another resident). For example, a LTCOP representative’s approach in response to an allegation of abuse in a small personal care home may differ from their approach in response to a similar allegation in a large nursing facility. The advocacy strategies we will discuss during this training are not comprehensive, but they provide a few examples of successful LTCOP advocacy in response to this delicate situation.

**Trainer’s Note:** Tell the trainees to close their manuals when discussing the case study below. The answers are in their manuals.

**Case Study:** You receive a complaint from an anonymous nursing facility staff member regarding another staff member hitting a resident named Ariella. What would you say to the complainant and what would you do?

Possible actions include:
• Tell the staff member that the Long-Term Care Ombudsman program is not the primary investigator and inform them of the role of the program
• Remind the complainant that under federal and state requirements facility staff must report allegations of abuse to the licensing agency or Adult Protective Services and/or local law enforcement
• Inform the complainant if your state allows anonymous reports
• Visit Ariella per your program’s policies and procedures
• Explain residents’ rights and your role as a representative
• Listen to Ariella’s concerns
• Follow the Ombudsman program complaint processing requirements and your program policies and procedures
Why would a resident choose not to report an allegation of ANE?

Fear of retaliation

“Fear of retaliation is one of the most common reasons residents do not want to pursue a complaint and disclose their identity. Since residents live in the facility and rely on staff for their basic needs their fear of retaliation cannot be overemphasized. It is critical that LTCOP representatives understand how fear of retaliation influences a resident’s, or another complainant’s, choices regarding complaint reporting and resolution.”

The Ombudsman Program’s Abuse, Neglect, and Exploitation Reporting Requirements

Trainer’s Note: This part of the training focuses on LTCOP reporting requirements. There are case studies for each situation that ask the trainees what they would do.

<table>
<thead>
<tr>
<th>Reporting Abuse, Neglect, and Exploitation (ANE)</th>
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<tbody>
<tr>
<td>Permission to report ANE is required whether a resident can communicate consent, or a resident cannot communicate consent and has a resident representative. Prior to getting permission, representatives:</td>
</tr>
<tr>
<td>✓ Discuss pros and cons of reporting and</td>
</tr>
<tr>
<td>✓ Discuss potential outcomes of reporting</td>
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</tbody>
</table>

Where the goals of a resident or resident representative are to report abuse, neglect, and exploitation, and the resident or the resident representative has communicated informed consent to the LTCOP, the Ombudsman program must assist with contacting and/or disclosing the provided information to the appropriate agency. This could include the LTCOP making the referral or providing the resident/resident representative with the contact information for them to make the referral themselves.

The text box to the left describes the required process when working with residents and/or their representatives regarding reporting allegations of ANE.

Most states have mandatory reporting laws that require certain individuals to report suspected ANE. However, “state law may not require reporting of suspected abuse, neglect or exploitation by the LTCO program where such reporting violates the Federal requirement that an ombudsman is prohibited from the disclosure of the identity of a complainant or resident without appropriate consent pursuant to Section 712(d) of the OAA.”

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32 Communication of informed consent may be made in writing, orally or visually, including through the use of auxiliary aids and services and such consent must be documented immediately.
33 AoA. Letter to Director Holmgren. op.cit.
Furthermore, anyone working as a representative of the Office is required to follow LTCOP disclosure requirements, regardless of holding a license that indicates mandated reporting.\textsuperscript{34}

Ombudsman program representatives must employ other advocacy strategies when responding to allegations of abuse, where consent is not given, to protect resident confidentiality and do their best to ensure resident safety. When responding to allegations of abuse, representatives should exhaust all possible advocacy strategies for the safety not only of the complainant resident but for the safety of all residents.

**Trainer’s Note:** Tell the trainees to close their manuals when discussing the case study below. The answers are in their manuals.

**Case Study: Noah**

A resident named Noah informs you about a staff member’s abusive actions towards him during his evening shower but does not give you permission to pursue the complaint. What would you do?

**Trainer’s Note:** After the trainees respond to the question “what would you do” make sure to go over the bullet points below.

Suggested practices for responding to this situation:\textsuperscript{35}

- Explore the reason for Noah’s reluctance to pursue the allegation of abuse and explain residents’ rights and the LTCOP role and responsibilities in supporting residents. Inform him of the complaint process, including how not disclosing his identity may impact complaint investigation and resolution, the potential risks of consenting to disclosure, as well as risks of not pursuing allegations of abuse. Offer to investigate the complaint without disclosing his name (e.g., reporting the time and dates the incidents occurred without disclosing his name or identifying information). If possible, visit Noah frequently, see if he is interested in seeking supportive services (e.g., counseling) and encourage him to give permission to


report the alleged abuse. Take care to ensure that Noah does not feel that you are pressing him to give permission to report.

- Ask Noah if he has shared this information with anyone else or if there is someone he trusts such as a family member, friend, or another staff person with whom he could share it. If so, ask if you can talk to that person.

- See if there are other residents with the same issue who are willing to pursue it to resolution. By resolving the issue for others, you might be able to resolve it for Noah.\(^{36}\) Be careful to avoid revealing Noah’s identity and to avoid elevating anxiety levels among other residents with whom you speak.

- Investigate to gather information regarding the allegation. If you gain information supporting the allegation, share the information with the facility administrator if it is possible to do so without identifying the resident(s) involved (e.g., “here is information we gathered supporting allegations that the nurse aide, Jackie, on the evening shift is…”). You should not recommend that the facility take any specific action against the accused employee, but rather remind the administrator of the facility’s responsibility to investigate and report allegations of abuse. If the facility administrator asks you for advice, you could suggest that they consult the regulations for guidance and contact the state survey agency with questions about how to proceed.

- For complainants other than the resident, inform them of the role of the LTCO program and refer them to the appropriate investigative entity (e.g., state licensing and certification agency, Adult Protective Services, law enforcement). Then speak with the resident regarding the complaint and their options including the advocacy strategies listed above.

**What if the Representative Witnesses Abuse, Gross Neglect, or Exploitation?**

If you witness physical or verbal abuse, there is often no time to stop and ask questions of consent as stopping the abuse from happening is the immediate priority. This often involves notifying staff to assist the resident who has been harmed.\(^ {37}\)

The LTCOP Rule describes the actions a representative must take if they personally witness suspected abuse, gross neglect, or exploitation. Essentially, if a representative witnesses abuse, gross neglect, or exploitation, the LTCOP must seek informed consent from the resident to disclose resident-identifying information to appropriate agencies.


Case Study: Denny
During a facility visit you witness a staff member harassing a resident named Denny by repeatedly tapping Denny’s head with a ruler and using an ethnic slur. Denny then lunges forward and begins punching the staff member. What would you do?

**Trainer’s Note:** After the trainees respond to the question “what would you do” make sure to go over the bullet points below.

If you witness abuse:38

- Stop what you are doing, remain calm, and call attention to the situation. For example, if it is a physical altercation (such as a resident-to-resident assault), don’t physically intervene, but capture the attention of the abuser, the victim, and others. Calling attention to the attack by yelling “stop” or “help” may stop it and attract staff. This is similar to action you would take if you found a resident in distress (such as a resident that fell or was choking).

- Pay close attention to details (e.g., what did you see and hear, what is the room number, who are the individuals involved). Identify other witnesses, especially facility staff since they are mandatory reporters of abuse.

- Following the incident: speak with the resident (or residents) about the incident; explain the role of the program; ask the resident if he/she wants to report the incident to the investigative agency; and inform the resident of the facility staff’s responsibility to report the incident and conduct an internal investigation.
  
  - If the resident does not want to report to the investigative entity, the LTCOP representative should explore the resident’s concerns, address any fear of retaliation, and discuss what steps can be taken to keep the resident safe (e.g., the advocacy strategies in above scenarios in which the resident does not provide consent).

  - If the resident cannot provide consent, in addition to documenting everything and consulting with your supervisor (staff, LTCOP representative, or Ombudsman):
    
    - Find out if the resident has a representative (e.g., family member, power of attorney, guardian) who can speak on behalf of the resident. Inform the representative of the need to involve outside individuals, such as facility staff or the investigative agency, and the role of the LTCO program. Work with the individual to develop a plan of action for resolution of the complaint.

- If the resident does not have a representative, or the representative cannot be reached, or the representative is not acting in the best interest of the resident and the resolution goal is for action by the state licensing and certification agency, Adult Protective Services and/or law enforcement, then the program representative should obtain approval from the Ombudsman or follow policies and procedures of the Office which provide for such disclosure.

- Document everything and contact your supervisor to report the incident, to debrief, and for support.

- Only after obtaining resident consent, or approval of the Ombudsman, ask the facility staff to work with the resident to develop a plan to maintain their safety, meet their needs after the incident (e.g., counseling) and prevent future incidents. For example, if this was a physical assault by another resident there are two issues to address immediately. First, how to ensure the safety of the victim of abuse and second, how the facility will ensure the other resident is properly supervised and will not harm anyone else.

**What if the Resident is Not Able to Communicate Informed Consent to Reporting Alleged Abuse, Gross Neglect, or Exploitation?**

This section covers information about how and when a representative may refer alleged ANE if a resident cannot communicate informed consent. Making a referral is different than getting immediate help. To clarify, the LTCOP may act in rare situations when a resident cannot communicate informed consent and the representative observes that the resident needs immediate assistance. This situation is demonstrated in the case study after a discussion of the LTCOP Rule outlining referral requirements.

*Trainer's Note: Go over the federal requirements for reporting alleged ANE of a resident who cannot communicate informed consent.*

The LTCOP Rule [§1324.19 (b)(6-7)] states that the Ombudsman program may refer the ANE matter and disclose resident-identifying information “to the appropriate agency or agencies for regulatory oversight; protective services; access to administrative, legal, or other remedies; and/or law enforcement action in the following circumstances.”

1. The resident is unable to communicate informed consent and has no resident representative and the LTCOP has reasonable cause to believe that an action, inaction, or decision may adversely affect the health, safety, welfare, or rights of the resident or
2. The resident has a resident representative and the LTCOP has reasonable cause to believe that the resident representative has taken an action, inaction or decision that may adversely affect the health, safety, welfare, or rights of the resident.

All conditions listed below (a, b, c) must be true for both number 1 and number 2 above.

a. LTCOP has no evidence indicating that the resident would not wish a referral to be made and
b. LTCOP has reasonable cause to believe that it is in the best interest of the resident to make a referral and
c. The representative obtains the approval of the Ombudsman

**Trainer’s Note:** Use the Figure 3 chart to explain the steps to disclose ANE of a resident who cannot communicate informed consent and does not have a resident representative. Use the Figure 4 chart to explain the steps to disclose ANE of a resident who cannot communicate informed consent and has a resident representative.

**What information do you need when a resident cannot communicate informed consent to a referral and has no resident representative?**

All information in Figure 3 must be true to make a referral.
**What information do you need when a resident cannot communicate informed consent to a referral and has a resident representative?**

All information in Figure 4 must be true to make a referral.

**Case Study: Bernice**

You visit a facility and are talking to a resident named Millie who tells you that the staff do not take care of her roommate, Bernice. Millie says that they only change the pad on Bernice’s bed once every couple of days and she needs help with eating, but staff don’t help her. Millie said she tries to feed her but is really worried about her. According to Millie, Bernice doesn’t get any visitors and she sleeps most of the day. You attempt to talk to Bernice, but she just stares at you and does not respond. You notice a strong odor of feces and urine in the room.

What’s the first thing you do in this situation?

✓ Get a staff member to come and care for the resident.

Someone comes in to change and clean Bernice. You ask the charge nurse if Bernice has someone who makes decisions on her behalf and the charge nurse tells you that Bernice has a daughter, Pam, who is her resident representative. The charge nurse says they have never seen Pam and she does not attend care plan meetings. The charge nurse gives you Pam’s phone number, but Pam doesn’t return your calls. You visit the following week to check in on Bernice and to talk to Millie who tells you nothing has changed, and the room smells like feces and urine again.
**What information have you gathered?**

- Bernice has a representative
- You have reason to believe that Bernice is being neglected by the facility
- You have reason to believe that Pam’s inactions may adversely affect Bernice’s health and safety
- You have no evidence Bernice would not want your assistance or a referral

After getting someone to assist Bernice with her care again, you are concerned about Bernice’s wellbeing.

**What do you do next?**

- Develop a plan of action with your supervisor to determine next steps to ensure the facility does not continue to neglect Bernice. Actions may include talking with appropriate facility staff, requesting to review the care plan, attempting to contact the resident representative again, contacting the Ombudsman, etc.
- Consult with your supervisor about obtaining permission from the Ombudsman to refer the complaint to the appropriate entity for investigation.

To reiterate, if you receive a complaint regarding abuse, gross neglect, or exploitation and the resident cannot provide consent to pursue the complaint:

- Find out if the resident has a representative (e.g., family member, power of attorney, guardian) who can speak on behalf of the resident. Inform the representative of the need to involve outside individuals, such as facility staff or the investigative agency, and the role of the LTCO program. Work with the resident representative to develop a plan of action for resolution of the complaint.
- If the resident does not have a representative, or the representative cannot be reached, or the representative is not acting in the best interest of the resident and the resolution goal is for action by the state licensing and certification agency, Adult Protective Services and/or law enforcement, then the program representative should obtain approval from the Ombudsman and disclose the identity of the resident to appropriate facility staff and the appropriate investigative agency.³⁹

³⁹ Federal Register DHHS AoA 45 CFR Parts 1321 and 1324 State Long-Term Care Ombudsman Programs; LTCOP Rule https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=5b7abe6b970a70ccdbff264ab58dcad2&mc=true&n=sp45.4.1324.a&r=SUBPART&ty=HTML#se45.5.1324_113


Learn more about the LTCOP role and responsibilities when responding to allegations of abuse.⁴⁰
MODULE 9

Who Investigates Allegations of Abuse, Neglect, and Exploitation?

Trainer’s Note: Remind trainees to always follow state policies and procedures when making a referral to another agency, especially when the referral contains resident or complainant-identifying information.

Once informed consent has been granted to report the allegation of abuse, or you have determined informed consent is not possible, where does the referral go? The answer will depend upon the direction of the resident, the resident representative, or the Ombudsman. It will also depend upon your state’s structure for investigating abuse in long-term care facilities. Remember to always follow policies and procedures for disclosure of information.

The Facility

Trainer’s Note: Nursing facilities are required to conduct an internal investigation, but those findings don’t have legal or regulatory consequences.

With consent of the resident, the resident’s representative, or the Ombudsman, you may inform the nursing facility of the alleged abuse. Facilities are required to conduct an internal investigation on all allegations of ANE immediately. In each facility, a staff member is designated as the responsible person to conduct an internal investigation. During the investigation, the facility is required to follow its policies and procedures and ensure the safety of residents. The facility must ensure that all allegations are reported immediately, but not later than 2 hours, if there is serious bodily harm, and no later than 24 hours if there is not serious bodily harm. The facility must inform the state survey agency and, in some states, Adult Protective Services (discussed below). Also, the facility must have policies and procedures ensuring that any reasonable suspicion of a crime is reported by individuals such as facility owners, operators, employees, managers, agents, or contractors to the state survey agency and one or more law enforcement entities.41

Representatives may also inform residential care communities (RCCs) of allegations of ANE with consent of the resident, resident representative, or the Ombudsman. RCCs have state requirements pertaining to a facility’s response to alleged abuse, neglect, and exploitation.

→ Include state-specific requirements for each type of residential care community (RCC) regarding reporting and investigating allegations of

abuse, neglect, and exploitation (ANE). Clarify whether all RCC staff and other contracted services providers are mandated reporters.

State Survey Agencies

→ Indicate the state survey agency(ies) responsible for investigating ANE for each facility type.

→ Include your procedures for filing complaints with the state survey agency for each type of facility. Include the contact information of the State Survey Agency(ies), information to be included in the referral, and required forms (paper or electronic) as applicable.

With consent from the resident, you may refer the complaint regarding ANE to the state survey agency or agencies responsible for regulating long-term care facilities and investigating allegations of abuse, neglect, and exploitation based on federal regulations and state licensing requirements. State survey agencies investigate to determine if federal or state regulations have been violated and assess the level of harm to the resident(s).

The state survey agency investigates more than complaints of abuse, neglect, and exploitation. They investigate any complaint that is a potential violation of federal and/or state regulations.

Adult Protective Services (APS)

→ Explain whether Adult Protective Services (APS) investigates allegations of ANE in long-term care facilities in your state. It could depend on the facility type where the ANE allegedly occurred, or whether the alleged perpetrator is a staff member, a family member, or a visitor. Explain the relationship your program has with APS, including when and how you would make a referral.

Trainer’s Note: If Adult Protective Services does not investigate allegations of ANE in long-term care facilities in your state, then skip to “Law Enforcement.”

With consent, you may refer the allegation of ANE to Adult Protective Services. APS is a social services program provided by state and/or local governments serving older adults and, in some states, adults with disabilities who need assistance because of abuse, neglect, self-neglect, or financial exploitation. APS responds to reports of abuse, neglect, and exploitation and works with individuals to provide the maximum possible degree of personal freedom, dignity, and self-determination.42

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42 https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
Law Enforcement

→ Explain your state’s policies and procedures on when and how a referral would be made to law enforcement, including the Medicaid Fraud Control Unit and any other offices within the Attorney General’s office.

With consent, you may refer the allegation of ANE to law enforcement. Law enforcement consists of people employed by a local, state, tribal, or federal justice agency. This includes police, courts, district attorney’s office, probation or other community corrections agency, and correctional facilities; including the State Medicaid Fraud Control Unit, as defined in section 1903(q) of the Social Security Act (42 U.S.C. 1396b(q)).

The Medicaid Fraud Control Unit (MFCU) investigates and prosecutes Medicaid provider fraud as well as abuse or neglect of residents in long-term care facilities. To find the MFCU in your state click here.

Attorney General

The role of an attorney general is to serve as counselor to state government agencies and legislatures, and as a representative of the public interest.
Section 3:
Additional Referral Agencies
There are difficult cases other than complaints of abuse, neglect, and/or exploitation for which the LTCOP may refer a complaint to another agency. Referrals made should be included in the plan of action and for the purposes of complaint resolution.

When working on a case, referrals are made with consent of the resident and when:

- another agency has resources that benefit the resident;
- actions to be taken are outside of the expertise or scope of the LTCOP; or
- the representative needs outside assistance for complaint resolution.

When a representative makes a referral to another agency, it does not necessarily mean there is no further work to be done. LTCOP actions will depend upon the direction of the resident, the plan of action, and the resident’s desired outcome.

**Trainer’s Note:** Read the scenario or ask the trainees to read it on their own. Reiterate that this example shows that just because referrals are made, the LTCOP’s work is not done. Also let them know that agencies that assist residents with moving out are discussed later in the training.

For example, a resident named Samantha expresses to you that she wants to move out of the facility to a less restrictive environment, but the facility says there is nothing they can do because Samantha is “too disabled” to live outside of long-term care. You explain the facility’s responsibilities to assist her with discharging to a preferred location and to include her wishes in the care plan. You also tell her about state programs that help residents move out of long-term care with services. Samantha asks you to refer her to the agency that assists with community living and also to file a complaint with the survey agency. You refer Samantha to be assessed for community living and you refer the complaint to the survey agency, but Samantha wants you to attend the next care plan meeting and advocate on her behalf to change her discharge plan.

There are other times when individuals contact the LTCOP with a concern that is outside of the scope of the program’s work. The LTCOP provides information and contact information to the individual about other agencies or entities based on the problem shared and the services provided.

For example, a representative of the Office receives a complaint about a facility type to which the LTCOP does not have access. In this situation, the Ombudsman program gives applicable information to the caller to address their situation and would have no further involvement.
Legal Services

Sometimes residents want or need legal assistance. Legal services include an entity or individual attorney providing legal representation and/or consultation to residents including but not limited to legal services funded through Older Americans Act or Legal Services Corporation funds, Ombudsman legal counsel, or any other attorney. The type of help available varies and ranges from legal advice to actual representation in a lawsuit against a facility. There are two federally funded programs that assist residents with legal issues: Legal Services for Older Americans Program and Protection and Advocacy.

Legal Services for Older Americans

→ Include the name(s) of the legal assistance program(s) in your area and discuss when and how you would make a referral.

The Legal Services for Older Americans Program provides older persons who live in long-term care facilities with legal assistance that may include:

- drafting advance directives;
- assisting with issues related to guardianship;
- accessing public benefits; and
- discharge proceedings.

Protection and Advocacy (P&A)

→ Include the name of the P&A agency in your area and explain the relationship your program has with the P&A, including when and how you would make a referral.

Protection and Advocacy (P&A) is a system to protect and advocate the rights of individuals with developmental disabilities as designated by the State, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.). P&As protect individuals with disabilities by empowering them and advocating on their behalf. There are 57 P&As in the United States and its territories, and each is independent of service-providing agencies in their states.

P&As provide legal support to residents with disabilities and ensure those residents are able to exercise their rights to make choices, contribute to society, and live independently.

Learn more about Protection and Advocacy and find the P&A agency(ies) in your state here.

46 https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
47 https://acl.gov/programs/legal-help/legal-services-elderly-program
48 https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
Guardianship and Conservatorship Resources

→ Add state-specific contact information for the entity or entities who provide guardianship or conservatorship, other than private guardians/conservators. Those entities could be state or county guardians, for example.

Circumstances when a representative would seek information about guardianships or conservatorships could be:

- The representative receives a complaint about a resident with a guardian/conservator
- A resident has a complaint against the guardian/conservator
- A resident wants to remove or change a guardian/conservator
- The guardian/conservator is not acting in the best interest of the resident

Aging and Disability Resource Centers (ADRCs)

→ Include state-specific information about when and how to contact the Aging and Disability Resource Center (ADRC) in your area.

Finding the right services for individuals can be confusing and challenging, so Aging and Disability Resource Centers (ADRCs)50 serve as a single point of entry for older adults and individuals with disabilities and their caregivers seeking long-term services and supports (LTSS) options.

The ADRC program is designed to streamline access by providing information and counseling to individuals with all levels of income to obtain LTSS in the most suitable and appropriate setting.

Money Follows the Person (MFP)

→ Include state-specific information about the Money Follows the Person program.

Trainer’s Note: Not all states have a Money Follows the Person program. Skip this section if your state does not have MFP. In states that have an MFP program, it may be called by another name. Provide the information specific to your state.

Money Follows the Person (MFP)51 is a Medicaid program that provides financial assistance to eligible nursing facility residents who want to move back into the community. Long-term services and supports are provided to help individuals successfully transition from institutional living to community living.

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51 https://www.medicaid.gov/medicaid/long-term-services-supports/money-follows-person/index.html
Some supports and services may include:

- Adult day center services
- Emergency response systems
- Home health care
- Home modifications
- Personal care assistance

**Medicaid Home and Community-Based Services (HCBS)**

Include the contact information for the agency responsible for Home and Community-Based Services (HCBS) in your area and explain the relationship your program has with them, including when and how you would make a referral.

Medicaid Home and Community-Based Services (HCBS) provide opportunities for Medicaid recipients to receive services in their own home or community rather than long-term care facilities. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.\(^{52}\)

**Centers for Independent Living (CILs)**

Include the contact information for the Centers for Independent Living (CILs) in your area and explain the relationship your program has with the CILs, including when and how you would make a referral.

Centers for Independent Living provide independent living services for people with all types of disabilities. CILs work to support community living and independence for people with disabilities across the nation based on the belief that all people can live with dignity, make their own choices, and participate fully in society. CILs provide tools, resources, and supports for integrating people with disabilities fully into their communities to promote equal opportunities, self-determination, and respect.

Learn more about Centers for Independent Living and find the CILs in your state here.\(^{53}\)

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State Health Insurance Assistance Program (SHIP)

Include information about the State Health Insurance Assistance Program (SHIP) in your state and explain the relationship your program has with SHIP, including when and how you would make a referral.

SHIP is a resource that provides free, in-depth, unbiased, one-on-one health insurance counseling and assistance to Medicare beneficiaries, their families, and caregivers. There are 54 SHIPs in the United States and its territories.

SHIPs assist people in obtaining coverage through options such as Original Medicare (Parts A & B), Medicare Advantage (Part C), Medicare Prescription Drug Coverage (Part D), and Medicare Supplement policies (Medigap). SHIPs also assist beneficiaries with limited income to apply for programs, such as Medicaid, Medicare Savings Program and Extra Help/Low Income Subsidy, which help pay for or reduce healthcare costs.

Learn more about State Health Insurance Assistance Programs and to find the SHIPs in your state here.54

Senior Medicare Patrol Program (SMP)

Include information about the Senior Medicare Patrol Program (SMP) in your state and explain the relationship your program has with SMP, including when and how you would make a referral.

The Senior Medicare Patrol program empowers and assists Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. SMP is a grant-funded project of the federal U.S. Department of Health and Human Services (HHS), U.S. Administration for Community Living (ACL).55

When Medicare beneficiaries or their loved ones bring their complaints to the SMP, a determination about whether fraud, errors, or abuse is made. When fraud or abuse is suspected, referrals are made to the appropriate state and federal agencies for further investigation.

Learn more about SMP here.56

54 https://acl.gov/programs/connecting-people-services/state-health-insurance-assistance-program-ship
55 https://www.smpresource.org/Content/What-SMPs-Do.aspx
Section 4:

Conclusion
Module 9 Questions

Trainer’s Note: Ask the following questions and make sure the correct answer is discussed. Allow approximately 20 minutes for this section.

1. True or False? The LTCOP is the finder of fact, meaning the LTCOP investigation is for the purposes of determining if ANE occurred.

   Answer: False. The LTCOP is not the finder of fact. The purpose of the LTCOP investigation is to gather necessary information to resolve the complaint to the satisfaction of the resident, not to determine whether any law or regulation has been violated for purposes of a potential civil or criminal enforcement action.

2. Which of the following statements are true? Ombudsman program advocacy during an ANE investigation can include:
   a. Assisting a resident with reporting abuse, neglect, and exploitation.
   b. Meeting with residents, including Resident Council members.
   c. Meeting with family members, including Family Council members.
   d. Working with the facility to ensure residents feel safe.
   e. Ensuring the facility makes efforts to protect residents from further harm.
   f. Following up with the facility to determine if proper reporting of ANE has been completed.
   g. Researching the facility’s abuse, neglect, and exploitation history.

   Answer: All are true

   For the remainder of the questions, assume you have permission from the resident to make the referral.

3. What agency(ies) could you make a referral to if the resident experienced abuse in a nursing facility by a staff member?
   a. The survey agency
   b. Adult Protective Services
   c. Medicaid Fraud Control Unit
   d. Local Law Enforcement
   e. SHIP
Answers will vary depending on your state. Answers “a”- “d” could all be correct. The wrong answer is SHIP. SHIP is a health insurance counseling program.

4. What agency(ies) could you make a referral to if the resident experienced abuse in an RCC by a staff member?
   a. The survey agency
   b. Adult Protective Services
   c. Medicaid Fraud Control Unit
   d. Local Law Enforcement
   e. MFP
   f. Other _______________

Answers will vary depending on your state. Answers “a”- “d” and “f” could all be correct. The wrong answer is MFP. Money Follows the Person helps some residents move back into the community.

5. What agency/entity could you make a referral to if the resident wants to move outside of long-term care?
   a. Money Follows the Person
   b. Centers for Independent Living
   c. Home and Community-Based Services
   d. Aging and Disability Resource Centers

Answers will vary depending on your state. Make sure you include age or financial qualifiers with these resources if applicable.
Module 9 Additional Resources

Abuse

- CMS Hand in Hand Module 2 What is Abuse?  
  [https://www.youtube.com/watch?v=INwczX2o0s](https://www.youtube.com/watch?v=INwczX2o0s)

- National Ombudsman Resource Center  

- Consumer Voice Fact Sheet Abuse, Neglect, Exploitation, and Misappropriation of Property  

- National Center on Elder Abuse (NCEA)  
  [https://ncea.acl.gov/What-We-Do/Education.aspx](https://ncea.acl.gov/What-We-Do/Education.aspx)
MODULE TEN
Documentation

TRAINER GUIDE

January 2022
# Table of Contents

Module 10 State-Specific Information ................................................................. 2  
Section 1: Welcome and Introduction ................................................................. 3  
Section 2: Long-Term Care Ombudsman Program Reporting Requirements .......... 9  
Section 3: Accurate Documentation .................................................................. 16  
Section 4: Conclusion ......................................................................................... 30

This project was supported, in part, by grant number 90OMRC0001-01-00, from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C., 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.
Module 10 State-Specific Information

The list below outlines state-specific information for trainers to discuss, provide a link to, or add directly to the Trainer Guide, Trainee Manual, and/or PowerPoints. When you get to the point in the training where you need to discuss, include a link to, or add state-specific information, you will see a bold, blue arrow (→) and a brief description of what to include.

→ State-Specific Information

Section 2 Long-Term Care Ombudsman Program Reporting Requirements

- Include information your state collects if it is beyond federal requirements.

- Explain your state-specific process for documentation training. Include whether you use the NORS training and/or your own state program training session. Let the trainees know when additional training is offered and expected to be completed.

- Explain state-specific requirements for opening and closing a case, including timelines.

- Include state-specific staff and volunteer documentation requirements for activities. Explain the deadline representatives have for entering information into the system after an activity has been conducted (e.g., you have 10 days to enter completed activities, or all activities must be entered at the end of the month).

Section 4 Conclusion

- Add the next steps trainees can expect to take to complete the certification process.
Section 1:
Welcome and Introduction
Welcome

**Trainer’s Note:** Allow at least 15 minutes for Section 1.

Begin the session by welcoming the trainees to the training session and thanking them for their interest in the program. Make sure everyone introduces themselves – even if they come late.

Welcome to Module 10 of certification training – **Documentation.** Thank you for being here to learn more about the Long-Term Care Ombudsman program and the certification process.

To begin, please share:
- Your name
- Where you are from
- One thing you learned from Module 9 - something that really stuck with you or surprised you
- What you hope to learn since the last module

After introductions, thank the trainees for their information and explain any housekeeping items that need to be addressed including the timeframe of the training day, breaks, location of restrooms, refreshments, etc. Ask the trainees to speak up if they have any questions throughout the training.

Welcome to Module 10 of certification training, **Documentation.** Thank you for being here to learn more about the Long-Term Care Ombudsman program and the certification process.
Module 10 Agenda

Trainer’s Note: The timeframes for each Section are approximate. Allow at least 3 hours for Module 10.

Section 1: Welcome and Introduction (15 minutes)
Section 2: Long-Term Care Ombudsman Program Reporting Requirements (60 Minutes)
BREAK (15 Minutes)
Section 3: Accurate Documentation (60 Minutes)
Section 4: Conclusion (20 Minutes)

Learning Objectives

Trainer’s Note: Go over the Module 10 learning objectives.

After completion of Module 10 you will understand:

- The core National Ombudsman Reporting System (NORS) documentation requirements
- A case, a complaint, and information & assistance
- The Long-Term Care Ombudsman program documentation requirements
- The purpose of documentation
- How to document
- What information must be documented
Module 10 Key Words and Terms

The key words and terms are defined as they are specifically applied to the Ombudsman program and are found throughout this Module. Take a moment to familiarize yourself with this important information.

**Abuse** - Any willful mistreatment of residents by facility staff, resident representative/family/friend, other residents, or an outside individual. There are three categories of abuse: physical, sexual, and psychological.¹

**Administration for Community Living (ACL)** – A division of the U.S. Department of Health and Human Services (HHS) that manages grant programs and serves as the federal focal point on matters concerning older adults.²

**ANE** – Abuse, neglect, and exploitation.

**Case** – Each case must have a minimum of one complaint. A case must contain a complainant, complaint code(s), a setting, verification, resolution, and information regarding whether a complaint was referred to another agency. For abuse, neglect, and exploitation, a perpetrator code is also required.³

**Code** – An alphanumeric assignment to a data element of a case (e.g., complaint code, verification code, disposition code, etc.).⁴

**Complainant** – An individual who requests Ombudsman program complaint investigation services regarding one or more complaints made by, or on behalf of, residents.⁵

**Complaint** - An expression of dissatisfaction or concern brought to, or initiated by, the Ombudsman program which requires Ombudsman program investigation and resolution on behalf of one or more residents of a long-term care facility.⁶

**Complaint Disposition (Resolution)** – Final resolution or outcome of the complaint.

**Complaint Verification (Verification)** – Confirmation that most or all facts alleged by the complainant are likely to be true.⁷

**Complaint Visit** – An Ombudsman program visit to a facility in response to a complaint when only complaint-related activities are conducted.

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² [https://acl.gov/](https://acl.gov/)
³ CA-04 Table 3: Part A [https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf](https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf)
⁴ These codes are also referred to as “element numbers” in NORS Tables 1, 2, and 3. Links to NORS Tables are available here: [https://ltcombudsman.org/omb_support/nors/nors-training](https://ltcombudsman.org/omb_support/nors/nors-training)
⁵ [https://ltcombudsman.org/omb_support/nors](https://ltcombudsman.org/omb_support/nors)
⁶ CA-04 Table 1: Part B - Complaint Data Components [https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf](https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf)
⁷ CD-07 Table 1: - Complaint Data Components [https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf](https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf)
Financial Exploitation (Exploitation) - The illegal or improper use of an individual’s funds, property, or assets for another person’s profit or advantage.8

Gross Neglect (Neglect) - The failure to protect a resident from harm or the failure to meet their needs for essential medical care, nutrition, hydration, hygiene, clothing, basic activities of daily living, or shelter, which results in a serious risk of compromised health and/or safety, relative to age, health status, and cultural norms.9

Information and Assistance - Information provided to an individual or facility staff about issues affecting residents (e.g., residents’ rights, care issues, services) and/or sharing information about accessing services without opening a case and working to resolve a complaint.10

National Ombudsman Reporting System (NORS) – The uniform data collection and reporting system required for use by all State Long-Term Care Ombudsman programs.

Office of the State Long-Term Care Ombudsman (Office, OSLTCO) – As used in sections 711 and 712 of the Act, means the organizational unit in a State or territory which is headed by a State Long-Term Care Ombudsman.11

Ombudsman – A Swedish word meaning agent, representative, or someone who speaks on behalf of another. For the purposes of this manual, the word “Ombudsman” means the State Long-Term Care Ombudsman.

Perpetrator - Person(s) who appears to have caused the abuse, neglect, or exploitation.12

Referral Agency - The agency or agencies to which a complaint was referred as part of the Ombudsman program’s plan of action for complaint resolution.13

Representatives of the Office of the State Long-Term Care Ombudsman (Representatives) - As used in sections 711 and 712 of the Act, means the employees or volunteers designated by the Ombudsman to fulfill the duties set forth in §1324.19(a), whether personnel supervision is provided by the Ombudsman or his or her designees or by an agency hosting a local Ombudsman entity designated by the Ombudsman pursuant to section 712(a)(5) of the Act.14

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10 https://ltcombudsman.org/omb_support/nors
11 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule
13 CD-06 Table 1 Part B – Complaint Data Components
https://ltcombudsman.org/uploads/files/support/NORS_Table_1_Case_Level_10-31-2024.pdf
14 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule
Routine Access Visit (Routine Visit) – A representative’s visit to a facility to conduct activities that promote regular and timely access to the LTCOP and as determined in the state program’s policies and procedures (e.g., visit with multiple residents, share information about the Ombudsman program, observe activities in the facility).¹⁵

State Long-Term Care Ombudsman (Ombudsman, State Ombudsman) – As used in sections 711 and 712 of the Act, means the individual who heads the Office and is responsible to personally, or through representatives of the Office, fulfill the functions, responsibilities, and duties set forth in §1324.13 and §1324.19.

State Long-Term Care Ombudsman Program (Long-Term Care Ombudsman program, the program, LTCOP) – As used in sections 711 and 712 of the Act, means the program through which the functions and duties of the Office are carried out, consisting of the Ombudsman, the Office headed by the Ombudsman, and the representatives of the Office.¹⁶

State Long-Term Care Ombudsman Programs Rule (LTCOP Rule) – The Federal Rule that governs the Long-Term Care Ombudsman program (45 CFR Part 1324).¹⁷

Subsection Symbol (§) – The subsection symbol is used to denote an individual numeric statute or regulation (rule).

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¹⁵ https://ltcombudsman.org/omb_support/nors
¹⁶ 45 CFR Part 1324 Subpart A §1324.1 Definitions Long-Term Care Ombudsman Programs Final Rule
Section 2:
Long-Term Care Ombudsman Program Reporting Requirements
Confidentiality

**Trainer’s Note:** Allow at least 60 minutes for Section 2. State-specific policies and procedures related to confidentiality and disclosure were discussed in detail during Module 5. Remind trainees of the requirements if/when necessary.

The State Long-Term Care Ombudsman (Ombudsman) is responsible for managing all files, records, and other information of the Ombudsman program, whether in physical, electronic, or other formats. **Such files are the property of the Office of the State Long-Term Care Ombudsman (Office).** The Ombudsman has the sole authority to make or delegate determinations concerning the disclosure of files, records, and other information maintained by the Ombudsman program.18 Always follow your program policies and procedures pertaining to confidentiality and disclosure.

All files, records, and other information of the Ombudsman program must be kept confidential and only disclosed at the discretion of the Ombudsman or designee of the Ombudsman per program policies. Per the LTCOP Rule, “identifying information of any resident with respect to whom the Ombudsman program maintains files, records, or information, except as otherwise provided by §1324.19(b)(5)-(8)” cannot be disclosed without informed consent of the resident or resident representative or in response to a court order.19 Similarly, identifying information of any complainant cannot be disclosed without informed consent of the complainant or in response to a court order.20 However, the Ombudsman may use discretion and disclose redacted files, records, or information that protects the identities of all residents and/or complainants.

Documenting Information

**Trainer’s Note:** Explain whether volunteers have access to the state-approved database system to enter information and, if not, explain how volunteers are to send their visit notes to the LTCOP. Is there a standardized form volunteers are required to

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19 45 CFR Part 1324 Subpart A §1324.11(e)(3) Long-Term Care Ombudsman Programs Final Rule
20 45 CFR Part 1324 Subpart A §1324.11(e)(3) Long-Term Care Ombudsman Programs Final Rule
use, or do they write a narrative of their visits? If you wish, you could show forms staff and/or volunteers are required to use to document visits.

The work of the LTCOP is significant, crucial, and necessary. Representatives improve the quality of life and the quality of care for residents daily. The only way to prove this is through timely and thorough documentation. Information is documented both informally, such as via pen and paper or electronic device, and formally in the state-approved electronic documentation system. Informal documentation is used to immediately record observations, interviews, and record reviews related to LTCOP activities and cases.

The information is then entered into a database system as a formal record of all LTCOP actions and is maintained by the Office of the State Long-Term Care Ombudsman.

The National Ombudsman Reporting System (NORS)

Based on the information recorded in the state-approved documentation system, the State Ombudsman is required to report specific information and activities to the Administration for Community Living (ACL), summarized in the uniform data collection and reporting system called the National Ombudsman Reporting System (NORS).

Data collected through NORS includes:

- The number of cases
- Types of complaints
- Federally required LTCOP activities
- Program information

The data is available to the public and is often used to justify funding and to represent the important work completed by the Long-Term Care Ombudsman program. NORS data also helps track current trends related to complaints and LTCOP activities. It is the only system that tracks data collected regarding problems faced by residents. Some states require representatives to document additional information as discussed later in this Module.

Data Reporting – The Bigger Picture

Your documentation translates into data. For example, the number of complaints and cases, and the instances of information and assistance provided all add up to paint a picture of the effectiveness of the program.

The Ombudsman uses data collected to show the State Unit on Aging (SUA) and the Administration on Aging (AoA) the impact of the work conducted by the LTCOP. The
data is also used to show Congress – the law makers – what trends are apparent, where the system is lacking, and what laws need to be modified or created.

Overall, the data demonstrates the need for funding to continue to do the necessary work and to increase federal and state support when a program lacks funds and staff to achieve state and federal requirements.

Ombudsman Program Activities

\[\rightarrow \text{Include information your state collects if it is beyond federal requirements.}\]

**Trainer’s Note:** NORS does not capture all program activities. States may choose to collect additional data on training, facility visits, survey participation, participation in resident and family councils, community education, and more.

In addition to complaint data, activities documented for the purposes of NORS include LTCOP actions required by the Older Americans Act (OAA) and the Long-Term Care Ombudsman Programs Final Rule (LTCOP Rule). Further information about documenting activities can be found in NORS Table 3: State Program Information.\(^\text{21}\)

Activities required to be documented include:

- Facility visits
- Information and assistance
- Training for representatives of the Office
- Training for facility staff
- State survey participation
- Resident Council and Family Council participation
- Community education

While you are required to enter all facility visits into your program’s system, some activities conducted during visits may need to be documented separately. Those activities include providing information and assistance, conducting training for facility staff, survey participation, and attendance at Resident Council and Family Council meetings. Any work on complaints is documented in the case file section of the electronic system, discussed below.

**Information and Assistance**

The most frequent LTCOP activity conducted is providing information and assistance. Information and assistance, as defined by NORS, is when the LTCOP provides information about issues impacting residents (e.g., residents’ rights, care issues, 

\(^\text{21}\) [https://ltcombudsman.org/uploads/files/support/NORS_Table_3_Program_Information_10-31-2024.pdf](https://ltcombudsman.org/uploads/files/support/NORS_Table_3_Program_Information_10-31-2024.pdf)
services) and/or provides assistance without opening a case and working to resolve a complaint. Representatives provide information and assistance most often by phone calls and during facility visits to anyone who may have a question or a concern.

**Ombudsman Program Cases**

Cases are comprised of at least one complaint. A case must also include the complainant, complaint code(s), a setting, verification, resolution, and information regarding whether a complaint was referred to another agency. Cases regarding abuse, neglect, and exploitation (ANE) also require the type of perpetrator (i.e., person(s) who appears to have caused the abuse or neglect or exploitation).

Additional case documentation requirements include case notes, proof/denial of consent to act, proof/denial of disclosure, and any other actions taken by the LTCOP.

You will learn more about case documentation definitions and requirements in NORS training and/or your state program’s documentation training. Additional information about what to include in a case can be found in the NORS Table 1 Part A-Case Data Components

→ **Explain your state-specific process for documentation training. Include whether you use the NORS training and/or your own state program training session. Let the trainees know when additional training is offered and expected to be completed.**

A **complaint** is an expression of dissatisfaction or concern brought to, or initiated by, the Ombudsman program which requires Ombudsman program investigation and resolution on behalf of one or more residents of a long-term care facility.

A **complainant** is an individual who requests Ombudsman program complaint investigation services regarding one or more complaints made by, or on behalf of, residents.

A **complaint code** is the alphanumerical assignment as defined by NORS to identify and label complaint types. There are 60 **NORS complaint codes.**

**Trainer’s Note:** Tell the trainees they will learn more about the complaint codes during additional documentation training. Indicate if your state tracks more than the 60 complaint codes required by NORS.

A **setting** is the facility type or setting for the case (nursing facility, residential care community, other setting).

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22 [https://ltcombudsman.org/omb_support/nors/nors-training#training](https://ltcombudsman.org/omb_support/nors/nors-training#training)
Verification is confirmation that most or all facts alleged by the complainant are likely to be true. A complaint is either “verified” or “not verified.”

A referral occurs when action is needed by another agency as part of the Ombudsman program’s plan of action for complaint resolution. All case documentation must include whether a complaint was referred.

Disposition is the final resolution or outcome of the complaint.

Opening and Closing a Case

→ Explain state-specific requirements for opening and closing a case, including timelines.

Trainer’s Note: Explain to the trainees that they are not expected to memorize or remember the codes.

Complaint

Once a complainant shares their concern and wants you to take action, the concern becomes a complaint, and you open a case.

Occasionally, you may hear from multiple people about the same problem. However, NORS only allows one complainant per case; the first person who makes a concern known to the LTCOP is listed in the case record as the complainant and cannot be changed during the investigation.

When opening a case, include all necessary information required by NORS and your state. Information will be added as you continue with the investigation. Usually, the pertinent information gathered at intake is sufficient when opening a case.

All cases must include a referral agency code. Sometimes a referral is necessary as part of the Ombudsman program’s plan of action for complaint resolution. There is a code for cases in which no referral is made. Referral agency codes are:

01-Licensing, regulatory, or certification agency
02-Adult protective services
03-Law enforcement or prosecutor
04-Protection and advocacy
05-Legal services
06-No referral was made
99-Other
Cases are closed when the investigation is complete and there is nothing further that can be done by the Ombudsman program. Completion of a case includes:

- Complaint verification status has been documented
- A referral agency code has been assigned
- Each complaint has been assigned a disposition code
- Closure dates for all complaints within the case have been entered
- All documentation has been entered into your state-approved system

The disposition code is based on the satisfaction of the resident, or the resident representative or the complainant if the resident cannot communicate their satisfaction. Disposition codes are:

- 01 - Partially or fully resolved
- 02 - No action needed or withdrawn
- 03 - Not resolved

**State Documentation Requirements**

→ Include state-specific staff and volunteer documentation requirements for activities. Explain the deadline representatives have for entering information into the system after an activity has been conducted (e.g., you have 10 days to enter completed activities, or all activities must be entered at the end of the month).
Section 3:
Accurate Documentation
Purpose of Case Documentation

A major part of each case record is the narrative describing the essential information from intake, the complaints(s), the investigation, and the resolution process.

<table>
<thead>
<tr>
<th>PURPOSE</th>
<th>HOW IS THIS ACHIEVED?</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDES A FACTUAL ACCOUNTING</td>
<td>• Documents the interactions and observations in a clear and factual manner.</td>
</tr>
<tr>
<td></td>
<td>• Does not include impressions, emotions, and preconceived ideas.</td>
</tr>
<tr>
<td></td>
<td>• Documents in a manner that enables a representative to pick up where another left off.</td>
</tr>
<tr>
<td>TRACKS THE PROGRESS OF THE CASE</td>
<td>• Allows for a review of actions completed.</td>
</tr>
<tr>
<td></td>
<td>• Documents the timeframes of actions to be completed.</td>
</tr>
<tr>
<td></td>
<td>• Records all actions needed to achieve resolution.</td>
</tr>
<tr>
<td>MONITORS THE PERFORMANCE OF THE OMBUDSMAN PROGRAM</td>
<td>• Provides a formal record which verifies to your supervisor, the State Ombudsman, residents, the courts, or others that the LTCOP has complied with the Older Americans Act (OAA) and the Long-Term Care Ombudsman Programs Final Rule (LTCOP Rule).</td>
</tr>
<tr>
<td>PROVIDES AN OFFICIAL RECORD OF COMPLAINTS</td>
<td>• Demonstrates and tracks violations of residents’ rights and facilities’ poor practices that can be used to help bring about systems change that may create better quality of life and/or quality of care for residents.</td>
</tr>
</tbody>
</table>

Watch this video on obtaining and documenting resident consent which is called How to Obtain Consent (Long-Term Care Ombudsman). The first part of the video, which focuses on consent, was shared in Module 7. The second part of the video describes the importance of documentation.

Based on the video, finish these sentences:

“If it’s not in the database______________.  
Answer: it didn’t happen.

“Documentation is proof that the Ombudsman has______________.
Answer: fully served the resident.

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25 Empowered Aging https://www.youtube.com/watch?v=v72Dt1CBsNI
What to Document
Most representatives take informal notes during or immediately after interviews, observations, record reviews, and any actions taken. Those notes must be transferred into the state-approved electronic documentation system. When taking informal notes, keep in mind the information you need to complete a proper investigation and to complete the required case documentation that becomes the formal record.

The foundation of all documentation starts with the Five Ws – who, what, where, when, and why. Document only the information related to the issue or the strategy to resolve the problem. For documentation to be complete, there are also certain topic areas that must be recorded.

Just the Facts
The Five Ws are the facts of the case. These are the same types of questions used when interviewing individuals during the Ombudsman Program Problem-Solving Process, which was covered in Modules 7 and 8. The facts of the case are:26

1. Who is involved? Include names, titles, relationship to the resident.
2. What exactly is the complaint (what happened or is happening) and what information is/was obtained related to the complaint?
3. Where does the problem occur?
4. When does the complaint take place? Include dates and times.
5. Why does the complaint arise? Include the root cause.

NOTE TAKING
When taking notes in front of a resident, family member, or resident representative, make sure to let them know your notes are confidential, you won’t share them with anyone, and you are doing so to assist with your memory.

Consider these examples:
“What you are saying is really important. I’m writing it down to help me remember your points, wishes, etc.”

“Thank you for sharing this information. I’m taking notes to make sure I understand exactly what you are saying. I cannot share anything you say to me without your permission.”

Topic Areas for Case Documentation
For a complete accounting of the case, certain topic areas must be clearly described. Those areas include: the problem, the resident, permission(s) granted, actions taken, evidence, resolution/outcome, and follow up.

26 Ombudsman Case Documentation Module Developed for the Long-Term Care Ombudsman Program by Sara Hunt, Consultant
<table>
<thead>
<tr>
<th>Topic Area</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The problem</strong></td>
<td><strong>Define the nature and extent of the problem.</strong> Starting with intake, explain the problem from the complainant’s point of view; when the resident is not the complainant, also provide an explanation of problem from the resident’s perspective.</td>
</tr>
<tr>
<td><strong>The resident</strong></td>
<td><strong>Describe relevant facts about the resident gained through observation, interviews, and possibly record reviews.</strong> This information is especially important when the resident’s ability to communicate informed consent is in question.</td>
</tr>
<tr>
<td><strong>Permission(s) granted</strong></td>
<td><strong>Explain exactly what permission(s) the resident has granted you.</strong> This includes permission to act as well as consent to talk to others and disclose confidential information.</td>
</tr>
<tr>
<td></td>
<td>• Name each person to whom the resident gives you consent to release their identity and talk about the problem. If the resident gives permission to speak with “anyone who can help” - document that statement. Make sure to note anyone to whom the resident explicitly told you <em>not</em> to talk.</td>
</tr>
<tr>
<td></td>
<td>• Document permission received or not received to disclose records and be specific about the information allowed to be disclosed or not disclosed within such records. Include who gave permission – the resident, the resident representative, and/or the Ombudsman.</td>
</tr>
<tr>
<td></td>
<td>• Clearly state the plan of action and include the agreed upon actions each party will take, including yourself, the resident, the resident representative, the complainant, and anyone else involved.</td>
</tr>
<tr>
<td><strong>Actions taken</strong></td>
<td><strong>Document all actions taken.</strong> This may include interviews, observations, face-to-face visits, phone calls, emails, record reviews, referrals, a change in the plan of action, etc.</td>
</tr>
<tr>
<td><strong>Evidence</strong></td>
<td><strong>Provide information gathered during the investigation.</strong> Document evidence that verifies or does not verify the problem. Include relevant federal/state regulations when necessary.</td>
</tr>
</tbody>
</table>
Follow-up | Document all follow-up actions. Include other actions that need to be taken or if the case is ready to be closed.
--- | ---
Resolution/outcome | Describe the resident’s perspective of the outcome of your advocacy. Is the problem resolved? If so, to what extent? Include a statement about the resident’s level of satisfaction.

**How to Document**

During an investigation, you will often gather a lot of information and it may seem overwhelming at times. Knowing how to record it in the formal case record helps you to organize information in a way that clarifies the facts of the case, assists with tracking your work, and helps plan for further action on the case.

**Dos and Don’ts of Documentation**

*Trainer’s Note:* When going through the Figure 3 chart, give brief examples of documentation you have experienced (good and bad), or use the examples provided below the chart. Inform the trainees that lengthy documentation does not equal effective documentation. Documentation should only consist of the necessary facts (e.g., we don’t need to know the resident was wearing blue pants and a red shirt with white flowers while they sat on their bed eating a candy bar – unless it is somehow related to the complaint).

Effective documentation clarifies the information gathered and can have an impact on the investigation strategy. Documentation must be factual, objective, and consistent. Your case documentation should be clear enough so that another representative can pick up where you left off.

**Figure 3**

<table>
<thead>
<tr>
<th>Effective Documentation is:</th>
<th>Effective Documentation is NOT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronological</td>
<td>Out of chronological order</td>
</tr>
<tr>
<td>Complete and accurate</td>
<td>Incomplete or inaccurate</td>
</tr>
<tr>
<td>Concise and organized</td>
<td>Unnecessarily wordy and disorganized</td>
</tr>
<tr>
<td>Clear and free from uncommon abbreviations</td>
<td>Difficult to understand</td>
</tr>
<tr>
<td>Confidential</td>
<td>Available to anyone outside of the LTCOP</td>
</tr>
<tr>
<td>Inclusive of necessary facts</td>
<td>Opinionated or full of useless information</td>
</tr>
<tr>
<td>Entered as soon as possible into the system</td>
<td>Delayed</td>
</tr>
</tbody>
</table>
Which of the following examples would you consider to be effective or ineffective documentation? Why?

Trainer’s Note: Optional - If you have time, you could ask the trainees to individually rewrite numbers 1 and 2 using the documentation skills learned so far. It would be interesting to see how different everyone’s notes are based on their interpretation of the initial information. It is a good way to demonstrate the importance of clear and concise documentation.

1. “When I entered the facility the activities director stopped me and was so excited about the upcoming fair she was organizing for the residents. She invited me to the event. Since Sharon has a complaint about activities, I brought it up to Kim and she said it was resolved.”

Answer: This is ineffective documentation. Information about the fair is not necessary. It doesn’t clarify who Sharon or Kim are – is one of them the Activities Director? The activities complaint is not explained. It is not clear who determined the complaint was resolved since there are two females and the word “she” is used.

2. “I have followed up with resident, Ralph, two times and both times he seemed uncertain of what he wanted to do about moving home. I think he is being influenced by his son.”

Answer: This is ineffective documentation. It does not say when or how the representative followed up with Ralph. The words “seemed uncertain” are vague. The writer also expresses an opinion about Ralph being influenced by his son with no facts to back up the statement.

3. “When entering White Oaks Assisted Living the morning of May 26, 2021, I saw several staff assisting residents out of the building. I spoke with resident Mel Jackson who said they think the fire alarm was pulled by a resident, but he did not know which resident. Another resident named Rosalee said she smelled smoke on the first floor, but no alarm went off. The manager, Bill, came over and said they were “looking into it” then immediately went back into the building. I talked with other residents outside who all said they weren’t sure what was going on and did not hear the fire alarm. They expressed concern about a potential broken alarm and asked if I would look into it. I stayed outside of the building and after about 10 minutes, the fire trucks arrived. I observed the situation for another 15 minutes and saw no other concerns. I will call the manager this afternoon.”

Answer: This is effective documentation. It is in chronological order, factual, concise, contains names and titles, free from unknown abbreviations, and includes next steps.
Fact or Opinion?
Individuals have a natural tendency to simplify descriptions by using perceptions or opinions instead of stating the facts. For example, a statement such as, “the resident was sad” is an assumption due to seeing a resident crying.

The habit of “opinionating” may influence your interpretation of a situation and could negatively impact factual documentation. It is important to avoid allowing personal feelings, preconceived notions, prejudices, or interpretations to influence documentation.

What is the difference between the two examples of the same situation below?
Trainer’s Note: The difference is that the first one uses opinions instead of facts and the representative allows preconceived notions to filter into the documentation. The second example is simply factual.

1. Of course, the manager yelled. He always gets mad when I bring problems to him.
2. The manager raised his voice saying he was tired of constantly getting complaints from the LTCOP.

Objective or Subjective?
When documenting, use objective language instead of subjective language.

Objective language is not influenced by personal feelings or opinions, and it is used to clearly communicate facts. When objective language is used, two people reading the description will have the same understanding of what happened.

“Travis stood up from his chair, shook his head, and said he needed a break. He left the room and walked down the hall.”

Subjective language is based on personal opinions, interpretations, emotions, and judgements. It is open to different interpretations. Two people can describe or understand the meaning in different ways.

“Travis became angry and stormed out of the room.”
“Travis was anxious and tried to leave the facility.”

Trainer’s Note: Explain the difference between the two examples above. The first example uses sentences that are clear and factual. The two sentences in the second example make implications that may or may not be true and are not followed up by facts.
Objective language describes behaviors.
“The Care Plan Coordinator said she had no comment when asked to reschedule the care plan conference. She raised her hands in the air and stated she had another appointment to get to and that the conversation was over.”

Subjective language labels behaviors.
“The Care Plan Coordinator was rude and unresponsive to my question.”

Objective language describes observations.
“During a visit, I saw stains and crumbs on the resident’s shirt.”

Subjective language interjects opinions.
“During a visit, the resident’s shirt was dirty, and he looked like he hadn’t been cleaned since breakfast. Staff are obviously not doing their jobs.”

Putting it All Together

Activity

Role-Play: Jo Phillips

Trainer’s Note: To conduct the role-play, you will need four trainees to volunteer - one narrator; one representative, Alex; one resident, Jo; and one manager. Make sure the trainees who are observing the role-play have a pen and paper or another means to take notes during this activity by answering the Five Ws questions listed after the role-play.

Narrator: The door to room 110 is open. The representative can see a resident sitting in a recliner reading the newspaper. The representative knocks on the door.

Resident: Come in.

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28 Modified from the Illinois Long-Term Care Ombudsman Program “Regular Presence Visit Training.”
Representative: Good morning. My name is Alex Smith, and I am a resident advocate with the Ombudsman program. What is your name?

Resident: I’m Jo Phillips. It is nice to meet you.

Representative: It is a pleasure to meet you as well. Are you familiar with the Ombudsman program?

Resident: No. What is it that you do?

Representative: I am an independent resident advocate. My goal is to work with residents in long-term care facilities like this one to make sure the rights of residents are protected. If you have any problems with the facility or anyone else, I will work with you to try to resolve those problems. Here is a brochure with more information as well as my phone number.

Narrator: Resident Dave Samuel wanders into Jo’s room, opens the bathroom door, looks around, and then walks back out into the hallway. Dave is wearing a baseball hat, t-shirt, and shorts.

Resident: Boy, that sure is annoying. I hate it when he does that. People have no respect for others anymore.

Representative: Does he do that often?

Resident: About once a day, usually after breakfast. I tell him to get out, but he doesn’t seem to hear me. I don’t know what to do.

Representative: Have you talked to staff about it?

Resident: Yes, but they say, “That’s Dave. You know he’s harmless.” I tell you what, they wouldn’t want someone just walking into their house uninvited. I told them that too. It still didn’t do any good.

Representative: You have a right to privacy. Is this something you’d like my help with? We could try talking to staff together or another option would be to discuss it at the Resident Council meeting.

Resident: You know, I think I would like your help. It isn’t a huge deal, but it’s really starting to get on my nerves when he just walks in uninvited. Do you have time to talk to the manager right now?

Representative: Yes, I do. Before we go, let’s talk about a plan to present to the manager. Would you like to share the problem from your perspective? I will be there to support you and to make sure your rights are understood and upheld.

Resident: Yes, I can take the lead but if the manager doesn’t listen to me, will you take over?
**Representative:** Yes, I can do that. What are your expectations for the meeting? Is your goal to always have Dave stay out of your room, or are you okay with an occasional visit? What do you want staff to do if they walk by and see him in your room?

**Resident:** I want them to take me seriously. I like visitors, but I want to invite them in. I don’t want anyone coming in without my approval. Maybe I can give the staff a thumbs up or a thumbs down if they walk by and see Dave in my room. If I give them a thumbs down, they should come in and get him out of my room.

**Narrator:** The representative and the resident agree on the plan and go to the manager’s office.

**Resident:** I have a problem with Dave Samuel always coming into my room every day after breakfast. I’m not telling you how to do your job, but somebody needs to do something about this.

**Manager:** I had no idea this is a problem for you. You should tell staff when you are bothered by something.

**Resident:** I have been complaining, but nothing ever changes. Staff just tell me he’s harmless.

**Manager:** I will talk to staff, but I can’t share information about Mr. Samuel with you. We can’t discuss his health issues.

**Narrator:** Jo looks at Alex and nods.

**Representative:** We are not asking you to share confidential information about any resident. We are asking for the facility to honor Jo’s right to privacy. While we do not need to know your plan about how to keep Mr. Samuel out of Jo’s room, we do appreciate knowing that you are following up on Jo’s complaint.

**Resident:** I just don’t want anyone to enter my room without my permission. I was thinking that when staff walk by, I could give them a thumbs up or a thumbs down and then they would know if they should come in and get Dave out of my room.

**Manager:** That sounds like a good idea. I’ll talk with the staff and see what we can do about Dave coming into your room uninvited. I’ll also check to see if there are any activities Mr. Samuel may want to participate in after breakfast.

**Narrator:** A week later, the representative follows up with Jo who is working on a puzzle alone in the activity room.

**Representative:** Good afternoon Jo! It’s Alex from the Ombudsman program. I’m visiting to follow up on your concern from our last visit. How are you?

**Resident:** I’m okay. Up until two days ago, Dave was still coming into my room. I’m not sure if the concern is resolved.
Representative: Have you utilized the thumbs up or thumbs down approach with staff?

Resident: No, I didn’t see any staff walk by when he was in my room. I ended up going to the manager again to complain. We’ll see if that works. I have your number and will call you if the problem continues.

Representative: Okay, and I will check in with you on my next visit to see how things are going.

Trainer’s Note: Tell the trainees this case is not ready to be closed, but the representative must document the two visits. Allow trainees to finish answering the questions below and ask those who participated in the role-play to begin to answer the Five Ws questions. After they have written down their answers, go through each question and ask them what their responses are. Make sure the correct answers are discussed.

Using the Five Ws, answer the questions below.

Who is involved? Include names, titles, relationship to the resident.

Answer: Resident and complainant, Jo Phillips; resident Dave Samuel; and the manager.

What exactly is the complaint and what information is obtained related to the complaint?

Answer: Jo Phillips does not want anyone entering Jo’s room without being invited. Mr. Samuel comes into Jo’s room uninvited every day after breakfast. Jo has told staff, but they don’t acknowledge it as a problem.

Where does the problem occur?

Answer: It occurs in Jo’s room.

When does the complaint take place?

Answer: It occurs every day after breakfast.

Why does the complaint arise?

Answer: At this point, the answer is unknown.
Case Notes Checklist

Trainer’s Note: Tell the trainees to use this checklist or if your program uses another checklist, use your state-specific form when determining if they have included all pertinent information in the case notes.

In general, did I…

✓ Record all events in chronological order by date and approximate time?
✓ Use quotes, when possible, especially to capture the speaker’s attitude, opinions, or observations?
✓ Limit the use of abbreviations to those that all representatives would understand, or initially define an abbreviation when questionable?
✓ Use names and titles of individuals and not “he,” “she,” “they”?
✓ Use objective language?
✓ Attach all required documents?

Documenting intake information, did I include…

✓ The description of the problem as presented by the complainant?
✓ Steps the complainant has already taken to resolve the problem?
✓ A statement about the complainant’s opinion of the resident’s ability to communicate informed consent (if the complainant is not the resident)? NOTE: The complainant’s opinion may or may not be accurate, but it is important to document their opinion. In later entries, you may need to include your own observations on this matter.
✓ A statement about permission to reveal the complainant’s identity?

Documenting the remainder of the investigation, did I include…

✓ The resident’s perception of the problem(s)?
✓ The resident’s desired outcome?
✓ The initial plan of action, including all involved parties?
✓ Each step taken in the investigation process, including interviews, observations, and record reviews?
✓ All actions taken to resolve the complaint(s)?
✓ A statement about the resident’s satisfaction with the resolution?
✓ Follow-up communication with the resident or other relevant parties?
Using the narrative for the role-play and documentation checklist, write case notes for both visits with Jo Phillips.

**Trainer’s Note:** Give the trainees at least 20 minutes to write the case notes. Ask the trainees to use the narrative for the role-play and the documentation checklist to write case notes for both visits regarding Jo Phillips.

After the trainees have written their case notes, explain the common mistakes below and relate them to the notetaking exercise by going over the last three paragraphs in this section. The role-play intentionally has unnecessary information to determine if trainees can distinguish between relevant information and pointless information for documentation purposes.

Common mistakes made with documentation include:

- Writing unnecessary information - long notes do not equal good notetaking
- Leaving out essential information
- Using unclear or confusing language

If you wrote about Jo sitting in a chair reading the newspaper, Dave’s clothes, or Jo putting a puzzle together… **you wrote too much.** None of these details are related to the complaint.

If you left out names and titles, the complaint from Jo’s perspective, steps taken to resolve the concern prior to the LTCOP’s involvement, the initial plan of action, Jo’s desired outcome, steps taken towards resolution, the manager’s response, or the follow up visit, **you left out vital information.**

If you used words such as “he” or “she” or subjective language, or if you did not document in chronological order, **your notes might not be clear.**

**Trainer’s Note:** Ask the trainees to make corrections to their notes based on the comments you just covered. Determine if you want the trainees to turn in their revised notes to you, or to their direct supervisor to review for feedback.
Next Steps

Documentation Training

_Trainer’s Note:_ Explain next steps to receive additional documentation training.

Developing documentation skills and routines is essential and requires time and effort to achieve. Accurate and timely documentation strengthens your skills as an advocate and aids in the success of the LTCOP.

Additional documentation training will teach you how to code cases and activities per state and/or ACL requirements. Depending on your state’s documentation training requirements, you will either attend state-specific documentation training and/or will complete the National Ombudsman Reporting System (NORS) training available through the National Ombudsman Resource Center.

The NORS four-part training reviews basic principles, definitions, codes, and activities.

- **Part I:** Case, Complaint, Complainant, and Information and Assistance Basic Principles
- **Part II:** Complaint Coding Basic Principles
- **Part III:** Verification, Disposition, Referral, and Closing Cases Basic Principles
- **Part IV:** Ombudsman Program Activities Basic Principles

NORS four-part training can be found [here](https://ltcombudsman.org/omb_support/nors/nors-training).\(^{29}\)

**State-Specific Next Steps**

→ Add the next steps trainees can expect to take to complete the certification process.
Section 4: Conclusion
Module 10 Questions

_Trainer’s Note_: Allow approximately 15 minutes for this section. Tell the trainees to complete these questions individually. Ask for volunteers to share their answers. Encourage the trainees to talk about their responses with their supervisor.

1. What questions do I still have?

2. What confuses me?

3. What am I excited about?

4. What am I going to do next?
   a. Visit the webpages in my manual
   b. Re-watch videos
   c. Research the resources
   d. Read the trainee manual
   e. Go on a facility visit with an experienced representative
   f. Complete certification paperwork
   g. Other______________________
Module 10 Additional Resources

**NORS**

- Training materials, frequently asked questions, and data:  
  https://ltcombudsman.org/omb_support/nors