CHAPTER 7: Resident and Family Councils
Resident and Family Councils

Chapter 7 describes resident and family councils and their purpose. It provides an understanding of the ombudsman role with both council types and in similar group meetings.

Learning Objectives

- Become familiar with resident and family council requirements.
- Understand the typical roles and responsibilities of resident and family council members.
- Distinguish between an ombudsman’s and facility staff’s responsibilities with councils.

Contents

- Resident and Family Councils
- Ombudsman Role with Resident and Family Councils
- State and National Advocacy Organizations for Family Members
- References in Texas Administrative Code for Resident Groups and Family Councils

DVD(s), Supplements, Forms

- DVD: Strength in Numbers: The Importance of Nursing Home Family Councils
- Supplement 7-A: Agenda Template for Resident or Family Council Meetings
- Supplement 7-B: Sample Council Meeting Minutes
- Supplement 7-C: Sample Resident or Family Council Bylaws
Resident and Family Councils

Resident and family councils can impact quality of life and care for residents. It is a constitutional right for any private citizen to organize. In nursing homes, laws and regulations support the residents’ right to meet as a group and the families’ right to form a council. A resident right to meet privately is supported by rules §19.706 and §92.125.

Fear of retaliation is one of the most significant barriers to residents and family members voicing their concerns. Meetings and councils can help individuals find strength in numbers and overcome that fear. Some councils plan joint meetings in a larger geographic area to share information, talk about challenges and successes, and address systemic problems.

Residents and families communicate and keep in touch by traditional communication such as phone calls, newsletters, and mail but they may explore social networking such as e-mail lists, Facebook, and Google groups.

Residents have the right to prompt efforts by the facility to resolve grievances. During annual and complaint surveys, Regulatory Services surveyors may review minutes of resident and family council meetings. Surveyors examine how facility staff handled grievances and kept residents and families apprised of efforts. Well documented grievances can help alert surveyors to concerns and how they were addressed.

At the end of the chapter, sample materials are supplements to share with resident and family councils who request ombudsman assistance. Note Supplement 7-B: Sample Council Meeting Minutes provides specifics on concerns and any response by management.

Resident Council

A resident council is a group of residents with a purpose. These residents, with or without the help of staff, identify a common need or request and take action. Resident councils have potential to evolve into any number of types and adopt any combination of functions, any of which are correct if desired by residents. Above all else, resident councils are about residents. The needs and desires of residents should drive council activity.

Nursing homes are not legally required to have a resident council, but they must ensure:

- residents have the opportunity to meet as a group or council;
- no interference occurs with council activities;
- residents are afforded privacy during meetings;
- group and individual complaints are responded to; and
- services and activities are based on the individual needs of residents.
A resident council is a practical way to obtain resident input in a variety of services, such as meal planning, social activities, and policies affecting residents. In management terms, a council might enhance a facility by offering to residents and staff the benefits of problem-solving; facility, resident, and staff communications; and empowerment for residents through opportunities to make decisions.

When successfully implemented, the benefits of a resident council far outweigh any administrative costs. The resources spent on a council are investments that provide short-term gains and long-term dividends in the residents’ well-being.

Councils provide a forum for residents to:

- Voice concerns directly to staff
- Hold a facility accountable for its promises
- Identify problems and solutions from the residents’ perspective
- Recognize staff they feel deserve it
- Discuss topics of interest
- Contribute and shape their world

Since residents are different, councils are different too. A strong resident council has:

- broad participation;
- agenda set by residents;
- freely expressed concerns and suggestions; and
- staff who are responsive to residents’ concerns.

Source: Resident Councils of Washington, 2001

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Ask the Trainer: Resident Council

What is the key to success of a resident council?

______________________________________________________________________

______________________________________________________________________

How do I learn when the council meets in the home where I am assigned?

______________________________________________________________________

______________________________________________________________________
Ombudsman Role with Resident Councils

Ombudsmen can help start new councils or support existing resident councils and other resident groups. Councils can bring grievances to the attention of management, thus providing another option to solve problems at the facility level.

Ombudsman tip: Watch for facility staff who appear to control the council agenda or who limit resident input. Be an advocate for the group by letting your staff ombudsman know about any concerns.

As a new ombudsman, seek out the following information:

- Does the facility have an active council?
- How often and when does it meet?
- Who is the president?
- Who did the facility designate as staff support to the council?
- About how many residents attend?
- Are meetings resident-directed?

Building a relationship with the council president is an important first step to make. Ombudsmen may ask for an invitation to attend a council meeting and attend when invited. Offer to introduce yourself to the council and to describe your ombudsman role.

As ombudsmen develop relationships with councils, promote the idea of the council bringing group concerns to management as a means of problem-solving. Share information as requested, but be aware the ombudsman presence changes the group dynamic. Since a resident council is for residents, respect this concept and avoid attending council meetings every time they are scheduled. Taking the role of the council seriously models for residents and facility staff to take it seriously too.

If requested, ombudsmen help council leaders develop skills to make meetings productive and structures to generate and maintain interest and involvement. In the chapter Supplements, see samples of an agenda, minutes, and bylaws.

Ombudsman tip: Be a source of information on specific laws, rights, services, and health issues. Search your community for resources to share. Ask your staff ombudsman for help if needed.
Ombudsmen can encourage residents to attend council meetings and talk about the meetings with residents. Encourage them to bring concerns to the council to determine if others have the same concerns. If they are reluctant, find out why. While protecting resident confidentiality, share feedback with the president of any identified barrier that should be addressed to help councils meet the needs of all residents who want to participate.

More ombudsman tips:

- Occasionally attend council meetings (if invited). After suggesting that councils can be a means to solve problems, tell residents you can attend with their permission. Some residents will welcome this support.
- Come early. Arrive about 30 minutes before the meeting. Visit residents who said they would like to attend, as they may need a reminder. If staff has not helped residents get to the meeting, your presence can be a needed prompt.
- Suggest writing concerns down. Some residents might write concerns and issues before the meeting. At the meeting, they have their concerns ready to share.
- Offer information about residents’ rights and regulations.

Ombudsmen attend council meetings if ______________.

A facility must assign a __________ ____________ to support council needs. Appropriate ways ombudsmen support councils (Mark the ones that apply):

___ Encourage residents to attend
___ Explain the ombudsman program at a meeting
___ Create and distribute minutes
___ Attend every month

A new ombudsman should make contact with the ___________________.

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**Family Council**

A family council is an organized group consisting of family members, legal guardians, and friends of residents in a nursing home or assisted living facility. The council usually governs itself, but a facility must provide some support and assistance. Not all facilities have family councils.

With the exception of laws and rules that are specific to resident groups, family councils function in a similar way and serve similar purposes to resident councils. The role of the ombudsman is also essentially the same.
Family councils:

- Help link the facility to the local community
- Support facility operations through suggestions and activity support
- Bring complaints on behalf of residents or members to management

One barrier to an active family council is time. Family members and friends may not have time to visit the residents and attend a meeting.

Family councils can provide needed validation for complaints and support and education to family and friends.

Family members may believe they are the only ones who experience a problem. But in the meeting, they may learn others experience similar problems. When a council submits complaints, the administrator is less likely to ignore the problem and more likely to take action.

**Ombudsman tip:** The greatest benefit of attending meetings for some family members is the opportunity to build friendships and support. When family cannot visit, they can ask others to look in on their relatives or friends. This “looking out” for each other contributes to a feeling that residents are safe and secure even when family cannot visit.

Some facilities hold information sharing sessions, support groups, or host evening meetings for families. These events can be a starting point for a family council to evolve. But, family councils are groups run by family and friends with support from staff. Staff and other people, like ombudsmen, attend by invitation only.

**Strength in Numbers: The Importance of Nursing Home Family Councils**

Run Time: 24 min

Family councils led by families benefit residents, family members, and facility staff alike. This video gives an overview of the focus, techniques, and strategies to develop effective councils. It shows how families and friends become empowered to improve the quality of care. Watch the video and answer the questions that follow.

1. On a scale from 1-10, how well do you think the administrator _____ and staff ______ would receive a family council in your assigned home?
2. How could the council recruit more family members? 
__________________________________________________________________
__________________________________________________________________

3. What guidelines might help a first meeting be successful?
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

4. Do you have any concerns about the family council at your assigned home?
__________________________________________________________________
__________________________________________________________________

5. Identify a barrier to starting a family council _____________________________
__________________________________________________________________
__________________________________________________________________

6. Identify a facility staff that supports a family council ____________________
__________________________________________________________________

Ombudsman Role with Family Councils

The ombudsman role with family councils is similar to resident councils.

- Encourage family, guardians, and friends of residents to attend.
- Occasionally attend council meetings (if invited).
- Come early. Arrive about 30 minutes before the meeting and greet people. Introduce yourself to members you have not met.
- Help members understand what is productive to discuss in a group forum and what might be better handled individually.
- Offer information about residents’ rights and regulations.

As a new ombudsman, find out if the facility has a family council, who serves as president, and who serves as the facility support staff. Seek out the president and ask:

- How often does the council meet?
- How well attended are the meetings?
• What are typical agenda items?
• How do families and friends learn about the council?
• How can an ombudsman help support the council?

If the facility does not have a family council, but there is a group of people who want to start one, an ombudsman can help. Encourage creation of a council that:

• Meets at a time convenient for a majority of members
• Has structure, including designated leadership and a grievance procedure
• Focuses on improving the quality of care and life for residents
• Educates members on topics of interest
• Creates opportunities for dialogue between staff and council members
• Provides a forum for family members to voice concerns

Members will likely participate only if the council seems worthwhile. Councils may benefit from help to develop their organization and elect leadership. Ombudsmen help members stay involved after the initial energy wanes. Work on particular issues so they see the value of their continued involvement.

Often families focus on personal situations without a greater understanding of how the facility and system work. Help them distinguish between personal concerns and:

• concerns of others;
• general issues about the facility; and
• issues affecting many residents or families.

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**Ombudsman tip:** Encourage family council participation as a means to resolve problems. For example, a family member is concerned facility staff is not meeting her relative’s needs. Root causes may include understaffing, lack of staff training, or insufficient management. Educate families about possible underlying causes to consider and help them recognize the benefit of working with the family council.

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**State and National Advocacy Organizations**

Some family members may want to connect to advocacy organizations with state or federal scope. The Consumer Voice for Quality Long-term Care is a national membership organization for residents, family members, long-term care ombudsmen, and other advocates. Many resources are available free on their website and help is available by telephone. Refer family members to this organization as a start to connecting with national resources. Ombudsmen can become members too.

Another good national resource for specific quality improvement tools is the campaign for Advancing Excellence in America’s Nursing Homes. Residents, family members, ombudsmen, and others can join the campaign as a consumer for free. Their website has tools to promote consistent assignment of caregivers to residents, measure resident and family satisfaction, and implement change based on the results, as well as ideas to improve clinical outcomes. [https://www.nhqualitycampaign.org/](https://www.nhqualitycampaign.org/)

Some family members find the Texas Advocates for Nursing Home Residents (TANHR) to be a helpful resource. TANHR headquarters is in Desoto, Texas but they take calls from family members statewide. It is a nonprofit organization that advocates for improvement in Texas nursing homes. [http://tanhr.net/pages/home](http://tanhr.net/pages/home).

References in the Texas Administrative Code – Resident and Family Councils

Nursing Facility Requirements for Licensure and Certification

- In nursing homes, residents and families have the right to assemble.

§19.706 Resident Group and Family Council
(a) A resident has the right to organize and participate in resident groups in a facility.
(b) A facility must assist residents who require assistance to attend resident group meetings.
(c) A resident's family has the right to meet in the facility with the families of other residents in the facility and organize a family council. A family council may:
   (1) make recommendations to the facility proposing policy and operational decisions affecting resident care and quality of life; and
   (2) promote educational programs and projects intended to promote the health and happiness of residents.
(d) If a resident group or family council exists, a facility must:
   (1) listen to and consider the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility;
   (2) provide a resident group or family council with private space;
   (3) provide a designated staff person responsible for providing assistance and responding to written requests that result from resident group and family council meetings; and
   (4) allow staff or visitors to attend meetings at the resident group's or family council's invitation.
(e) If a family council exists, a facility must:
   (1) upon written request, allow the family council to meet in a common meeting room of the facility at least once a month during hours mutually agreed upon by the family council and the facility;
(2) provide the family council with adequate space on a prominent bulletin board to post notices and other information;
(3) designate a staff person to act as the family council's liaison to the facility;
(4) respond in writing to written requests by the family council within five working days;
(5) include information about the existence of the family council in a mailing that occurs at least semiannually; and
(6) permit a representative of the family council to discuss concerns with an individual conducting an inspection or survey of the facility.

(f) Unless the resident objects, a family council member may authorize, in writing, another member to visit and observe a resident represented by the authorizing member.

(g) A facility must not limit the rights of a resident, a resident's family member, or a family council member to meet with an outside person, including:
   (1) an employee of the facility during the employee's nonworking hours if the employee agrees; or
   (2) a member of a nonprofit or government organization.

(h) A facility must not:
   (1) terminate an existing family council;
   (2) prevent or interfere with the family council from receiving outside correspondence addressed to the family council or open family council mail; or
   (3) willfully interfere with the formation, maintenance, or operation of a family council, including interfering by:
       (A) denying a family council the opportunity to accept help from an outside person;
       (B) discriminating or retaliating against a family council participant; or
       (C) willfully scheduling events in conflict with previously scheduled family council meetings, if the facility has other scheduling options.

Licensing Standards for Assisted Living Facilities

- In assisted living facilities, residents' right to assemble and residents' right to access to resident councils is addressed in rule.

§92.125 Resident's Bill of Rights and Provider Bill of Rights (Excerpt)

(a) Resident's bill of rights.

(3) Each resident in the assisted living facility has the right to:
   (J) unrestricted communication, including personal visitation with any person of the resident's choice, including family members and representatives of advocacy groups and community service organizations, at any reasonable hour; and
   (R) privacy, while attending to personal needs and a private place for receiving visitors or associating with other residents, unless providing privacy would infringe on the rights of other residents. This right applies to medical treatment, written communications, telephone conversations, meeting with family, and access to resident councils. If a resident is married and the spouse is receiving similar services, the couple may share a room.
Supplement 7-A: Agenda Template for Resident or Family Council Meetings

Date
Time (beginning and ending)
Location

I. Welcome and Introductions
   a. Members
   b. Guests (facility staff, ombudsman, other)

II. Minutes and Correspondence
   a. Review minutes from the previous meeting
   b. Review any correspondence from or to the council since the last meeting

III. Officer or Committee Reports (as applicable)

IV. Report from Facility Support Staff or Administrator

V. Old Business

VI. New Business

VII. Guest Speaker / Program

VIII. Concerns (includes status of issues submitted by the council to management and new concerns)

IX. Adjourn
   a. Announce date, time, and location of next meeting
   b. Reminder of other upcoming council events

X. Social Time

Adapted from the Resident Council Handbook, Resident Councils of Washington and Nursing Home Family Council Manual, Texas Advocates for Nursing Home Resident
Supplement 7-B: Sample Council Meeting Minutes

Name of Council
Date
Time
Location of meeting

Welcome and Introductions

The meeting was called to order by [name and time].
Present: list the names of attendees; identify titles of officers and guests

Minutes and Correspondence

[Example] The December minutes were approved as distributed. Correspondence included a letter from Happy Elementary thanking the resident council for their donation of decorations for the school’s annual carnival and a letter inviting our resident council to participate in Senior Days in our community.

Officer and Committee Reports

[Example] President Davis reported she was invited to participate in Happy Elementary board of directors meeting scheduled February 5 to provide ideas on how the school and nursing home can plan meaningful activities for the residents and students. The list of ideas was discussed, additional ideas were included, and all ideas were prioritized by the council.

Treasurer Smith reported the barbeque fundraiser earned $211 for the activities department.

The Welcoming Committee reported we have 6 new residents since the last meeting. There will be a write-up in our newsletter next month about them. They were introduced to the council board.

The Dietary Committee is pleased to announce the Dietitian will be a guest speaker at our next meeting and we have made progress with residents choosing when they prefer to eat breakfast with more menu options.

The Sunshine Committee announced that Mr. Sound is better and returned from the hospital. Mrs. Valley is still in the hospital and a card is being sent.

Report from Facility Support Staff or Administrator
Old Business

[Example] Building remodeling continues. The Bluebonnet hallway is being gutted and flooring, furniture, and fixtures will be replaced. Administrator Montana reports staff moved all the residents and personal items to their temporary rooms on Monday according to the contractor’s schedule, and he is shopping for an aquarium for the sitting room. See concern listed below.

The idea generated from the last meeting regarding a suggestion box is being pursued by the maintenance department as to size and location. We suggested the box is placed at chair height for easy access.

New Business

[Example] Campaigning for mid-term elections will be starting soon. The council decided to invite candidates to our home on September 1 for dialogue. We discussed inviting residents from nearby nursing homes to join us. The activity director and President Davis will extend an invitation.

Guest Speaker / Program

[Example] John Willis was introduced as our guest speaker. Mr. Willis is Executive Director of the local Alzheimer’s organization. A copy of his presentation is available at the front desk and highlights will be published in the next newsletter.

 Concerns

[Example] Concerns included:
• People on Bluebonnet hallway were not given enough notice about being relocated. Staff told them Friday that they would be moved to other rooms on Monday.
• Weekend access to management staff. If a serious problem occurred on the weekend, we are unsure how to reach the administrator and regional director. President Davis agreed to speak with the administrator about this concern and get everyone access to phone numbers for emergencies.

Adjournment

The meeting was adjourned at 2:30 p.m.

Respectfully submitted,
[Name], title
Supplement 7-C: Sample Resident or Family Council Bylaws

I. Name
The name of our council shall be ______________________.

II. Purpose
The purpose of our council is: [Example] to provide a tool from which residents can communicate their needs and interests in the affairs of their home.

III. Membership
Every resident is a member of the __________ resident council. Each resident can vote. In the case of a family council, specify who can serve on the council.

IV. Officers and their duties
Officers of the council shall be:
- President (Chair) – presides over all meetings
- Vice President (Vice Chair) – presides in the absence of the president
- Secretary – takes minutes and writes correspondence as directed by the council
- Treasurer – responsible for all financial business of the council

[Recruiting for officer positions can be a challenge. Members might be willing to serve as co-chairs to share the leadership role. Using a standard agenda each month will make it easy to update and use.]

V. Committees
The council shall have the following committees as needed:
- Executive (officers and committee chairs)
  Purpose: to give direction and organization to the council
- Food
  Purpose: to serve as a liaison between dietary services and the residents for suggestions and improvements.
- Grievance
  Purpose: to serve as a sounding board for grievances and to follow up on complaints with administrator or ombudsman
- Program
  Purpose: to coordinate guest speakers and refreshments for meetings
- Sunshine
  Purpose: to prepare cards for residents in the hospital, for birthdays and other important events
- Volunteer
  Purpose: to enlist members to organize and volunteer for special projects in the community and to improve quality of life in the facility
- Welcoming
  Purpose: to greet new members, orient them to the facility, and encourage participation in the council
Elections

Elections of officers and other representatives will be held every
__________________________ (date, month).

VI. Meetings

Meetings will be held every ______________________________ (day, time and location). If committees will meet, include these dates as well.

VII. Amendments

Amendments may be made to the bylaws at any regular or special meeting of the council by vote. Amendments are announced at least one month prior to a vote.

VIII. Rules of Order

Each meeting will be conducted according to a written agenda. [Rules could also follow Robert’s Rules of Order or be determined by the group.]
CHAPTER 8: Care Planning
Care Planning

Chapter 8 is about the care planning process for individuals in nursing homes and assisted living facilities and about advance care planning. Individual care planning includes assessments, care or service plan meetings, and care or service plan documents. Advance care planning is about making decisions to direct future health care decisions should a person have physical or mental incapacity.

Learning Objectives

- Understand the care (nursing home) and service (assisted living facility) planning process
- Know the advance care planning concept and documents to communicate future health care wishes
- Understand who may serve as a surrogate decision maker and under what circumstances

Contents

- Individual Care Planning
- Comparison of Nursing Home and Assisted Living Facility Regulations
- Advance Care Planning
- Ombudsman Role in Advance Care Planning

DVD(s), Supplements, Forms

- DVD: CMS Hand in Hand Training Module 6: Being with a Person with Dementia: Making A Difference
- Supplement 8-A: I Want to Tell You about My Mother
- Supplement 8-B: Agonizing Schiavo Case Shows Need to Put Medical Wishes in Writing
Individualized Care Planning

According to federal and state laws, each nursing home must “provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which … is initially prepared, with participation to the extent practicable, of the resident, the resident’s family, or legal representative.” A person should not decline in health or wellbeing because of the way a nursing home provides care.

According to state licensing standards, a written plan of care in an assisted living facility (ALF) has special significance. The plan, known as a service plan, is the basis for providing services required to meet the needs of the resident.

The Ombudsman Role

An ombudsman is not responsible for creating a resident's care or service plan; however, an ombudsman may use the care planning process to solve problems. Ombudsmen must be knowledgeable about person-directed care practices in order to incorporate this in their conversations with residents, families, and providers and in their advocacy. Ombudsmen only attend a care or service plan when invited by the resident or resident’s LAR if the resident is unable to make the request.

Assessment

To give good care, staff must assess each resident and plan care and services to support each person's life-long patterns, current interests, strengths, and needs. Resident and family involvement gives staff information to assure residents get good care.

Assessments gather information about how well residents can take care of themselves and when they need help in functional abilities, such as walking, talking, eating, dressing, bathing, seeing, hearing, communicating, understanding, and remembering. Staff should ask and learn about habits, activities, and relationships to help residents live more comfortably and feel more at home. Assessments help staff look for what causes a problem. Assessments should also pay attention to strengths.

In both assisted living facilities and nursing homes, assessments must be completed within 14 days of admission. In nursing homes, assessments must be reviewed at least once a year with reviews every three months (quarterly), and when a resident's physical or mental condition changes. In assisted living, the service plan must be updated annually or upon a significant change in condition, based upon an assessment of the resident.
Plan of care

A care plan for nursing home residents must be developed within seven days after an assessment. It describes a strategy for how staff will help a resident and what each staff will do and when it will happen, such as, “The nurse aide will help me walk to each meal to build my strength.” Staff should be familiar with all care plans, document services provided according to them, and revise as needed.

In assisted living, a service plan must be developed within 14 days of a resident's admission to the facility.

Meeting to develop the plan

Staff, residents, and families talk about life in the nursing home or assisted living facility, including meals, activities, therapies, personal schedule, health care, and emotional needs. Residents and families bring up problems, ask questions, and offer information to help staff provide care. All staff who works with a resident should be involved such as nurse aides, nurses, physician, social worker, activities staff, dietician, and therapists.

To the degree possible, residents should talk about what they need and how they feel. They can ask questions about care, daily routines, food, activities, interests, staff, personal care, and medications. They should be persistent about concerns and choices. Staff must discuss treatment and only do what a resident agrees to.

Ombudsman Tip: Ombudsmen attend care meetings at the invitation of a resident or legal representative. Ombudsmen can help residents and family prepare for a meeting by giving information on how a meeting typically works and helping them practice discussing specific comments, questions, or concerns. Staff generally leads a care conference, but residents, family, and ombudsmen can direct discussion of issues most important to the resident. Ombudsmen may also suggest a care plan meeting as a strategy for resolving a problem.

Participation

Residents have the right to make choices about care, services, and daily life and be involved in the care-planning meeting.

Before the meeting, residents can:

- Tell staff their concerns, needs, and goals.
- Ask the doctor or staff who know about their condition, care, and treatment.
- Ask to meet when family can come, if they want them there.
During the meeting, residents can:

- Discuss options for treatment and for meeting needs and preferences.
- Ask for terms and procedures to be explained if needed.
- Decide if they agree with the plan and feel it meets their needs.
- Ask for a copy.
- Get the name of a person to talk to if they want changes.

After the meeting, residents can:

- Monitor how the plan is followed.
- Talk with nurse aides, other staff, or their doctor about it.

Good care or service plans:

- Are specific, individualized, and written in common language
- Reflect resident concerns and support well-being, functioning, and rights
- Do not label resident choices or needs as "problem behaviors"
- Use a multi-disciplinary team approach and use outside referrals as needed
- Are re-evaluated and revised routinely (watch for care plans that never change)


A care plan may include:

- What kind of services are needed
- What type of health care professional should provide the services
- How often the services are needed
- What kind of equipment or supplies are needed (like a wheelchair or feeding tube)
- If a special diet is required
- Health goal (or goals), and how the care plan will help the resident reach this goal


**Comparison: Nursing Home and Assisted Living Facility Regulations**

The State of Texas requires nursing homes to develop care plans and assisted living facilities to develop service plans. Compare the requirements in the following sections.
Nursing Facility Requirements §19.801 Resident Assessment

A facility must conduct initially and periodically a comprehensive accurate, standardized, reproducible assessment of each resident's functional capacity. The facility must electronically transmit admission, annual, quarterly and significant change assessments to the State of Texas.

(1) Admission orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

(2) Comprehensive assessments.
   (A) A facility must make a comprehensive assessment of a resident's needs, using the Resident Assessment Instrument, including the Minimum Data Set (MDS).
   (B) The assessment must include at least the following information:
      (i) identification and demographic information;
      (ii) customary routine;
      (iii) cognitive patterns;
      (iv) communication;
      (v) vision;
      (vi) mood and behavior patterns;
      (vii) psychosocial well-being;
      (viii) physical functioning and structural problems;
      (ix) continence;
      (x) disease diagnoses and health conditions;
      (xi) dental and nutritional status;
      (xii) skin condition;
      (xiii) activity pursuit;
      (xiv) medications;
      (xv) special treatments and procedures;
      (xvi) discharge potential;
      (xvii) documentation of summary information regarding the additional assessment performed through the resident assessment protocols;
      (xviii) documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.
   (C) A facility must conduct a resident comprehensive assessment as follows:
      (i) within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.
      (ii) within 14 calendar days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. For purposes of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff.
or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.

(iii) not less often than once every 12 months.

**Nursing Facility Requirements §19.802 Comprehensive Care Plans**

(a) A facility must develop a comprehensive care plan for each resident that includes measurable short-term and long-term objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs identified in the comprehensive assessment. The plan must describe:

1. the services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being as required under §19.901; and
2. any services that would otherwise be required under §19.901 but are not provided due to the resident's exercise of rights, including the right to refuse treatment under §19.402(g).

(b) The comprehensive care plan must be:

1. developed within 7 days after completion of the comprehensive assessment;
2. prepared by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by resident needs, and, to the extent practicable, with the participation of resident, resident's family, or legal representative;
3. periodically reviewed and revised by a team of qualified persons after each assessment; and
4. for a resident under 22 years of age, annually reviewed at a comprehensive care plan meeting between the facility and the resident's LAR.

(c) A comprehensive care plan must include:

1. for a resident under 18 years of age, activities, services, and supports when provided or facilitated by the facility will enable the resident to live with a family; or
2. for a resident 18-22 years of age, the activities, supports, and services that when provided or facilitated by the facility will result in the resident having a consistent and nurturing environment in the least restrictive setting, as defined by the resident and LAR.

(d) A comprehensive care plan may include a palliative plan of care. It may be developed only at the request of resident, surrogate decision maker, or legal representative for residents with terminal conditions, end stage diseases, or other conditions for which curative medical interventions are not appropriate. It must have goals that focus on maintaining a safe, comfortable, supportive environment in providing care to a resident at the end of life.

(e) For a resident under 22 years of age, facility must provide written notice to the LAR of a meeting to conduct an annual review of the resident's comprehensive care plan no later than 21 days before the meeting date and request a response from the LAR.

(f) The services provided or arranged by the facility must:
(1) meet professional standards of quality; and
(2) be provided by qualified persons in accordance with each resident's written plan of care.

(g) Comprehensive care plan must be made available to all direct care staff.

Licensing Standards for Assisted Living Facilities §92.41(c) Resident assessment

Within 14 days of admission, a resident comprehensive assessment and an individual service plan for providing care, based on the comprehensive assessment, must be completed. The assessment must be completed by appropriate staff and documented on a form developed by the facility. When a facility is unable to obtain required information, the facility should document its attempts to obtain the information.

(1) The comprehensive assessment must include:
   (A) location from which resident was admitted;
   (B) primary language;
   (C) sleep-cycle issues;
   (D) behavioral symptoms;
   (E) psychosocial issues;
   (F) Alzheimer's/dementia history;
   (G) activities of daily living patterns;
   (H) involvement patterns and preferred activity pursuits;
   (I) cognitive skills for daily decision-making;
   (J) communication;
   (K) physical functioning;
   (L) continence status;
   (M) nutritional status;
   (N) oral/dental status;
   (O) diagnoses;
   (P) medications;
   (Q) health conditions/ possible medication side effects;
   (R) special treatments and procedures;
   (S) hospital admissions within the past 6 months or since last assessment; and
   (T) preventive health needs.

(2) The service plan must be approved and signed by the resident or a person responsible for the resident's health care decisions. The facility must provide care according to the service plan. The service plan must be updated annually and upon a significant change in condition, based upon an assessment of the resident.

(3) For respite clients, the facility may keep a service plan for six months from the date on which it is developed. During that period, the facility may admit the individual as frequently as needed.

(4) Emergency admissions must be assessed and a service plan developed for them.
Basics of Individualized Quality Care

Traditionally, care plans are developed using a medical model. They are written from a staff perspective rather than a resident perspective. This model is not suited to individualized care. Individualized plans provide care and service that support quality of life for each resident.

Example: Fred is an 84-year old man with osteoarthritis. He is very pleasant and social, frequently visiting staff and residents. He ambulates with minimal assistance or moves independently in a wheelchair. His wife was a resident. They were happily married for 61 years and did not have children. They shared a room until she died six months ago. He is now in a private room. Recently he began acting out sexually (grabbing at staff and residents). He is alert and aware of his surroundings, has minimal cognitive impairment, and is hearing impaired.

Traditional Care Plan

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Approaches</th>
</tr>
</thead>
</table>
| Inappropriate sexual behavior | Resident will not touch staff or residents against their wishes. | • 15-minute checks to monitor location.  
                                     |                               | • Praise appropriate behavior.  
                                     |                               | • Re-direct and allow time alone in room when sexual behavior occurs.  
                                     |                               | • Private room. |

Individualized Care Plan

<table>
<thead>
<tr>
<th>Needs</th>
<th>Goal</th>
<th>Approaches</th>
</tr>
</thead>
</table>
| I need companionship.        | I will choose a roommate by next resident care plan meeting. | • I prefer to have a roommate.  
                                     |                               | • When I’m in my room, I like to watch action movies. Share any action DVDs you have with me.  
                                     |                               | • I like to read books.  
                                     |                               | • I look up words in my dictionary.  
                                     |                               | • I enjoy wild birds. I have a bird feeder outside my window. Leave shades open and ensure I have birdseed so I can fill the feeder.  
                                     |                               | • When I’m out of my room, I enjoy eating in the dining room.  
                                     |                               | • Offer opportunities to be around staff and other residents. I may not talk a lot, but I like company.  
                                     |                               | • Speak clearly and directly to me, hearing is difficult.  
                                     |                               | • Introduce me to single women who are seeking companionship and friendship. |

SOURCE: Susan Misiorski and Lynn MacLean, Apple Health Care Inc. Avon, CN

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**Exercise: Create Wilma’s Care Plan**

Wilma is an 88-year old woman with dementia. She has a short attention span and usually has a cheerful demeanor. Wilma likes to walk around the facility for most waking hours. She is unable to distinguish between areas she is allowed to enter and those that she should not. Her ambulation skills are excellent; she requires no assistance. Wilma disturbs some residents because she may enter their rooms against their wishes. She prefers to be with staff at all times; she does not tolerate being alone very well. She and her husband raised eleven children. They owned a hardware store and were respected business owners in town.

### Traditional Care Plan

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wanders due to dementia</td>
<td>Resident will not wander into other resident rooms through next resident care plan meeting.</td>
<td>Redirect resident to appropriate areas of facility. Praise for cooperation. Teach not to go into rooms with sashes across the door.</td>
</tr>
<tr>
<td>Short attention span</td>
<td>Resident will participate in one group program per week for 15 minutes through next care plan meeting.</td>
<td>Invite to group activities. Praise for participation.</td>
</tr>
</tbody>
</table>

### Individualized Care Plan

<table>
<thead>
<tr>
<th>Needs</th>
<th>Goal</th>
<th>Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Each person who lives, works, and volunteers in a nursing home or assisted living community makes a difference in the lives of everyone around him or her, staff as well as residents. While watching CMS Hand in Hand Module 6, think about how Mrs. Johnson’s changing needs could be addressed in her care plan.

Answer the following questions about CMS Hand in Hand Module 6.

1. In the Mrs. Johnson, Part I video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?
   •
   •
   •

2. In the Mrs. Johnson, Part 2 video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?
   •
   •
   •

3. In the Mrs. Johnson, Part 3 video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?
   •
   •
   •

4. In the Mrs. Johnson, Part 4 video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?
   •
   •
   •
5. In the *Mrs. Johnson, Part 5* video clip, how does Gloria meet Mrs. Johnson where she is in her dementia?

- __________________________________________
- __________________________________________
- __________________________________________

6. Good dementia care involves fulfilling these basic human needs:

- __________________________________________
- __________________________________________
- __________________________________________

**Advance Care Planning**

Advances in health care and the growing number of Americans who are living longer create some challenges when people can no longer make decisions or express their needs. Sometimes when people are in accidents or have terminal illnesses, they are not able to talk or let others know how they feel. Directing how a person wants to be treated at the end of life, regardless of capacity, can be achieved through certain legal documents. Directions on what a person does or does not want can be included.

Advance care planning requires an individual to:

1. determine what wishes need to be shared;
2. direct choices about care if staying home, in a nursing home, or in a hospital;
3. talk with family and doctors about what treatment is desired and what is not;
4. document treatment wishes in the event of a serious accident, illness, or terminal condition; and
5. tell others what is decided.

Some advance care planning documents are legal forms. They may be completed with the help of an attorney, but an attorney is not required. The most common forms are:

**Medical Power of Attorney** — Authorizes, except to the extent a person states otherwise, a named agent to make any and all health care decisions in accordance with the person’s wishes, including religious and moral beliefs, when a person is no longer capable to make them;

**Directive to Physicians and Family or Surrogates** — Communicates wishes to doctors, family, and others about medical treatment at some time in the future when a person is unable to make wishes known because of illness or injury;

**Out-of-Hospital Do Not Resuscitate** — Instructs emergency medical personnel and health care professionals to not attempt resuscitation and to allow natural...
death; it does not affect receiving other emergency care and treatment including comfort care

**Statutory Durable Power of Attorney** — Designates an agent who is empowered to take certain actions regarding property and finances; it does not typically authorize anyone to make medical and other healthcare decisions

In a Medical Power of Attorney form, the named person (called an “agent”) speaks for the individual when he or she is no longer able to. A Directive to Physicians or Medical Power of Attorney may include a person’s written wishes about specific medical procedures. The documents can be updated by marking through an area and writing in current wishes or completing a new form and destroying the old one. It is the individual’s responsibility to inform family members and doctors about any changes.

The person named in a Medical Power of Attorney to make decisions is called the _____________________.

Other advance care planning forms include:

**Consent to Medical Treatment** - This process can be used by hospitals, nursing homes, home health agencies, and hospice for a person who has not issued a directive and needs medical care. It does not include withholding or withdrawing life sustaining treatment.

**Declaration for Mental Health Treatment** - This form allows a person to make decisions in advance about mental health treatment and specifically three types of mental health treatment: psychoactive medication, convulsive therapy, and emergency mental health treatment. The instructions in this declaration will be followed only if a court believes a person is incapacitated to make treatment decisions. Otherwise, a person is considered able to give or withhold consent for the treatments.

**Procedure When Person Has Not Executed or Issued a Directive and Is Incompetent or Incapable of Communication** - This process can be used if an adult patient has not executed or issued a directive and is incapacitated, or mentally or physically incapable of communication. In that case, the attending physician and the resident's legal guardian or an agent under a medical power of attorney may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment from the resident.
If help is needed to understand advance care planning forms, facility and hospital staff can explain them. Benefits counselors at area agencies on aging are trained to help complete Medical Powers of Attorney. The Texas Legal Services Center can provide information about legal forms and under some circumstances attorneys to assist in the completion of these documents.

Regulations pertaining to advance care planning:

- Nursing Facility Requirements §19.419
- Licensing Standards for Assisted Living Facilities §92.41(g)

Health care professionals cannot ignore the wishes expressed in an advance care planning document. If a doctor, nurse, hospital, assisted living facility, or nursing home is not able or willing to follow a person’s instructions, they must transfer care for the person to someone who will.

Ask the Trainer: Family Members Disagree

The doctor told a resident there are no more treatments to improve her health and he recommends hospice care. One daughter agrees but the other wants aggressive treatments to continue.

- Whose wishes do you advocate for? ____________________________
- What should an ombudsman do when family members disagree?
  ______________________________________________________________
  ______________________________________________________________

Consent for Medical Treatment

If a person can no longer make medical decisions and did not appoint an agent through an advance directive, a surrogate can consent to medical care. A surrogate is a substitute, or proxy, who acts on behalf of a person who needs medical care and decision-making.

Texas Health and Safety Code §313.004, Consent for Medical Treatment sets situations under which others make medical decisions for people unable to decide on their own. After two physicians certify in writing the person’s incapacity to make medical decisions, the law allows the following people in order of priority to be surrogate decision makers:

1. patient's spouse;
2. adult child of the patient who has the waiver and consent of all other qualified adult children of the patient to act as the sole decision-maker;
3. majority of the patient's reasonably available adult children;
4. patient's parents; and
5. individual clearly identified to act for the patient by the patient before the patient became incapacitated, patient's nearest living relative, or a member of the clergy.

Surrogates can give informed consent for all medical decisions needed, except:
- voluntary inpatient mental health services;
- electro-convulsive treatment; and
- appointment of another surrogate decision-maker.

Surrogates try to make decisions based on what people would want by considering:
- Current diagnosis
- Prognosis
- Any preference expressed about the treatment
- Religious or personal beliefs
- Feeling about similar treatment for other people
- Expressed concerns about effects of illness and treatment on family or friends

If surrogates have no information about a person’s wishes, they use the standard of best interest. They look at the benefits and burdens of treating and not treating, such as:
- Effects of treatment on the physical, emotional, and mental functions
- Pain suffered from the treatment
- Pain suffered without treatment
- Humiliation, loss of dignity, and dependency suffering because of the condition or would suffer because of the treatment
- Effect of the treatment on life expectancy
- Potential for recovery, with and without the treatment
- Risks, side effects, and benefits of the treatment
- Religious beliefs and values

Name one person who can be a surrogate decision maker?
______________________________________________________________
Ombudsman Role in Advance Care Planning

Ombudsmen should encourage residents to exercise their right to develop an advance care plan that directs their care when they are no longer able to make decisions for themselves. Ombudsmen support residents’ decisions about their care and life.

If residents ask for help to create advance directives, direct them to the facility social worker or facility management for assistance. Ombudsmen may also coordinate with Texas Legal Services Center, AAA Benefits Counselors, and other public legal options for a resident who requires legal advice or representation. Some residents prefer to arrange for legal services on their own or may prefer to use a private attorney.

A resident may revoke an MPOA or DPOA at any time. If a resident raises questions about limits placed on their ability to exercise rights, an ombudsman’s role is to educate, help the resident explore why those limitations exist, and work to overcome unnecessary limits.

If a resident requests help to revoke or change a power of attorney, first determine if the resident has a guardian of the person. If no guardianship exists, and with resident consent, the ombudsman obtains a copy of the resident’s power of attorney. An ombudsman should carefully review the power of attorney and consult the state office if questions arise.

Whether a certified ombudsman directly helps a resident revoke a POA depends on the resident's capacity to understand the potential consequences of the decision to revoke. Refer to the ombudsman protocol provided by the state office.

It is a conflict of interest for an ombudsman to serve as a resident decision-maker, such as a guardian or agent in a Medical Power of Attorney. Decline any such request and explain our role as an advocate. This limit does not apply to an ombudsman serving as a decision-maker for a family member in a facility where the ombudsman does not serve residents. If you ever have any questions, speak with your supervising staff ombudsman or state ombudsman.

Unless specifically authorized by a court, or named by a resident as an agent in advance directives, family members and professional caregivers do not have legal authority to make decisions for residents. _________
True (T) or False (F)
Supplements 8-A and 8B provide two perspectives on end of life.

**Supplement 8-A: I Want to Tell You about My Mother**
Guide developed by Carter Catlett Williams, MSW, ACSW

Family members can give a variety of information to give staff at admission and anytime. Tell facts about your mother's:

- Birth date and place
- Number of sisters and brothers; her place in birth order; siblings still living
- Rural or urban childhood
- Your mother’s ethnic community
- Schooling
- Marriage and date of marriage; Date of widowhood or divorce
- Children
- Employment outside of home before and after marriage
- Religious affiliation
- Hobbies
- Living arrangements during marriage and afterwards
- Reason for entering the nursing home

A person’s story includes hopes, accomplishments, disappointments, losses, and things that didn’t go so well. It includes his or her ways of handling the “ups and downs” of life.

Suggestions to help you think over your mother's life and tell her story:

- What she looked forward to in life: as a child, as a teenager
- How much she was able to realize her dreams
- If she had an outside career, what it meant to her; how she and her family coped with the Great Depression; how wars affected her life (World Wars I and II, Korean, and Vietnam)
- What she wanted for her children
- Her relationships with her family
- Was religious faith important and how does she express that: prayer; reading scripture; attending church, synagogue, or mosque; volunteer activity
- What she had, and now has, the most fun doing: cooking for family; hosting family gatherings; gardening; singing; reading; fishing; playing bingo; handwork; going to the movies; sports as a player or spectator; enjoying nature; seeing family and old friends
- Whether she likes to crack jokes or enjoys other's jokes
- How she handled money
- Whether she had pets and what they meant to her
• What angers her
• What pleases her
• What saddens her
• What comforts her
• Whether she generally has an optimistic attitude or sees the darker side of things
• Her major satisfactions and disappointments
• What she values most in life
• What you value most about her

To add further richness to your mother’s story, collect photographs in an album for her room and take others to hang on her walls.

What makes a good day for your mother?

**Daily schedule**
• When she likes to get up and go to bed, times of rest and quiet
• How she prefers to spend her day
• What her mornings and evenings are like at home
• Times of her favorite radio and/or TV programs
• When and what she likes for snacks
• When and how often she likes to go outside
• Her usual bowel and bladder patterns
• Her patterns with: bathing, eating, and food preferences

**Particular things that give her satisfaction and pleasure**
• Particular foods at certain meals
• Careful grooming in the style she prefers
• The chance to be alone at least some part of each day
• Activities she enjoys: music, movies
• Attendance at worship service or other expression of her faith
• Where she prefers to place things in her room and at her bedside
• How she typically expresses affection and is comfortable receiving affection such as hugs, kisses, touching?

Remember no detail is too small if it’s significant to your relative!

For your father, the same information is important. In addition, be sure activities and staff responses consider things from a man’s perspective. The facility might need to offer more traditionally masculine pursuits for your father.

*SOURCE: Nursing Homes Getting Good Care There, Appendix 4*
Supplement 8-B: Agonizing Schiavo Case Shows Need to Put Medical Wishes in Writing

by Bruce Bower, Texas Legal Services Center

Love within families is a complex fabric woven from pride, tenderness and countless other shades of human emotion. It’s a tough love, too, reinforced with unbreakable threads of trust and mutual responsibility. Most of us will do whatever it takes to avoid letting family down. So imagine the special sadness of failing them, not through betrayal or weakness, but omission.

The Terri Schiavo case in Florida epitomizes all that family caregivers dread. Ms. Schiavo had been in a coma since a 1990 heart attack. Husband Michael said, well before her heart attack, she told him to refuse offers of artificial life support if she ever became unable to make her own medical decisions. Nothing was ever put in writing, though.

Without taking sides, we can agree this is about Terri Schiavo and her right to direct her own health care. The trouble is, as she lay in her hospital bed with tubes nourishing a robust body that houses a lifeless cerebral cortex, there was little hope she could ever make those calls on her own.

The Legal Hotline for Texans urges all Texans to assure their loved ones never face such a snarl. If you’re 60 or older, contact a AAA benefits counselor for free advice and access to legal documents that spell out all your preferences in advance:

- Whether you want emergency personnel to resuscitate you
- How far doctors should go to save or sustain your life
- Treatment or medication you don’t want to receive
- Who will be your designated legal proxy or guardian if you become incapacitated

Most advanced planning documents can be prepared free of charge. Either way, it’s a more than fair exchange for the power you have to assure someone who shares your personal value system is making medical decisions on your behalf.

Don’t wait until the need arises; incapacitation often is sudden and unexpected. Worried that you’ll change your mind after the papers are completed? Don’t be. You can change the documents at any time.

Before calling the AAA, consult your physician who can discuss commonly used resuscitation techniques and life-sustaining treatments. This will help you make a more informed decision.

After you sign the legal documents, give copies to your physician to add to your medical records. Be sure to give copies to the person(s) you’ve named as decision-maker and agent. Keep the originals and at least one copy of each document.
Whom should you designate? Most typical are family members, friends, spouses, and attorneys. Just be sure the person knows you well enough to fully understand and be able to attest to your beliefs and preferences. (Important: never assume familiarity with your wishes guarantees willingness to carry them out.)

Procrastination can be forgivable, even endearing, in some life situations. But not when it brings pain and unnecessary stress to the people you love. Do right by them and specify in writing all of your life- and health-care preferences. Do it today.

Bruce Bower is an attorney for the Texas Legal Services Center that operates the Legal Hotline for Texans.
CHAPTER 9: Recognizing, Receiving, and Investigating Complaints
Recognizing, Receiving, and Investigating Complaints

Chapter 9 describes an ombudsman’s approach to recognizing, receiving, and investigating complaints on behalf of residents.

Learning Objectives

- Learn methods to recognize and receive complaints
- Identify basic investigation methods
- Learn how to collect evidence
- Recognize and employ good interview approaches

Contents

- Intake: Recognizing and Receiving Complaints
- Investigating Complaints
- Investigation Documentation

DVD(s), Supplements, Forms

- DVD: LTCO Casework: Advocacy and Communication Skills
- Supplement 9-A: Form 8619 Long-Term Care Ombudsman Case Record
Overview

To solve problems for residents, ombudsmen use basic investigation and problem-solving skills. Above all else, ombudsmen use common sense and stay resident-directed throughout the process.

Common sense is instinct, and enough of it is genius.

Henry Wheeler Shaw

Intake: Recognizing and Receiving Complaints

Ombudsmen receive complaints from a variety of sources including residents, residents’ family, facility staff, and others acting on behalf of residents. Individuals who voice the complaint are called complainants. Complaints are received in-person, by phone, text, mail, and email. The rules of confidentiality and anonymity apply to all complainants, not just residents.

Listen carefully to what people say and note any concerns the person presents. Complaints are not always easily recognized. They may be made in an indirect manner and require you to probe for more information. For example, a resident tells you that he doesn’t like facility staff to administer his medication. The resident implied he has a concern so this type of comment requires further exploration. Your task is to listen, observe, and ask questions in order to determine when an expression of dissatisfaction is a request for help.

While receiving a complaint:

- **Involve the resident.** Support and maximize the resident’s participation in the complaint resolution process. Find a private place to meet with the resident to discuss the complaint and to determine the resident’s perspective. If the complainant is not the resident, explain you are required to involve the resident and take action according to the resident’s wishes.

- **Gather information.** Listen more than talk. Stay neutral and allow the complainant to tell his or her story without responding positively or negatively. Remember you are hearing only one side of the story. Be careful not to promise anything. Avoid judgmental statements like "That's horrible" or "That should not have happened."

- **Direct the conversation if needed.** The complainant may be overwhelmed by the situation, feel emotional, or
confused. In these cases, ombudsmen can help by taking the lead. Ask open-ended questions for someone who is not offering much detail; ask closed-ended questions and redirect for someone who is overly talkative or lacks focus. Do not hurry the process.

Sometimes ombudsmen identify complaints while making facility visits and are therefore the complainant. Complaint identification stems from an ombudsman’s senses: sight, sound, smell, taste, and touch. For example, while making a facility visit you smell unpleasant odors, witness a problem with food service, and hear a resident continually crying out for assistance. All of these observations are potential complaints and need further investigation.

When receiving a complaint from anyone other than a resident, let that person know you take ______________ according to the resident’s wishes.

Investigating Complaints

Investigating is one step in the ombudsman problem-solving process. (More information on the five-step problem-solving process is described in Chapter 10.) Investigating is the process of gathering information to help explain what happened and to help those involved determine a suitable response.

Follow the investigative process outlined in Ombudsman Policies and Procedures.

The nature and scope of an investigation will depend on the circumstances of each case, resident requests, and any relevant statutory requirements that may apply. Not every complaint requires an in-depth investigation. Many concerns presented to ombudsmen can be resolved quickly and informally. These are, however, still complaints that must be reported.

Evaluate the complaint then determine what information is needed, what questions need to be answered, and the best way to obtain that information. Factors to take into account include whether the complaint:
• is a communication problem that can be resolved with explanation or discussion;
• is an issue with facility policies, procedures, or practices;
• involves conduct of individuals;
• is one of a series of complaints which may indicate a pattern or a widespread problem (systemic);
• is a significant issue for the complainant, resident, or the facility;
• needs to be referred to other agencies such as Regulatory Services, Adult Protective Services, or law enforcement.

An ombudsman does NOT conduct an investigation when:
• the complaint is about personnel issues with facility staff that do not affect residents;
• there is a conflict of interest, or the perception of a conflict of interest or impropriety;
• the complaint is an allegation of abuse, neglect, or exploitation (follow Chapter 4 Ombudsman ANE Complaint Guidelines); or
• there is no consent from the resident or complainant.

Gathering Evidence

Evidence is anything used to determine or demonstrate the truth of an assertion. It is a relevant fact which has the potential to assist in describing and explaining what occurred. An ombudsman’s job is to collect the evidence (those relevant facts) that will verify a complaint.

Verified or Not Verified

An ombudsman verifies a complaint by determining after the work completed in an investigation (interviews, observations, record inspections, and other actions discussed in this chapter) that circumstances described in the complaint exist or are generally accurate.

Regardless of whether a complaint is verified, ombudsmen try to resolve any complaint made by a resident. When a complainant - especially a resident - tells an ombudsman something happened and there is no evidence to the contrary, take the complainant’s word for it.
During an investigation, be open-minded. Don’t draw conclusions. Don’t offer opinions.

Three Methods of Evidence Collection

Ombudsmen use observation, interviews, and record review to collect facts or evidence during an investigation.

Observation

The ombudsman role as observer starts the moment you step into the facility. Skillful observation during unannounced visits will reveal important information. Observe the facility environment, staff and resident behaviors, as well as the facility's policies, procedures, and protocols.

Watch the YouTube video *The Monkey Business Illusion*

Follow this link:  [http://www.youtube.com/watch?v=IGQmdoK_ZfY](http://www.youtube.com/watch?v=IGQmdoK_ZfY)
Run Time: 1 min 41 sec

In the video people are passing basketballs. One group is wearing white shirts; the other group is wearing black shirts.

Count the number of times the team in white shirts passes the basketball. Answer the questions posed in the video.

How many times did the team in the white shirts pass the basketball?  

The video demonstrates selective observation: when you look too hard for one thing, you can miss an important piece of evidence. If you didn’t see something unusual, watch the video again.
Tips for Observation

When observing conditions in a facility, be as impartial as possible. If you look for evidence that fits a preconceived theory, you risk misinterpreting evidence or missing other relevant evidence. Decide what observations will help you investigate a particular complaint.

For example, a resident, Mrs. Smith, tells you that staff are not responding promptly to her call light every day from 11 a.m. to 1 p.m. By making a couple of unannounced visits to the facility between 11 a.m. and 1 p.m., you can observe staff response time to Mrs. Smith’s call light. You can also observe the response time to other residents’ call lights to see if there is a systemic issue.

Ombudsmen do not observe personal care being given to a resident. Evidence about inadequate or poor care must be gathered from other sources. In some cases, complaints about how care is delivered could be referred to Regulatory Services for investigation, if the resident consents.

Interview

An interview is a conversation with the purpose of gathering information. One tip to a successful interview is to regard the interview process as a discussion.

Take time to prepare for the interview. Try to find a setting that is comfortable, quiet, and private. Make sure you have the right amount of time allotted so the interview will not feel rushed. Before an interview, determine:

- whether you have permission to identify the resident, complainant, or other identifying information during the conversation;
- who you need to talk to; and
- what questions you need answered and what specific information you need.

Build rapport before you start to ask questions that address the problem. The relationship you develop at the beginning of the interview will affect what is said. It is a good strategy to confirm your role as an ombudsman, and the goals of the meeting, before starting the interview.

- Introduce yourself
- Shake hands
- Give your credentials
- Explain confidentiality
- Be clear about the purpose of the meeting
Don’t provide too much information about what you are investigating because you might reveal identifying information such as the names of other witnesses. Ombudsman policy requires you to protect confidentiality of any resident or complainant.

The way you introduce yourself to an interviewee and what you say about the purpose of the interview may differ depending on the person’s role. For example, you need to find out if staff respond to resident call lights in a timely manner. If you are talking to a family member, you might explain that you are trying to find out if staff meet the needs of the residents. If you are talking to the administrator, you might ask whether there has been a recent turnover of staff.

Order of Interviews

The order of who you interview can be important. Who do you interview first when you are conducting an investigation?

- First, interview the complainant. If this is not the resident, then interview the resident next.
- Second, interview any known witness in the case
- Third, conduct background interviews, such as:
  - Direct care staff (CNA)
  - Supervisors (charge nurses)
  - Director of Nurses
  - Executive Director or Administrator

Share very little information about yourself other than your role as an ombudsman. If your personal information is not consistent with the witness’s value system, the witness might not want to develop rapport with you.

Interview Techniques:

Ask clear questions.

- If you aren’t receiving answers, rephrase, and re-ask.
- Ask your supervising ombudsman to help if you are uncomfortable asking difficult questions.
- Be mindful of nonverbal cues; these can be evidence too.

An interview should be similar to a funnel. Start with “larger” open-ended questions then refine and channel information with close-ended questions. At the bottom of the funnel you ask close-ended questions meant to pinpoint and clearly define some facts.
Open-ended Questions

An open-ended question cannot be answered with “yes,” “no,” or “maybe.” Open-ended questions invite the witness to provide a lot of information. In general, it is the best kind of question to ask in an investigative interview. Formatting a question this way also helps to avoid asking leading questions which suggest the answer you want to hear.

Start an interview with open-ended questions. They help define the big picture and elicit the interviewee to describe or explain. Open-ended questions increase the chances of getting additional details and ensure a greater accuracy of the facts from the interviewee’s perspective.

Use open-ended questions to understand, rather than confirm, or use them to gather details from the interviewee’s perspective.

___________________________________________________________________

While conducting an interview, remember that only with permission of a resident or complainant may ombudsmen release confidential information. See Ombudsman Policies and Procedures, Disclosure of Confidential Information, for detail.

___________________________________________________________________

Close-ended Questions

A close-ended question can be answered with a “yes,” “no,” or “maybe.” Use close-ended questions to clarify or confirm. They can also be used to get specific times or dates.

Long-term Care Ombudsman Casework: Advocacy and Communication Skills
Run Time: 22 min - Scene 1 - Anne Walker 22 min 12 sec
YouTube: https://www.youtube.com/watch?v=Sm-8DsnDnxo&feature=youtu.be

Scenario #1: Anne Walker

INSTRUCTIONS: Watch the video and answer the following questions. Be prepared to discuss your responses with your trainer.
Note: Some questions seek specific examples from the scenarios so it may be helpful to review the questions before watching the video to understand what you will be asked to identify.
An ombudsman investigation should be ___________________, ________________, and ____________________.

How did Gloria use her senses to gather evidence?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Why did Gloria visit during the morning shower time?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

What challenges might an ombudsman encounter when visiting early mornings, nights or weekends?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Identify other ways Gloria could approach the investigation of this complaint.
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

When Ms. Walker expressed her concern about not wanting to be identified with this complaint and said residents have been discharged due to sharing their concerns, what else could Gloria have said in response to her statement?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

What does Gloria do to protect Ms. Walker’s confidentiality, and what are some other things she could do to ensure Ms. Walker isn’t identified as the complainant unless she is ready?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

What concerns did you hear Ms. Walker express in this scenario? Were all of them addressed?
Why didn’t Gloria review Ms. Walker’s care plan to check her preferences about showers?

For purposes of ombudsman visits and complaint investigations, make unannounced visits to facilities.
Effective Communication Skills

Gloria used both open-ended and close-ended questions during her complaint intake, investigation, and resolution process.

**Exercise:** Use the chart below to identify some of the open-ended and close-ended questions you heard Gloria ask and describe what information she was trying to obtain with those questions.

<table>
<thead>
<tr>
<th>OPEN-ENDED</th>
<th>CLOSE-ENDED</th>
<th>INFORMATION GAINED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
The Emotional or Uncooperative Witness

A successful interview is sometimes hampered by an emotional or uncooperative witness. Empathic listening is important and gives the person undivided attention which can make the interview more productive. Try to be nonjudgmental and acknowledge the person's feelings, not just the facts.

Think about potential emotional responses from witnesses and plan your response before it's needed. This can prepare you to de-escalate an emotional or uncooperative witness.

Ask the Trainer: Brainstorm appropriate responses to an emotional or uncooperative witness. In the table, list an approach for each emotional or uncooperative response.

<table>
<thead>
<tr>
<th>Witness’s Response</th>
<th>Ombudsman Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crying</td>
<td>Acknowledge the witness’s feelings and consider offering tissues</td>
</tr>
<tr>
<td>Pacing</td>
<td></td>
</tr>
<tr>
<td>Slamming things</td>
<td></td>
</tr>
<tr>
<td>Pointing fingers</td>
<td></td>
</tr>
<tr>
<td>Eye rolling</td>
<td></td>
</tr>
<tr>
<td>Lack of eye contact</td>
<td></td>
</tr>
<tr>
<td>Screaming or yelling</td>
<td></td>
</tr>
<tr>
<td>Folded arms or other body language</td>
<td></td>
</tr>
<tr>
<td>Excessive talking</td>
<td></td>
</tr>
<tr>
<td>Giving the same response to every question</td>
<td></td>
</tr>
<tr>
<td>Sarcasm</td>
<td></td>
</tr>
<tr>
<td>Cursing</td>
<td></td>
</tr>
<tr>
<td>Blaming</td>
<td></td>
</tr>
<tr>
<td>Avoiding</td>
<td></td>
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</tbody>
</table>
Record Review

Review of relevant documentation may be necessary to thoroughly investigate a problem. Accessing a confidential resident record requires the resident’s consent and is described in Chapter 12. Facility policies and admissions paperwork are public and available by request.

Documents most frequently reviewed are confidential resident records and public facility policies. Types of documents and records you might review include:

- Care or service plans
- Resident medical records
- Advanced directives
- Facility policies and procedures
- Ombudsman reports
- Powers of attorney
- Admission agreements, or contracts
- Grievance reports
- Resident council meeting minutes
- Resident or family journals
- Resident personal care logs
- Facility transfer sheets
- Police reports
- Incident reports regarding a specific resident

In general, a record review can help you learn:

- the condition of a resident before and after an incident;
- whether staff have assessed, care planned, implemented care, and evaluated the outcome of the care as specified by regulatory requirements; and
- how the facility documented their response to an incident and how the facility documented care delivered to a resident.

Review a facility’s policies and procedures to determine if they are logical and consistent with requirements. An ombudsman might review the facility’s policies and procedures to determine if the facility has adequate requirements for training employees, policies for protecting residents, or rules that limit resident rights.

Investigation Documentation

To document a case, ombudsmen use Form 8619, *Long-Term Care Ombudsman Case Record* or Form 8620, *Long-Term Care Ombudsman Activity Report*. Detailed information on ombudsman casework, documentation, and reporting is covered in Chapter 11.
### Supplement 9-A: Form 8619 Long-Term Care Ombudsman Case Record

**Long-Term Care Ombudsman Case Record**

**CONFIDENTIAL**

<table>
<thead>
<tr>
<th>Ombudsman</th>
<th>Reference Title for the Case</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Intake Date</th>
<th>First Action Date</th>
<th>Closed Date</th>
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</table>

**Intake Summary**

<table>
<thead>
<tr>
<th>Anonymity Requested?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consent Obtained to Work on Residents Behalf</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Consent to Review Records</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>If yes, oral or written</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Complainant**

<table>
<thead>
<tr>
<th>Complainant Role</th>
<th>Complainant Name</th>
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<table>
<thead>
<tr>
<th>Agency/Company</th>
<th>Address</th>
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<thead>
<tr>
<th>Home Area Code and Telephone No.</th>
<th>Work Area Code and Telephone No.</th>
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<tr>
<th>Cellular Area Code and Telephone No.</th>
<th>Fax Area Code and Telephone No.</th>
<th>E-mail Address</th>
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**Facility**

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<tr>
<th>Type</th>
<th>Name</th>
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<tbody>
<tr>
<td>NF</td>
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<tr>
<td>ALF</td>
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</tbody>
</table>

**Facility**

**Resident**

<table>
<thead>
<tr>
<th>Legally Authorized Representative?</th>
<th>If Yes, Name</th>
<th>Type of Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td></td>
<td>Legal Guardian</td>
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<tr>
<td>No</td>
<td></td>
<td>DPOA</td>
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<tr>
<td></td>
<td></td>
<td>MPoA</td>
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</table>

**Complaints**

**Code (1 – 132)**

<table>
<thead>
<tr>
<th>Notes (describe the problem)</th>
<th>Verified?</th>
<th>Disposition</th>
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</table>

**Actions (Journal)**

**CONFIDENTIAL**
Notes:
Notes:
CHAPTER 10: Resolving Complaints
Resolving Complaints

Chapter 10 discusses the skills and strategies used to resolve complaints, including the five-step problem-solving process.

Learning Objectives

- Understand different complaint resolution skills
- Understand potential barriers to resolving conflict
- Learn how to apply the Five-Step Problem-Solving Process
- Practice using the Five-Step Problem-Solving Process

Contents

- Complaint Resolution Skills
- Potential Barriers to Resolving Conflict
- Putting it All Together: The Five-Step Problem-Solving Process
- Case Examples

DVD(s), Supplements, Forms

- DVD: LTCO Casework: Advocacy and Communication Skills
Overview

There are several skills ombudsmen use to help resolve complaints on behalf of residents in nursing homes and assisted living facilities. Chapter 10 discusses conflict resolution, self-advocacy, mediation, and negotiation. The entire five-step problem-solving process used to receive, investigate, and resolve complaints is described.

Complaint Resolution Skills

Conflict Resolution

Conflict arises from differences. It occurs whenever people disagree over their values, perceptions, ideas, or even care choices. Small conflicts can produce strong feelings. Everyone needs to feel safe and secure, to feel respected and valued, and to know their voice is heard.

Conflict resolution skills are the methods and processes people use to help bypass personal differences. They help parties involved to see possibilities and to search for solutions. A wide range of methods and processes for addressing conflict exist, including mediation and negotiation. Healthy responses to conflict are characterized by:

- the capacity to recognize and respond to important matters;
- a readiness to move forward;
- the ability to seek resolution (and avoid punishing); and
- a belief that resolution can support the interests and needs of both parties.

SOURCE; http://www.edcc.edu/counseling/documents/Conflict.pdf

Self-Advocacy

Self-advocacy is the ability to speak-up for yourself and the things that are important to you. It works for residents who are empowered. Encourage residents to advocate for themselves as much as they are able. They may prefer to work with an ombudsman for support or with the ombudsman taking the lead.

Residents who self-advocate are able to ask for what they need and want, and tell people about their thoughts and feelings. It also means they know their rights and responsibilities, they speak-up for their rights, and they are able to make choices and decisions that affect their lives.

Strategies to promote self-advocacy include:

- Educate a resident on residents’ rights.
- Support a resident’s participation in his or her care or service plan.
- Coach a resident in ways to negotiate with facility staff.
- Encourage a resident to bring his or her complaint to the resident council.
- Bring residents with similar concerns together to work on the problem.
- Encourage a resident to use the facility grievance process.

Mediation

Formal mediation requires a mediator to be impartial and all parties to have equal power. Mediators are not decision-makers; they help the parties agree to mutual resolution. Ombudsmen do not serve as mediators because:

- Ombudsman work is on behalf of residents. Although impartial in investigation, ombudsmen are resident advocates when resolving a problem.
- Parties are not usually equal in power. Mediation can be appropriate when two residents or two family members are the parties in conflict.

**Ombudsman Tip.** For ombudsmen to resolve conflicts, the problem and the parties need to fall within the scope of the ombudsman program.

If the conflict is not within the ombudsman scope of services, the involved parties could work with a mediation organization to help resolve the issues.

Negotiation

Negotiation is the complaint resolution skill most frequently used by ombudsmen. It is a dialogue between two or more people intended to reach an understanding, resolve points of difference, to gain advantage for an individual or collective, or to craft outcomes to satisfy various interests.

Negotiating is bargaining with the focus on *interests* rather than *positions*. Interests are what cause you to make decisions, such as “I want to be treated with dignity and respect.” Positions are things you decide upon, such as “That nurse cannot come into my room.” Some negotiation principles are especially relevant for ombudsmen to reach a “win-win” solution for the resident and the facility. When it comes to residents’ rights, *how* a resident right is met can be negotiated, but not *if* it is met.

- Focus on interests, not positions
  - Explore interests.
  - Each side may have multiple interests; try to find similar interests to form the basis of a win-win solution.
  - Avoid having a bottom line.

For example, “We agree residents need the best care possible. Let’s discuss what Mr. Tanaka needs to feel safe and secure in his home.”
• Negotiate on the merits
  ▪ Recognize people are problem-solvers.
  ▪ Concentrate on achieving a wise outcome, reached efficiently and agreeably.
    - Focus on solving the problem.
    - Do not try to score debate points or outsmart the other party.

For example when speaking to facility staff, “You have a huge responsibility and it is difficult to please everyone. However, having residents receive clothes that do not belong to them and are the wrong size is a problem. It can be solved if we work together.”

• Separate the people from the problem
  ▪ Be soft on the people and hard on the problem.
  ▪ Be aware the other person probably sees the situation differently.
  ▪ Do not react to emotional outbursts; allow the other side to let off steam.
  ▪ Phrase ideas in terms you think will solve a problem, not in terms of what someone should do.

For example, “I know your facility strives to meet resident’s needs. However, trays left without giving help and removed without the resident being able to eat is a serious issue. Let’s focus on ways to avoid this. It could help if the aides were clear about which residents need help with eating and drinking, whose responsibility it is to help, and how to assist the residents.”

The difference between a position and an interest is: ______________________________
__________________________________________
__________________________________________
__________________________________________

• Look for options with mutual gain
  ▪ Develop multiple options and decide later.
  ▪ Look for solutions that allow both sides to gain something, in contrast to using compromises where both sides lose something.
  ▪ Be open to different solutions.
  ▪ Try to develop a win-win solution based on shared interest.

For example, “Based on our discussion, we agree Mr. Dillard needs more opportunities to move around and to be outdoors. Can we brainstorm some ideas about how his needs can be met while considering his safety and need for supervision?”

• Insist on using objective criteria
Try to reach a solution based on standards independent of will, such as laws, written rules, and outside experts.

- Reason and be open to reason (apply logic, establish and verify facts, and hear new or existing information).
- Yield to principle, not pressure.

For example, “I understand your concern that Mrs. Everett’s health will decline if she doesn’t take the medicine her doctor ordered. You have done an excellent job of explaining the consequences of her decision and offering other options. Nevertheless, residents have the legal right to refuse treatment.”

**SOURCE:** *Getting to Yes: Negotiating Agreement without Giving In* by Roger Fisher and William Ury

---

When negotiating with management, separate the ________________ from the problem.

---

**Negotiation Styles**

There are many ways to resolve a complaint. Each situation may require a different negotiation style and some may involve multiple ones over time. Review the appropriateness of your strategy and ask, “Is this the best method to resolve this problem with this person?” Negotiation styles include collaboration, competition, accommodation, compromise, and avoidance.

**Collaboration**

The collaboration style is characterized by assertiveness and willingness to cooperate. This is the primary style ombudsmen use in complaint resolution. It is solution-focused and can be time intensive. The ombudsman or resident emphasizes the resident’s position while also inviting other views.

Collaboration promotes open discussion about concerns and encourages both sides to explore solutions and resources to find a solution that works long-term for both parties. To be successful, the resident, staff, ombudsman, or others discuss concerns in a non-
threatening way and think creatively. This style of negotiation builds trusting relationships, merges perspectives, and encourages high levels of cooperation.

### Competition

A competitive approach is characterized by high levels of assertiveness with a reluctance to cooperate or compromise. It emphasizes achieving goals over maintaining smooth relationships. A competing style is one in which the concerns and the position of the opposition are ignored. If the ombudsman or resident uses this style, there is no concern about the facility, facility staff, or how they will live with the decisions.

The competition style is used when the goal is quick action or when there is little hope of consensus ever being reached. Competition is critical when you are certain that something is not negotiable and immediate compliance is required. An ombudsman might use this style if there is an emergency or the issue is vital to the resident’s welfare.

A disadvantage of the competition style is that it may keep the others involved from voicing important concerns. If the resident or ombudsman wins, it may be at the expense of important information which could have altered the decision.

### Accommodation

The accommodation style is characterized by a high degree of cooperativeness with low assertiveness. This style works to ensure goodwill among everyone involved and emphasizes meeting the needs of others. This approach focuses on preserving relationships.

Use this style when the issue is something of minimal importance to the resident but important to the facility. This technique can backfire if the ombudsman uses it all the time as it can earn the reputation of “not standing your ground.” If residents feel their concerns are never acknowledged or their opinions are ignored, then the ombudsman may be too accommodating.
Compromise

The compromise style of negotiation is characterized by moderate levels of assertiveness and cooperativeness. It emphasizes flexibility and finding middle ground. Both parties give up part of what they want to settle the problem.

Ombudsmen should consult with the resident when using the compromise style. It’s important to follow the resident’s guidance and be careful to not give up something of great importance to the resident.

- Both parties may give away something important which leaves them feeling dissatisfied.
- Try to identify things that mean a lot to the other side but not as much to the resident. Give these up first.

Avoidance

The avoidance style of negotiation is characterized by low assertiveness and cooperativeness. This style is appropriate when the issues are not important to the resident or when more information is needed or forthcoming. It may also be appropriate if the resident or ombudsman is being pressured to negotiate a minor issue and there is a more important concern pending.

An avoiding style should be used sparingly and only when something is going to change: the resident, the other person, or the situation. For example, it’s okay to avoid a conflict between the administrator and the resident if you already know the resident is planning to move soon.

Potential Barriers to Resolving Conflict

Response to Authority Figures

Since ombudsmen encounter conflict on a routine basis, it is important to understand personal responses to authority figures that might present barriers to problem-solving.

Common responses include:

- **Intimidation**
  Feeling intimidated by a person in authority is not uncommon. Sometimes the professional title, expertise, or social status associated with a person can lead to feeling intimidated about personal training or capabilities.

- **Anger or fear**
  Working with authority figures who may not share the complainant's point of view can lead to feelings of anger or fear. Confronting authority figures who lack empathy can be stressful and take a toll on the person confronting the problem.

- **Avoidance**
  It is not uncommon for people to avoid directly confronting a problem. It can feel safer to avoid face-to-face communication to solve a problem, especially if a past experience was negative.

To most effectively work with authority figures, use the following strategies:

- Make an objective assessment of the person. Authority figures can be potential allies or opponents.
- Evaluate perceived prejudices, preferences, and decision-making patterns shown by authority figures. Study their personalities and adjust your responses to communicate better. For example, knowing four personality types known by terms such as controller, promoter, feeler, and thinker, you can build better relationships. If they are thinkers, give them facts; if they are feelers, share personal stories; and so on.
- Know the lines of communication. If a person in authority makes an unfavorable decision, find out who has higher authority, appeal rights, or opportunities.
- Be aware of policies, guidelines, rules, regulations, and laws that govern the authority figure. Know which ones the person has authority to control.
- Use residents' rights and other laws when they apply. Laws are powerful tools that ombudsmen must know and use. Refer to nursing home and assisted living facility rules cited in Chapter 1, Supplement 1-B: Statutory and Rule References.
Other Barriers to Resolving Conflict

Personal values and beliefs

- Everyone is influenced in varying degrees by the values of their family, culture, religion, education, and social group.
  For example, an ombudsman has a resident who has requested her assistance because he is being discharged for smoking in his room. She does not put much effort into helping him because smoking is bad for his health and she does not want to support his habit.
- Ask your supervising staff ombudsman for help if your values and beliefs inhibit your ability to be an effective advocate for a resident whose values and beliefs conflict with yours.

Emotional involvement

- Ombudsmen are human. Occasionally a resident’s concern may touch an emotional note with an ombudsman.
  For example, residents who remind an ombudsman of one of his parents receives more attention to concerns than most residents.
- Ombudsmen should not become overly invested in the resident’s issue. Check your personal boundaries to remain objective.
- Ask your supervising staff ombudsman for help or ask your staff ombudsman to take the case.

Friendly with facility staff

- It is important to establish a professional, friendly, yet firm, rapport with the facility staff.
- If ombudsmen become too familiar or friendly with staff, they may have difficulty being an effective advocate for residents. Review Walk the Fine Line from Chapter 6.
- Seek guidance from your supervising staff ombudsman or MLO if you have difficulty being an effective advocate in your assigned facility.

Long-term Care Ombudsman Casework: Advocacy and Communication Skills
Run Time: 13 min - Scene 2 - Brian Brashear 13 min
YouTube: https://www.youtube.com/watch?v=BZJtzm_sA1Q&feature=youtu.be

INSTRUCTIONS: Watch the video and answer the following questions. Be prepared to discuss your responses with your trainer.
Note: Some questions seek specific examples from the scenarios so it may be helpful to review the questions before watching the video to understand what you will be asked to identify.

What concerns did you hear Mr. Brashear expressing in this scenario? Were all of them addressed?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

What is the PEP method? ______________________, ______________________,
________________________, ______________________.

How did Gloria address Mr. Brashear’s concerns in relation to his rights and the other residents’ rights when speaking with Mr. Cook? Was that effective? Explain your answer.

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

How did Gloria ensure her complaint investigation was resident-directed while reminding Mr. Cook of the need for resident-directed care and quality of life? How did this impact her credibility with Mr. Brashear? With Mr. Cook?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

As it states in the video, the ombudsman needs to remain “calm, objective, and in control” at all times, especially when a situation has escalated. When speaking with Mr. Cook what techniques did Gloria use, both verbal and nonverbal, to maintain her professionalism and remain calm, but assertive?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________
In the follow-up conversation with Mr. Brashear and Mr. Cook, how did Gloria demonstrate her support of Mr. Brashear when facilitating that conversation? Why was that important?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Putting It All Together: The Five-Step Problem-Solving Process

Ombudsmen use a five-step problem-solving process to receive, investigate, and resolve complaints. This process is how an ombudsman works a case from start to finish. It includes working with a resident to support and maximize his or her participation in the complaint resolution process.

**STEP 1** Identify the problem from the resident’s perspective, investigate, and research statutory support.

Ombudsmen are resident-directed advocates. Therefore, when an ombudsman receives a complaint from someone other than a resident, the ombudsman must first consult with the resident who was identified prior to taking any actions. If the resident acknowledges the problem and gives the ombudsman permission to work to resolve it, the ombudsman investigates.

For each complaint, consider whether there are residents’ rights involved and whether there is statutory support that will help resolve it.

Resident-directed advocacy means the ombudsman should:

______________________________________________________________________

______________________________________________________________________

**STEP 2** Consider underlying causes and determine scope of the problem

A problem is more effectively resolved by finding its underlying or root cause. Once a complaint is investigated, analyze the information to determine the reason the problem occurred. It may reveal the root cause is not the problem that was originally reported.
Factors for ombudsmen to consider are:

- Was the problem an oversight or does it seem deliberate?
- Is the problem related to facility policies or procedures?
- Does the facility offer any justification for the problem?
- What role does staff have in the problem?
- What is the resident’s role in the problem?
- What roles do family or visitors have in the problem?
- How many residents are affected by the problem?

Responsibility may rest with one or more of the following:

- facility staff failed to perform their duties properly;
- unclear regulations about the issue;
- services cannot be reimbursed;
- outside professionals gave unclear instructions; or
- resident or family contributed to the problem.

Scope refers to how many residents are affected by a complaint. The scope determines who needs to be involved in an investigation and may steer the approach an ombudsman takes towards resolution.

Finding the root cause of a problem is essential to a lasting solution.

STEP 3  Explore solutions and take action

Information gathered during an investigation is used to resolve the complaint. Before jumping to resolution, take time to analyze the information collected, explore resolution strategies, and make an action plan with the resident or complainant.

To identify possible solutions, ask yourself:

- What will resolve the problem?
- What will it take to keep the problem from reoccurring?
- What obstacles might be encountered with each solution?
- What are the resident’s options regarding their medical and physical needs?
Sometimes there are several ways to resolve a problem. Options help ombudsmen be prepared with ideas for possible solutions, anticipate potential obstacles, and have suggestions ready to overcome obstacles to resolution.

**Example: Exploring Solutions**

A resident complains, “I pay a lot to live here but I can’t have a baked potato for lunch.” She asks the ombudsman for help.

Possible Solutions: Changing menu options
Potential Obstacles:
- Cost or supply issues
- No other similar requests have been made
- Resident preferences have not determined menu decisions in the past

Suggestions to Overcome Obstacles:
- Temporary use of another supplier or alternate purchase source
- Seeking assistance from the resident council
- Put concern in writing
- Create Dietary Council or Food Council

Possible Solutions: Updating the resident's food preferences
Potential Obstacles:
- Dietary manager unavailable
- Dietary manager unwilling
- Decision making is delegated to a family member

Suggestions to Overcome Obstacles:
- Speak with manager with authority over dietary manager
- Educate on resident rights

Possible Solutions: Changing dietary orders
Potential Obstacles:
- There is a medical reason potatoes are not provided
- The resident has an order for mechanically softened foods

Suggestions to Overcome Obstacles:
- Facilitate communication between resident and dietary staff
- Explore options with physician or dietitian

Possible Solutions: Staff training
Potential Obstacles:
- Time lag to next training
- Not all staff in attendance
- Staff turnover

Suggestions to Overcome Obstacles:
- Request interim training, ongoing training, and training across all shifts
Exercise: Brainstorm possible solutions, potential obstacles, and suggestions to overcome obstacles below.

Ms. Garcia wants to stay up late at night. An evening charge nurse knows her preference and will accommodate her. This nurse doesn’t work every night. How can a lasting solution be reached?

Possible Solutions: _______________________________________________________
Potential Obstacles: _____________________________________________________
Suggestion to Overcome Obstacles: ________________________________

Possible Solutions: _____________________________________________________
Potential Obstacles: _____________________________________________________
Suggestion to Overcome Obstacles: ________________________________

Possible Solutions: _____________________________________________________
Potential Obstacles: _____________________________________________________
Suggestion to Overcome Obstacles: ________________________________

Possible Solutions: _____________________________________________________
Potential Obstacles: _____________________________________________________
Suggestion to Overcome Obstacles: ________________________________

Sometimes, ombudsmen develop a solution and suggest it to all parties. At other times, they bring people together to discover the best solution. Complaints can be resolved in a number of ways, but try to find a solution that addresses the root cause and supports the resident’s wishes.
Individual care or service plans should be updated to meet a resident’s needs. Ombudsmen can suggest a care or service plan meeting to resolve a variety of problems.

Check with the Resident

Once an ombudsman has investigated a complaint, identified the underlying problem, identified possible solutions, obstacles, and resolution strategies, it is time to pause and check with the resident. Reasons for this are to:

- share with the resident what the ombudsman learned;
- be sure the resident wants you to continue trying to resolve the problem;
- confirm the outcome the resident seeks;
- discuss ideas regarding how to resolve the problem;
- encourage the resident to participate in the resolution process;
- discuss potential consequences to the resident, if any;
- discuss possible outcomes; and
- determine what will satisfy the resident.

Before taking action to resolve, be sure you know what the ____________ wants.

Take Action

To take action requires resident consent. Seek resident-directed resolutions. Once the resident is consulted and an approach is chosen, act to resolve. Be respectful, reasonable, confident, and have a good attitude. Not all complaints can be resolved using laws and rules. Some require persuasion which is dependent on an ombudsman’s ability to identify the problem, listen, plan and prepare, and build credibility.

A meeting may be necessary to get the right parties in the same room to discuss a resolution. To prepare for a resolution meeting, have a plan of action:

- Investigate first
- Know what the resident wants
• Determine who needs to be involved and request their participation
• Establish who will lead the meeting
• Rehearse
  ▪ Visualize what to do and say in the meeting
  ▪ Be clear what your role is
  ▪ Set the time and place and be sure parties are aware
  ▪ Anticipate obstacles and have potential solutions ready
• Pay attention to others in the meeting. Note body language, eye contact, facial expressions, gestures, and tone of voice. Think about what negotiating style other parties may use. Do they appear submissive, assertive, or aggressive?
• Anticipate surprises
  ▪ Do not agree to something under pressure if it does not fit with resident direction
  ▪ Ask for time if needed
  ▪ Trust your gut
  ▪ Call all parties the day before to confirm

As you prepare for a meeting, visualize a cooperative environment where you serve as a guide toward resolution.

Ombudsmen take a complaint as far as possible to accomplish the resident’s desired outcome. Some tools an ombudsman may use to work toward resolution include:

• care planning to focus attention on resident needs, routines, strengths, and preferences;
• resident and family councils;
• laws and rules that support the resident, especially residents’ rights; or
• regulatory agencies which oversee health care facilities and use investigations, citations, and penalties to enforce laws and rules.

Ombudsmen should follow up with other agencies and the resident when a complaint is referred. Check back with the resident later if a complaint was withdrawn.
Other Resolution Strategies

If a complaint cannot be resolved by interventions at the facility, it may be necessary to use more adversarial strategies. Volunteer ombudsmen refer these complaints to the supervising staff ombudsman; he or she works with the managing local ombudsman who coordinates with the State Ombudsman and serves as the lead in these strategies. These strategies might include:

- legal services – advice, litigation;
- courts – judgments, enforcement, recovery, damages;
- elected officials – add, edit, or delete laws and rules; and
- local media – publicity, news, opinions.

STEP 4 Check on progress and outcomes

The resident should always be an ombudsman’s first source to check progress. This is often done in person, but also may be by phone. Other than in your confidential reports to the ombudsman program, be careful not to identify any resident as a complainant if he or she requested anonymity. A volunteer and staff ombudsman may work together to resolve and follow-up on a complaint.

If the complainant is someone other than a resident, ombudsmen have an obligation to inform the complainant of progress, according to the resident’s direction. If a resident does not perceive the complaint as a problem, the ombudsman informs the complainant of the resident’s perspective and provides options.

At any point while working towards a resolution, things may fall apart or there may be little to no progress. In such cases, investigate the cause and take action to restart the process or attempt a new strategy.

Resident communication styles and abilities guide follow-up strategy. Some residents do not hesitate to report to an ombudsman that the problem is getting worse or not improving. Others wait until an ombudsman visits or may hesitate to report bad news. An ombudsman listens, interprets nonverbal communication, redirects conversations, or probes for more information, depending on each resident’s needs.

How often and how long you follow-up varies with each case. The facility’s response, the complexity of the problem, and how quickly and successfully staff implemented changes may affect follow-up plans. Check back at least once or twice. For less complex cases, check back with the resident anywhere from several days to several weeks. If the problem was complex, check back in several weeks to several months to confirm the solution is lasting.
STEP 5  Determine resident or complainant satisfaction with outcome.

Once an ombudsman has done all the work they can toward resolution, identify an outcome for each complaint, and close the case. Ombudsmen call the outcome a disposition. The resident or complainant determines the outcome, so contact the person to check whether the problem was resolved to his or her satisfaction.

In the beginning, an ombudsman checks with the supervising staff ombudsman to determine when to close a case. With experience, ombudsmen often determine when to close a case on their own, but consulting the supervising staff ombudsman is always an option.

Close a case when you have done all the ____________ you can reasonably do.

Ombudsmen report the disposition of a complaint or case, as follows:

- Resolved (include referred complaints with a resolved outcome)
- Partially resolved, part of the problem remains (include referred complaints that are partially resolved)
- Withdrawn
- Referred to another agency:
  - Disposition not obtained
  - Agency failed to act in accordance with policy
  - Agency did not substantiate
  - No action needed or appropriate
  - Not resolved
  - Cannot be resolved and requires regulatory or legislative action

If the complaint was referred to another agency to investigate, check with your supervising staff ombudsman on the status of investigation or action. If the problem continues, contact the agency again as necessary.

Remember two factors while working to resolve complaints:

1. Some complaints cannot be resolved. Sometimes a complaint can’t be resolved even with thorough investigation, unquestionable verification, and wise and persistent efforts by the ombudsman.
2. Complaint resolution is not always clear-cut.
- A problem may go away and then reappear.
- Parts of the problem will be resolved but not others.
- The complainant will not be completely convinced the situation is as good as it should be.
- The complainant may say everything has been solved even if the ombudsman would prefer to continue pursuing the matter.

**Case Example**

**The Five-Step Problem-Solving Process**

**Complainant** – Mr. Smith, Administrator of Golden Oaks Retirement

**Resident** - Mr. Flynn

**Complaint** – Mr. Smith tells you (the ombudsman) that Mr. Flynn will not bathe and he wears the same clothes every day. His body odor is unpleasant for his roommate, caregivers, and other residents. Mr. Smith says that the facility is concerned they can't meet Mr. Flynn's needs.

**STEP 1** Identify the problem from the resident’s perspective, investigate and research statutory support.

You consult with Mr. Flynn. Mr. Flynn acknowledges there is a problem and gives you permission to take action. You open a case and begin to collect information.

Mr. Flynn tells you he prefers to wear overalls. The pair he wears everyday fits well but he doesn’t trust the facility laundry to wash them because they’ve lost or damaged several pairs in the past.

He also tells you that bathing is not something he looks forward to because the aides rush him, the shower water isn’t hot enough, and aides don’t let him wash himself.

With Mr. Flynn’s consent, you interview some of his direct caregivers. They report he refuses a bath no matter what they try, including letting him bathe himself. They tell you at one time Mr. Flynn didn’t mind taking showers, but the CNA that formerly helped him no longer works there. They tell you some residents complain of Mr. Flynn’s odor but can’t provide you with any specific names.

Statutory support for this case that is applicable:

- Residents have the right to refuse treatment and care.
- Residents have a right to a decent living environment.
- Residents have a right to have their choices and preferences respected and to secure their personal property from theft or loss.
- The facility must help maintain Mr. Flynn’s highest practicable level of functioning, allow him to participate in his care plan, and maintain or enhance his quality of life.
STEP 2  Consider underlying causes and determine scope of the problem

Issues Mr. Flynn shared with you:
- The bathing environment is unpleasant.
- He needs some new clothes that are clearly labeled.
- Laundry sorting process does not ensure residents get their laundry returned.

Things that need further exploration by you:
- Is Mr. Flynn embarrassed by some part of the bathing process?
- Do the bathing times match his preferences?
- Do the caregivers know or respect Mr. Flynn’s bathing preferences?
- Do the caregivers need additional training?

Scope: the problem primarily affects Mr. Flynn

STEP 3  Explore possible ways to resolve and take action

- Mr. Flynn identifies he wants to bathe in the afternoons and to have all the time he wants in the shower. He agrees to allow a CNA to check on him at regular intervals and to pull the call light when he is finished or if he needs help.
- Mr. Flynn agrees to the purchase of new overalls and shirts of the same brand and size, using his trust fund. He will allow the activity director to label his clothing. Laundry bags will be used to distinguish his clothes.
- You and Mr. Flynn meet with the social worker in Mr. Flynn’s room. Mr. Flynn takes the lead with his requests. The social worker says the facility may need to set a limit on the shower time and Mr. Flynn agrees to 20 minutes.
- The social worker confirms the nursing home should replace any items lost in the laundry.

STEP 4  Check on progress and outcomes

The administrator brings Mr. Flynn his new clothes to approve.
- Mr. Flynn signs the receipts for the new overalls. He is satisfied.
- The overalls are clearly labeled with Mr. Flynn’s name.
- The first day of Mr. Flynn’s requested scheduled bath is successful. He has to persuade staff to allow him to bring his soiled clothes back to his room for the laundry, but this is also successful.
- The social worker writes down a procedure for bathing with his input and gives him a copy. She places a copy in his medical records and updates his care plan. His direct caregivers are briefed on the procedures.
Mr. Flynn reports he is very satisfied with the outcome. If he encounters problems, he plans to speak with the social worker or administrator first, then the ombudsman if needed.

Exercise:
Case Discussion: “Show me the Money”

Ms. James lost several clothing items. Her sister Ms. Martin visits often. On the last visit, Ms. James was wearing clothes that did not belong to her. She told her sister some clothes had been taken out of her dresser. When Ms. Martin asked, the administrator said Ms. James is confused.

Ms. Martin heard that her sister should be able to keep some money out of her check each month. Ms. James doesn’t know about this. Ms. Martin suggests the administrator use the money to buy a new dress for her sister. He says there isn’t any money left after bills are paid each month. When Ms. Martin asked where the money was kept, staff replied that only the legal guardian could have that information.

Other residents report their funds are not accounted for. The administrator reports:
- Because of theft, personal needs allowances are given on an as-needed basis.
- At admission, every resident signs a form authorizing the facility to administer funds for security purposes. For residents who have a diagnosis of dementia, a family member is asked to agree to this procedure by signing the form.

Step 1: Identify the problem and research statutory support

Step 2: Consider causes and scope

Step 3: Explore ways to resolve and take action

The process continues in real cases…
Step 4: Check on progress and outcomes
Step 5: Determine satisfaction

Case Discussion: “Discharge – Unable to Meet Needs”

Lacey Dalton is married and 45 years old. Her husband lives in their home and she lives in a nursing home. The administrator issued her a 30-day discharge notice stating they cannot meet her needs.

The facility contacted Mr. Dalton numerous times to discuss his wife’s behaviors, but he changed his phone number and address. Mrs. Dalton reportedly gave her husband Power of Attorney when she was in the hospital, but the facility does not have a copy. The facility reports Mrs. Dalton is noncompliant with treatment and has placed her health at risk. Mrs. Dalton says her husband cannot take care of her. She calls the ombudsman to help her stay in the nursing home.

Step 1: Identify the problem and research statutory support

_____________________________________________________________________

Step 2: Consider causes and scope

_____________________________________________________________________

Step 3: Explore ways to resolve and take action

_____________________________________________________________________

The process continues in real cases...
Step 4: Check on progress and outcomes
Step 5: Determine satisfaction

Case Discussion: “No Appropriate Food Choices”

Jerry Smith lives in Happy Hills Assisted Living. He recently shared his concern about the facility’s lack of food choices appropriate for a person with diabetes. Mr. Smith states he inquired about appropriate menus for diabetes before moving into Happy Hills. At that time, the executive director told Mr. Smith they always have two entrée choices at each meal and that he can choose the best option that serves his dietary needs.
Mr. Smith showed the monthly menu to the ombudsman. He highlighted the entrée choices which did not meet his dietary needs. Many lunches and dinners listed two high carbohydrate options such as chicken spaghetti and tuna noodle casserole. No sugar free desserts were indicated.

Mr. Smith said he recently told the executive director and the nurse about his dietary concerns. He shows you a copy of the facility disclosure statement which indicates no special diets are offered by his assisted living facility. He feels that meeting his needs requires a specialized diet and that the facility promised they would do so before he moved in. See below.

### Step 1: Identify the problem and research statutory support

______________________________________________________________________

______________________________________________________________________

### Step 2: Consider causes and scope

______________________________________________________________________

______________________________________________________________________

### Step 3: Explore ways to resolve and take action

______________________________________________________________________

______________________________________________________________________

**The process continues in real cases…**

Step 4: Check on progress and outcomes
Step 5: Determine satisfaction
CHAPTER 11: Staying Connected
Staying Connected

Chapter 11 is about a certified ombudsman’s communication with the Long-term Care Ombudsman Program and ways volunteers, local program staff, and the state office stay connected.

Learning Objectives

- Recognize the importance of strong communications among ombudsman volunteers and staff to stay connected
- Understand the conditions when consultation with the ombudsman program is required
- Recognize the methods used for volunteers, staff, and staff from the Office of the State Long-term Care Ombudsman to stay connected
- Learn how to complete and submit a monthly report to the ombudsman program office

Contents

- Communicating with the Ombudsman Program
- Ways to Stay Connected
- Consulting with Ombudsman Program Staff
- AoA Complaint Codes
- Reporting Ombudsman Work

DVD(s), Supplements, Forms

- AoA Ombudsman Complaint Codes (1-132)
- LTC Ombudsman Activity Report, Form 8620
- Instructions Form 8620 (Reporting Instructions Long-term Care Ombudsman Activity Report, Form 8620)
- Supplement 11-A - Researching Statutory Support
- Supplement 11-B – Consistency in Reporting Casework
- Supplement 11-C - Complaint Codes Descriptions - LTCOP
Staying Connected with the Ombudsman Program

Good communication between volunteers, local ombudsmen, and state office staff is essential to an effective ombudsman program. Staying connected and communicating ensures all ombudsmen feel supported and have access to help when needed. Good program communication also helps residents receive the advocacy they need, when they need it.

Ombudsman program communications are vital for effective advocacy. Ombudsmen stay connected through:

Consultations*
Ombudsmen should never feel alone. Call your supervising staff ombudsman for problem-solving ideas and for guidance about ombudsman procedures. Request a joint visit when needed.

Visits
A staff ombudsman makes periodic visits with a volunteer. Joint visits allow ombudsmen to learn from one another. Take advantage of these visits to ask questions, make observations, and exercise critical thinking skills while observing another ombudsman in action.

Training
In addition to training received for initial certification, every ombudsman must earn 12 hours of continuing education each year. Continuing education keeps ombudsmen informed of changes in the long-term care system and builds upon the foundation of initial training. Training in person with other ombudsmen is critical to staying connected.

Reporting
As a federally- and state-funded program, reporting is required. Reports communicate the real needs of residents and serve as the basis for legislative advocacy. To maintain certification, every ombudsman must report their activities monthly.

Evaluation
Annual feedback from program evaluations helps local programs plan continuing education for the coming year and identify program strengths and weaknesses. Personal evaluations recognize certified ombudsman performance and keep the program dialed into the needs and concerns of the ombudsman team.

Other
In addition to required forms of communication, programs may issue newsletters, send letters, and use social media and web communications. These efforts keep a strong connection among ombudsmen and improve the statewide program’s effectiveness.

* “Consultation” refers to providing information or consultation to residents.

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https://www.facebook.com/texasltcombudsman
Every certified ombudsman is required to earn ____ hours of continuing education each year.
Staff ombudsmen report daily and volunteers report every ____________.

Consulting with Ombudsman Program Staff

Consultation provides all ombudsmen the support they need while ensuring ombudsmen follow procedures to protect residents’ rights and the integrity of the ombudsman program. In some circumstances, consultation is advised. At other times, it is required.

Consultation is encouraged for many situations, including when ombudsmen:

- need information about possible resources;
- are unsure about laws and rules that may apply to a problem;
- have questions about ombudsman procedures;
- feel stuck on a case or problem; or
- suspect facility staff are not taking a complaint seriously.

Consultation is **required** when ombudsmen:

- feel uncomfortable helping a resident or have a personal belief that may interfere with their ability to assist a resident with a particular problem;
- have a conflict of interest related to any person associated with the facility where they serve;
- believe a person is interfering in the course of an ombudsman’s official duties;
- are asked to disclose confidential information and consent from the resident, resident’s LAR, or complainant cannot be obtained;
- need access to a resident’s medical record and the resident cannot consent and has no LAR;
- suspect ANE of a resident and the resident is unable to consent to reporting and has no LAR;
- do not have consent to report ANE, but suspects other residents are at risk;
- feel a serious risk to resident health and safety exists in the facility where the ombudsman serves; and
- are directed to consult with their supervising staff ombudsman as described in this training manual or in other written procedures.
State Long-term Care Ombudsman approval is required in the following circumstances:

- access to confidential records without consent;
- ANE reporting without resident consent; and
- conflicts of interest.

Consultation provides all ombudsmen the support they need while ensuring they follow procedures to protect residents’ rights and the ____________ of the ombudsman program. Consultation is required when ombudsmen are asked to disclose confidential ____________ and __________ from the resident, resident’s LAR, or complainant cannot be obtained.

Reporting Ombudsman Work

On a daily basis, staff ombudsmen report their activities in a statewide reporting database. The database stores confidential information about ombudsman work and supports communication among ombudsman program representatives. The system protects all documentation from release to anyone other than an ombudsman involved in a case unless permission is given by the resident or by court order. The statewide database makes it possible for the state office and local ombudsman programs to analyze and report work in order to meet federal and state requirements.

The State Long-term Care Ombudsman creates a biennial report of program accomplishments for the Texas Legislature and Governor and reports annual program accomplishments. Reports are available on the Texas Long-term Care Ombudsman Program website. You can find a copy of these reports at http://www.dads.state.tx.us/news_info/ombudsman/annualreport.html
Volunteers report their work monthly to the local ombudsman program using the Long-term Care Ombudsman Activity Report (Form 8620). Starting with the first month of visiting residents in a facility as an ombudsman intern, volunteers fill out this report to describe activities completed on behalf of residents. Once an intern is certified, these reports are part of state and federal reporting of program work.

If a volunteer or staff ombudsman keeps visit or other work notes on a personal computer or other electronic device, it must be password protected to prevent access by others. The electronic record should be deleted after submitting the monthly report. Protection of information in hard copy is equally necessary.

The first step in reporting is to get familiar with codes that describe problems an ombudsman encounters. A list of codes is provided in this chapter, followed by a detailed description of each. To categorize each complaint, codes are organized into separate headings that include:

- Resident Rights,
- Resident Care,
- Quality of Life,
- Administration, and
- Problems with Outside Agency, System, or People.

Under the headings are subheadings indicated by letters A through Q and titled for additional guidance.

Example of a complaint subheading and complaints:

M. Staffing

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>096</td>
<td>Communication, language barrier</td>
</tr>
<tr>
<td>097</td>
<td>Shortage of staff</td>
</tr>
<tr>
<td>098</td>
<td>Staff: training, lack of screening</td>
</tr>
<tr>
<td>099</td>
<td>Staff: unresponsive, unavailable</td>
</tr>
<tr>
<td>100</td>
<td>Staff: unresponsive, unavailable</td>
</tr>
<tr>
<td>101</td>
<td>Supervision</td>
</tr>
<tr>
<td>102</td>
<td>Eating assistants</td>
</tr>
</tbody>
</table>

Exercise: Find the Best Complaint Code

Use the list of complaint codes to assign the best code to describe a complaint. Circle the complainant in each complaint. For detailed descriptions of each complaint code, refer to Supplement 11-C (Complaint Code Descriptions - LTCOP) at the end of this chapter. The complaint code descriptions will help you determine the best code to use.
Example: An ombudsman observed a resident with fingernails and hair that appeared dirty. The best complaint category and code is: **F 45**, personal hygiene.

___ 1. A resident tells you “A CNA is mean. I get nervous when she comes to my room.”

___ 2. A daughter reports the nursing home is moving her Mom to make room for a special rehabilitation unit. She has lived in the same room for two years and doesn’t want to move. She says, “The social worker is harassing us.”

___ 3. A resident says, “My roommate hollers out and keeps me up at night. I want him moved.”

___ 4. A facility staff tells you, “Breakfast looks awful. The pancakes are rubbery, the eggs are powdered, and the coffee is cold.” You ask residents and they agree.

___ 5. A resident reports the facility held her care plan meeting without her.

___ 6. The social worker reports, “Mr. Jones is going into resident rooms and stealing.”

___ 7. A resident reports, “Rehab has stopped physical therapy because they say I am no longer improving enough, but I know I can progress with more therapy.”

___ 8. The daughter said, “Mom called me very upset. The blouse and pants they put on her are not hers.”

___ 9. The ombudsman observes the bathroom in a resident’s room has feces, standing water, and live roaches.

___ 10. The ombudsman notices several call lights are not within residents’ reach in bed.

___ 11. The daughter of a resident says, “My mother is allergic to fish and she couldn’t eat what was served. No one told her she could order something else so she went to bed hungry.”

___ 12. The facility called the ombudsman for assistance. They report a resident wants to go home but the nursing home does not think he can live safely at home.

___ 13. An ombudsman is aware a resident is diagnosed with an anxiety disorder. The resident’s son calls and reports to the ombudsman that he was not
informed his father’s doctor ordered two psychotropic drugs. The son is concerned after reading about serious side effects.

___ 14. The ombudsman notices the facility’s living room smells of smoke. The smoking area is off the living room and has a large ashtray full of cigarette butts in the corner.

___ 15. A resident's daughter says, “Every time I visit my mother, she is sitting in the wheelchair in the hall staring at the walls.”

___ 16. An ombudsman observes a resident looks very thin and does not eat lunch. The resident calls out for milk, but no one gets it for her.

___ 17. A resident reports, “My dentures got lost three months ago. I am still waiting for them to be replaced.”

___ 18. The ombudsman learns a resident is Spanish speaking, but her caregivers don’t speak or understand Spanish.

___ 19. A resident says, “I’m in terrible pain. The nurse is giving me Tylenol but it doesn’t help. I told her but no one pays attention.”

___ 20. A resident says, “Last evening I called the CNA to use the bathroom. The CNA said, “I'm busy now. Go in your diaper.”

___ 21. A resident tells you she has left messages for her MCO service coordinator, but none of her calls are returned.

___ 22. A resident’s customized power wheelchair is broken and the facility says the MCO will not agree to get it fixed.
### RESIDENTS' RIGHTS

#### A. Abuse, Gross Neglect, Exploitation
1. Abuse: physical (including corporal punishment)
2. Abuse: sexual
3. Abuse: verbal / psychological (including punishment, seclusion)
4. Financial exploitation (severe complaints)
5. Gross neglect (use categories F & G for non-willful forms of neglect)
6. Resident-to-resident physical or sexual abuse
7. Not used

#### B. Access to Information by Resident or Resident’s Representative
8. Access: own records
9. Access by or to ombudsman / visitors
10. Access to facility survey, staffing reports, license
11. Information: advance directive
12. Information: medical condition, treatment and any changes
13. Information: rights, benefits, services, the resident’s right to complain
14. Information communicated in understandable language
15. Not used

#### C. Admission, Transfer, Discharge, Eviction
16. Admission contract and/or procedure
17. Appeal process: absent, not followed
18. Bed hold: written notice, refusal to readmit
19. Discharge / eviction (including abandonment)
20. Admission discrimination: condition, disability
21. Admission discrimination: Medicaid status
22. Room assignment / change, intra-facility transfer
23. Not used

#### D. Autonomy, Choice, Preference, Exercise of Rights, Privacy
24. Choose personal physician, pharmacy, hospice, other health care provider
25. Confinement of facility against will (illegally)
26. Dignity, respect, staff attitudes
27. Exercise preference and choice and/or civil and religious rights, individual’s right to smoke
28. Exercise right to refuse care / treatment
29. Language barrier in daily routine
30. Participate in care planning by resident and/or designated surrogate
31. Privacy: telephone, visitors, couples, mail
32. Privacy: treatment, confidentiality
33. Response to complaints
34. Reprisal, retaliation
35. Not used

#### E. Financial, Property (except for exploitation)
36. Billing and charges: notice, approval, questionable, accounting wrong or denied (includes overcharge of private pay residents)
37. Personal funds: mismanaged, access and information denied, deposits and other money not returned (report criminal-level misuse of personal funds under A.4)
38. Personal property lost, stolen, used by others, destroyed, withheld from resident
39. Not used

### RESIDENT CARE

#### F. Care
40. Accidental or injury of unknown origin, falls, improper handling
41. Failure to respond to requests for assistance, call lights
42. Care plan / resident assessment: inadequate, failure to follow plan or physician orders
43. Contracture
44. Medications: administration, organization
45. Personal hygiene (includes nail care & oral hygiene) and adequacy of dressing & grooming
46. Physician services (including podiatrist)
47. Pressure sores, not turned
48. Symptoms unattended (including pain, pain not managed), no notice to others of changes in condition
49. Toileting, incontinent care
50. Tubes: neglect of catheter, gastric, NG tube
51. Wandering, failure to accommodate / monitor exit seeking behavior
52. Not used

#### G. Rehabilitation or Maintenance of Function
53. Assistive devices or equipment
54. Bowel and bladder training
55. Dental services
56. Mental health, psychosocial services
57. Range of motion, ambulation
58. Therapies: physical, occupational, speech
59. Vision and hearing
60. Not used

#### H. Restraints: Chemical and Physical
61. Physical restraint: assessment, use, monitoring
62. Psychoactive drugs: assessment, use, evaluation
63. Not used
QUALITY OF LIFE

I. Activities and Social Services
   64. Activities: choice and appropriateness
   65. Community interaction, transportation
   66. Resident conflict (including roommates)
   67. Social services: availability / appropriateness 
       (use G.56 for mental health, psychosocial counseling / service)
   68. Not used

J. Dietary
   69. Assistance in eating or assistive devices 
   70. Fluid availability / hydration 
   71. Food service: quantity, quality, variation, 
       choice, condiments, utensils, menu 
   72. Snacks, time between meals, late / missed meals
   73. Temperature of food 
   74. Therapeutic diet 
   75. Weight loss due to inadequate nutrition 
   76. Not used

K. Environment / Safety
   77. Air / environment: temperature and quality 
       (heating, cooling, ventilation, water), noise 
   78. Cleanliness, pests, general housekeeping 
   79. Equipment / buildings: disrepair, hazard, poor lighting, fire safety, not secure 
   80. Furnishings, storage for residents 
   81. Infection control 
   82. Laundry: lost, condition 
   83. Odors 
   84. Space for activities, dining 
   85. Supplies and linens 
   86. Americans with Disabilities Act (ADA) accessibility

ADMINISTRATION

L. Policies, Procedures, Attitudes, Resources 
   87. Abuse investigation / reporting (including failure to report) 
   88. Administrator(s) unresponsive, unavailable 
   89. Grievance procedure (use C for transfer, discharge appeals) 
   90. Inappropriate or illegal policies, practices, record-keeping 
   91. Insufficient funds to operate 
   92. Operator inadequately trained 
   93. Offering inappropriate level of care (for ALFs) 
   94. Resident or family council interfered with, not supported 
   95. Not used

M. Staffing 
   96. Communication, language barrier 
   97. Shortage of staff 
   98. Staff training 

99. Staff turn-over, over-use of nursing pools
100. Staff: unresponsive, unavailable
101. Supervision
102. Eating assistants

PROBLEMS WITH OUTSIDE AGENCY, SYSTEM, OR PEOPLE (not against the facility)

N. Certification / Licensing Agency
   103. Access to information (including survey) 
   104. Complaint, response to 
   105. Decertification / closure 
   106. Sanction (including intermediate) 
   107. Survey process 
   108. Survey process: ombudsman participation 
   109. Transfer or eviction hearing 
   110. Not used

O. State Medicaid Agency and Managed Care
   100134 MC – Enrollment 
   100135 MC – Service coordination 
   100138 MC – Value added 
   100140 MC – Appeals, denials 
   100142 MC – Dignity, respect, MC staff attitudes 
   100143 MC – Choice of provider or doctor 
   100144 MC – Add-on service (ACD, CPWC, CWC, DME, additional therapies) 
   111. Access to information, application 
   112. Denial of eligibility 
   113. Non-covered services 
   114. Personal Needs Allowance (PNA) 
   115. Services 
   116. Not used

P. System / Others 
   117. Abuse, neglect, abandonment by family member, friend, guardian or, while on visit out of facility, any other person 
   118. Bed shortage: placement 
   119. Facilities operating without a license 
   120. Family conflict; interference 
   121. Financial exploitation or neglect by family or other not affiliated with facility 
   122. Legal: guardianship, conservatorship, power of attorney, wills 
   123. Medicare 
   124. Mental health, developmental disabilities (including PASRR) 
   125. Problems with resident’s physician / assistant 
   126. Protective Service agency 
   127. SSA, SSI, VA, other benefits / agencies 
   128. Request for less restrictive placement

Q. Complaints about services in settings other than long-term care facilities or by outside provider 
   129. Home care 
   130. Hospital or hospice 
   131. Public or other congregate housing not providing personal care 
   132. Services from outside provider 
   133. Not used
Exercise: Practice Completing a Monthly Report

Use the ombudsman’s notes provided below to complete a May 2015 Ombudsman Activity Report. An activity report and instructions follows this exercise.

May 1 (2.5 hours)
- Ms. Green reports it is too noisy at night and she can’t sleep. Reported to administrator and discussed changes in nighttime supervision.
- Mr. White says his roommate keeps his light on until midnight and it keeps him awake. His sheets have not been changed in a week. Housekeeping changes sheets while I am there. Visited 29 residents.

May 10 (2 hours)
- Mr. Mustard tells me, “I don’t know why I am here, I want to go home.” We speak with the social worker who calls the relocation contractor for an assessment.
- Ms. Scarlet reports never having a water pitcher and says she is thirsty. Three other rooms do not have water available and two hallways have only one CNA working.
- Attended Family Council meeting in p.m. Visited with 9 family members.

May 13 (1 hour)
- Ms. Brown wants to get outdoors but says everyone is too busy. Activities assistant helps her outside while I am there.
- Mr. White and I discuss his relationship with his roommate who was sent to the hospital last night. He reports several housekeeping staff quit. Trash cans are full and the restroom needs attention. Requested housekeeping services.

May 14
- Called Mr. White. Housekeeping cleaned his room yesterday afternoon.

May 21 (1.5 hours)
Followed up with all residents on complaints. Visited with 10 residents and 2 families.
- Ms. Green says nights are quieter. Other residents report the same. I reported to the administrator improvements and thanked her for intervention.
- Mr. Mustard hasn’t seen the relocation contractor for an assessment. Asks me to call and find out the status of his request.
- Ms. Brown reports not getting outside since last week. Calendar includes no outdoor activities. Activity director is not available to talk; left a note for administrator to call me.
- Mr. White’s roommate has returned from the hospital and is sleeping more. Room has been quiet at night, but he feels it is temporary.
- Observed water pitchers being distributed to each resident. Ms. Scarlet reports she has received water every day since I reported it. Close case, but watch for how often water is replenished and if solution lasts next month.
- Housekeeping still looks behind – beds not made at noon. Trash overflowing.

---

**Ombudsman tip:** Start your monthly report after your first visit of the month and add to it each time you visit. As soon as you make your last visit in the month, e-mail or mail it to your ombudsman program.
### Long-Term Care Ombudsman Activity Report

**Ombudsman:** ___________________________  **Facility:** ___________________________  **Month/Year:** ________________

<table>
<thead>
<tr>
<th>Visit Date</th>
<th>No. of Contacts</th>
<th>Time – Hrs:Mins</th>
<th>Mileage Optional</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Resident</td>
<td>Family/Other</td>
<td>Staff</td>
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**Cases and Complaints**

<table>
<thead>
<tr>
<th>Date Opened</th>
<th>Complainant</th>
<th>Resident / Complainant (name or description)</th>
<th>Consent</th>
<th>Complaints</th>
<th>Verified</th>
<th>Disposition</th>
<th>Date Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes No</td>
<td>(1-132)</td>
<td>Notes optional</td>
<td>Yes No</td>
<td></td>
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**Complainant**


**Disposition**

<table>
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<tr>
<th>Date Opened</th>
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<th>Verified</th>
<th>Disposition</th>
<th>Date Closed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes No (1-132) Notes optional</td>
<td></td>
<td></td>
<td>Yes No</td>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Complainant</th>
<th>Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Resident 4 Ombudsman 7 Social/health agency</td>
<td>a Govt./legislative d1 Referred: disposition not obtained e No action needed</td>
</tr>
<tr>
<td>2 Relative/friend 5 Facility staff 8 Unknown/anonymous</td>
<td>b Not resolved d2 Referred: failed to act on complaint f Partially resolved</td>
</tr>
<tr>
<td>3 Guardian/legal rep6 Medical staff 9 Banker, clergy, law</td>
<td>c Withdrawn d3 Referred: complaint not substantiated g Resolved</td>
</tr>
</tbody>
</table>
Reporting Instructions for Activity Report
(Long-term Care Ombudsman Activity Report, Form 8620)

Long-term Care Ombudsman Activity Report
Certified volunteer ombudsmen are required to submit Form 8620, Activity Report, each month. The report can be submitted electronically or as a paper copy. Submit the report by the due date set by the local long-term care ombudsman program. Staff ombudsmen may use Form 8620 and then enter in OmbudsManager.

Instructions
Enter your name, assigned facility, and the report month and year.

Visits
Required: Enter dates and time spent on site.
- Your local program decides whether you are required to track number of contacts, travel time and mileage.
- Date – Enter each date you visited.
- No. of Contacts – Enter the number of separate contacts for resident, family/other (non-relative visitors) and staff. A contact consists of meaningful interaction and can be done by phone, e-mail, letter, or in person.
- Time On Site – Enter time spent in the facility and/or resolving complaints.
- Travel – Enter time spent traveling to and from the facility.
- Mileage – Enter miles traveled to and from the facility.

Note to the managing local ombudsman – Determine whether certified ombudsmen will report on the items listed above. When reporting donated hours of service, count time on site, travel time and mileage (if the volunteer is not reimbursed).

Activities
Enter a date you participated in an activity during the month or if you attended more than one, enter a number attended for each type of activity, as appropriate.
- Care plan meeting – Attendance at the invitation of a resident or legally authorized representative.
- Family council – Attendance at the invitation of a family council member.
- Resident council – Attendance at the invitation of a resident council member.
- Survey – Participation in any part of a Regulatory Services annual survey or complaint investigation; count only once per survey.

Notes
This section is optional. Enter information about other activities or, information such as referrals to legal services; facility staff changes; changes in overall quality; and requests for information and assistance or consultations you provided.
Cases and Complaints

- **Date Opened** – Enter the date you received or identified the first complaint within a case.

- **Resident/Complainant** – Complainant roles include:
  1. resident
  2. relative/friend of resident
  3. guardian/legal representative
  4. ombudsman
  5. facility staff or former staff
  6. medical physician/staff
  7. social/health agency representative
  8. unknown/anonymous
  9. bankers, clergy, law enforcement, public officials, etc.

- **Consent** – To show resident or complainant consent, mark Yes or No. With consent, work to resolve complaint(s). Without consent, seek guidance from supervising staff ombudsman or managing local ombudsman.

- **Complaints (Codes 1-132)** – Enter the code that best matches the complaint and/or enter information about the complaint in the Notes field. Your local long-term care ombudsman program can provide a list of the complaint codes.

- **Verified** – After investigation, mark Yes if you verified the complaint (found it to be generally accurate). If not, mark No. A certified ombudsman may work to resolve a complaint regardless of verification.

- **Disposition** - For each complaint, choose a disposition that best describes the outcome after you have done all you can to seek resolution. If you refer a complaint to an agency that reports the outcome to you, code with the appropriate disposition. If the agency did not notify you of the disposition, choose d1, d2 or d3. Dispositions include:
  a. government/legislative (policy, regulatory change or legislative action is required)
  b. not resolved
  c. withdrawn
  d1. referred: disposition not obtained
  d2. referred: failed to act on complaint
  d3. referred: complaint not substantiated
  e. no action needed
  f. partially resolved (some problem remained)
  g. resolved

- **Date Closed** – Enter the date you closed the case because complaints required no further action.
Supplement 11-A – Researching Statutory Support

This exercise may be completed either in class or as self-study as directed by your instructor. Use the provided links (or handbook) to find the rule. The first one has been completed for you. To shorten your search using the links below, you can use “Ctrl F” to complete a word search.


Nursing Home

1. Can medications be released to residents? Reference §19. 507(a)(b)


2. Who prepares the comprehensive care plan? Reference §19. __________

3. What is the facility’s responsibility for enforcement of smoking policies? Reference §19. __________

4. What is the maximum time period between meals? Reference §19. __________

5. Must the facility provide physician-ordered medical transportation to medical services outside the facility? Reference §19. __________

6. Can a resident administer his or her own medications? Reference §19. __________

7. What types of information must be conspicuously and prominently posted in a licensed facility? Reference §19. __________

8. Does the resident have to be provided access to representatives of the ombudsman program? Reference §19. __________


10. Where can you find information about appropriate reasons for a discharge? Reference §19. __________
Supplement 11-A – Researching Statutory Support


Assisted Living Facilities (ALFs)

1. What criteria are used to determine if a resident is placed appropriately in a Type A assisted living facility? [Hint: Types of ALFs] Reference §92.3(b)

2. Does the resident service plan have to be approved and signed by the resident or resident’s responsible party for making health care decisions? Reference §92.


4. Which staff can administer medications to a resident and what training does he or she need? Reference §92.

5. The assisted living facility must keep supplies of staple foods for a minimum of _______ day period and perishable foods for a minimum of a ____ day period. Reference §92.

6. Does the resident have to be provided access to representatives of the ombudsman program? Reference §92.

7. What required postings must an assisted living facility prominently and conspicuously post for display in a public area of the facility that is readily available to residents, employees, and visitors? Reference §92.

8. Can a facility discharge a resident because covert electronic monitoring is being conducted by or on behalf of a resident? Reference §92.


10. Can an assisted living facility provide skilled nursing services? Reference §92.
Supplement 11-B – Consistency in Reporting Case Work

1. A resident tells the ombudsman she used her call light twice today. Each time, she had to wait 20 minutes before someone came to help. She asks the ombudsman for help. The ombudsman asks the resident to push the call button and checks the nurses’ station. The call light works. The ombudsman asks who worked the morning shift. A new CNA started yesterday. Staff said they would focus training on call lights. During a follow up visit, the resident says she doesn’t have to wait long for someone to respond to the call light. The ombudsman closes the case.

   Number of complaints:
   Complainant:
   Complaint(s) verified: Yes ___ No ___
   Complaint code(s):
   Disposition:

2. A resident complains his home only offers one alternative meal at dinner and he would like two. He would also like to have a larger screened TV in the lounge closest to his room. He requests to remain anonymous and asks the ombudsman to investigate. The facility says the small lounge rooms are too small for a big screen TV, but there is a big screen TV in the main lounge. Staff arranges two alternative meals during the week but cannot offer two on weekends. The resident is satisfied with alternative meals during the week, because his family often brings special treats on the weekends. But, he is not happy about the TV. The ombudsman closes the case.

   Number of complaints:
   Complainant:
   Complaint(s) verified: Yes ___ No ___
   Complaint code(s):
   Disposition:

3. A daughter complains that her mother needs to move closer to the nurse’s station. The daughter has MPoA (An MPoA (medical power of attorney) allows the agent to make health decisions for the principal if the principal (mother) is incapacitated.) for her mother. The resident agrees she would feel safer in one of two rooms near a nurse station. The ombudsman investigates and finds no empty beds in either room. The daughter insists that her mother needs to move. The ombudsman visits the resident twice and both times, she says she wants to forget the whole thing. Her current room is OK, and all the commotion about moving is upsetting her. The ombudsman closes the case.

   Number of complaints:
   Complainant:
   Complaint(s) verified: Yes ___ No ___
   Complaint code(s):
   Disposition:
4. The ombudsman observes roaches in three resident rooms. This is the fourth complaint opened concerning roaches in the past year. Each time, the ombudsman contacts the local health department and corporate office. The facility addressed the problem temporarily, but the roaches return. This time, after contacting the health department and corporate office, the ombudsman refers the case to Regulatory Services. (For this exercise, assume there is nothing more the ombudsman can do.) Regulatory staff doesn’t find any roaches the day they inspect the facility so they do not substantiate the complaint. The ombudsman closes the case.

   Number of complaints:
   Complainant:
   Complaint(s) verified: Yes __ No __
   Complaint code(s):
   Disposition:

5. A resident’s son calls the ombudsman with a complaint about food. Meat is often tough to cut and chew, and his mother rarely eats most of her dinner. He visits his mother most dinner meals. The ombudsman offers to investigate by speaking with the complainant’s mother on a future visit. The ombudsman visits the nursing home and discreetly visits the resident to ask about food quality, temperature and taste. The resident doesn’t report any concerns. The ombudsman tells the resident about her son’s call and his concern that sometimes the meat is tough. The resident says her son “worries too much” and she doesn’t mind the food. The ombudsman watches the evening meal and asks eight residents about the meal. No concerns are noted. By phone, the ombudsman informs the son that as a resident advocate, she takes action based on resident interests. The son is dissatisfied to learn the ombudsman will not work the complaint further. The ombudsman closes the case.

   Number of complaints:
   Complainant:
   Complaint(s) verified: Yes __ No __
   Complaint code(s):
   Disposition:

6. A Resident Council president makes a complaint about the amount of the Personal Needs Allowance (PNA) for Medicaid residents. Invited to the next council meeting, the ombudsman explains the Texas Legislature determines the PNA. The residents ask the ombudsman’s help to present this issue to an advocacy organization to lobby on behalf of residents. The ombudsman meets with an advocacy organization representative, and the organization agrees to lobby for a PNA increase during the next legislative session. The ombudsman closes the case.

   Number of complaints:
   Complainant:
   Complaint(s) verified: Yes __ No __
   Complaint code(s):
   Disposition:
7. On June 1, the ombudsman observes seven call buttons out of reach of residents:
   - 3 residents told the ombudsman they didn’t realize the call buttons were out of reach.
   - 1 resident said he would call out if he needed anything.
   - 3 residents were unable to express their needs and didn’t seem to be able to use the call button.

   The ombudsman visited 25 rooms and contacted 40 residents. Some beds with call buttons out of reach were made while others were not, indicating housekeeping may have misplaced the call buttons. For the remaining rooms, the ombudsman talks with a nurse and two CNAs. The nurse reports it is a mistake and places the buttons within residents’ reach. Both CNAs report they check more frequently on the residents who cannot use the call buttons. The ombudsman reports the concern to the administrator who states she will talk with the housekeeping supervisor and in-service direct-care staff on proper placement of call buttons. The ombudsman suggests more frequent checks on residents by a CNA seems a good strategy to help meet all residents’ needs. The ombudsman keeps the case open.

On July 14, the ombudsman monitors the original seven residents and others who did not have access to their call buttons. Housekeeping has cleaned each room, and all buttons are within the residents’ reach. The male resident says it works to call out for help. CNAs report making frequent checks on residents who cannot use a call button. The ombudsman interviews another nurse who goes into a resident’s room and asks, “Do you know how to use the call light?” The resident replies, “yes,” but the ombudsman suspects the resident may not be capable. The ombudsman reports to the administrator: CNAs appear to have a good protocol; housekeeping appears to have made adjustments; but nurses appear to not recognize how to best meet the residents’ needs. The administrator says she can’t do more than provide another in-service. The ombudsman offers to assist, but the administrator declines. The ombudsman closes the case.

Number of complaints:
Complainant:
Complaint(s) verified: Yes ___  No ___
Complaint code(s):
Disposition:
Supplement 11-C – Complaint Codes Descriptions - LTCOP

A complaint is about a problem of commission or omission.

Each case may have more than one complaint. However, each problem will have only one code. Use only one category for each type of problem. (Do not check both A.3 and D.26 for the same staff behavior. Determine which category is most appropriate to the particular problem.)

<table>
<thead>
<tr>
<th>Residents’ Rights</th>
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</thead>
</table>

A. **ABUSE, GROSS NEGLECT, EXPLOITATION**

Use categories in this section only for serious complaints of willful mistreatment of residents by facility staff, management, other residents (use category 6), or unknown or outside individuals who have gained access to the resident through negligence or lax security on the part of the facility or for neglect which is so severe that it constitutes abuse. Use P.117 and P.121 for complaints of abuse, neglect, exploitation by family members, friends, and others whose actions the facility could not reasonably be expected to oversee or regulate.

For all categories in this part, use the broad definitions of abuse, neglect, and exploitation in the Older Americans Act (OAA), which is almost identical to that in regulations for nursing homes participating in the Medicare and Medicaid programs (42 CFR 488.301): The term Abuse means the willful

(A) infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain or mental anguish; or
(B) deprivation by a person, including a caregiver, of goods or services necessary to avoid physical harm, mental anguish, or mental illness. (OAA, Section 102 [13])

(Financial) exploitation means the illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit or gain. (OAA, Section 102[24])

In addition to the above broad definitions, use the definitions for specific categories below from the Centers for Medicare and Medicaid Services (CMS) Interpretive Guidelines, section 483.13(b) and (c). The guidelines are available at https://www.cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf

See page 61 and surveyor guidance at deficiency tags F223 to F226.

Use resident-to-resident physical or sexual abuse (A.6) only for willful abuse of one resident by another resident, not for unintentional harm or altercations between residents who require staff supervision, which should be coded in category I-66, “Resident conflict, including roommates.” (For example, a confused resident who strikes out is categorized at I.66 and an alert resident who strikes out is A.6.)
1) **Abuse, physical (including corporal punishment)**
   Includes hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment.

2. **Abuse, sexual**
   Includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault.

3. **Abuse, verbal/psychological (including punishment, seclusion)**
   Use of oral, written, or gestured language that includes disparaging and derogatory terms to residents or to their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability. (Use D.26 for less severe forms of staff rudeness or insensitivity; use M.100 if staff is unavailable, unresponsive to residents.) Psychological or mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Involuntary seclusion means the separation of a resident from other residents or from his/her room against the resident’s will or the will of the resident’s legal representative. Emergency or short term monitored separation is not considered involuntary seclusion if used for a limited period of time as a therapeutic intervention to reduce agitation.

4. **Financial exploitation (use categories in Section E for less severe financial complaints)**
   The illegal or improper act or process of an individual, including a caregiver, using the resources of an older individual for monetary or personal benefit, profit or gain.

5. **Gross neglect (for non-willful forms of neglect, use Care, Sections F & G)**
   The willful deprivation by a person, including a caregiver, of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness. (Use only for the most extreme forms of willful neglect. Use the appropriate categories under Resident Care, Quality of Life or, in some cases, Administration for less severe forms or manifestations of resident neglect.)

6. **Resident-to-resident physical or sexual abuse**
   Use only for complaints of abuse by a resident against one or more other residents which meet the definitions of abuse provided above. (For unintentional harm or altercations between residents who require staff supervision, use category I-66, “Resident conflict, including roommates.”)

7. **Not Used**

B. **ACCESS TO INFORMATION BY RESIDENT OR RESIDENT’S REPRESENTATIVE**
   Use categories in this section for complaints involving access to information or assistance made by or on behalf of the resident or the resident’s representative. Use B.9 if the ombudsman is denied access in response to a complaint. If there is a general problem with ombudsman access to one or more particular facilities
or types of facilities, but no complaint has been filed, do not use complaint categories. Describe the access problem under Part III, B - Statewide Coverage. Categories B.14, D.29, and M.96 all involve communication /language barriers and yet are different. Use B.14 if information regarding rights, medical condition, benefits, services, etc. is not communicated in an understandable language.

8. **Access to own records**
   Use if complainant is denied or delayed access to resident’s record.

9. **Access by or to ombudsman/visitors**
   Use if access to the facility or certain parts of the facility is denied to the ombudsman. Use also if ombudsman or visitors are denied access to a resident.

10. **Access to facility survey/staffing reports/license**
    Use if the licensing and certification agency’s survey is not posted in a prominent place or not provided when requested. Use also when the facility’s license is not posted or available. Use if the facility daily staffing report is not posted.

11. **Information regarding advance directive**
    Use related to advance health care directive, living will, do not resuscitate (DNR) order, and similar problems.

12. **Information regarding medical condition, treatment and any changes**
    Use if information is denied, delayed.

13. **Information regarding rights, benefits, services, the resident’s right to complain**
    Use related to resident rights (including the right to complain), Medicaid information/process, social services, staff not wearing name badges, and similar problems.

14. **Information communicated in understandable language**
    Use if information is not provided in a language which the resident or her representative can understand or the staff speaks in a confusing manner.

15. **Not Used**

C. **ADMISSION, TRANSFER, DISCHARGE, EVICTION**
   Use the appropriate category for complaints involving placement, whether into, within or outside of the facility. If resident requests assistance in transferring to another facility and there is no stated problem (complaint), record as information and assistance to individuals in Part III, Other Ombudsman Activities. If a resident requests assistance in moving out of the facility but there are no feasible alternative options, record as P.128 “Request for less restrictive placement,” since the problem is a lack of care alternatives within the long-term care system.
16. **Admission contract and/or procedure**  
   Use if no contract; contract contains illegal wording requiring waiver of rights or guarantee of payment; admission procedure not followed; admission procedure does not contain required elements, and similar problems.

17. **Appeal process - absent, not followed**  
   Use if resident/representative not given required number of days to appeal a discharge; facility failed to follow appeal ruling; no appeal process in place; and similar problems.

18. **Bed hold - written notice, refusal to readmit**  
   Use if bed not held required number of days; resident/representative not advised of bed hold policy; incorrect bed hold procedure; bed held but resident not readmitted and similar problems.

19. **Discharge/eviction- planning, notice, procedure, implementation, including abandonment**  
   Use if no discharge notice; required notice not given to resident/representative; required notice not given to the ombudsman program in required time frame; required notice lacks documentation, is incomplete, incorrect; discharge is for inappropriate reasons; discharge planned or implemented to inappropriate environment; level of care is changed against resident’s will, and similar problems.

20. **Discrimination in admission due to condition, disability**  
   Use for refusal to admit resident due to medical condition, disability.

21. **Discrimination in admission due to Medicaid status**  
   Use if resident not admitted due to Medicaid status or pending Medicaid status.

22. **Room assignment/room change/intra-facility transfer**  
   Use if resident wants room change or resident objects to planned room change; no notice or inadequate notice of change; excessive room changes; or similar problems.

23. **Not Used**

D. **AUTONOMY, CHOICE, PREFERENCE, EXERCISE OF RIGHTS, PRIVACY**  
   *Use for any complaint involving the resident’s right, as stated in the category. If it is a related problem, but not one specific to this heading, use a category under another heading. For example, if the resident is permitted to choose her personal physician but that physician is unavailable, use P.125.*

   *Note that D.29, B.14 and M.96 all involve communication/language barriers and yet are different. Use D.29 if the resident has a communication or language barrier. Use M.96 if staff has the communication or language barrier.*
Use D.27 for right to smoke. Use K.77 for smoke-polluted air.

24. **Choose personal physician/pharmacy/hospice/other health care provider**
   Use when the resident is denied the right to choose his own physician/pharmacy/hospice or other outside health care provider.

25. **Confinement of facility against will (illegally)**
   Use when the resident is denied the right to leave the facility or go outside of the facility. (Use P.128 “other” for resident requests for assistance in moving out of the facility when feasible alternative options are not available.)

26. **Dignity, respect - staff attitudes**
   Use when resident is treated with rudeness, indifference or insensitivity, including failure to knock before entering room, facility posts signs relating to individual’s care and similar problems.

27. **Exercise preference/choice and/or civil/religious rights, individual’s right to smoke**
   Use when the resident is denied choice and exercise of rights; for example: voting; speaking freely; access to a smoking area, preference in sleeping and rising times, community activities, the outdoors, television program of choice and similar problems. (Use D. 31 for rights involving privacy.)

28. **Exercise right to refuse care/treatment**
   Use if the resident is denied the right to refuse care/treatment; including resident’s right to refuse eating, bathing, or taking medication.

29. **Language barrier in daily routine**
   Use if caregiver does not speak the resident’s language, resident cannot communicate.

30. **Participate in care planning by resident and/or designated surrogate**
   Use if the resident or the resident’s legal representative is denied access to or not informed of a care plan/care plan meeting.

31. **Privacy - telephone, visitors, couples, mail**
   Use if the resident is denied access to a telephone, visitors or mail; phone calls are monitored; mail is opened by someone other than the resident or the resident’s legal representative; couples denied privacy.

32. **Privacy in treatment, confidentiality**
   Use if the resident is denied privacy in treatment; confidential information has been disclosed.

33. **Response to complaints**
Use if complaints are ignored or trivialized by facility staff: administrator, social worker, nurses, and other staff.

34. **Reprisal, retaliation**  
Use if the resident has experienced reprisal/retaliation (threat of discharge, lack of care, requests ignored, call lights unanswered, rough handling, etc.) as a result of a complaint.

35. **Not Used**

E. **FINANCIAL, PROPERTY (EXCEPT FOR FINANCIAL EXPLOITATION)**  
*Use the appropriate category for complaints involving non-criminal mismanagement or careless with residents’ funds and property or billing problems. Use A.4 for complaints involving willful financial exploitation, including, but not limited to, criminal activity.*

36. **Billing/charges - notice, approval, questionable, accounting wrong or denied (includes overcharge of private pay residents)**  
Use if complainant alleges resident does not owe the amount billed; the resident never received the bill for amount owed; bill in error, supplies not provided as part of the daily rate and similar problems.

37. **Personal funds - mismanaged, access/information denied, deposits and other money not returned (report criminal-level misuse of personal funds under A.4)**  
Use for problem with personal funds, for example, staff denies a resident use of her personal needs allowance; staff uses a nursing home resident’s trust fund without consent, and similar problems.

38. **Personal property lost, stolen, used by others, destroyed, withheld from resident**  
Use for property (including prostheses, dentures, hearing aid, glasses, radio, watch) missing/stolen at the facility or if the facility withholds or mismanages personal property (non-monetary). Use K.82 for loss of laundry.

39. **Not Used**

### Resident Care

**F. CARE**  
*Use appropriate category for complaints involving negligence, lack of attention and poor quality in care of residents. If the care situation is so poor the resident is in a condition of overall neglect which is threatening to health and/or life, use A.5, “gross neglect.”*

40. **Accidental or injury of unknown origin, falls, improper handling**
Use for unexplained bruises, scratches, cuts, skin tears; falls from bed, wheelchair, or when standing; when resident is handled improperly or dropped during transfer or other assistance; and similar problems.

41. **Failure to respond to requests for assistance**
   Use for call lights or requests for assistance not answered, or not answered in a timely manner. Includes requests for going/returning to resident’s room, transfers to chairs/bed, etc.

42. **Care plan/resident assessment - inadequate, failure to follow plan or physician orders (put lack of resident/surrogate involvement under D. 30)**
   Use for problem related to care plan: plan is incomplete or not reflective of resident’s condition; staff has disregarded or is not informed of the plan; staff fails to respond, or responds slowly, to physician orders and similar problems.

43. **Contracture**
   Use for problem related to resident’s hands, arms, feet, or legs being drawn up and contorted.

44. **Medications - administration, organization**
   Use for medications not given on time or not at all, medication administration not documented or incorrectly documented, medications not secured, incorrect medication or dosage; negligence, lack of attention or poor quality in care related to medication that is: run out; expired; not filled in a timely manner; incorrectly labeled, and similar problems.

45. **Personal hygiene (includes nail care & oral hygiene) and adequacy of dressing & grooming**
   Use for resident: not bathed in a timely manner, not clean, not bathed at all, allowed to remain in soiled clothing, diaper, bed, chair; hands and face not washed after meals; teeth/dentures not cleaned; and similar problems.

46. **Physician services, including podiatrist**
   Use for failure of facility to obtain physician services upon a change in resident’s condition, or if medical attention, including podiatrist service, is not obtained in a timely manner or not obtained at all.

47. **Pressure sores, not turned**
   Use for pressure sore(s) that may have occurred at the facility or elsewhere. Use when facility fails to treat, document, monitor pressure sores. Use if resident is not turned per medical order or treatment standard, or when turning is undocumented.

48. **Symptoms unattended, including pain, pain not managed, no notice to others of changes in condition**
Use if facility fails to accommodate, notice, or provide services related to a change in resident’s condition.

49. **Toileting, incontinent care**
Use when resident is not toileted in a timely manner, as needed or requested, or as directed by the care plan; facility is using diapers or catheters rather than toileting. Use G.54 for inadequate or non-existent bowel and bladder plan/training.

50. **Tubes - neglect of catheter, gastric, NG tube (use D.28 for inappropriate, forced use)**
Use if tube is not cleaned, changed, or monitored appropriately.

51. **Wandering, failure to accommodate/monitor exit-seeking behavior**
Use for resident wandering, failure to redirect wanderers.

52. **Not Used**

**G. REHABILITATION OR MAINTENANCE OF FUNCTION**
Use appropriate category for complaints involving failure to provide needed rehabilitation or services necessary to maintain the expected level of function.

53. **Assistive devices or equipment**
Use if facility lacks, fails to maintain or has problems with Hoyer lift, handrails/grab bars, toilet seat, elevators, ambulation aids, wheelchair (no brakes or footrests, etc.), hearing or visual aids, and other assistive devices or equipment.

54. **Bowel and bladder training**
Use if facility fails to provide training, has no schedule, or schedule not maintained. See F.49.

55. **Dental services**
Use if dental services not provided or arranged for resident.

56. **Mental health, psychosocial services**
Use if these services not provided, arranged for resident.

57. **Range of motion/ambulation**
Use if services not provided; resident not assisted or encouraged in ambulation as appropriate; no appropriate exercise available; exercise resident wants is unavailable.

58. **Therapies, physical, occupational, speech**
Use for failure to provide or arrange for therapies with outside agency or provider.
59. **Vision and hearing**
Use for failure to provide or arrange for vision and hearing services or for problems with services.

60) **Not Used**

H. **RERAINTS - CHEMICAL AND PHYSICAL**
*Use the appropriate category for any complaint involving the use of physical or chemical restraint.*

61. **Physical restraint - assessment, use, monitoring**
Use for any physical restraint: lap buddy, bed rail(s), bindings, placement of furniture, resident not released from restraints for a specified time; no order in file; and similar problems including locked units.

62. **Psychoactive drugs - assessment, use, evaluation**
Use for any chemical restraint including excessive or unnecessary medication.

63. **Not Used**

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**Quality of Life**

I. **ACTIVITIES AND SOCIAL SERVICES**
*Use categories under this heading for complaints involving social services for residents and social interaction of residents. Note transportation is included in category I.65 because community interaction sometimes (not always) depends upon transportation.*

64. **Activities - choice and appropriateness**
Use for lack of activities appropriate for each resident; facility fails to consider residents' ability to perform certain activities/and preferences; variety limited; no activities; posted activities not conducted.

65. **Community interaction, transportation**
Use for any complaint involving the resident’s need for transportation, for whatever reason and/or when facility does not assist residents in participating in community services or activities or curtails community interaction.

66. **Resident conflict, including roommates**
Use for any complaint involving conflict between residents, including roommate conflict and inappropriate behaviors that impact another resident’s quality of life.

67. **Social services – availability/appropriateness (use G.56 for mental health, psychosocial counseling/service)**
Use if social services department fails to provide social services or encourage social interaction; fails to provide services if resident isolates himself or refuses to participate in activities, and similar problems.

68. Not Used

J. DIETARY
*Use the appropriate category for complaints involving food and fluid intake. Use the appropriate category under A (A.1 or A.5) for willful cases of food deprivation.*

69. Assistance in eating or assistive devices
Use for failure to provide assistance in eating; facility has not provided tools to assist resident in self-feeding, meal set-up, i.e., opening milk cartons, tray not within reach.

70. Fluid availability/hydration
Use for complaint that resident is not reminded to drink; bedside water is not provided, not fresh or not in reach; fluids are not readily available; resident is dehydrated.

71. Food service - quantity, quality, variation, choice, condiments, utensils, menu
Use for posted menu not served; alternate selections not offered; servings too small; no variety; quality is poor; food has little nutritional value, nutrients out of date, condiments or utensils not provided, presentation, timely delivery and/or removal of trays.

72. Snacks, time span between meals, late/missed meals
Use for snacks not readily available or offered between meals; excessive time span between dinner and breakfast.

73. Temperature
Use for food or beverage not served at appropriate temperature.

74. Therapeutic diet
Use for complaint resident’s therapeutic diet is not served as ordered; resident’s dietary needs not accommodated.

75. Weight loss due to inadequate nutrition
Use A.1 or A.5 for willful food deprivation.

76. Not Used

K. ENVIRONMENT/SAFETY
*Use the appropriate category for complaints involving the physical environment of the facility and resident’s space.*
77. **Air/environment: temperature and quality (heating, cooling, ventilation, water), noise**
   Use for complaints about building, room or water temperature too hot or cold; ventilation inadequate; indoor cigarette smoke; noise in the facility; and similar problems.

78. **Cleanliness, pests, general housekeeping**
   Use for uncleanness or pests (insects, vermin - live or dead) in resident’s room or other facility area. Also use for ant, snake, rat or mosquito bite.

79. **Equipment/Buildings - disrepair, hazard, poor lighting, fire safety, not secure**
   Use for elevator malfunctioning/not maintained; paint/wallpaper peeling; lights burned out or insufficient lights; exterior not maintained, littered; inaccessible entrances/exits or hallways; inadequate/non-functioning/expired fire extinguishers; malfunctioning automatic doors; fire alarms, smoke detectors, and other emergency equipment not present, malfunctioning or inadequate; and any other building maintenance problem. Also use for premises not secured; lacking or broken window bars; unauthorized person gained entrance to facility; unauthorized weapon in facility, and similar problems.

80. **Furnishings, storage for residents**
   Use for furnishing in disrepair; lack of furnishings; inadequate storage space for belongings, including valuables.

81. **Infection control**
   Use for insufficient measures to prevent infection; spread of infection; resident at risk; infection unreported or not treated appropriately, and similar problems.

82. **Laundry - lost, condition**
   Use for no clean clothes available; clothing lost, damaged.

83. **Odors**
   Use for urine, feces, any other offending odor or any odor which is a detriment to the health of the resident.

84. **Space for activities, dining**
   Use for: inadequate space for scheduled activity or residents’ attendance/participation in activity; dining area does not promote resident interaction; inadequate space for wheelchair or other assistive devices while dining; activity, dining areas converted to other uses.

85. **Supplies and linens**
   Use for no clean linens available or in poor condition; shortage of supplies, for example, soap, gloves, toilet paper, incontinence pads, and nursing supplies.
86. **Americans with Disabilities Act (ADA) accessibility**
Use for complaints regarding the facility’s compliance with the ADA; for example, no handicapped access.

<table>
<thead>
<tr>
<th>Administration</th>
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<tbody>
<tr>
<td>L. <strong>POLICIES, PROCEDURES, ATTITUDES, RESOURCES</strong></td>
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<tr>
<td><em>Categories under this heading are for acts of commission or omission by facility managers, operators, or owners in areas other than staffing or specific problems included in previous sections.</em></td>
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87. **Abuse investigation/reporting, including failure to report**
Use for failure of facility to report or investigate suspected resident abuse/neglect or exploitation to the specified authority, no matter where alleged abuse occurred.

88. **Administrator(s) unresponsive, unavailable**
Use for failure of administrator or administrative staff to respond to or communicate with others.

89. **Grievance procedure (use C for transfer, discharge appeals)**
Use if there is no grievance procedure for handling complaints or if the procedure is not made known to residents or not complied with by the facility.

90. **Inappropriate or illegal policies, practices, record keeping**
Use if records are incomplete, missing, or falsified, including staff references not checked, or when required background screening has not been performed. Use also for complaints about health care fraud, waste, and abuse.

91. **Insufficient funds to operate**
Use if there is a substantiated complaint of shortage of staff, lack of food, utilities cut off, etc. that could indicate bankruptcy or insufficient funds. Also use if a complainant alleges the facility has insufficient funds to operate.

92. **Operator inadequately trained**
Use for complaint that owner/administrator has no documentation of administrator’s license, training or updates, and other certifications required by the state.

93. **Offering inappropriate level of care (for B&C/similar)**
Use if facility admits or retains resident whose medical and/or care needs are greater than the facility can meet or arrange to have met and similar problems.

94. **Resident or family council/committee interfered with, not supported**
Use if facility interferes with or fails to support resident or family councils, attempts to organize councils and related problems.

95) Not Used

M. STAFFING

Use appropriate categories under this heading for complaints involving staff unavailability, training, turnover, and supervision.

96. Communication, language barrier

Use for staff language or other communication barrier. Use D.29 if problem involves resident inability to communicate.

97. Shortage of staff

Use for insufficient staff to meet the needs of the resident(s); staffing is below the minimum standard.

98. Staff training

Use when staff has not received training sufficient to meet the needs of the resident(s); including basic care and technical training, including the use of a Hoyer lift, CPR, first aid, mental health, and dementia training.

99. Staff turnover, over-use of nursing pools

Use when there is no continuity of care for the residents; new staff on board and pool/agency staff are regularly used.

100. Staff unresponsive, unavailable

Use if staff is unresponsive or unavailable. Use D.26 if staff is available but rude or otherwise disrespectful to resident. Use A.3 or other category under A if rudeness or disrespect is so severe that it qualifies as abuse.

101. Supervision

Use when the staff duties are not overseen or not reviewed by a supervisor. Use when there is no ALF staff monitoring residents.

102. Eating Assistants

Use for complaints about inappropriate use of and training of eating assistants. Use J. 69 for failure to provide assistance in eating or facility has not provided tools to assist resident in self-feeding, meal set-up, i.e., opening milk cartons, tray not within reach.
**Problems with Outside Agency, System, or People**
*(Not Against the Facility)*

*Use these categories for all complaints involving decisions, policies, actions or inactions by the state agencies which license facilities and certify them for participation in Medicaid and Medicare.*

**N. CERTIFICATION/LICENSING AGENCY**

103. **Access to information (including survey)**
Use if licensing agency does not provide facility information to ombudsmen, public.

104. **Complaint, response to**
Use when agency fails to respond adequately to any complaint or referral, from the resident, ombudsman or public.

105. **Decertification/closure**
Use for individual complaints about decertification/closure and if agency fails to decertify/close a facility when within residents’ best interests or with disregard to residents’ rights.

106. **Sanction, including Intermediate**
Use if licensing agency fails to sanction facility appropriately.

107. **Survey process**
Use if agency fails to survey facility as required by law.

108. **Survey process - Ombudsman participation**
Use if ombudsmen not notified and/or included in survey process.

109. **Transfer or eviction hearing**
Use for complaints of decisions, policies, actions or inactions by the licensing agency regarding resident discharge hearings.

110. **Not Used**

**O. STATE MEDICAID AGENCY and MANAGED CARE**
Categories in this section are for complaints about Medicaid coverage, benefits and services.

* For each managed care complaint (MC), OmbudsManager records must indicate which MCO is associated with the case. Specify the MCO in the “user field” of a case record. Journal entries and details in the complaint intake fields are also needed to explain the problem and who is at fault, such as the nursing facility, MCO, or both.

MCO – Managed Care Organization
100134 MC Enrollment*
Use if the nursing facility is steering residents to a certain MCO or if an MCO is coercing residents to choose them. Also report technical issues with enrollment.

100135 MC Service coordination*
Use if MCO service coordinator is unavailable, not helpful, or disrespectful to the resident.

100138 MC Value added*
Use if resident needs a value added service and the MCO does not deliver that service; or if the resident continues to need a value added service and it is denied.

100140 MC Appeals, denials*
Use if resident has received a denial, reduction, or termination of any service provided through the MCO. This code includes helping the resident or representing the resident in an MCO appeal or a state fair hearing if it relates to a managed care decision.

NOTE: Facility discharge notices are the responsibility of a nursing facility or ALF, not an MCO. Code discharge issues as 17, 19, or 109 as appropriate.

100142 MC Dignity, respect, MC staff attitudes*
Use if any MCO staff are not treating the resident with dignity or respect, regardless of the issue.

100143 MC Choice of provider or doctor*
Use if the MCO is not allowing choice of providers or doctors, either by purposely blocking a resident from seeing a certain physician or because the physician the resident wants is not with the plan or is not accepting new patients.

100144 MC Add-on service (ACD, CPWC, CWC, DME, additional therapies)*
Use if MCO is not helping a resident get services they need that require authorization from the MCO to get the service.

111. Access to information, application
Use if information is denied or delayed to resident or legal representative; case worker is unavailable, or unresponsive to requests for information or application status.

112. Denial of eligibility
Use for complaint that resident is denied Medicaid.

113. Non-covered services
Use for complaints about services not covered by Medicaid.
114. **Personal Needs Allowance**
Use for complaints about the insufficiency of the personal needs allowance.

115. **Services**
Use for complaints about the quality or quantity of services covered by Medicaid or difficulty in obtaining services. (Use 113 for non-covered services.)

116. **Not Used**

P. **SYSTEM/Others**
*Use appropriate categories in this section to document the range of complaints against or involving individuals who are not managers/staff of facilities * or of the State=s licensing and certification or Medicaid agency. (*except for 119, as specified)*

117. **Abuse/neglect/abandonment by family member/friend/guardian or, while on visit out of facility, any other person**
Use for abuse/abandonment by individuals other than facility staff, when the facility could not reasonably have been expected to observe the acts. Use A.1 or other A categories when the facility should have overseen and acted.

118. **Bed shortage - placement**
Use when resident is unable to find a facility placement, or for a bed shortage.

119. **Facilities operating without a license**
Use for complaints about facilities providing services to residents which should only be offered in a regulated environment.

120. **Family conflict; interference**
Use when a family conflict interferes with resident=s care. Use only if the conflict or problem affects the resident=s care or wellbeing.

121. **Financial exploitation or neglect by family or other not affiliated with facility**
Use for cases of financial exploitation or financial neglect of a resident by individuals whose actions the facility could not reasonably be expected to oversee or be responsible.

122. **Legal - guardianship, conservatorship, power of attorney, wills**
Use if the complaint involves any of the above legal issues.

123. **Medicare**
Use if resident has complaint related to Medicare coverage.
124. **Mental health, developmental disabilities, including PASRR**
Use for problems with access to services for persons with mental illness or developmental disabilities or for problems involving implementation of the Pre-Admission Screening and Resident Review (PASRR) requirements of the Nursing Home Reform Act related to individuals with mental illness, mental retardation, or a developmental disability living/making application to live in a Medicaid-certified nursing home.

125. **Problems with resident’s physician/assistant**
Use if the resident’s physician or assistant fails to provide information, services, is not available, or makes inappropriate or fraudulent charges. (Use F.46 if facility fails to arrange for physician service and P.48 if facility fails to attend to medical symptoms or notify family of change in resident’s condition.)

126. **Protective Service agency**
Use for complaints involving the agency in the State charged with investigating reports of adult abuse or exploitation and providing protective services for victims of abuse and exploitation.

127. **SSA, SSI, VA, other benefits/agencies**
Use for complaints for these non-Medicaid and non-Medicare benefits and the agencies which administer them.

128. **Request for less restrictive placement**
Use for a complaint against any other agency or individual, but not facility staff or licensing agency staff. Use for resident requests for assistance in moving out of the facility and/or ombudsman initiative to help resident find less restrictive placement. Includes work to implement the Supreme Court’s Olmstead decision.

Q. **COMPLAINTS ABOUT SERVICES IN SETTINGS OTHER THAN LONG-TERM CARE FACILITIES OR BY OUTSIDE PROVIDER**
Use categories in this section to document any complaints accepted and acted upon by the ombudsman involving individuals living in private residences, hospitals or in hospice care, and congregate and/or shared housing not providing personal care. Also use for services in a facility provided by an outside provider.

129. **Home care**
Use if complaint is made by or on behalf of an individual living in a private residence.

130. **Hospital or hospice**
Use for complaint involving hospital or hospice care, service, or administration.
131. **Public or other congregate housing not providing personal care**
Use for complaint made by or on behalf of individual living in public or private congregate housing unit where personal care is not included in the rental contract.

132. **Services from outside provider**
Use for services from an outside provider which are not included in other categories for which the facility makes arrangements; for example, personal and homemaking services in an assisted living facility, therapies, non-Medicaid transportation, psychosocial service. (Use P.125 for outside physician services.)

133. **Not Used**
Notes:
Notes:
CHAPTER 12: Resident Records
Resident Records

Chapter 12 is about ombudsman program authority to access resident records and other confidential information. Ombudsmen must get resident consent before accessing their records and then must keep all information confidential.

Learning Objectives

- Know which facility records ombudsmen can access
- Understand the requirement to get resident consent
- Distinguish when reviewing resident records is necessary
- Identify elements of medical records

Contents

- Ombudsman Access
- Consent to Access Confidential Records
- Request, Review, and Use of a Record
- Types of Resident Records

DVD(s), Supplements, Forms

- DVD: YouTube Video - Medical Records and Terminology
- Supplement 12-A: Common Medical Chart Abbreviations
- Supplement 12-B: Consent to Release Records to the Certified Ombudsman Form 8624-O (oral)
- Supplement 12-C: Consent to Release Records to the Certified Ombudsman Form 8624-W (written)
Ombudsman Access

The Older Americans Act requires each state to ensure ombudsmen have access to facilities, residents, and medical and social records of residents. In Texas, only certified ombudsmen may access a resident’s records with consent. Ombudsman interns do not have access to a resident’s record or its contents.

In Texas, laws and rules require nursing homes and assisted living facilities to allow ombudsman entry and private visits with residents. All information documented in a resident’s records or shared orally by a caregiver, resident, or physician is confidential. Laws and rules require ombudsmen to protect resident confidentiality. Never share information about a resident without the resident’s consent.

Residents or legal representatives have the right to access the residents’ records, and facilities must comply with:

- Nursing facility requirement §19.403(f)
- Assisted living facility standard §92.125(a)(3)(m)

Residents have the right to review all medical and financial records pertaining to them. __________ True (T) or False (F)

Consent to Access Confidential Records

In all cases, obtain resident consent to access a confidential record and document it. If the resident declines, stop the process. Other situations may include:

- If the complainant is not the resident, get resident consent before proceeding.
- If the resident is unable to communicate consent and has a Legally Authorized Representative (LAR), get the LAR’s consent.
- When a resident is unable to communicate consent and has no LAR, consult with your supervising staff ombudsman who then consults with the state ombudsman. Certified staff ombudsmen (including managing local ombudsmen) who want to review a record of a resident who cannot consent and has no LAR must have approval from the state ombudsman before accessing the record.
Obtain resident consent to access a __________________ record.

Request, Review, and Use of a Record

After a resident grants consent, request only the records necessary to investigate. Request a record at the nurse’s station or administrative office. If facility staff asks for proof of consent, present documentation such as Form 8624, or if the resident consented orally, staff may confirm the request with the resident.

Records that facilities are not required to provide to ombudsmen include:

- Personnel
- Facility budget and accounting
- Quality assurance committee documentation

To review a record, find a private location. Review only records pertinent to the concern or inquiry and use the findings appropriately. If possible, involve the resident in the review.

Inform the resident, or LAR if appropriate, of findings on an ongoing basis. Present information to facility staff only according to resident wishes.

Documentation

Ombudsmen document consent in case notes, the Long-term Care Ombudsman Activity Report, Consent to Release Records to the Certified Ombudsman Form 8624-O (oral), or Consent to Release Records to the Certified Ombudsman Form 8624-W (written). See Supplement 12-B and Supplement 12-C at the end of this chapter.

In preparation for some meetings, such as care or service plan meetings or fair hearings, an ombudsman may make copies from the resident’s clinical record. These then become a confidential record and should be protected as such.

Before closing a case, transfer temporary notes to a reporting form and submit all records and documentation to the local ombudsman program, who must keep it secure.
Types of Resident Records

To access a resident’s medical, incident, financial, and other records, an ombudsman must get consent from the resident or his or her legal representative.

**Medical:** Refer to the medical records section of this chapter for more information.

**Incident:** Regulatory Services requires staff to report incidents that are abnormal events, including accidents or injury to staff or residents. A facility may keep incident reports in one location rather than in an individual resident record.

**Financial:** Residents have the right to manage their financial affairs. If a facility manages funds for the resident, it must protect resident funds with some distinction between licensed-only and Medicaid-certified facilities.

**Other records:** Facilities keep records such as:
- Care or service plans
- Bathing schedules
- Care notes
- Dietary orders
- Grievance reports
- Medication administration records
- Care notes
- Grievance reports
- Medication administration records

Residents, guardians, family members, powers of attorney, the state ombudsman, or your supervising staff ombudsman may ask you to review a record. In every case, follow ombudsman procedures.

- When residents ask you to look at their records, you may assist immediately and involve them in the request to facility staff.
- If you decide that review of a record is necessary to investigate a complaint, volunteers should consult with your supervising staff ombudsman before proceeding.
- Always get written or oral consent from the resident or legal representative.
- Always document that the resident or legal representative gave consent and provide documentation to your ombudsman office.

Consider the following questions before consulting your supervising staff ombudsman:

- What is the issue or concern?
- With consent, could you get reliable information by asking questions to a facility staff person?
- Does the resident understand a request for records will identify him or her?
- Does the resident know he or she has the right to review personal records?
- What factors make review of a record necessary?
- What specific facts are you looking for?
- Does the resident have a legally authorized representative?

Based on the answers, you may need to access a resident record. The next step is to consult with your supervising staff ombudsman to seek agreement that review of a
A medical record is necessary. Under some circumstances, a staff ombudsman must also consult with the state ombudsman. If all parties agree, proceed with seeking consent from the resident; if parties do not agree, stop.

Medical Records

Ombudsmen do not need to be experts on clinical records. However, records can be an important source for information during investigation of a complaint. Do not make medical assumptions, interpretations, or provide medical advice. As an advocate, ask questions and stay grounded in resident rights.

To provide quality care, members of the health care team must communicate. Medical records should facilitate communication among all team members who are involved. Medical offices, hospitals, and care facilities keep medical records. Records may be paper, electronic, or a combination. All entities must comply with privacy laws:

- State: Health and Safety Code Chapter 181 Medical Records Privacy
- Federal: Public Law 104-191 Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Medical records in nursing homes and assisted living facilities vary on how much and what resident information is included. Because nursing homes provide more services, a nursing home resident’s medical record will be extensive. In an assisted living facility, the medical record might be more limited, especially in smaller, residential assisted living facilities.

On Your Own: Medical Records and Terminology

Watch the video Medical Records and Terminology found on the Texas Long-term Care Ombudsman YouTube channel. Refer to Supplement 12-A: Common Medical Chart Abbreviations found at the end of this chapter.

Follow this link: https://www.youtube.com/watch?v=2B216kPZpTY
Run Time: 23 min
Staff organize content in a resident medical records by sections that often include the following information.

Administration
- Admission paperwork (contracts, face sheet, required information notification acknowledgements)
- Advance care planning such as Directive to Physician, Medical Power of Attorney, Durable Power of Attorney, Out-of-Hospital Do Not Resuscitate, and Guardianship

History and Physical
- Latest comprehensive medical history and physical exam done by the physician
- Sometimes includes a discharge summary from a recent hospitalization
- Medical overview of the patient

Vital Signs
- Temperature
- Blood pressure
- Heart rate
- Respiratory rate
- Pain assessment
- Other measurements
- I/Os (input and outputs), such as fluid intake or a bowel movement log

Progress Notes
- Dated “SOAP” notes
  - S = Subjective: what the patient states or is reported
  - O = Objective: what the physician can measure or evaluate by a physical examination
  - A = Assessment: summary of the current situation and working diagnoses
  - P = Plan: what the physician plans to do next
- Physicians must sign their notes.

Physician Orders
Instructions to support personnel for any service to be done for the resident
- Medication
- Lab test or x-ray
- Therapy: speech, physical, occupational
- Activity level

Individual Assessment, Care and Service Plans
- See Chapter 8: Care Planning
Nurses Notes
Reports on what happened during each shift

Labs
Reports of laboratory results
- Blood chemistry
- Urine cultures
- Sputum cultures
- Feces test

Imaging
Reports of any imaging study
- X-rays
- CT scans (computed tomography)
- MRIs (magnetic resonance imaging)
- Others

Do not make medical assumptions, interpretations, or provide medical advice.

Therapy
- Physical Therapy (PT)
- Occupational Therapy (OT)
- Speech Therapy (ST)

Case Management
- Transfer or discharge plan: which location and when
- Social service notes

Negotiated Risk Agreements
- Documentation of a negotiated risk such as a resident refusing thickened liquids to prevent choking, or documentation that a resident understands the risk involved in using a bed mobility and transfer assist device like a bed assist rail.

Information that may be stored outside of an individual medical record:
- Medication Administration Record (MAR). This is the list of all medication given; usually found in or near the medication room or nurses’ desk
- Social services and activity notes may be stored in individual charts or in a separate folder
- Incident reports
If you cannot find information, ask a charge nurse for help. Many care providers use electronic records and an ombudsman has access to the same information in them as a written medical record.

Exercise: Name the Medical Record Section

In which section of the medical record would you find the following?

1. What care does the morning shift need to give following the night shift?
   __________________________________________

2. Who did the resident name as her Medical Power of Attorney?
   __________________________________________

3. What kind of rehab does the resident need and how often?
   __________________________________________

4. When was the last x-ray to check whether the hip healed?
   __________________________________________

5. When did the resident return from the hospital?
   __________________________________________

6. What is the resident’s working diagnosis?
   __________________________________________

7. Did the physician prescribe Ativan?
   __________________________________________

8. When does the facility plan to discharge the resident?
   __________________________________________
### Supplement 12-A: Common Medical Chart Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AB</td>
<td>Antibody</td>
</tr>
<tr>
<td>ABD, ABDOM</td>
<td>Abdomen</td>
</tr>
<tr>
<td>ABN</td>
<td>Abnormal</td>
</tr>
<tr>
<td>ADENOCA</td>
<td>Adenocarcinoma</td>
</tr>
<tr>
<td>ADM</td>
<td>Admission</td>
</tr>
<tr>
<td>ADR</td>
<td>Adverse drug reaction</td>
</tr>
<tr>
<td>AK(A)</td>
<td>Above knee (amputation)</td>
</tr>
<tr>
<td>AKA</td>
<td>Also known as</td>
</tr>
<tr>
<td>BCC</td>
<td>Basal cell carcinoma</td>
</tr>
<tr>
<td>BE</td>
<td>Barium enema</td>
</tr>
<tr>
<td>B/F</td>
<td>Black female</td>
</tr>
<tr>
<td>BIL</td>
<td>Bilateral</td>
</tr>
<tr>
<td>BK(A)</td>
<td>Below knee (amputation)</td>
</tr>
<tr>
<td>BM</td>
<td>Bone marrow</td>
</tr>
<tr>
<td>BM</td>
<td>Bowel movement</td>
</tr>
<tr>
<td>B/M</td>
<td>Black male</td>
</tr>
<tr>
<td>BP</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>BX</td>
<td>Biopsy</td>
</tr>
<tr>
<td>CC</td>
<td>Chief complaint</td>
</tr>
<tr>
<td>CHF</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>CIS</td>
<td>Carcinoma-in situ</td>
</tr>
<tr>
<td>CRF</td>
<td>Chronic renal failure</td>
</tr>
<tr>
<td>CT SC</td>
<td>Computerized tomography scan</td>
</tr>
<tr>
<td>CVA</td>
<td>Cerebrovascular accident</td>
</tr>
<tr>
<td>CVA</td>
<td>Costovertebral angle</td>
</tr>
<tr>
<td>CXR</td>
<td>Chest x-ray</td>
</tr>
<tr>
<td>DC</td>
<td>Discharge</td>
</tr>
<tr>
<td>DC</td>
<td>Discontinued</td>
</tr>
<tr>
<td>DNR</td>
<td>Do not resuscitate</td>
</tr>
<tr>
<td>DO</td>
<td>Doctor of Osteopathic Medicine</td>
</tr>
<tr>
<td>DTR</td>
<td>Deep tendon reflex</td>
</tr>
<tr>
<td>DX</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>ECF</td>
<td>Extended care facility</td>
</tr>
<tr>
<td>ECG, EKG</td>
<td>Electrocardiogram</td>
</tr>
<tr>
<td>EGG</td>
<td>Electroencephalogram</td>
</tr>
<tr>
<td>EENT</td>
<td>Eyes, ears, nose, &amp; throat</td>
</tr>
<tr>
<td>EGD</td>
<td>Esophagogastroduodenoscopy</td>
</tr>
<tr>
<td>EMG</td>
<td>Electromyogram</td>
</tr>
<tr>
<td>ENL</td>
<td>Enlarged</td>
</tr>
<tr>
<td>ENT</td>
<td>Ear, nose &amp; throat</td>
</tr>
<tr>
<td>FBS</td>
<td>Fasting blood sugar</td>
</tr>
<tr>
<td>FU</td>
<td>Follow up</td>
</tr>
<tr>
<td>FUO</td>
<td>Fever unknown origin</td>
</tr>
<tr>
<td>FX</td>
<td>Fracture</td>
</tr>
<tr>
<td>GB</td>
<td>Gallbladder</td>
</tr>
<tr>
<td>GI</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>HGB</td>
<td>Hemoglobin</td>
</tr>
<tr>
<td>HEENT</td>
<td>Head, eyes, ears, nose, throat</td>
</tr>
<tr>
<td>H&amp;I</td>
<td>History and physical</td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscular</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>K</td>
<td>Potassium</td>
</tr>
<tr>
<td>L1-L5</td>
<td>Lumbar vertebrae</td>
</tr>
<tr>
<td>LE</td>
<td>Lower extremity</td>
</tr>
<tr>
<td>LFT</td>
<td>Liver function test</td>
</tr>
<tr>
<td>LLE</td>
<td>Left lower extremity</td>
</tr>
<tr>
<td>LLL</td>
<td>Left lower lobe (lung)</td>
</tr>
<tr>
<td>LLQ</td>
<td>Left lower quadrant (abdomen)</td>
</tr>
<tr>
<td>L-SPINE</td>
<td>Lumbar spine</td>
</tr>
<tr>
<td>LUE</td>
<td>Left upper extremity</td>
</tr>
<tr>
<td>LUL</td>
<td>Left upper lobe (lung)</td>
</tr>
<tr>
<td>LUQ</td>
<td>Left upper quadrant (abdomen)</td>
</tr>
<tr>
<td>MD</td>
<td>Doctor of Allopathic Medicine</td>
</tr>
<tr>
<td>MI</td>
<td>Myocardial infarction</td>
</tr>
<tr>
<td>MRI</td>
<td>Magnetic resonance imaging</td>
</tr>
<tr>
<td>NEURO</td>
<td>Neurology</td>
</tr>
<tr>
<td>N&amp;V</td>
<td>Nausea and vomiting</td>
</tr>
</tbody>
</table>
**Differential Diagnosis:** The process of weighing the probability of one disease versus that of other diseases possibly accounting for a patient's illness. For example, the differential diagnosis of rhinitis (a runny nose) includes allergic rhinitis (hay fever), the abuse of nasal decongestants, and the common cold.
Supplement 12-B: Form 8624-O (oral)
Consent to Release Records to the Certified Ombudsman
http://www.dads.state.tx.us/news_info/ombudsman/certifiedombudsman/

Long-Term Care Ombudsman Program (LTCP)
Consent to Release Records to the Certified Ombudsman

As a representative of the Office of the State Long-Term Care Ombudsman, I received permission from
(Name of Resident)
(Name of Facility)
to access the following records:
☐ Medical
☐ Incident
☐ Financial
☐ Other

Disclosed records are protected under confidentiality laws that apply to the LTCP and may be released only by a
resident or by court order. A copy of this form may be provided to the facility for its records. If health information is released to
other parties, it may no longer be protected by privacy regulations.

Printed Name – Certified Ombudsman
Signature – Certified Ombudsman
Date

Relevant Law and State Regulations
Federal Law – 42 USC 1396(o)(3)(E)
Nursing homes and assisted living facilities must allow certified ombudsmen access to residents, resident information and records
according to state regulations.

- Nursing Facility Requirements for Licensee and Medicaid Certification
  40 TAC §19.413 Access and Visitation Rights
- Licensing Standards for Assisted Living Facilities
  40 TAC §92.801 Access to Residents and Records by the Long-Term Care Ombudsman Program
Supplement 12-C: Form 8624-W (written)
Consent to Release Records to the Certified Ombudsman
http://www.dads.state.tx.us/news_info/ombudsman/certifiedombudsman/

Texas Department of Aging and Disability Services
Form 8624-W
May 2009

Long-Term Care Ombudsman Program
Consent to Release Records to the Certified Ombudsman

I give permission to the Long-Term Care Ombudsman Program (LTCOP) to access my records from the following facility:

Records:
☐ Medical
☐ Incident
☐ Financial
☐ Other

I give this consent to the LTCOP to respond to my request(s) and my consent continues until

(Date or Description of Situation), I may revoke this consent at any time, but revocation will not affect any information already disclosed.

I understand that disclosed records are protected under confidentiality laws that apply to the LTCOP and may be released only by my request or by court order. A copy of this form may be provided to the facility for its records. If I authorize release of my health information to other parties, it may no longer be protected by privacy regulations.

Printed Name – Resident or Legally Authorized Representative

Signature – Resident or Legally Authorized Representative

Date

If I am not the subject of the records, I have authority to sign because I am the:

☐ Legal guardian
☐ Power of attorney
☐ Other:

Ombudsman Section
I have verified the legally authorized representative’s authority.

Printed Name – Certified Ombudsman

Local LTCOP

Relevant Law and State Regulations

Federal Law – 42 USC 1396(o)(3)(E)
Nursing homes and assisted living facilities must allow certified ombudsmen access to residents, resident information and records according to state regulations.

- Nursing Facility Requirements for License and Medicaid Certification
  40 TAC §19.413 Access and Visitation Rights
- Licensing Standards for Assisted Living Facilities
  40 TAC §92.801 Access to Residents and Records by the Long-Term Care Ombudsman Program
CHAPTER 13: Regulators and Other Resources
Regulators and Other Resources

Chapter 13 is about federal and state agencies that license and certify nursing homes. It also discusses agencies that license assisted living facilities and programs within state agencies that can impact residents.

Learning Objectives

- Become familiar with federal and state agencies that regulate nursing homes and assisted living facilities
- Know the basic roles of each agency
- Learn the enforcement options available to regulatory to bring operators into regulatory compliance
- Learn about programs related to residents and staff

Contents

- Regulatory Agencies
- Surveys and Licensures
- Enforcement
- Credentialing
- Resources
- Ombudsman Role

DVD(s), Supplements, Forms

- Supplement 13-A: Program Agreement between Long-term Care Ombudsman Program and Regulatory Services
- Supplement 13-B: Memorandum of Understanding between DFPS Adult Protective Services and Long-term Care Ombudsman Program
- Supplement 13-C: PASRR Excerpt from Nursing Facility Requirements for Licensure and Medicaid Certification
Regulatory Agencies

Agencies in our federal and state governments have responsibilities to oversee health care facilities on behalf of residents as consumers, beneficiaries, and citizens. Responsibilities belong to:

- Federal - Centers for Medicare and Medicaid Services (CMS)
- State - Regulatory Services

Nursing homes are regulated by CMS and Regulatory Services. Assisted living facilities are regulated by Regulatory Services only.

Centers for Medicare and Medicaid Services (CMS)

The CMS mission is to assure health care security for beneficiaries with the goal to protect and improve beneficiary health and satisfaction. The agency has program and operational objectives. Program objectives are:

- give access to quality care by protecting beneficiaries from substandard or unnecessary care; and
- provide services to beneficiaries by improving beneficiary satisfaction with programs, services, and care.

Ombudsmen do not often interact with CMS surveyors and other staff. The CMS surveyor role is to monitor state surveyors for compliance with federal policy and procedures in the survey process; thus, ensuring federal requirements are consistently applied across state survey agencies.

Because assisted living has no federal definition or requirements, CMS has no role in regulating assisted living facilities.

Regulatory Services

Regulatory Services’ main responsibilities are licensure and certification of facilities. This is accomplished through inspections of a number of facility types and services related to long-term services and supports. It monitors facilities for compliance with rules in the Nursing Facility Requirements and Licensing Standards for Assisted Living Facilities. Another major responsibility is to conduct investigations of complaints and incidents.

Regulatory Services staff who conduct inspections are commonly referred to as “surveyors.”

Regulatory Services staff:

- determines that regulated facilities comply with federal and state rules;
- Determines if providers are meeting the minimum standards and requirements for service, determines conditions that may jeopardize client health and safety, and identifies deficient practice areas;
- Monitors providers’ plans of correction to ensure that areas of inadequate care are corrected and comply with state and federal requirements; and
- Takes enforcement actions if facilities are not in compliance with requirements.

By federal and state laws, both Regulatory Services and the Long-term Care Ombudsman Program have mandates to receive and investigate complaints. To expedite investigations, a Program Agreement explains their joint and individual responsibilities. See Supplement 13-A: Program Agreement at the end of this chapter.

Regulatory Services and the Long-term Care Ombudsman Program are mandated to investigate complaints. To expedite investigations, a Program Agreement explains our joint and individual responsibilities.

Important: The Long-term Care Ombudsman Program does not investigate whether alleged ANE happened. Regulatory Services determines if alleged ANE occurred in a facility.

Surveys and Licensures

Initial Licensure

Background checks are conducted on the individuals and corporations responsible for resident health and safety in nursing homes and assisted living facilities. Checks are made to ensure the responsible parties have a good history of operating long-term care facilities. If new owners and operators are added to a license, their backgrounds are also checked and must be approved for a license to remain valid.

For a facility to keep its license, the results of any inspection, follow-up visit, complaint investigation, and incident investigation must show the facility complies with current state licensure laws and rules.

- Nursing Homes
  To become a provider, a nursing home operator submits a license application, pays an annual fee, and the facility passes a health and life safety code inspection. Facilities choose to be private pay (licensed only), Medicaid- or Medicare-certified, or dually certified to be reimbursed for Medicaid and Medicare services.
- **Assisted Living Facilities**
  To become licensed, an applicant submits an application, completes Assisted Living Facility Pre-licensure computer-based training, pays an annual fee, and the facility passes a health and life safety code inspection. Under some circumstances, a facility can get licensed after a life safety inspection only.

Regulatory Services conducts surveys and licensing inspections of nursing facilities. The licensing inspection is usually conducted in conjunction with the annual recertification survey. These visits:
  - are unannounced;
  - may take place on any day of the week at any time of day;
  - have results that are available to the public; and
  - are resident-directed and outcome-oriented.

For assisted living facilities, Regulatory Services conducts similar licensure inspections, on average once every two years, to determine if the facility is in compliance with licensing standards. These standards are less rigorous than requirements of nursing homes.

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Just like ombudsman visits, surveyor visits to facilities are unannounced. If you become aware of a scheduled Regulatory Services survey, it is a felony to disclose the information outside of the ombudsman program.

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**Purposes of a Survey**

Surveys monitor whether nursing homes provide care and services to residents that meet licensing standards. In certified facilities, surveys also determine if the facility meets standards for participation in Medicare or Medicaid. Inspections include a sample of residents to gather information about facility compliance with requirements. Outcomes include both actual and potential negative outcomes, as well as failure of a facility to help residents achieve their highest practicable level of well-being.

They also monitor whether assisted living facilities provide services and care to residents that meet licensing standards.
Ombudsman Tip: Survey inspection reports and copies of other inspection reports must be made available to the ombudsman upon request to Regulatory Services.

Surveyors complete seven tasks during a standard survey.

1. **Offsite preparation.** Surveyors review the facility’s history and identify any existing concerns. They may pre-select potential residents for the sample. They determine if any features of the facility require specialty surveyors, such as pharmacists and dieticians, to join the survey team. These surveyors may be onsite only for the portion of the survey relevant to their expertise.

2. **Entrance conference and onsite preparatory activities.** At the entrance conference, the team leader informs the administrator of the survey and introduces the team members. While the team leader requests additional information from the administrator, other team members may begin task 3, the initial tour.

3. **Initial tour.** Surveyors review the facility, staff, and residents, obtain an initial evaluation of the environment including the kitchen, confirm or invalidate any pre-selected concerns, and add concerns discovered during the tour.

4. **Sample selection.** Surveyors select a case-mix stratified sample of residents based on quality indicators (known as QIs) and other offsite and onsite sources of information in order to assess compliance with resident-centered requirements.

5. **Information gathering.** Surveyors make observations of the facility, kitchen, residents, quality of life assessments, medication passes, quality assessment and assurance review, and abuse prohibition review. They hold a resident group interview and ask standard questions about rights and care.

6. **Information analysis for deficiency determination.** Surveyors review the collected information and determine whether or not the facility failed to meet one or more of the regulatory requirements.

7. **Exit conference.** Surveyors inform the facility of their observations and the preliminary findings.

The purpose of a survey is to determine whether facilities meet licensing standards and whether the facility meets standards for ______________ in Medicare or Medicaid.
Throughout the survey, the team discusses observations and information collected. Surveyors can extend a survey beyond the typical four days in a nursing home and one day in an assisted living facility.

If the facility is out of compliance with any regulations, they send an official statement of deficiencies to the facility within 10 working days after the end of a survey. The facility must respond within 10 calendar days with a plan of correction for each item of noncompliance and establish a timeframe for correcting the problem. Regulatory Services will then conduct a follow-up visit, or conduct a desk review, to determine if the proposed corrections were made.

Complaint Investigations

A survey team may also conduct an abbreviated survey to investigate a complaint and determine if the facility violated any requirements. If a complaint specifies conditions on a certain day, such as on weekends, or during a particular shift, then the survey team should investigate on that day or during that time frame.

Substandard Quality of Care (SQC)

SQC indicates a systemic deficiency in quality of care and quality of life within a nursing home. For this designation, citations relate to the quality of resident care such as wound care. In addition, for this designation, the deficiency must be severe or impact several residents. An SQC finding indicates Regulatory Services found the nursing home to have had a significant deficiency (or deficiencies), which the home must address and correct quickly to protect the health and safety of residents.

Immediate Jeopardy (IJ) or Immediate Threat (IT)

An IJ or IT is a situation in which the provider's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident or several residents. If surveyors identify an IJ to residents’ health and safety, they notify the administration with specific details, including the individuals at risk, before the survey team leaves the facility. The facility must immediately implement corrective measures and faces daily fines until the problem is corrected. Only onsite confirmation by surveyors of the facility’s corrective actions can remove IJ status.

SOURCE: Nursing Facility Requirements §19.409, Examination of Survey Results
Residents have the right to examine the results of the survey of a facility conducted by federal or state surveyors and any plan of correction.

The facility must make the results available for examination in a place readily accessible to residents, and must post notice of their availability.

Enforcement

The Enforcement Section of Regulatory Services may impose remedies on all licensed facilities and Medicaid-certified facilities. When surveyors determine a facility is out of compliance with licensure rules, they may send a warning letter to the facility. The letter notifies the facility that the violations of licensing rules must be corrected. The Enforcement Section may take one of several possible actions against an operator's license, and may take several actions simultaneously, including:

- suspension of a license;
- revocations of a license;
- emergency suspension and closing order;
- referral to the Attorney General;
- suspension of admissions; and
- administrative penalties, which range from $100 to $10,000 based on severity.

If a nursing facility is Medicaid-certified, additional compliance remedy options exist. Enforcement actions in a Medicaid-certified facility are recommended by Regulatory Services to CMS and have slightly different means of correction and appeal for the provider. Appeal options include informal dispute resolution arbitration, and appeal through CMS. Nursing facility Medicaid enforcement actions include:

- imposition of civil money penalties; and
- termination of the provider agreement (loss of Medicaid contract).

Administrative Penalties

Administrative penalties are created by state law and rule. Most administrative penalties allow a facility to correct the problem and remove the penalty. Some violations are not eligible for the right to correct, including:

1. a violation that:
   - results in serious harm or death to a resident,
   - is a serious threat to the health or safety of a resident, or
• substantially limits the facility’s capacity to provide care;
2. specific portions of the criteria for denying a license; or
3. a violation of a resident right.

Ask the Trainer: Enforcement

Which enforcement action have you seen most commonly taken?

Amelioration

Amelioration is a term used in enforcement to describe the option to make facility improvements with money imposed as a penalty. Amelioration allows a facility to submit a plan for approval by the State of Texas. The plan must propose how part of the administrative penalty will be used to improve services in a nursing home or assisted living facility. Rules apply.

Trustee Appointment

With assistance from the Office of the Attorney General, Regulatory Services may petition a Travis County court for the involuntary appointment of a trustee. This enforcement action is rare as it is costly and likely results in the forced closure of the facility and relocation of all residents. Regulatory Services argues its case to the court and the facility has an opportunity to make counter arguments. If a trustee is appointed, the trustee controls all facility operations and serves as an officer of the court until dismissed by the court.

Another option of a trustee placement is by agreement between Regulatory Services and the facility operator. In the case of a trustee by agreement, the operator pays all costs for the trustee. In practice, operators are more likely to hire a consultant to serve this function and not formally agree to a trustee.

Credentialing

Many types of personnel work in nursing homes and assisted living facilities. Professional boards license physicians, nurses, pharmacists, social workers, and others are regulated by state agencies and boards. The programs are regulated in the same agency as Regulatory Services.
Nursing Facility Administrator (NFA) Licensing and Investigations Program
• Issuance, renewal, revocation of a license, as well as continuing education
• Investigate complaints or referrals resulting from findings of substandard quality of care and violations of the NFA standards of conduct
• Impose and monitor sanctions
• Provide quarterly training for administrators in training

Nurse Aide Registry
• Maintain a registry of all nurse aides who are certified. Certified Nurse Aides are required to have:
  ▪ participated in a state-approved nurse aide training and competency evaluation program: 60 classroom hours; 40 hours clinical training
  ▪ passed skills and written portions of the competency evaluation program test
  ▪ review and investigate allegations of abuse, neglect, or misappropriation of resident property by nurse aides

Medication Aide Program
• Issue and renew Medication Aide permits and review continuing education
• Impose sanctions
• Approve and monitor medication aide training programs
• Develop educational, training, and testing curricula
• Coordinate and administer tests

All long-term care facilities must check the Nurse Aide Registry and Employee Misconduct Registry on the state website (https://emr.dads.state.tx.us/DadsEMRWeb/) before hiring a person. This will determine if the person is listed as having committed an act of abuse, neglect, exploitation, misappropriation, or misconduct against a resident or consumer, and is therefore, unemployable.

All nursing home and assisted living facility employees must be determined employable. Operators must check what two registries?
1. 
2. 

____________________________________________________________________
Resources

Within state government, agencies hold authorities and responsibilities that may impact people who live and work in nursing homes and assisted living facilities. Long-term care ombudsmen interact with agency staff on various levels. Ombudsmen most often work with staff in divisions of the following agencies:

- Health and Human Services Commission
- Department of Family and Protective Services

Center for Policy and Innovation

Quality Monitoring Program (QMP)

The Quality Monitoring Program (QMP) provides an educational - rather than regulatory - approach to quality improvement in facilities.

QMP helps providers improve services and supports, so the right thing is done for the right person at the right time. To promote the highest quality services and supports, the program shares best practices for specific focus areas such as pain management, managing fall risk, and use of antipsychotics.

QMP is not a regulatory program. Quality monitors do not cite nursing homes or assisted living facilities for deficient practices. Staff includes nurses, dietitians, pharmacists, psychologists, and social workers. Located across Texas, they work together with providers to implement best practices. Through partnerships, providers and monitors assess and strengthen facility clinical systems to improve resident outcomes.

The Quality Monitoring website was developed by the Center for Policy and Innovation (CPI). This website will direct you to a variety of resources and initiatives that are resources for ombudsmen to share with facility staff or to learn more about evidence-based best practices for providers:

http://www.dads.state.tx.us/providers/qmp/about.html

Preadmission Screening and Resident Review (PASRR)

The Preadmission Screening and Resident Review (PASRR) process is a federal requirement to ensure that people are not inappropriately placed in nursing homes. It requires all applicants, prior to admission to a Medicaid-certified nursing home, are assessed to determine whether they might have mental illness, an intellectual disability, or a developmental disability. The preadmission screening is called a “PASRR Level I Screen.”
• If an individual’s PASRR Level I (PL1) screen is negative, the person is not suspected of having a mental illness, an intellectual disability, or a developmental disability. The PASRR process ends for that person.

• If the person’s PASRR Level I screening is positive, additional screening is provided. For a person with an intellectual disability, a professional from a local intellectual and developmental disability authority (LIDDA) completes and submits an in-depth PASRR II evaluation. For a person with a mental illness, a local mental health authority (LMHA) responds.

PASRR evaluations help determine the most appropriate setting, and help to develop recommendations for specialized services for the person’s plan of care.

See Supplement 11-C: PASRR Excerpt from Nursing Facility Requirements for Licensure and Medicaid Certification for a detailed discussion of the process.

Client Trust Fund – Nursing Homes

Residents have the right to manage their financial affairs or designate other people to do so. Some residents deposit personal funds with the nursing home. Families and guardians often want facilities to assume this responsibility. If residents deposit their funds, staff manages resident funds but must keep them separate from facility funds.

To safeguard Medicaid-eligible residents’ money, nursing homes use an accounting system for their incomes and expenses. Trust Fund Monitors audit facility systems that include:

• A collective bank account for all participating residents;
• Individual resident files showing all deposits and withdrawals;
• A petty cash fund to provide small amounts of money; and
• Receipt files for each resident of all purchases and payments made by and for that resident.

When a resident dies or moves, the nursing home closes the resident’s trust fund account. Within 30 days of death, the facility must release the resident’s funds to the individual or probate jurisdiction managing the estate. If the resident moves, the facility releases the funds within five days. Details about nursing home trust funds are in Protection of Personal Funds NFR §19.404, which is part of the resident’s rights section of nursing home rules. Assisted living facility licensing standards do not address resident trust funds.
Promoting Independence

Money Follows the Person (MFP)

The Promoting Independence initiative came about as a result of the 1999 Supreme Court decision known as Olmstead, which upheld the rights of individuals with disabilities to receive services and supports in the setting of their choice and in the least restrictive setting possible. MFP allows residents to move out of nursing homes to receive services in the community. They bypass any waiting list for long-term services and supports (Medicaid waiver services). In 2008 the state was awarded a federal grant from CMS called the MFP Demonstration. The state receives extra federal funding for people who choose to participate in the MFP Demonstration. The grant provides federal funding for a variety of efforts that supports a person’s choice to live in the community (home, apartment, assisted living) instead of an institutional setting (nursing home). The Long-term Care Ombudsman Program is part of the grant, and received funds to support our work from 2012-2016.

To support people who choose to relocate to the community, relocation contractors across the state hire relocation specialists. Specialists work with residents and managed care service coordinators to explore their interest in returning to the community. Residents have a right to interact with relocation specialists to get information about moving back to the community. Specialists educate residents and identify those who want to access community services through MFP.

Nursing home administrators and staff must support and assist in all MFP activities. Facilities should give relocation specialists private access to residents, along with family and others with the resident’s approval, and provide access to clinical records and other documentation as needed.

Department of Family and Protective Services (DFPS)

Adult Protective Services (APS)

APS investigates abuse, neglect, and exploitation of adults who are age 65 or older, and age 18-64 with a disability.

APS caseworkers investigate reported abuse, neglect, or exploitation to determine if the reported situation exists and to what extent it adversely affects the elder or adult with disabilities. They must initiate an investigation within 24 hours of receipt of the report by DFPS. Through assessments, they determine the alleged victims’ situations and needs as well as identify and address root causes.

To lessen or prevent further mistreatment, caseworkers provide or arrange for services such as financial help for rent and utilities, social and health services, and referrals to a
Guardianship Program. Caseworkers may provide direct services, arrange services by others, or purchase services on a short-term, emergency basis.

For people who live in nursing homes, assisted living facilities, and other institutions, APS investigates financial exploitation if the alleged perpetrator lives in the community. If abuse, neglect, and exploitation happens within a facility by staff or others, Regulatory Services staff investigates.

Refer to Supplement 13-B: *Memorandum of Understanding* (Between APS and Long-term Care Ombudsman Program) for more information about how these two programs work together.

Health and Human Services Commission (HHSC)

Fair and Fraud Hearings

The Fair and Fraud Hearings section of the HHSC Appeals Division receives appeal requests from applicants and clients to contest actions taken regarding benefits and services. The programs include all Medicaid-funded services, the Supplemental Nutrition Assistance Program (formerly known as the Food Stamp Program), and other agency programs required by law or rule to provide the right to a fair hearing. Fair and Fraud Hearings provide accessible, neutral forums to conduct administrative hearings while issuing just and impartial decisions with respect for the dignity of individuals and their due process rights. Hearings officers’ conduct the hearings, consider evidence, and issue decisions in accordance with rules, regulations, and laws.

State and federal laws require hearings officers to be impartial and to not have prior knowledge of any case. They may only consider evidence and testimony provided at the hearing to make a decision on a case.

Most hearings are held by phone but may be face-to-face if requested. The date, time, and call-in number are in the hearing notice. Once everyone is in attendance, the hearings officer explains what will happen and swears in everyone. The agency representative explains the action they took. Then appellants ask questions and explain why they disagree with the agency’s action or inaction.

Hearings officers must issue a decision no later than 90 days from the date of the appeal request. Some circumstances could extend the time. Appellants have 30 days from the date on the decision to ask the hearings officer to reopen an appeal.

Office of Eligibility Services

Staff who determine Medicaid eligibility are called eligibility workers and are often responsible for handling other benefit applications. Duties of these workers include
interviewing applicants and verifying application information, as well as helping clients to obtain necessary documentation. Authorizing approval for benefits, maintaining records, and investigating possible fraud are other required activities.

Residents interact with Medicaid eligibility (ME) workers if and when they apply for the Medicaid program or if they want to appeal a discharge from the nursing home. ME workers almost always provide assistance over the telephone because they assist clients all over the state. Ombudsmen may contact ME workers to assist in overcoming any barriers to services for a resident, to get information about eligibility or the application process, and to initiate an appeal request on behalf of a resident.

Nursing Home Discharge Appeal

If a nursing home resident wants to stay in a facility while a discharge appeal decision is made, the nursing home resident has 10 days from the date of the notice to request an appeal with the Office of Eligibility Services. Otherwise, the resident has 90 calendar days from the date of the notice to request an appeal. (Assisted living facility residents do not use this appeal process.)

To file a discharge appeal, fax the request to the statewide fax intake for appeals at (866) 559-9628*. An ombudsman can help with this step. The request should include:

- Resident’s name
- Date of birth
- Social security or Medicaid number
- Facility name and address
- Name(s) of anyone who will serve as a witness or representative for the resident, including address and phone number
- Need for interpreter, if applicable
- A copy of discharge notice, if possible
- Signature of the resident or authorized representative
- Date

The resident or resident’s representative is not required to notify the nursing home.

*If you have trouble faxing to this number, fax the request to TIERS in Midland. (877) 447-2839
KEPRO – Medicare Quality Improvement Organization (QIO)

KEPRO is a QIO that works under contract with the CMS. KEPRO is a resource for residents who are Medicare recipients. Residents who are not satisfied with the quality of care received, the discontinuation of skilled nursing services, or Medicare discharge plans, can call the KEPRO Medicare Beneficiary Helpline at 1-844-430-9504. A complaint form can be downloaded from the company’s website at www.keproqio.com/bene/helpline.aspx.

More information about QIOs may be found on the CMS website at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html

Exercise: Help! – Identify the Right Resource

Write the program or the best person to help solve each problem. To take action on a resident’s behalf, you always need resident consent. For this exercise, assume you obtained consent from the resident.

1. Mrs. Cash moved to a new nursing home. She asks for her personal funds deposited with the home and is told no money is available.  ____________________________________________

2. When Mr. Rich moved in, he was private pay. Now he has spent down to a total of $2,000 in his accounts. Where does he apply for Medicaid?  ____________________________________________

3. You notice numerous residents are restrained. Facility staff says they use physical restraints to prevent falls, but they want to learn best clinical practices to keep residents safe.  ____________________________________________

4. Mr. Brown’s bill hasn’t been paid for the past three months. His dementia got worse and his son started paying. The business office manager believes the son is paying his own house payments out of his dad’s money.  ____________________________________________

5. Each time you visit Ms. Morrow, she talks about moving out of the nursing home because everyone is old and she believes she could live in an apartment.  ____________________________________________
6. The nursing home sent Mr. Chang a 30-day discharge notice that they cannot meet his needs. He doesn’t understand because other residents are in the same condition. He wants to stay.

Ombudsman Role

With regulators and other agency resources, ombudsmen communicate professionally as advocates and work on behalf of residents with their consent. They maintain resident and complainant confidentiality.

A member of the Regulatory Services survey team should contact the local ombudsman program within two hours of entering a facility to ask about concerns and to say when the resident group interview is scheduled. With resident and complainant permission, ombudsmen provide resident names to include in the survey sample or for record review, and family members for interviews. Ombudsmen may attend the resident group meeting if invited by residents, attend the exit interview, and participate in other activities as agreed upon.

Ombudsmen also describe systemic or serious concerns they have not been able to resolve. Generally, ombudsmen do not report complaints they are currently working to resolve as it may trigger the surveyors to investigate the same issue.

If you arrive at a nursing home or assisted living facility while Regulatory Services is conducting a survey, introduce yourself to the lead surveyor, provide relevant information about the facility, and exit the building unless you plan to attend the resident group interview. This signals to residents and facility staff that surveyors are regulators and ombudsmen are advocates.

While educating, advocating, or solving problems, ombudsmen may consider supports and services at agencies and programs. Before using outside resources, discuss the situation with your supervising staff ombudsman. By contacting these resources or referring others to them, staff with in-depth knowledge of their agency programs provide answers in the most effective and efficient manner. With consent from residents and complainants, provide detailed information to help reach resolution appropriately and quickly.

If you make referrals, follow up with the residents to see if they received answers to their questions, information about their issues, or resolution to their problems. If not, ask whether they want you to take further action or pursue a different approach. Even when you refer a problem to another resource, it’s your responsibility to follow-up and follow-through with the case. Assign a disposition to each complaint based on the resident’s or complainant’s feedback on resolution.
Supplement 13-A: Program Agreement
(Between Long-term Care Ombudsman Program and Regulatory Services)

http://www.dads.state.tx.us/handbooks/oppm/res/Program%20Agreement%20Between%20LTC%20OP%20and%20RS.pdf

Supplement 13-B: Memorandum of Understanding
(Between DFPS Adult Protective Services and Long-term Care Ombudsman Program)


Supplement 13-C: PASRR Excerpt from Nursing Facility Requirements for Licensure and Medicaid Certification

Subchapter BB, Preadmission Screening and Resident Review

§19.2701 Purpose

The purpose of this subchapter is to:

(1) describe the requirements of a nursing facility related to preadmission screening and resident review (PASRR), which is a federal requirement in Code of Federal Regulations, Title 42, Part 483, Subpart C to ensure that:

(A) an individual seeking admission to a Medicaid-certified nursing facility and a resident of a nursing facility receives a PASRR Level I screening (PL1) to identify whether the individual or resident is suspected of having mental illness (MI), an intellectual disability (ID), or a developmental disability (DD); and

(B) an individual or resident suspected of having MI, ID, or DD receives a PASRR Level II evaluation (PE) to confirm MI, ID, or DD and, if confirmed, to evaluate whether the individual or resident needs nursing facility care and specialized services; and

(2) describe the requirements of a nursing facility related to a designated resident who receives service planning and transition planning.

§19.2704 Nursing Facility Responsibilities Related to PASRR

(a) If an individual seeks admission to a nursing facility, the nursing facility:

(1) must coordinate with the referring entity to ensure the referring entity conducts a PL1; and

(2) may provide assistance in completing the PL1, if the referring entity is a family member, LAR, other personal representative selected by the individual, or a representative from an emergency placement source and requests assistance in completing the PL1.
(b) A nursing facility must not admit an individual who has not had a PL1 conducted before the individual is admitted to the facility.

(c) If an individual's PL1 indicates the individual is not suspected of having MI, ID, or DD, a nursing facility must enter the PL1 from the referring entity into the LTC Online Portal. The nursing facility may admit the individual into the facility through the routine admission process.

(d) For an individual whose PL1 indicates the individual is suspected of having MI, ID, or DD, a nursing facility:

   (1) must enter the PL1 into the LTC Online Portal if the individual's admission category is:

       (A) expedited admission; or

       (B) exempted hospital discharge; and

   (2) must not enter the PL1 into the LTC Online Portal if the individual's admission category is pre-admission.

(e) Except as provided by subsection (f) of this section, a nursing facility must not admit an individual whose PL1 indicates a suspicion of MI, ID, or DD without a complete PE and PASRR determination.

(f) A nursing facility may admit an individual whose PL1 indicates a suspicion of MI, ID, or DD without a complete PE and PASRR determination only if the individual:

   (1) is admitted as an expedited admission;

   (2) is admitted as an exempted hospital discharge; or

   (3) has not had an interruption in continuous nursing facility residence other than for acute care lasting fewer than 30 days and is returning to the same nursing facility.

(g) A nursing facility must check the LTC Online Portal daily for messages related to admissions and directives related to the PASRR process.

(h) Within seven calendar days after the LIDDA or LMHA has entered a PE or resident review into the LTC Online Portal for an individual or resident who has MI, ID, or DD, a nursing facility must:

   (1) review the recommended list of nursing facility specialized services, LIDDA specialized services, and LMHA specialized services; and

   (2) certify in the LTC Online Portal whether the individual's or resident's needs can be met in the nursing facility.

(i) After an individual or resident who is determined to have MI, ID, or DD from a PE or resident review has been admitted to a nursing facility, the facility must:
(1) contact the LIDDA or LMHA within two calendar days after the individual's admission or, for a resident, within two calendar days after the LTC Online Portal generated an automated notification to the LIDDA or LMHA, to schedule an IDT meeting to discuss nursing facility specialized services, LIDDA specialized services, and LMHA specialized services;
(2) convene the IDT meeting within 14 calendar days after admission or, for a resident review, within 14 calendar days after the LTC Online Portal generated an automated notification to the LIDDA or LMHA;
(3) participate in the IDT meeting to:
   (A) identify which of the nursing facility specialized services, LIDDA specialized services, and LMHA specialized services recommended for the resident that the resident, or LAR on the resident's behalf, wants to receive; and
   (B) determine whether the resident is best served in a facility or community setting.
(4) provide staff from the LIDDA and LMHA access to the resident and the resident's clinical facility records upon request from the LIDDA or LMHA;
(5) enter into the LTC Online Portal within 3 business days after the IDT meeting for a resident:
   (A) the date of the IDT meeting;
   (B) the name of the persons who participated in the IDT meeting;
   (C) the nursing facility specialized services, LIDDA specialized services, and LMHA specialized services that were agreed to in the IDT meeting; and
   (D) the determination of whether the resident is best served in a facility or community setting;
(6) include in the comprehensive care plan:
   (A) the nursing facility specialized services agreed to by the resident or LAR; and
   (B) the nursing facility PASRR support activities;
(7) if Medicaid or other funding is available:
   (A) initiate nursing facility specialized services within 30 days after the date that the services are agreed to in the IDT meeting; and
   (B) provide nursing facility specialized services agreed to in the IDT meeting to the resident; and
(8) for a resident who is a Medicaid recipient, annually document in the LTC Online Portal all nursing facility specialized services, LIDDA specialized services, and LMHA specialized services currently being provided to a resident.

§19.2708 Educational and Informational Activities for Residents

A nursing facility must:

(1) allow access to residents by representatives of the Office of the State Long Term Care Ombudsman and Disability Rights Texas to educate and inform them of their rights and options related to PASRR;
CHAPTER 14: Resident-directed Care
Resident-directed Care

Chapter 14 is about nursing homes and assisted living facilities providing care based on what each individual resident wants and needs and involving residents, family members, staff, and management. “Resident-directed care” is the goal.

Learning Objectives

- Increase knowledge of individualized care as directed by the resident
- Be aware of reasons why facilities are changing
- Know major components of resident-directed care
- Distinguish between resident-directed and traditional practices

Contents

- Resident-directed Care and Culture Change
- Traditional Care Practices
- Person-directed Practices
- Connecting Regulatory Compliance with Resident-directed Care
- Language of Long-term Care

DVD(s), Supplements, Forms

- Mystery Game
- DVD: CMS Hand in Hand Training Module 4: Being with a Person with Dementia: Actions and Reactions
- Internet Video: Dining With Friends
Resident-directed Care and Culture Change

A nursing home must “care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.” Based on the Nursing Home Reform Law of 1987, this requirement emphasizes dignity, choice, and self-determination for the people who live in nursing homes.

Even with laws emphasizing the need to focus on each resident, many nursing homes continue to provide institutionalized care based on a medical model. Since the 1990s, advocates, regulators, and providers have been working to more effectively blend a medical model with a social model. This transformation movement is known as culture change.

Like a nursing home, an assisted living facility is responsible for all care provided to residents. Residents should receive the kind and amount of supervision and care they require to meet their basic needs. No federal regulations exist for assisted living facilities, but in Texas, facilities must comply with Licensing Standards for Assisted Living Facilities.

While residents who live in assisted living tend to be more independent, the facilities also risk becoming institutionalized. Culture change principles can transform assisted living facilities the same as nursing homes.

Culture Change

- Culture change - a movement working to radically transform facility care and help facilities transition from institutions to homes
- Person-directed care - residents make decisions about individual routines of daily life, as well as directly influence how their home operates

Culture change is a philosophy that focuses on fostering a person-centered, and ideally a person-directed, care system. Person-directed care means the resident actively determines the course of his or her life in daily activities, care, and choices. When a resident cannot fully direct personal care, because of physical or cognitive disabilities, caregivers and advocates look to the person’s expressed wishes for clues to provide resident-centered care.

Culture change is a philosophy that focuses on fostering a person-centered, and ideally a person-directed, care system. Person-directed care means the resident actively determines the course of his or her life in daily activities, care, and choices.
Clues can come from advance care planning documents, known or previously expressed wishes, lifelong preferences, and input from family and friends. Person-centered and person-directed care requires regular communication with the resident to learn the resident’s wishes and to create opportunity for the person to exercise choice and control over his or her life. Ombudsmen are trained to follow this same principle as we work to protect resident rights and resolve complaints.

Care providers report that a commitment to culture change improves the quality of care and life for residents and the quality of work experience for staff.

**Continuum of Resident-directed Culture**

Sue Misiorski and Joanne Rader developed this continuum of direction to the differences between staff-directed and person-directed culture. Staff directed cultures are low on the continuum of resident-directed care. The progression of resident-directed culture is outlined below.

<table>
<thead>
<tr>
<th>Low</th>
<th>Continuum of Person-directedness</th>
<th>High</th>
</tr>
</thead>
</table>

**Provider-directed**

Management makes most decisions with little conscious consideration of the impact on residents or staff.
Residents accommodate staff preferences and are expected to follow existing routines.

**Staff-centered**

Staff consults residents or puts themselves in the residents’ place while making the decisions.
Residents accommodate staff much of the time but have some choices within existing routines and options.

**Resident-centered**

Resident preferences or past patterns form the basis of decision-making about some routines.
Staff begins to organize routines to accommodate expressed or observed resident preferences.

**Resident-directed**

Residents make daily decisions about individual routine. When not capable of stating needs, staff honor habits and observed preferences.
Staff organizes their hours, patterns, and assignments to meet resident preferences.
The State of Texas supports moving nursing homes and assisted living facilities away from institutional models to person-directed models. The initiative expands the focus of care to include not only clinical and safety concerns but also residents’ quality of life, relationships, and respect for individual needs and wishes.

Words can affect our ability and willingness to change by influencing how we see the people and places around us. Words can make a difference, such as calling a child difficult rather than high-spirited, or the grocery store clerk slow instead of careful.

Changing our language can lead to changing our perspective on the places residents call home. For help with the exercise below, refer to the Language of Long-term Care table at the end of this chapter.

Exercise: Suggest how traditional words could be replaced with words that emphasize the person.

1. Nursing facility ________________________________
2. Staff ________________________________
3. Resident ________________________________
4. Hallway/unit ________________________________
5. Nourishment ________________________________
6. Pet therapy ________________________________
7. Activities room ________________________________
8. Resident council ________________________________
9. Therapy room ________________________________
10. Meal tray ________________________________
Traditional Care Practices

Traditional care practices focus on the efficiency of business. Many nursing homes are large physical buildings based on efficiency principles to maximize economies of scale and get things done quickly, smoothly, and routinely. Power is held by managers and corporate staff.

For efficiency, management tightly controls staff life. Direct care staff voice concerns including:
- Lack of respect
- Not being valued by the organization
- Lack of good leadership role models
- Stress of working short staffed
- Lack of empowerment or adequate training
- Limited opportunities for growth

Facility practices encourage absenteeism:
- Incentives to waive benefits
- Denial of pay for absences less than two days
- Use-it-or-lose-it sick pay
- Rotating staff assignments; not having consistent caregivers inhibits relationships between residents and caregivers

Person-directed Practices

The person-directed care model involves three interconnected areas: environment, care, and work. Changes can range from simple and inexpensive to complex and costly.

Environmental
- Create a home with a sense of community and safety for residents and staff.
- Demonstrate affection, validation, and support.
- Shift toward neighborhoods and communities within a building.
- Reduce noise from overhead paging with pagers or wireless phones.
- Change centralized nursing stations to several nursing areas.
- Exchange medication carts for locked medication storage in resident rooms.
- Remove institutional signage.
- Serve meals from a buffet or use table service rather than using trays.
- Construct private rooms and private baths.
- Build smaller houses where 10-12 residents live together with a caregiver.
Care

- Use creative care solutions based on resident preferences.
- Be flexible about waking and sleeping times.
- Make dining more personal and pleasant.
- Accommodate resident bathing preferences.
- Create and honor rituals and celebrations.
- Design social activities based on individual and group preferences.
- Staff promotes individuality and normalcy and gives residents as much choice and control as possible.

Workplace

- Establish relationships as the number one organizational priority.
- Promote high quality leadership.
- Value and respect caregivers and their needs.
- Develop leadership opportunities for direct care staff.
- Assign direct care staff consistently to the same residents.

How can person-directed care improve quality of life in nursing homes and assisted living facilities?

Comparing Models of Care

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Person-directed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff provides standardized treatments based on medical diagnosis</td>
<td>Staff establishes care based on individualized care needs and personal wishes</td>
</tr>
<tr>
<td>Facility designs schedules and routines; staff and residents comply</td>
<td>Flexible schedules and routines match resident needs and wishes</td>
</tr>
<tr>
<td>Task-oriented work; staff rotates assignments and knows how to perform tasks on any resident</td>
<td>Relationship-centered work; consistent staff assignments brings personal knowledge of residents into caregiving</td>
</tr>
<tr>
<td>Traditional</td>
<td>Person-directed</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Management makes all decisions</td>
<td>Residents and those close to them make decisions</td>
</tr>
<tr>
<td>Facility is staff’s workplace</td>
<td>Facility is resident’s home</td>
</tr>
<tr>
<td>Isolation, loneliness, and feeling of homelessness are common</td>
<td>Residents and staff share a feeling of community and belonging</td>
</tr>
<tr>
<td>Resident adapts to facility</td>
<td>Facility adapts to the resident. Residents make decisions about their daily routines such as waking, sleeping, dining, bathing, and participating in activities</td>
</tr>
<tr>
<td>Medical model focus</td>
<td>Staff supports quality of life with quality of care by considering the resident’s spiritual, mental, and physical well-being in all decisions</td>
</tr>
<tr>
<td>Impersonal work practice</td>
<td>Facility involves employees, residents, and family to support relationships; invests in staff through time, education, and commitment</td>
</tr>
<tr>
<td>Authoritarian process</td>
<td>Facility creates opportunities where individuals make decisions and take greater responsibility to better the home and their lives and implements a team-driven change process</td>
</tr>
<tr>
<td>Resident sees the nursing home as a place to die</td>
<td>Rituals and celebrations acknowledge life and establish an environment where everyone thrives and grows</td>
</tr>
<tr>
<td>• noting large and small accomplishments</td>
<td>• celebrating the lives of residents and employees</td>
</tr>
<tr>
<td>• supporting life and growth through daily activities</td>
<td>• providing purpose, diversity, and spontaneity</td>
</tr>
</tbody>
</table>

List two differences between traditional care practices and person-directed care practices.

Traditional _______________________________
Person-directed _______________________________

Traditional _______________________________
Person-directed _______________________________
Activity: Mystery Game

Objectives:
This game introduces person-directed thinking through three objectives:
1. Recognize how current circumstances and culture inadvertently create problems.
2. Apply person-directed thinking to develop solutions for the resident.
3. Understand that changing to more person-directed practices requires changes in the entire facility system and all departments.

Directions:
Starting with a set of 42 clues, hand out the clues, face up, as if dealing a deck of cards. Everyone at the table will have several clues. Game time is about 20 minutes.

Each card contains pieces of information about Thomas McNally who lives in a nursing home. Information is clinical and personal. All the information is necessary to solve the mystery.

After all clues are handed out, everyone shares their clues with each other to solve the mystery. The facilitator can document answers on a board or chart.

Discussion:
The group answers the following:
- How are facility routines contributing to Mr. McNally’s decline?
- What clues do you have about his strengths and interests?
- How can staff use his strengths and interests to start a person-directed approach that may reverse his decline?
- What changes in his routine need to be put in place? What changes in facility routine need to happen so his personal routines can be restored?
- What additional information is needed?
- Who else needs to be involved in the discussion?

Additional Discussion
Learn the word “i-atro-gen-e-sis,” which is Greek for “we caused it.” A formal definition is “inadvertent and preventable induction of disease or complications by the medical treatment or procedures of a physician.” This term describes a clinical problem caused by clinical treatment. Draw a parallel to using restraints: while used for safety, they unintentionally cause harm.

Other facility routines meant to provide care for residents inadvertently harm them. Centering care around a person’s routines, instead of facility routines, can reverse this harm and help people thrive.
What can an ombudsman do to help a facility implement person-centered care planning?

_________________________________________________________________

_________________________________________________________________

CMS Hand in Hand Training – Module 4: Being with a Person with Dementia: Actions and Reactions
Run Time: Approximately 1 hour to view video clips and discuss

When we think about behaviors of persons with dementia, we may often think of them as negative, bad, or challenging. When we reframe behaviors as actions and reactions, it helps us understand that behaviors are a form of communication.

There are many reasons why a resident with dementia might act the way they do. These reasons might be related to health conditions, medications, communication, the environment, the task itself, unmet needs, a resident’s life story, and your interaction with that resident. When we understand the meaning of the actions and reactions of the resident, we are better able to respond to them and fulfill their needs.

Answer the following questions about CMS Hand in Hand Module 4.

1. All behaviors or actions are a form of ____________. We must try to understand their world.

2. List three possible reasons behind the actions or reactions of an individual with dementia:
   a) ____________________________________________________________
   b) ____________________________________________________________
   c) ____________________________________________________________

3. Medications can contribute to changes in a resident’s actions. Any change in a resident’s behavior or condition should be ____________ immediately.

4. In the I Want to Go Home video clip, why might Mrs. Caputo say she wants to go home?
   a) ____________________________________________________________
5. In coming up with ways to respond to actions and reactions, what are the three ‘P’s’ you should think about? Define the three P's.
   a) ____________________________________________________________
   b) ____________________________________________________________
   c) ____________________________________________________________

Connecting Regulatory Compliance with Resident-directed Care

Facility staff may find it challenging to connect culture change principles and regulatory compliance. The Centers for Medicare and Medicaid (CMS) State Operations Manual provides interpretive guidelines on how to conduct nursing home surveys and determine compliance. The manual is routinely updated and many culture change principles are incorporated.

This section reviews several State Assisted Living Standards, and Nursing Facility Requirements. It is adapted from training designed for providers and surveyors to understand and support culture change in Texas nursing homes.

In light of person-directed principles of respect, choice, empowerment, relationships, and community, ombudsmen help influence how facilities can change. When reviewing the following pages, think about how assisted living facilities and nursing homes can comply with regulations and be resident-directed.

Exercise: Practice Connecting Regulatory Compliance with Resident-directed Care

Directions:
Review the following regulations for nursing homes (TAC §19) and assisted living facilities (TAC §92). Answer the correlating questions to practice promoting resident-directed care.
Introduction

Nursing Homes
§19.401

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident.

Assisted Living Facilities
§92.1 (b)

Assisted living services are driven by a philosophy that emphasizes personal dignity and autonomy to age in place in a residential setting while receiving increasing and decreasing levels of services as the person’s needs change.

List some practices a facility can do to promote dignity and choice?

- Build relationships with residents, families, and physicians to understand residents as individuals and provide care according to resident preferences.
- Enable residents to self-administer medications if they want to and it is safe.
- Learn the person’s cultural and spiritual practices and how they may affect treatment decisions.
- Determine exactly what service a resident is refusing and why.

Notice of Rights and Services

Nursing Homes
§19.403

(h) The resident has the right to refuse treatment, to formulate an advance directive, and to refuse to participate in experimental research.

Assisted Living Facilities
§92.125 (a) (P)

The resident has a right to be given the opportunity to refuse medical treatment or services after the resident is advised of the possible consequences and acknowledges understanding.

How can a care provider support resident-directed care, including the right to refuse care?

- Learn the person’s cultural and spiritual practices and how they may affect treatment decisions.
- Determine exactly what service a resident is refusing and why.
Grievances

**Nursing Homes**
§19.408

A resident has the right to voice grievances without discrimination or reprisal.

**Assisted Living Facilities**
§92.125

(a)(3)(H) A resident has a right to complain about the resident’s care or treatment. The complaint may be made anonymously or communicated by a person designated by the resident. The provider must promptly respond to resolve the complaint. The provider must not discriminate or take punitive action against the resident who makes a complaint.

**How can the right to complain be assured?**

- Empower residents to feel comfortable voicing complaints to the ombudsman, facility staff, and family members to find a solution to their complaints.
- Empower resident and family groups to help resolve conflicts, grievances, and complaints, thus keeping problems close to their source.

Privacy and Confidentiality

**Nursing Homes**
§19.407

The resident has the right to personal privacy and confidentiality of his personal and clinical records.

1. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.
2. The resident may approve or refuse the release of personal and clinical records to any individual outside of the facility.
3. The resident's right does not apply when transferred to another health care institution; record release is required by law; or during surveys.

Assisted Living Facilities
§92.125 (a) (Q) & (R)

A resident has a right to unaccompanied access to a telephone at a reasonable hour or in case of an emergency or personal crisis. A resident also has a right to privacy, while attending to personal needs and a private place for receiving visitors or associating with other residents, unless providing privacy would infringe on the rights of other residents. This right applies to medical treatment, written communications, telephone conversations, meeting with family, and access to resident councils. If a resident is married and the spouse is receiving similar services, the couple may share a room.

Assisted Living Facilities
§92.41 (h) (1)

Records that pertain to residents must be treated as confidential and properly safeguarded from unauthorized use, loss, or destruction.

How can privacy be respected and allow residents to thrive?

- Teach staff that only persons directly involved in providing treatments, delivering care, or to whom the resident has given consent can be present during care.
- Ensure privacy when residents go to the bathroom and receive other hygiene care.
- ________________________________________________________________
- ________________________________________________________________

Ombudsman Access

Nursing Homes
§19.413 Access and Visitation Rights (a)

A resident has the right to have access to, and the facility must provide immediate access to a resident to a representative of the Office of the State Long Term Care Ombudsman.

Assisted Living Facilities
§92.801 Access to Residents and Records by the Long-term Care Ombudsman Program (a)

A resident has the right to be visited by, and a facility must provide immediate access to any resident to:
(1) a staff person of the Office of the State Long-term Care Ombudsman (the Office) employed by DADS;
(2) a certified ombudsman; and
(3) an ombudsman intern.

How can ombudsmen respect residents’ privacy?

In rooms:

_____________________________________________________

Visiting a resident with a complaint:

_____________________________________________________

Investigating a complaint:

_____________________________________________________

Accessing resident’s medical records:

_____________________________________________________

Quality of Life

**Nursing Homes**

§19.701

A facility must care for its residents in a manner and environment that promotes maintenance or enhancement of each resident's quality of life. Suggest some changes in facility environments to enhance quality of life.

- Furnish the home with personal items, such as pictures and furnishings that belong to the residents.
- Offer parties, dinners, and celebrations.
- Provide a variety of spiritual opportunities, such as speakers, services, and music.
- __________________________________________________
- __________________________________________________
Dignity

Nursing Homes
§19.701(1)

The facility must promote care in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of individuality.

Assisted Living Facilities
§92.125

(a) (E) A resident has a right to be treated with respect, consideration, and recognition of his or her dignity and individuality, without regard to race, religion, national origin, sex, age, disability, marital status, or source of payment. This means that the resident has a right to make his/her own choices regarding personal affairs, care, benefits, and services; has the right to be free from abuse, neglect, and exploitation; and if protective measures are required, has the right to designate a guardian or representative to ensure the right to quality stewardship of his/her affairs.

How can resident dignity, respect, and individuality be enhanced?

- Get resident input before choosing a radio or television station.
- Offer choice of paint colors to decorate rooms.
- ____________________________________________
- ____________________________________________

Activities

Nursing Homes
§19.702

The facility must provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, interest, and the physical, mental, and psychosocial well-being of each resident.

Assisted Living Facilities
§92.41 (b)

A facility must provide an activity and/or social program at least weekly for the residents.
Assisted Living Facilities
§92.51 Alzheimer’s Certified Facilities (g)

A facility must encourage socialization, cognitive awareness, self-expression, and physical activity in a planned and structured activities program. Activities must be individualized, based upon the resident assessment, and appropriate for each resident’s abilities.

How can a home provide meaningful activities that offer interesting activity for all?

- Incorporate lifelong interests into activity options.
- Consider male and female, all ages, and various cultures and religions.
- ________________________________
- ________________________________
- ________________________________

Quality of Care
Nursing Homes
§19.901

Each resident must receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

How can care practices help a person attain physical and mental well-being?

- Ensure direct care staff recognize and know how to report changes in a resident’s condition.
- Develop a staff training program with opportunities for interactive learning and resident participation.
- ________________________________

Food
Nursing Homes
§19.1108

Each resident must receive and the facility must provide food prepared by methods that conserve nutritive value, flavor, and appearance and food that is palatable, attractive, and proper temperature.
Assisted Living Facilities
§92.41 Food and nutrition services (m) (3)

Menus must be planned one week in advance and must be followed. Variations from the posted menus must be documented. Menus must be prepared to provide a balanced and nutritious diet, such as that recommended by the National Food and Nutrition Board. Food must be palatable and varied. Records of menus as served must be filed and maintained for 30 days after the date of serving.

How can food taste and appear better to residents?

- Kitchen staff can be trained on cooking methods that enhance tastiness.
- During meals, observe whether food is attractive and eaten.
- Routinely survey all residents about their opinions of food served.
- Make fresh fruits and vegetables readily available.
- ________________________________

Nursing Homes
§19.1110 Frequency of Meals

(a) Each resident receives and the facility provides three meals daily, at regular times.
(b) There must not be more than 14 hours between a substantial evening meal and breakfast the following day.
(c) The facility must offer snacks at bedtime daily.
(d) When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast.

Assisted Living Facilities
§92.41 Food and nutrition services (m) (2)

At least three meals or their equivalent must be served daily, at regular times, with no more than a 16-hour span between a substantial evening meal and breakfast the following morning. All exceptions must be specifically approved by DADS.

What are some ways for residents to direct meal times?

- Use neighborhood meetings (resident councils) to identify the best meal times.
- Accommodate individual preferences regarding waking and sleeping.
- ________________________________
- ________________________________
On Your Own:

Watch the Alzheimer’s Resource Center of Connecticut, Inc. twenty minute video about an innovative approach to dining for people with dementia, “Dining with Friends.”

https://www.arc-ct.org/dwf_view.php
Run Time: 21 min 45 sec

This video shows innovative solutions to the adverse effects dementia has on nutrition, hydration, and socialization. It addresses these obstacles and intends to improve the lives of people with dementia.

Language of Long-term Care

The language of long-term care belongs to all of us. The most urgent task may be agreeing which old words to throw away. Finding new ones should be easier. It’s a matter of choosing accurate and respectful words.

<table>
<thead>
<tr>
<th>PEOPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>OLD WORDS</td>
</tr>
<tr>
<td>grandma, mommy, sweetie, kid, honey, girls, old timer</td>
</tr>
<tr>
<td>wheelchairs/walkers</td>
</tr>
<tr>
<td>the elderly</td>
</tr>
<tr>
<td>patient</td>
</tr>
<tr>
<td>residents known by diagnosis</td>
</tr>
<tr>
<td>wanderers</td>
</tr>
<tr>
<td>disabled, diabetic, , quad, , CVA</td>
</tr>
<tr>
<td>toilet resident</td>
</tr>
<tr>
<td>activity director</td>
</tr>
<tr>
<td>non-nursing/ancillary staff</td>
</tr>
<tr>
<td>new admit</td>
</tr>
<tr>
<td>feeder, feeder table</td>
</tr>
<tr>
<td>dementia/demented</td>
</tr>
<tr>
<td>girl, guy (CNA)</td>
</tr>
<tr>
<td>I</td>
</tr>
<tr>
<td>nurse aide, CNA, nursing assistant, frontline staff</td>
</tr>
<tr>
<td>food service worker, hey you</td>
</tr>
<tr>
<td>problem resident, behavior problem</td>
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</tbody>
</table>
### PLACES

<table>
<thead>
<tr>
<th>OLD WORDS</th>
<th>NEW WORDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>facility, institution, nursing home</td>
<td>home, life center, living center</td>
</tr>
<tr>
<td>agency</td>
<td>supplemental staffing</td>
</tr>
<tr>
<td>lobby, common area</td>
<td>living room, parlor, foyer</td>
</tr>
<tr>
<td>ward, unit</td>
<td>Village, neighborhood</td>
</tr>
<tr>
<td>nurses' station</td>
<td>work area, den, support room, desk</td>
</tr>
<tr>
<td>tray line</td>
<td>fine dining</td>
</tr>
<tr>
<td>100-bed facility</td>
<td>100 people live in this home</td>
</tr>
</tbody>
</table>

### THINGS

<table>
<thead>
<tr>
<th>OLD WORDS</th>
<th>NEW WORDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>activities</td>
<td>meaningful things to do</td>
</tr>
<tr>
<td>mechanical soft food</td>
<td>chopped food</td>
</tr>
<tr>
<td>nourishment</td>
<td>snack</td>
</tr>
<tr>
<td>bibs</td>
<td>napkin, clothing protector</td>
</tr>
<tr>
<td>diapers, pampers, pull-ups</td>
<td>briefs, panties, attends, brand names</td>
</tr>
<tr>
<td>dietary services, food service</td>
<td>dining services</td>
</tr>
</tbody>
</table>

### ACTIONS

<table>
<thead>
<tr>
<th>OLD WORDS</th>
<th>NEW WORDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>admit, place</td>
<td>move in</td>
</tr>
<tr>
<td>discharge</td>
<td>move out</td>
</tr>
<tr>
<td>transport</td>
<td>assist to...</td>
</tr>
<tr>
<td>ambulation, wandering</td>
<td>walking</td>
</tr>
<tr>
<td>eloped, escaped, elopement</td>
<td>left the building, unescorted exiting</td>
</tr>
<tr>
<td>toileting</td>
<td>using the bathroom</td>
</tr>
<tr>
<td>baby-sit</td>
<td>resident interaction</td>
</tr>
<tr>
<td>allow</td>
<td>help, facilitate, encourage, welcome</td>
</tr>
<tr>
<td>claims</td>
<td>states, says</td>
</tr>
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### ATTITUDES

<table>
<thead>
<tr>
<th>OLD WORDS</th>
<th>NEW WORDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>care plan problem</td>
<td>resident strength</td>
</tr>
<tr>
<td>&quot;I didn't know she could do that.&quot;</td>
<td>&quot;I love it when she does that!&quot;</td>
</tr>
<tr>
<td>problem</td>
<td>challenge, opportunity</td>
</tr>
<tr>
<td>&quot;You need to...&quot;</td>
<td>&quot;Would you like to...?&quot;</td>
</tr>
<tr>
<td>&quot;Sit down, you'll fall.&quot;</td>
<td>&quot;Let's walk!&quot;</td>
</tr>
<tr>
<td>&quot;Trays are here.&quot;</td>
<td>&quot;Dinner is served.; It is dinnertime!&quot;</td>
</tr>
<tr>
<td>&quot;He's on the pot.&quot;</td>
<td>&quot;He's not available right now.&quot;</td>
</tr>
<tr>
<td>long-term care industry</td>
<td>long-term care community</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>a two-assist</td>
<td>requires two helpers</td>
</tr>
<tr>
<td>&quot;We’re already doing that.&quot;</td>
<td>&quot;We need to really do that.&quot;</td>
</tr>
<tr>
<td>&quot;We tried that.&quot;</td>
<td>&quot;Let’s try again.&quot;</td>
</tr>
<tr>
<td>&quot;That’s not my job.&quot;</td>
<td>&quot;I’ll take care of that.&quot;</td>
</tr>
<tr>
<td>14-hour rule</td>
<td>freedom of choice</td>
</tr>
<tr>
<td>old ways</td>
<td>change in order</td>
</tr>
<tr>
<td>can’t escape</td>
<td>would like to go outside</td>
</tr>
</tbody>
</table>

### CONDITIONS

<table>
<thead>
<tr>
<th>OLD WORDS</th>
<th>NEW WORDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>confined to wheelchair</td>
<td>uses a wheelchair</td>
</tr>
<tr>
<td>&quot;victim of...&quot; or &quot;suffering from...&quot;</td>
<td>person &quot;has...&quot; or &quot;with...&quot;</td>
</tr>
<tr>
<td>agitated</td>
<td>active, communicating distress</td>
</tr>
</tbody>
</table>

SOURCE: Culture Change Language, Pioneer Network

SOURCE: Karen Schoeneman, Senior Policy Analyst, Centers for Medicare and Medicaid Services, Opinions expressed above are those of the author, not necessarily shared by CMS.
CHAPTER 15: Systems Advocacy
Systems Advocacy

Chapter 15 describes how influencing and changing a system benefits people who live in nursing homes and assisted living facilities. Long-term care ombudsmen can impact changes to laws, regulations, policies, facility practices, and community attitudes.

Learning Objectives

- Distinguish between individual and systems advocacy
- Be aware of relevant statutory language in the Older Americans Act
- Understand the ombudsman role in systems change

Contents

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

DVD(s), Supplements, Forms

- Internet video: Reducing Antipsychotic Drug Use – A Story of Hope
What is Systems Advocacy?

Ombudsmen can advocate to change systems as well as to solve individual problems. Changing a system can impact a single facility, all facilities operated by a provider, or all facilities in the U.S. This level of advocacy requires ombudsmen to identify broad trends across the long-term care system and to work in unison with the state ombudsman.

Chapter 14 described person-directed care and culture change, which are systems change efforts. In assisted living facilities and nursing homes, systems may need to change in order to improve the quality of life and care of the people who live there. Systems may also improve the work setting of facility staff.

The Older Americans Act and Systems Advocacy

The federal Older Americans Act established the long-term care ombudsman program and ombudsman mandates. Ombudsman representatives at the state and local programs fulfill several duties. The following references from the Older Americans Act are closely related to systems advocacy:

- **Represent the interests of residents before government agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the residents.**
  
  Example: Participate in coalitions to improve long-term care services and represent the interest of residents.

- **Review and comment on existing and proposed laws, regulations, and other government policies and actions, pertaining to resident well-being and rights.**
  
  Example: Testify at a public hearing to illustrate the impact of a law on long-term care residents.

- **Facilitate the public’s ability to comment on laws, regulations, policies, and actions.**
  
  Example: Share state ombudsman notices of opportunities to comment or testify with the ombudsman network and other advocates.

- **Promote and provide support for the development of resident and family councils.**
  
  Example: Provide councils samples of agendas and bylaws.

- **Carry out other activities the ombudsman determines to be appropriate.**
  
  Example: Respond to state ombudsman requests to comment on proposed state rules about assisted living facility operations.
To assure resident interests are represented to the public and lawmakers, ombudsmen:

- Report complaints and other work as part of state and federal reporting;
- Educate advocacy groups, governmental agencies, and policy-makers regarding the impact of laws, policies, or practices on residents;
- Provide community education or information; and
- Educate other aging service providers, advocacy groups, and the public on long-term care issues.

Additionally the State Long-term Care Ombudsman will:

- Provide leadership to ombudsmen on the statewide systems advocacy efforts on behalf of long-term care residents.
- Provide information to public and private agencies, legislators, the media, and other people, regarding the problems and concerns of residents and recommendations related to the problems and concerns.
- Represent the determinations and positions of the State Long-term Care Ombudsman Program and not necessarily represent the determinations or positions of the State agency where the program is located.

According to Federal Rule [Part 1327.13(a)(7)(vii)], systems advocacy efforts by ombudsmen on behalf of long-term care facility residents do not constitute lobbying activities. “In carrying out systems advocacy efforts of the Office on behalf of long-term care facility residents and pursuant to the receipt of grant funds under the Act, the provision of information, recommendations of changes of laws to legislators, and recommendations of changes of regulations and policies to government agencies by the [State] Ombudsman or representatives of the [State] Office do not constitute lobbying activities as defined in 46 CFR part 92.”

For effective coordination, state and local ombudsmen need to exchange information on systems advocacy issues and activities. Good communication and coordination synchronizes messages and creates a broader impact to align systems with residents’ interests. Based on ombudsman complaint data, the state ombudsman sets a systems advocacy agenda that serves as the basis for local and state systems advocacy.

**Distinguishing Individual and Systems Change**

Making changes can help one person, several individuals, or thousands.

Common complaints ombudsmen investigate have different root causes, such as unanswered call lights (out of resident reach, electrical malfunctioning, short staffing), dental care (neglect, access to dentists, lack of social and health services, lack of information about benefits), or physical restraints (family fears a fall and injury, resident wants to assume certain risks, facility policies). Solving any one of these problems for one person is an example of individual change. If an ombudsman works to change the problem’s root cause and takes into account how the same problem can be avoided in
the future, an ombudsman can help develop a systemic solution to impact many residents.

Outcome for both individual and systems change may appear the same, but difference is apparent over time. Systems change will show a more lasting impact on the problem.

U.S. citizens have the right to vote in local, state, and national elections. Individual and systemic approaches can help ensure this right.

- Individual - arranging transportation for one resident to travel to the voting precinct on Election Day.
- System - arranging for residents in a nursing home to vote via absentee ballots, establishing the nursing home as a precinct voting site, supporting the resident council’s efforts to invite candidates to the home for a debate, and arranging transportation to a voting location on Election Day.

These activities are not directly arranged by an ombudsman, but ensuring the facility fulfills its obligation is action the ombudsman can take to provide individual and systems advocacy regarding voting rights.

---

A resident council discusses their home’s cutting back van travel on weekends. Identify one individual and one systems advocacy approach to resolve this problem.

Individual - ____________________________________________
_______________________________________________________________________

Systems - ____________________________________________
_______________________________________________________________________

---

Moving out of a Nursing Home

Another activity that demonstrates the difference between individual and systems change is the process of a person moving out of a nursing home. This example also shows how individual advocacy may depend first on systems change.
Systems Change

1. A guardian ad litem for two individuals with mental and cognitive disabilities who live in a state institution files a lawsuit for their right for care in an integrated setting. The lawsuit is based on the Americans with Disabilities Act.

2. The U.S. Supreme Court rules in Olmstead v. Zimring that states must provide community-based services for persons with disabilities who would be entitled to institutional services.

3. Governor George W. Bush issues an Executive Order in 1999, requiring the state of Texas to offer community-based alternatives for persons with disabilities.

4. The Texas Health and Human Services Commission develops the Texas Promoting Independence Plan with an initiative allowing an individual with a disability to live in the most integrated care setting available.

5. Governor Rick Perry signs Executive Order RP 13, also relating to community-based alternatives for people with disabilities.

6. The Money Follows the Person (MFP) initiative helps people who receive long-term services and supports in a nursing home or state supported living center return to the community to receive their services without waiting. Texas receives federal funds to help older adults and people with disabilities move out of institutional settings. Ombudsmen help statewide by identifying residents who wish to move and supporting residents with resolving complaints associated with relocation.

7. By 2012, more than 30,000 Texans moved to community-based settings with long-term services and supports.

8. The Minimum Data Set (MDS) version 3.0, Section Q began implementation in September 2010. The assessment tool now asks every nursing home resident in the U.S. about their wishes to live in a community-based setting and requires the nursing home to act upon those wishes. Ombudsmen helped shape the MDS 3.0 assessment tool, trained facility staff, and will monitor for interference with residents’ rights.

Individual Change

1. A resident sits in a wheelchair in the front lobby. She tells everyone who walks by that she would like to go home.

2. During a visit, the ombudsman speaks with the woman about what she would like to do and where she would like to live.

3. She has lived in the nursing home for 14 months, is Medicaid-eligible, and owns her home.

4. Explaining MFP policy, the ombudsman asks if the resident would like to speak with the local relocation contractor.

5. The resident asks the ombudsman to start the process on her behalf. The ombudsman contacts the local relocation specialist.

6. A relocation specialist visits the resident and explains the process of moving out of the home using MFP. The resident works with agencies to prepare for her
move. The ombudsman follows up to monitor progress and respond to the resident’s concerns about the process.

7. The relocation specialist works with nursing home and managed care staff regarding the resident’s needs and arranges for the necessary long-term services and supports. The specialist arranges housing, furnishings, Medicaid-waiver services, and home delivered meals.

8. The resident moves back to her home to receive care. She knows who to call if problems arise and has a network in place to support her. The relocation specialist follows up with her for six months after her return home.

How does the successful relocation of the person described above depend on a systems change?  
______________________________________________________________________

Find two system advocacy activities in the example above in which ombudsmen can participate:  
______________________________________________________________________

Membership Organizations

There are two national membership organizations that support quality of care. Many ombudsmen choose to join.

1. The National Consumer Voice:  
The National Consumer Voice for Quality Long-Term Care advocates for public policies that support quality care and quality of life in all long-term care settings. Signup to receive, via email, the weekly Voice, Action Network alerts and more at this link:  
http://wfc2.wiredforchange.com/o/8641/signup_page/join-us

2. National Association of Local Long-Term Care Ombudsmen (NALLTCO):  
NALLTCO works to organize and provide a common voice for long-term care ombudsmen. More information about NALLTCO can be found at this link:  
http://www.nalltco.org/
Systems Advocacy in Texas

The long-term care ombudsman program in Texas has been active in systems change since the mid-1980s. Some activities have succeeded such as an increase above the $30 federal personal needs allowance and others with limited success such as improving consumer protections for assisted living residents.

Systems within the industry, regulatory services, funding sources, advocacy groups, legal resources, and others may be involved. The needed change will determine which stakeholders must work together to achieve the best outcome.

The following examples demonstrate the:
- stakeholders involved;
- change accomplished; and
- future advocacy needed to resolve the systemic problem.

Example 1: Personal Needs Allowance Increase

Medicaid-eligible individuals who live in nursing homes and assisted living facilities keep some of their income. This is called Personal Needs Allowance (PNA) and they use the money as they choose. The remainder of their income, known as applied income, is paid to the facility for their care.

Federal law established PNA to provide funds for Medicaid residents in nursing homes to purchase goods and services. The federal minimum PNA is $30 a month. State legislatures can appropriate additional funds. On September 1, 1999, Texas increased PNA to $45. Since then, it has been $60, back to $45, and as of 2011, is $60.

- **Stakeholders**
  - Residents and family members
  - Citizen advocacy groups
  - Health and Human Services Commission Office of Medicaid Eligibility
  - Regulatory Services, LTC Ombudsman Program
  - Nursing home and ICF-MR providers

- **Changes**
  - The Texas Legislature enacts laws within the Texas Human Resources Code (HRC) Chapter 32 – Medical Assistance Program; this chapter enables Texas to provide medical assistance on behalf of needy individuals (Medicaid) and to obtain all benefits for persons authorized under the Social Security Act or any other federal act.
  - Policy interpretation is released to clarify PNA for veterans and others.
    - For Supplemental Security Income (SSI) recipients who receive the $30 reduced federal benefit, the state pays the person the remaining $30 to reach the minimum PNA level set by HHSC.
- If a veteran without a spouse or child, or a surviving spouse without a child, is covered by Medicaid for nursing home services, the Veterans Administration pays $90 to the veteran or surviving spouse in addition to the PNA amount.

- Future advocacy
  - Change laws impacting PNA to include a cost of living adjustment to avoid needing to routinely seek statutory change.
  - Monitor for residents who are restricted from using their PNA as they wish and identify policy changes that may be necessary.
  - Monitor for issues of possible financial exploitation related to PNA and continuously educate facility staff of their requirement to report suspected financial exploitation. Continue to educate Adult Protective Services about their role in financial exploitation alleged to have occurred by family or others not associated with the nursing home.

Example 2: Physical Restraint Reduction

A physical restraint is anything that keeps residents from moving around or getting to a part of the body. Residents have the right to be free from physical restraints imposed for discipline, convenience, or when not required to treat the resident's medical symptoms. Family members and facility staff may believe restraints keep people safer.

If used inappropriately, restraints can be harmful. Residents who have been restrained for long periods can have poor circulation, constipation, incontinence, weak muscles and bones, pressure sores, poor appetite, and infections. Restraints can cause agitation, less ability to do daily activities, less social contact, withdrawal, depression, and poor sleep. Some residents have died from restraints.

- Stakeholders
  - Residents and family members
  - Citizen advocacy groups
  - Quality Monitoring Program, Regulatory Services, and LTC Ombudsman Program
  - Nursing homes and assisted living facility providers

- Changes
  - In 2000, Texas ranked among the four states with the highest prevalence of restraint use. A statewide assessment indicated 19.5% of nursing home residents were physically restrained.
  - Nursing home providers, Regulatory Services, Quality Monitoring, and LTC ombudsman programs concentrated education, policy, and practice on restraint reduction.
  - Quality monitors organized training for facility staff, long-term care ombudsmen conducted education programs for families, facility staff revised policies and procedures, and residents and families discussed restraint use in care plan meetings.
• In fall 2005, the Centers for Medicare and Medicaid Services reported restraint use in Texas at 6%.
• In 2012, the Advancing Excellence in America’s Nursing Homes campaign issued new goals. Increase Resident Mobility recognized the importance of mobility to physical and psychological well-being. Staff addressed range of motion, restraint use, fall prevention, and transfer. Consumers, staff, and advocates helped to influence reducing and eliminating restraints.
• Based on resident data, medically unavoidable restraints are estimated at 1-2%. Restraint reduction trials show restraint use can be decreased to 5% or less. Therefore, Texas’ goal is to reduce the occurrence of restraint use to below 5%.
• As of April 2015, the percent of daily usage of physical restraints in Texas is less than 1%.

• Future advocacy
  • In some facilities, restraint use is on the rise, including the use of bed rails.
  • See Consumer Voice material on the dangers of bedrails and provide to resident and family councils as needed. See Consumer Voice information at this link: http://theconsumervoice.org/uploads/files/long-term-care-recipient/PhysicalRestraintFreeCare-FINAL.pdf

Example 3: Consumer Protection for Residents in Assisted Living Facilities

The people who live in assisted living facilities (ALFs) today would have lived in nursing homes 10-15 years ago. ALF residents may be on hospice, have complex medical needs, and many have cognitive impairments associated with dementia of the Alzheimer’s type. While needs have increased, licensure standards do not require ample training of staff, nor provide sufficient consumer protection from discharge or other adverse actions.

• Stakeholders
  • ALF residents and family members
  • Texas Association of Area Agencies on Aging (T4A), Texas Senior Advocacy Coalition (TSAC), AARP, Inc. (formerly the American Association of Retired Persons), and Texas Silver Haired Legislature (TSHL)
  • Quality Monitoring Program, Regulatory Services, and LTC Ombudsman Program
  • Assisted living facility providers, including the Texas Assisted Living Association (TALA) and the Texas Organization of Residential Care Homes (TORCH)
  • Physicians, physician assistants, nurse practitioners, nurses, and unlicensed caregivers
• Changes
  ▪ After stakeholders identified issues related to medications in assisted living facilities, the state began to revise rules with input from the State Long-term Care Ombudsman, and invited stakeholders including local long-term care ombudsmen to form a medication administration work group. All parties agreed on rule revisions for greater clarity. After this accomplishment, the rule process stalled and new rules have not been released.
  ▪ After unanimous support from T4A, TSAC, and TSHL, funding for assisted living long-term care ombudsmen was incorporated in the 2012-2013 and 2014-2015 agency legislative appropriations request. This effort failed due to state budget constraints, but served as the foundation for future requests.
  ▪ In the 83rd Texas Legislature, a request for assisted living facility ombudsman funds was approved for an increase of 1.8 million dollars over the 2014-2015 biennium.
  ▪ In the 84th Texas Legislature, a second request for assisted living facility ombudsman funding was approved. Another 1.9 million was approved for the 2016-2017 biennium, and the previous 1.8 million continues to support assisted living facility ombudsmen.

Future advocacy – ombudsmen can:
  ▪ Use the Long-term Care Ombudsman annual report recommendations to keep the needs of assisted living residents on the minds of stakeholders and lawmakers.
  ▪ Tell the public and lawmakers about the benefits of applying the assisted living facility Alzheimer’s licensure standards for manager and staff training, staffing, and activities to all Type B assisted living facilities. Review the standards in Chapter 92 of the Texas Administrative Code.
  ▪ Support the need to require assisted living facility employees who provide direct care to be Certified Nurse Aides (CNAs). Inform the public and stakeholders about the benefits of trained and certified caregivers on the quality of life and care for assisted living facility residents.
  ▪ Advocate for the need to provide a fair hearing appeal for assisted living residents facing discharge to give assisted living facility consumers protection from illegal eviction.

List two ways you can help the public and lawmakers understand the needs of people who live in assisted living facilities.

1. ____________________________________________
2. ____________________________________________
Example 4: Resident-directed Care

Chapter 14 described person-directed care and culture change. Resident-directed care requires many people to change their attitudes about nursing homes from institutions of efficiency to places where individuals live, thrive, and exercise choice and control. This transformation requires changes in organization practices, physical environments, relationships at all levels, and workforce models. The change from institutional to individual practices does not require radical physical changes or expensive remodeling. In fact, it does not have to cost anything, but must be supported by direct care providers and management.

Ombudsmen can play an important role in a home’s decision to implement resident-directed care and to change their culture from an institution to a place to thrive.

- **Stakeholders**
  - Residents and family members
  - citizen advocacy groups
  - Quality Monitoring Program, Regulatory Services, and LTC Ombudsman Program
  - Nursing home and assisted living facility providers, including the Texas Health Care Association (THCA) and LeadingAge Texas

- **Changes**
  - Several early models of this change were presented at the 1995 National Consumer Voice conference. One outcome was the Pioneer Network.
  - At the invitation of the Texas State Long-term Care Ombudsman, the Pioneer Network Board of Directors conducted training for providers and ombudsmen in San Antonio in 2002.
  - In 2006, CMS provided national guidance to support facility implementation of culture change. The federal State Operations Manual includes guidance that encourages person-directed care and other elements of culture change.
  - The state hosted regional joint training on individualized care for providers, regulatory services staff, and long-term care ombudsmen; provided at no charge.
  - In 2010, state agency staff interested in moving nursing homes from an institutional to a person-directed model created a Culture Change Initiative. The group’s mission is to promote and support nursing home providers as they transform from a traditional system-directed culture to one that is person-directed or centered. For resources, go to www.dads.state.tx.us/culturechange.
  - In July 2010, the Texas Culture Change Coalition (TxCCC) was formed. The statewide membership of consumers, providers, advocates, agencies, and organizations is dedicated to culture change in a variety of aging and disability service provider types, including nursing homes and assisted living facilities.
In 2014, Texas Administrative Code was changed to reflect a new state law to encourage building small home nursing homes. (Small house waiver: TAC §19.2232(h)(9) and Small house requirements: TAC §19.345)

Exercise: Future Advocacy

Promote resident-directed care. Brainstorm ideas for systemic change in your assigned facility. Consider the following areas:

- Meal service: ______________________________
- Bathing and hygienic experiences: ______________________________
- Social activities: ______________________________
- Sexual intimacy: ______________________________

In general, what is one change that could provide all residents with an opportunity to exercise more choice and control?

Example 5: Reducing Unnecessary Antipsychotics in Nursing Homes

Texas holds the dubious status of being one of the worst nursing home state for its use of antipsychotic drugs. About 26% of all long-term care residents are on an antipsychotic drug. Nationally, there has been a 15% reduction in the prevalence of antipsychotic use for long-stay residents between 2011 and 2012. Texas has only reduced use by 8.1%.

The Texas Legislature recognized the need to improve person-centered care in Texas nursing homes and directed the state regulatory agency to conduct a pilot project to help nursing homes understand, consider, and implement resident-centered care. This pilot project will be completed concurrently with a statewide training and support effort lead by the Quality Monitoring Program.


• Stakeholders
  ▪ Residents and family members
  ▪ Citizen advocacy groups
  ▪ Quality Monitoring Program (QMP), TMF Health Quality Institute, and LTC Ombudsman Program
  ▪ Nursing home providers

• Changes
  ▪ CMS launched a 2012 initiative: *Improve Behavioral Health and Reduce the Use of Antipsychotic medication in Nursing Home Residents.*
  ▪ The *National Partnership to Improve Dementia Care* training for surveyors was released and changes to the CMS State Operations Manual were made. Changes set expectations of dementia care that does not rely on chemical restraints or misuse of drugs to sedate dementia residents.
  ▪ In 2013, local program staff ombudsmen were trained in CMS *Hand in Hand: A Training Series for Nursing Homes.* *Hand in Hand* addresses how to better understand and how to provide improved care for residents with dementia. Ombudsmen can train any facility using these materials.
  ▪ In 2014, QMP, TMF*, and the Long-term Care Ombudsman program launched an initiative to reduce the unnecessary use of antipsychotic medications and improve dementia care in Texas nursing home residents: *Get on Board the TRAIN (Texas Reducing Antipsychotics in Texas).*
  ▪ Phase I provided one-day training sessions to nursing home staff in 10 regions throughout the state.
  ▪ QMP visit strategies were changed to include antipsychotic medication usage and pain assessment for people with dementia.
  ▪ In 2015, QMP, Regulatory Facility Liaisons, TMF Quality Improvement Organization, Quality Innovation Network consultant staff, and members of the Texas Advancing Excellence Campaign Local Area Network of Excellence recruit nursing homes into Phase II of the project, where individualized assistance and support will occur.
  ▪ Phase II includes: special focus visits with individualized assistance and support, regional nursing home staff peer to peer meetings, dementia care certification, and person-centered care classes.
  ▪ In 2015, ombudsman basic certification training incorporated the Hand in Hand training to ensure all certified ombudsmen understand and promote the principles of individualized dementia care.

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*TMF Health Quality Institute (TMF) is a federally funded Austin, Texas-based consulting company focused on promoting quality health and quality care through contracts with federal, state, and local governments, as well as private organizations.*
Name the training material that ombudsmen can deliver to long-term care staff.
CMS __________ _____ __________.

Long-term care ombudsmen have been and continue to be active in systems advocacy issues. When systems change, ombudsmen watch to assure the change is implemented as intended and resident quality of care and life are improved.

On Your Own: *Reducing Antipsychotic Drug Use – A Story of Hope*

Reducing antipsychotics in Texas nursing homes is possible. Watch the YouTube video *Reducing Antipsychotic Drug Use – A Story of Hope*. Use the link below.

Follow this link: [https://www.youtube.com/watch?v=wjSVY3kf9S8&app=desktop](https://www.youtube.com/watch?v=wjSVY3kf9S8&app=desktop)
Run Time: 7 min 48 sec

Name one thing Town and Country changed or implemented in their nursing home to reduce the use of antipsychotics.
Notes:
Notes: